

# Investigating Culturally Competent Reflective Practice in Diabetes Healthcare

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### Abstract

Cultural competence is a relatively recent term describing appropriate ways of working with increasingly diverse cultures in society. By interviewing diabetes practitioners, this study sought to investigate the interaction between scientific knowledge and the practice of diabetes healthcare with patients from non-Western cultural groups.

A purposive sample of 22 participants (21 females and one male) included 18 nurses specialising in diabetes care, three psychologists and one dietician. Their ethnic backgrounds were 15 Anglo Australians; 5 Chinese; one Vietnamese, Egyptian and Dutch. Ages ranged from 27 to 59 years with a mean age of 45.7 years. Seventeen practitioners were in the 40 to 60 year age range.

Diabetes practitioners' unique perspectives were sought as a guide to investigate the context and complexity of their practice. Grounded theory was used with references from the academic literature, combined with constructionist approaches, to create a framework suitable for analysis of the data.

In response to their patients' cultural diversity diabetes practitioners developed skills complimentary to their evidence-based practice training. It was found through a reflective and patient-centred orientation, practitioners reported challenging the status quo of Western scientific ideology to reflect on their own and others' belief systems, power relations, communication, and psychological perspectives. Aristotle's rarely discussed concept of *phronesis*, or ethical knowledge, was a useful concept in the dynamic *culturally competent reflective practice* model describing practitioners' ethical and reflective practice. This study may also contribute to the larger debate in healthcare practice regarding flexibility versus fidelity in evidence-based practice, and to a greater understanding of the unique challenges faced by culturally focused interventions.

## Declaration

I, Peter Murray Abraham, declare that the Doctor of Psychology (Clinical Psychology) thesis entitled *Investigating Culturally Competent Reflective Practice in Diabetes Healthcare* is no more than 40,000 words in length, including quotes, exclusive of tables, figures, appendices, references, bibliography and footnotes. To the best of my knowledge and belief, this thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature:

Date: 31<sup>st</sup> January 2012

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### **Preamble: Forming Relationships**

As I write this thesis I continue to teach and counsel at risk adolescents in a school that caters for what are often called “too hard kids” from the Western suburbs of Melbourne. I always interpreted my educational work from a psychological perspective and my psychology studies translate well into my teaching practice.

I had the view that *communication competence*, acceptance of “difference” and reflection, applied to both my teaching practice and to healthcare. The requirements of practice in both areas involved a humane approach that was respectful, empathic and attentive to power relationships. For me this meant forming links between my knowledge, training and my practice with others and with their different lifeworlds. I refer to lifeworlds as all the immediate experiences, activities, and contacts that make up an individual’s world (The Australian Concise Oxford Dictionary of Current English, 1997). Without this reciprocity between practitioner and patient in healthcare, the “voice of medicine” (Mishler, 1984, p.6) imposes knowledge, power and authority into practice. I find this “assumed authority of knowledge” unacceptable, nor useful, to effective education or healthcare practice.

When I began this study there was research momentum at my university focusing on new approaches to healthcare practice, especially in diabetes healthcare and culture. It was argued that the delivery of *evidence-based practice* alone was not sufficient for adequate treatment. This different approach was referred to as *cultural competence*, and its input to practice was in response to the increasing prevalence of this chronic disease with patients from culturally and linguistically diverse backgrounds. This thesis investigates how health practitioners navigated the complex practice of working with patients from different cultural backgrounds.

After all interviews were transcribed, my supervisor moved to another university. However, my new supervisor had a reputable background in cultural issues. Associate Professor Christopher Sonn brought awareness to the broad sense of principles he held in psychological practice especially his regard for equity, diversity and empowerment. I believe his principles were compatible with a practitioner's sympathetic view to engage and empower patients from culturally and linguistically diverse backgrounds.

## Chapter 1

### Introduction

This study sets out to investigate the experience of healthcare practitioners who work in a cultural context with diverse cultural populations. There has been extensive and important research relating to diabetes care with Australian Aboriginal and Torres Strait Islander people as well as culturally and linguistically diverse (CALD) populations. Although it is crucial that practitioners be culturally competent when working with Aboriginal and Torres Strait Islander people, this study focuses exclusively on practitioners who work with CALD communities.

Practitioners' educational tradition was evidence-based or biomedical science-based. At the time the interviews were conducted, their specialist training curricula did not integrate cultural issues. As a result, practitioners reported developing their own culturally oriented approaches to deliver healthcare.

Conventional healthcare in Western society involves *evidence-based practice* (EBP). This informs the specialist training required working with patients' specific needs. Diabetes practitioners include generalist nurses, practice nurses, Indigenous health workers, and allied health professionals including psychologists. Their training primarily focuses on facilitating effective management of blood glucose control. This incorporates not only dissemination of medical knowledge essential to the patient's management regime, but also consideration of the patient's personal welfare. Focus is on the individual and the family to maximise the patient's ability to manage effectively their blood glucose levels at a healthy level.

The increasing prevalence of diabetes globally has brought about the need to consider new ways of practicing healthcare. Individuals from non Euro-Western cultures who

encounter scientifically trained health practitioners often do not respond to treatment. They might understand health or respond differently to treatment because their culture may hold different views. The urgency of implementing evidence-based health interventions is not in dispute. *Evidence-based research* informs Western scientific thinking and provides the framework of reference for healthcare practice that is seen as the most effective way to treat most known diseases. This viewpoint applies to both diabetes health and to mental health. However, the positivist (scientifically verified) approach is not deemed to be sufficient, and inclusion of a constructionist (where phenomena are interrelational and dynamic) approach to compliment established healthcare practice is now argued by Breen and Darlaston-Jones (2010) to be relevant.

Jürgen Habermas' (1987) *Theory of Communicative Action* also informs the focus for this study. Habermas belongs to those contemporary "master thinkers" who cannot be located in one specific division of academic disciplines. His works cover a broad field of human and social sciences: philosophy, ethics, social theory and sociology, political theory, law and legal theory (Tuori, 2011).

In his *Theory of Communicative Action*, Habermas provides a unique focal point for thinking and reflecting on data from participants who practice healthcare with diverse communities. Habermas identifies the power of language and communication, and how healthcare professionals in Western cultures use it systematically in power relations with patients. This thesis draws on his study and raises the implications of the voice of medicine and the systematic disempowerment of individuals as a relevant argument contributing to the promotion of *culturally competent reflective practice* in healthcare.

The thesis draws its knowledge and perspective by asking questions of those professionals whose healthcare practice brings them face-to-face with patients from diverse cultural backgrounds. These will focus on EBP and its limitations, hierarchy and

practitioners' reports of patient perception of their work. Through interviews with practitioners, many assumptions of evidence-based practice are examined. There is also an examination of practitioners' experience of communication with patients from differing cultures; of practice focusing on many aspects of their work including respect for cultural and religious differences, and systems of belief. This analysis reveals the respect and power given to patients by practitioners and highlights the efficacy of patient-centred culturally competent reflective practice. It also focuses on the importance of the role and values of practitioners in all areas of multicultural healthcare practice.

Practitioners' experiences with patients from culturally and linguistically diverse backgrounds are outlined. In addition, there are practitioners' views on the presence of cultural competence in healthcare training, and also explanation of culturally competent reflective practice learnt "in action" (whilst consulting patients). There is also recognition and illumination of interpreters' skill in communicating with patients from different cultures. To complement EBP, the efficacy of patient-centred and holistic approaches to practice is highlighted. This is coupled with emphasis on the overall importance of forming respectful and empathic relationships with patients from differing cultures. This ethical approach relates to the Aristotelian concept of *phronesis*, which is expanded on in Chapter 2 and discussed as relevant to the findings and interpretation and discussion in Chapters 5 and 6.

The thesis will investigate healthcare perspectives within a cultural context, with reference to professional practice as a common thread throughout. It is a qualitative study drawing from the perceptions and experiences of diabetes educators on the issues relating to understanding different cultures (culturally competent practice). The study captures the interaction that occurs between practitioner and patient, especially patients from culturally and linguistically diverse backgrounds. A purposive sample of volunteer diabetes educators, psychologists and a dietician were recruited via their workplaces.

Research questions ask practitioners what importance they place on EBP; to identify knowledge gaps between training and practice; and how they adapt their EBP to work with multicultural groups.

The overarching aim of this thesis is to investigate the interface between culture and EBP in diabetes healthcare. The primary focus is to investigate if culturally competent reflective practice is particularly beneficial to improve the health and wellbeing outcomes in practitioners' work with patients from culturally and linguistically diverse backgrounds.

### **Structure of Thesis**

The introduction in Chapter 1 gives an overview of this thesis. In Chapter 2, the literature review presents relevant studies and literature in the field from a global and Australian perspective relating to multicultural healthcare policy and practice. It also introduces cultural competence healthcare models. There is a brief outline of Jürgen Habermas' (1987) *Critical Theory of Society and Communication*, which extends debate on effective and humane communication in all spheres of society, including healthcare practice. Chapter 3 outlines the methodology. The researcher presents their epistemological perspective, which also emphasises the importance of the role and values of a psychologist in practice. Chapter 4 follows with a description of the research process, data collection, and method of analysis. Chapter 5 presents relevant findings and interpretation drawing on the literature to examine the data gathered from participants. A link was made between examples of existing cultural competence models and practice as reported by participants. Chapter 6 discusses the findings and interpretation, followed by a summary and conclusions.

## **Chapter 2**

### **Literature Review**

The preamble and previous chapter outlined the basis for the genesis of this thesis. It included a description of my professional background, which focused on engaging with others who have different backgrounds and systems of belief to my own. In addition to that, my belief in the importance of engaging others and forming relationships professionally requires a wide range of skills that also takes into consideration gender, social politics, power relations, and culture. In the context of practice and healthcare, this thesis set out to investigate these areas of interest and the presence of other underlying dynamics. This was followed by a thesis overview.

Drawing on a range of relevant national and international studies, this chapter briefly defines Diabetes Mellitus as well as outlines the development of multicultural healthcare policies to deal appropriately with the international prevalence of diabetes. Movement of populations globally have gradually influenced the focus of healthcare practice to include cultural perspectives. The chapter also outlines arguments claiming that the interactions between individuals and groups need to be reassessed, especially between professionals and their clients or patients, to take account of cultural difference. This is followed by examples and comparisons of culturally focused models of care, leading to the research questions underlying the structure of the thesis.

#### **Diabetes Mellitus**

Diabetes Mellitus (Type 2 diabetes) is a chronic metabolic disorder (Churchill's Illustrated Medical History, 1989) of the endocrine system that affects the body's capacity to manufacture or properly use insulin (Taylor, 1995). It is highly prevalent in society and the

incidence of Type 2 diabetes (described below) in communities is increasing worldwide. It is characterised by abnormal levels of blood glucose (Livneh & Antonak, 1997). The global incidence of diabetes is rising and the number of people affected is projected to exceed 300 million by the year 2025 (World Health Organization, 2006). To successfully manage this chronic disease the patient is required to make significant lifestyle changes. This includes management of medication, maintenance of healthy diet, and engagement in age and abilities-appropriate physical activity.

Type 2 diabetes affects more people than those affected by Type 1 diabetes. The World Health Organisation predicted that in the years of 2000-2025 the number of Type 2 diabetes patients was going to double (Domza, Drzewicka, & Pasternak, 2004). This gives rise to a conclusion that diabetes prevention is becoming one of the priority tasks of all medical professionals. The way this is carried out requires modifying or creating more effective preventative strategies and interdisciplinary practices to encompass a cross-cultural context.

### **Healthcare: Global Perspective**

In 1989 the World Health Organization, Forty-second World Health Assembly adopted resolutions on the prevention and control of diabetes mellitus, and in 2004 adopted a global strategy focusing on diet, physical activity and health (International Diabetes Federation, 2006). The World Health Organisation brought together researchers to develop and produce a cross-cultural measure of quality of life for use in health and healthcare. Importantly, it was based around a reflexive methodology that placed assessment of the consumer at the centre of healthcare (Skevington, Sartorius, & Amir, 2004), which is an empowering patient-centred approach.

In 2006, the United Nations recognised the urgent need to pursue multilateral efforts to promote and improve human health, and to provide access to treatment and health-care

education. Specifically, in relation to diabetes care, a resolution was adopted by the United Nations General Assembly to designate 14<sup>th</sup> November, the current World Diabetes Day as a United Nations Day. Since 2007 this has been observed every year (United Nations General Assembly, 2007).

A significant challenge to the treatment of diabetes worldwide is control and management of symptoms. With regimen management as a major problem, a multidisciplinary, multicultural approach to treatment is required. Consequently, health psychologists are often involved in identifying barriers and promoting successful self-care for patients in multicultural contexts (McNabb, 1997).

### **Diabetes Care**

Diabetes is a global problem of increasing proportions and requires keeping to tight treatment targets to effectively help manage blood glucose levels (Hill, 2005). The primary goals in treating patients with diabetes are maintaining blood glucose levels as close to normal as possible and making a relatively normal quality of life achievable. Both of these goals are influenced by a multitude of somatic, psychological and cultural factors that should be seen as building a complex network (Rose, Fliege, Hildebrandt, Schirop, & Klapp, 2002; Jeffreys, 2006; Chong, Renhard, Wilson, Willis & Clarke, 2011).

By 2030, it is predicted that Type 2 diabetes will affect 4.4% of the world's population, an estimated 366 million individuals. Educating the patient about the importance of lifestyle change, and ensuring that lifestyle and pharmacological interventions are sustained, are important components of effective care. Choosing therapies that enable patients to reach their treatment goals with a simple dosage regimen may also help to maximize patient concordance. Individualized care, in which the patient becomes fully engaged with their treatment plan and personal goals, appears attainable. This may help to reduce the

projected burden of Type 2 diabetes and its complications on healthcare services in the future (Adiseshiah, 2005).

### **Diabetes Mellitus in Australia**

Diabetes is also recognised as an important health problem Australia-wide, paralleling the prevalence in most countries, particularly in Western countries (Mathur, Gajanayake, & Hodgson, 2000). More than one million Australians are expected to develop diabetes over the next fifteen years unless effective prevention strategies are implemented (Mathur et al., 2000). It is estimated there are approximately 42,000 new cases of diabetes per year and his number is expected to increase by 50% every 15 years (Australian Diabetes Foundation, 1986). Further, there is a prevalence of diabetes among Aboriginal populations with a dramatic increase in its incidence occurring. This increase means there are growing demands for knowledge, and also for appropriate and effective culturally competent practice by professionals to support patients in managing their diabetes.

It is a disease that can lead to poor quality of life, disability and premature mortality. The situation is worsening with lifestyle issues of diminishing physical activity and obesity, particularly in children (Armstrong, Bauman, & Davies, 2000). De Courten, Dunstan, Cameron, Welborn, and Zimmet (2000) suggest that in Australia, one in four people over twenty-five years of age have an impaired glucose metabolism or diabetes. The considerable proportion of cost to healthcare expenditure, including the on-going complications of the disease, accounts for 2.2% of total health system costs (Mathur et al., 2000).

Type 2 diabetes and its associated consequences are endemic in our society. It has become an indicator of the state of Australian public health. The Australian Burden of Disease Study considered the combined impacts of mortality, disability, impairment, illness and injury arising from over 176 diseases. It indicated that diabetes was the seventh leading cause of burden of disease and injury in Australia in 1996 (Australian Institute of Health &

Welfare, 1999). Thus, diabetes was estimated to be responsible for 3% of the total burden of disease in Australia, (Mathers, Vos, & Stevenson, 1999). The report added that if the burden of cardiovascular disease attributable to diabetes was included with diabetes, its total attributable disease burden increases to 4.9% (Mathers, et al., 1999). Consequently, diabetes is the third leading cause of disease burden in Australia. This finding implies a physical and psychological burden that underlies the experience of having diabetes and suggests that the combination of these can result in significantly detrimental impacts on health and wellbeing. Considering the associated human and fiscal costs that permeate all areas of people's lives, the outcomes are bleak for society and are a concern to all.

Promoting self-management of diabetes through collaborative goal-setting skills-enhancement reflects an approach to diabetes care that encompasses an ecological approach (a holistic and interactive approach), as compared to delivery of healthcare focusing on medical facts alone (Fisher et al., 2005).

Therefore, it is important to collaboratively engage diabetes patients in promoting changes in their lives. This requires patients to understand their disease and set new goals for self-management. These changes can be very difficult to cope with and can have a profound effect on one's sense of self and of the world around them. Therapeutic education is part of a humanist medical approach centred on patients, which allows them to take care of their own treatment in order to improve their quality of life and deal with potential complications. The healthcare providers teach, train, negotiate, motivate, and accompany their patients in the long-term follow-up of their diseases (Golay, Lager, Chambouleyron, & Lasserre-Moutet, 2005).

The prevalence of diabetes in Aboriginal and Torres Strait Islander people is very high, and acknowledgement of their differing belief systems and the diversity of their disadvantaged circumstances are imperative. Further, in more recent times, due to the influx

of immigrants to Australia from different cultures and diverse cultures, it has become increasingly important to not only focus healthcare centred on patients taking care of their own treatment, but to also focus on patients' belief systems. Previous assumptions about what constitutes Euro-Western scientific healthcare does not now necessarily apply to all patients. It appears that an approach to practice is needed that is more responsive to the healthcare needs of patients from different cultures.

### **Policy and Culture**

Inequities occur as a result of the consequence of differences in opportunity, such as unequal access to health services (World Health Organization, 1998). By exercising recognition of justice and equity in making healthcare available to all Australians, the planning of health services must be influenced by demographic and health trends toward reducing disease and disability. Qualitative research and quantified measures of health status and utilization can both be used by policy makers to evaluate the adequacy and effectiveness of existing programs, and to plan new strategies (Shui & Singh, 2008).

The definition of healthcare focuses on the physical and mental dimensions of health. Currently the World Health Organisation's definition of health is most often cited as the ideal for healthcare delivery systems. It defines health as "a complete state of physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organisation, 1946, p.94). This definition specifically identifies social *wellbeing* as vital to one's health. In doing so, it emphasises the importance of positive social relationships. The World Health Organisation's (1946) definition recognises that optimal health is more than a mere absence of disease or infirmity and is referred to as the biopsychosocial model of health. The World Health Organisation (1946) has also defined a healthcare system as all the activities whose primary purpose is to promote, restore, or maintain health. It appears that healthcare should include much more than medical care. Thus, healthcare would include a

variety of services such as psychological help to help improve a person's health and wellbeing. Consequently, wellbeing in healthcare brings forth many other dimensions of care to include recognition and respect for difference, especially in Australia's increasingly diverse multicultural society.

It is an essential human right for everyone to express freely their own cultural values.

People having different cultural values should be respected in terms of their cultural values and the healthcare they are to be given should be offered considering this fact (Tortumluoglu, 2006, p.11).

Health inequalities exist for many culturally and linguistically diverse background (CALD) communities and Aboriginal people. There are conventional preparations for practice that is best described as evidence-based. The National Health and Medical Research Council (2006) report found there was a need for evidence in developing healthcare strategies for Australia's population, but there was a lack of evidence-based practice around research including individuals from CALD and Aboriginal backgrounds. Further, there were many gaps in the evidence-base, both in terms of research on intervention, and the more serious issue that individuals and groups from CALD and Aboriginal backgrounds were being systematically excluded in research. This appeared to be due to the challenges and additional investments required to ensure their participation. At the time of the report it was found there was work underway across Australia in culturally appropriate health promotion and health interventions, but research issues, methodologies and rigour vary widely. It was also acknowledged that additional work is required with Aboriginal and Torres Strait Islander people. (National Health & Medical Research Council, 2006).

In response to these disparities, Australia became more responsive to the needs of people from diverse backgrounds. Policies exist at National, State and Territorial levels that enshrine the right of all Australians to equal access to health services that meet their needs.

Despite these policies the health system is challenged to meet the needs of a population with a broad range of cultural and linguistic backgrounds. Implementing policies effectively to ensure equity and access to health promotion, healthcare and social services for a diverse population requires action at every level of the health system (National Health & Medical Research Council, 2006).

In Australia, the National Health and Medical Research Council (2006) observed the development and implementation of numerous multicultural policies and programs over the past 30 years. Furthermore, there has been improvement in the overall responsiveness of healthcare services to the complex needs of people from diverse cultural and language backgrounds. Despite this, Johnstone and Kanitsaki (2008) argue:

There is emerging evidence and increasing recognition by those in the field, that people of minority cultural and linguistic backgrounds in Australia, including Indigenous Australians, are generally underserved by local healthcare services, experience unequal burdens of disease, confront cultural and language barriers to accessing appropriate healthcare, and receive a lower level and quality of care when they do access healthcare, compared to the majority population (p.177).

Consequently, the delivery of general healthcare in Australia is not well adapted yet to culturally competent practice. Until recently, there had been some concerted efforts to develop policies to address this (The National Health & Medical Research Council, 2006). Due to diabetes' high international prevalence and Australia's multicultural population growth, there is now a cultural focus in delivery of care beginning to be formally addressed in this area. These recent developments can also provide scope for culturally competent practice in many other areas of health.

Despite this, politically there are many problems and complexities that appear to be in a constant state of flux. Policies are being introduced that exclude immigrants from specific

cultures who reported as being sick, in poor health or for other reasons. For example, in 2010 Indian and Sri Lankan's seeking to immigrate to Australia were being refused entry into the country (Foster, 2010). This policy may change within twelve or twenty-four months according to the prevailing political viewpoints or effectiveness of pressure groups.

### **Healthcare in a Cultural Context**

There are societies in every continent that are holding on to their traditions, cultural practices, and most importantly, their language (Monk, Winslade, & Sinclair, 2007). This means that the integrity of differing cultures needs to be understood and respected.

Communication through speech is elemental to sociocultural life. Since "speech is the distinctive and pervasive medium of life at the human level, the theory of communication is the foundation study for the human sciences ... It discloses the universal infrastructure of sociocultural life" (McCarthy, 1984, p.282)." These perspectives are clearly elemental to the discipline of psychology.

"The subject does not speak, it is spoken" (Verhaeghe, 2004, p.56). This was a description by French psychoanalyst Jacques Lacan for his assertion that we are divided in so many ways that we are not consciously aware. We use language in ways that reflect our past, our experience, socio-historical background or culture. They all influence us so deeply that even our thoughts are not our own, but the outcome of our forebears and development history. In effect, we seldom think for ourselves. Our language and very way of thinking are given to us (Monk, Winslade, & Sinclair, 2007).

Culture is a system of behavioural patterns that are shared by members of a given group (Lynch & Hanson, 1992). These behaviours are learned through a process of enculturation, where the younger generation is guided in taking up the culture's ways of thinking and behaving. Each culture provides a flexible framework for its members to interact with each other and the environment. An individual's culture also prescribes

meanings for abstract concepts and symbolism. For example, culture can prescribe the meaning and the cause of health, sickness or death. Dupre and Goodgold (2007) assert that only when evaluated within the context of the individual's culture can behaviours be viewed as adaptive or maladaptive. Nevertheless, not everybody within a culture should be expected to think and behave the same.

Culture has been defined by Betancourt, Green and Carillo (2002) as:

An integrated pattern of learned beliefs and behaviours that can be shared among groups. It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs. Culture is shaped by multiple influences, including race, ethnicity, nationality, language, and gender, but it also extends to socioeconomic status, physical and mental ability, sexual orientation, and occupation, among other factors. These influences can collectively be described as sociocultural factors, which shape our values, form our belief systems, and motivate our behaviors (p.1)

Culture is also said to be a multi-dimensional construct with influences occurring at regional, community, family and individual levels. Cultural influences occurring at the regional level include spoken language with its dialect and common phrases and idioms, and also the choice of diet due to cultural and religious beliefs. For example, fasting is a requirement during the Muslim religion's Ramadan. Community level examples of cultural influences are socioeconomic background and types of housing. Also in lower socioeconomic neighbourhoods with multifamily households, it is common for residents to know each other and shop in the same venues. On the other hand, upper-middle class residents usually live more separately and may have little contact with their neighbours (Black & Purnell, 2002).

Culture is reflected on a family level through the family power structure, spiritual or religious worship, and the ways in which stress is manifested. For example, in families that

follow traditional gender role models, the father typically has the final authority. At the individual level, cultural influences include coping methods and socialisation. For example, one study revealed a cohort of Chinese migrants to Australia reported rarely sharing their problems and feelings outside the immediate family, or among close friends (Black & Purnell, 2002; Dupre & Goodgold, 2007; Blignault, Ponzio, Rong, & Eisenbruch, 2008).

Cultural pluralism is often used interchangeably with multiculturalism. Monk, Winslade, and Sinclair (2007) argue there are signs in discourse that may lead us a step beyond multiculturalism and biculturalism. It is an equal partnership founded on a partnership between the indigenous people and the former colonists. This idea had the greatest currency in New Zealand with Maori people. This contrasted with the earlier treaties made by those who colonised Australia and Indigenous Australians were subjected to a drive for assimilation into a domineering white society.

A commitment to cultural competence in Australia is to respectfully engage people from all cultures in an ongoing process involving a willingness to improve cross-cultural communication and practice. It extends elements of cultural respect, cultural awareness, cultural security and cultural safety. Cultural competence and cultural safety are also used widely in Indigenous and CALD health contexts and “they form the basis for effective patient centred care and the professional advocacy role of the general practitioner” (Nguyen, 2008, p. 990).

Cultural respect is considered a fundamental element of cultural competence involving the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples. Cultural respect is about shared respect where the healthcare system is a safe environment for Aboriginal and Torres Strait Islander peoples (Walker & Sonn, 2010).

Clear (2008) cited in Walker and Sonn (2010) makes the significant point that culturally safe practice focuses on clinical practice that is effective for a person from a different culture. Also, that unsafe cultural practice disempowers, demeans and diminishes the cultural identity and wellbeing of an individual'. "Importantly, for individuals, cultural competence requires more than becoming culturally aware or practicing tolerance. It can be defined as ability to identify and challenge one's own cultural assumptions, one's values and beliefs" (Walker & Sonn, 2010, p. 161.) To create a culturally safe space involves a high level of critical reflexivity, as practitioners may not always be aware of how their behaviour and method of interaction could make people from different cultures feel unsafe, with negative consequences for client access and continuity of care (Walker & Sonn, 2010).

### **Why Culturally Competent Healthcare in Australia?**

According to the 2005 *Census of Population and Housing*, Australians (22% of who were born overseas) overall claim more than 250 ancestries, speak over 400 different languages at home, and practice over 116 different religions (Australian Bureau of Statistics, 2006). Although the majority of Australia's population originates from English-speaking countries and is English speaking, a significant minority (over 19% of people) do not speak English at home and may have difficulty communicating in English outside of the home context. For example, in mainstream healthcare contexts where a patient's English language skills need to be at a high level of competency (Allotey, Manderson & Reidpath, 2002).

Johnstone and Kanitsaki (2008) point out that:

Australia is positioned as one of the most multicultural countries in the world. This is a profile that is likely to develop further with changing migration and refugee and asylum-seeking patterns, enlightened approaches to cultural diversity, and with the identification and understanding of ethnicity becoming more enlightened and sophisticated (p.176).

For those working in the area of healthcare, there are both problems and opportunities. The realities of the problems are clear when it is considered that the emergency presentation and hospital admission rates for people with English as a second language in metropolitan health services in Melbourne and Sydney, as the most culturally diverse cities in Australia, is often close to 50% of all emergency and hospital admission rates per annum (Johnstone & Kanitsaki, 2008).

Aboriginal people comprise a significant percentage of those seeking help and needing healthcare where there are high levels of miscommunication.

### **Developments in Care and Practice**

#### **Cultural competence.**

Through ongoing immigration Australian society has become increasingly more culturally and linguistically diverse. Consequently, for research to represent Australians there is a need for research to operate effectively in a multicultural context (Ethnic Communities' Council of Victoria, 2006).

Earlier this millennium there were mixed views regarding the efficacy of cultural competence in healthcare. Betancourt et al. (2002) revealed that:

Few studies made a direct link between cultural competence and the elimination of racial/ ethnic disparities in healthcare. However, experts in government, academia, and community healthcare, make a clear connection between cultural competence, quality improvement, and the elimination of racial/ ethnic disparities (p.6).

Views on adequate healthcare practice, both internationally and in Australia, have focused on addressing the needs of multicultural populations including Indigenous Australian and Torres Strait Islander populations. To be effective this requires a shift in thinking about the delivery of healthcare. Cultural competence has emerged as a very important concept.

Cross, Bazron, Dennis and Isaacs (1989) describe cultural competence as, “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations” (p.13). Additionally, Betancourt et al. (2002) describes cultural competence in healthcare as, “... the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (p.5).

Cultural competence may claim to assume that knowledge and skills related to a particular culture are required for working with members of that culture. The purpose of this framework was to foster constructive interactions between people of different cultures. However, this assumption has since been challenged and it is now generally recognised that cultural competence for one population may not translate to another. It is a way of working rather than using set skills and culture-specific knowledge (Kim, Kim & Kelly, 2006; Ranzijn, McConnochie, Day, Nolan & Wharton, 2008; Sue, 1999; Sue, 2006).

Jeffreys (2006) views cultural competence as an ongoing, multidimensional learning process that integrates transcultural skills in three dimensions; cognitive, practical, and affective. This involves self-efficacy, or confidence, as a major influencing factor and aims to achieve culturally congruent care in others. Further, Rose, Fliege, Hildebrandt, Schirop, and Klapp (2002) found self-efficacy was the most relevant for patients achieving their primary treatment goals.

It is widely known that Australia’s population is culturally diverse. “All Australians have the right to healthcare that meets their needs and that ... cultural issues need to be central to every level of the health system in all areas, which include systemic, organisational, professional and personal” (National Health & Medical Research Council, 2006, p 39). Furthermore, a culturally competent approach to education and treatment of disease is an

important consideration in a country like Australia where over 40% of the population has English as a second language. Cultural competence is much more than awareness of social differences. It focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services. To become more culturally competent, a system needs to: value diversity; have the capacity for cultural knowledge; and adapt to service delivery so that it reflects an understanding of the diversity between and within cultures (National Health & Medical Research Council, 2006).

### **Culturally competent practitioners**

Culturally competent practitioners should be trained to be “self-reflective” (Betancourt et al., 2002, p.6). If not trained, they are still likely to have undergone a process of self-reflection to understand the impact of their personal cultural identity on his or her practice. This may typically involve the health professional focusing on positive messages, such as appropriate foods and food preparation techniques from their patient’s culture of origin and the host country. A *reflective practitioner* might also reconsider their approach and seek expert CALD background input with specialist medical and allied health professional advice. This would occur when an individual finds that patients from a particular CALD background do not respond to dietary information and instructions for diabetes management (Betancourt et al., 2002).

People who live in Australia come from diverse social, political and economic backgrounds. Consequently, they have a wide range of experiences, behaviours, and beliefs in relation to health and illness. The impact of colonisation, settlement and acculturation varies widely depending on their experience and situation. As a result, the health and wellbeing of CALD communities depends on a complex balance of social, economic, environmental, individual risk, and protective factors. Policies exist at National and State, or

Territorial levels that enshrine the right of all Australians for equal access to health services to meet their needs (National Health & Medical Research Council, 2006).

### **Cultural competence in healthcare training.**

Initially, few studies found direct links between cultural competency and healthcare improvement. Betancourt et al. (2002) found, “medical literature that does make an explicit connection centers on the need to address language barriers between providers and patients and to train providers to care for diverse patient populations” (p.6).

Healthcare cultural competence models in the USA cited by Lipson and Desantis (2007) as very effective were by Purnell (2002), and Giger and Davidhizar (2002). Also notable was Campinha-Bacote’s (2002) Process of Cultural Competence in the Delivery of Healthcare Services model and The Cross Model of Cultural Competence by Terry Cross (1988).

### **Purnell Model of Cultural Competence**

The *Purnell Model of Cultural Competence* (Purnell, 2002) in Figure 1 was originally developed for use by nurses as an assessment tool. However, nurses, physicians, physical therapists, and social workers in the United States, Canada, Central America, and Europe use it in acute care, long-term care, and home health. It has been used in Australia, Belgium, Canada, Central America, Great Britain, Korea, South America, and Sweden. The Purnell model consists of four dimensions: person; family; community; and global society. Each dimension has 12 domains. Some examples of elements within these domains are given: communication (dialectics, differences, spatial distancing, eye contact, volume, tone, facial expressions, touch, time, greetings, temporality); family roles and organisation (head of the household, gender roles, social status, goals and priorities); workforce issues; biocultural ecology; high risk behaviours; nutrition; pregnancy; death rituals; spirituality (religious

practices, use of prayer, meaning of life, individual strength, spirituality, and strength); healthcare practices; heritage; and healthcare practitioners (practitioners' perceptions) (Lipson & Desantis, 2007).

Purnell's model also includes a four-part continuum of cultural consciousness used in diversity training. This continuum consists of four parts: unconsciously incompetent; consciously incompetent; consciously competent; unconsciously competent. Unconsciously incompetent: not being aware that one is lacking knowledge about another culture. Consciously incompetent: being aware that one is lacking knowledge about another culture. Consciously competent: learning about the patient's culture, verifying generalisations about the patient's culture, and providing culturally specific interventions. Unconsciously competent: automatically providing culturally congruent care to patients of diverse cultures (Lipson & Desantis, 2007).

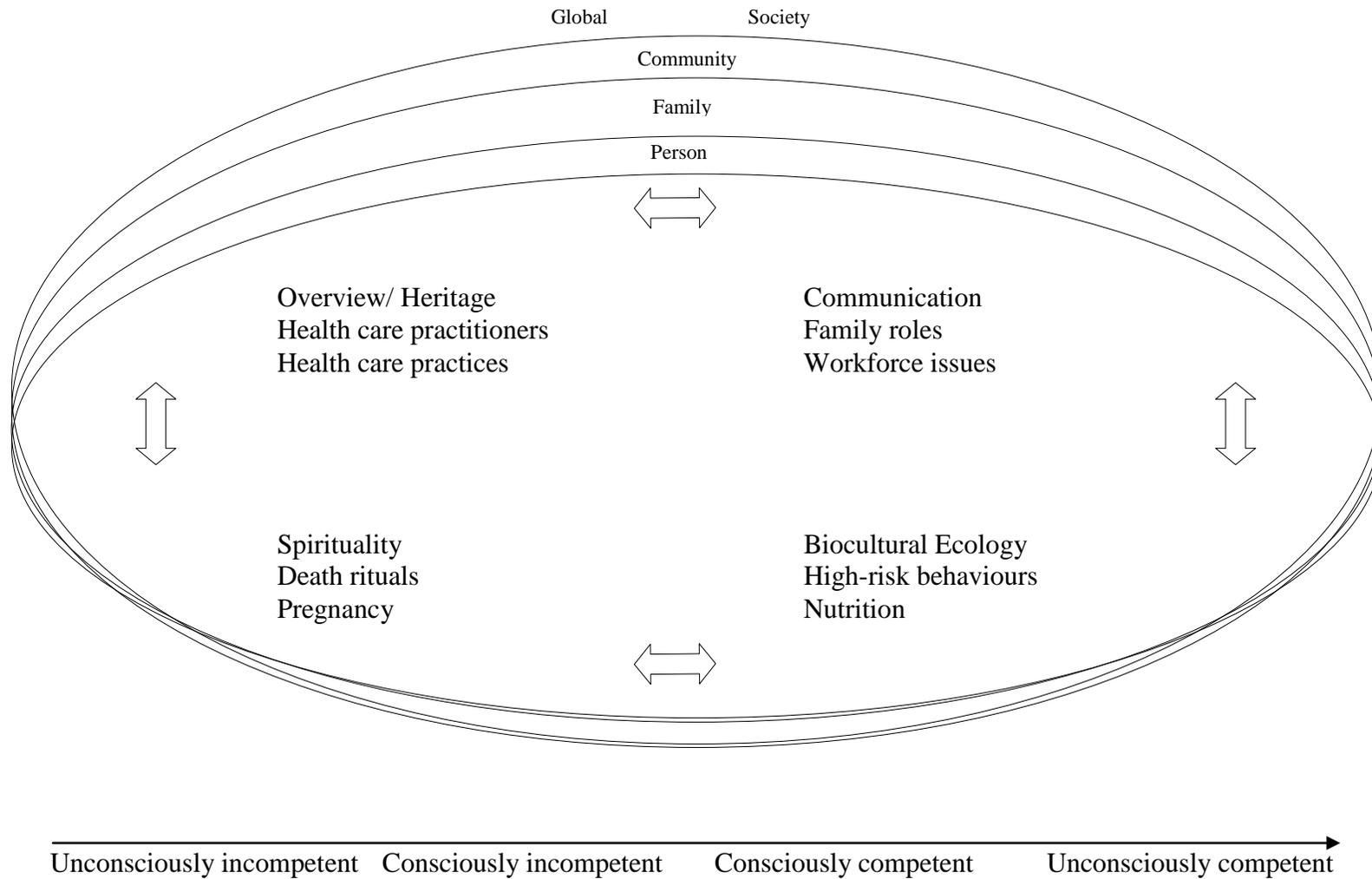


Figure 1: Adapted from Purnell Model of Cultural Competence (2002).

### **Giger and Davidhizar Transcultural Assessment Model**

The Giger and Davidhizar *Transcultural Assessment Model* (Figure 2) was developed in 1988 for undergraduate nursing students in the United States to assess and provide care for patients that were culturally diverse. This model consists of six domains: communication; space; social organisation; time; environmental control; and biological variations. The model defines cultural competence as connoting a “higher, more sophisticated level of refinement of cognitive skills and psychomotor skills, attitudes and personal beliefs” (Giger & Davidhizar, 2002, p.187; Lipson & Desantis, 2007).

Giger and Davidhizar (2002) expand on these domains. *Communication* embraces the entire world of human interaction and behaviour, which includes intercultural communication. It is the means by which culture is transmitted and preserved. *Space* refers to the distance between individuals when they interact. All communication occurs in the context of space. *Social organization* refers to the manner in which a cultural group organizes itself around the family group. Family structure and organization, religious values and beliefs, and role assignments may all relate to ethnicity and culture. *Time* is an important aspect of interpersonal communication. Cultural groups can be past, present, or future oriented. Preventative healthcare requires some future time orientation because preventative actions are motivated by a future reward. *Environmental control* refers to the ability of the person to control nature and to plan and direct factors in the environment that affect them. Many Westerners believe they control nature to meet their needs and thus are more likely to seek healthcare when needed. If persons come from a cultural group in which there is less belief in internal control and more in external control, there may be a fatalistic view in which seeking healthcare is viewed as useless. *Biological variations* mean that diet and medication can affect different bodies according to genetic and cultural groups (Giger & Davidhizar, 2002; Xu & Davidhizar, 2005).

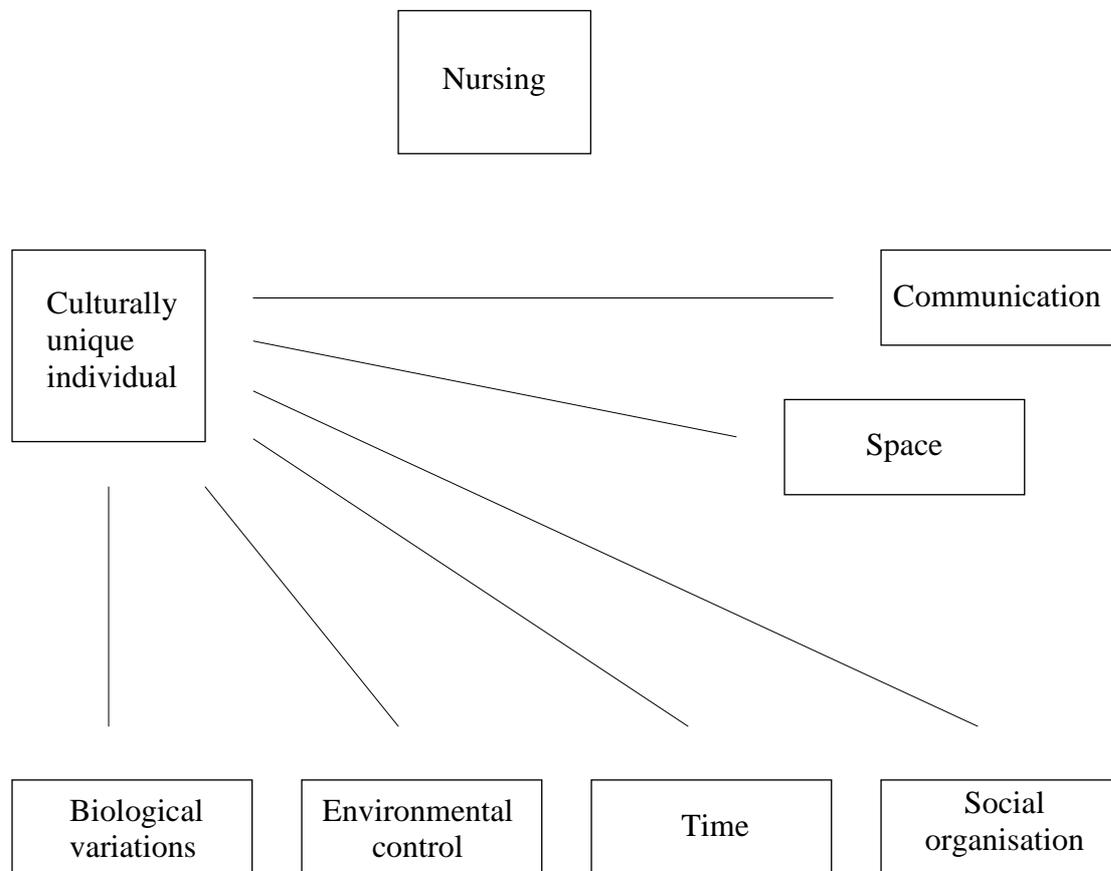
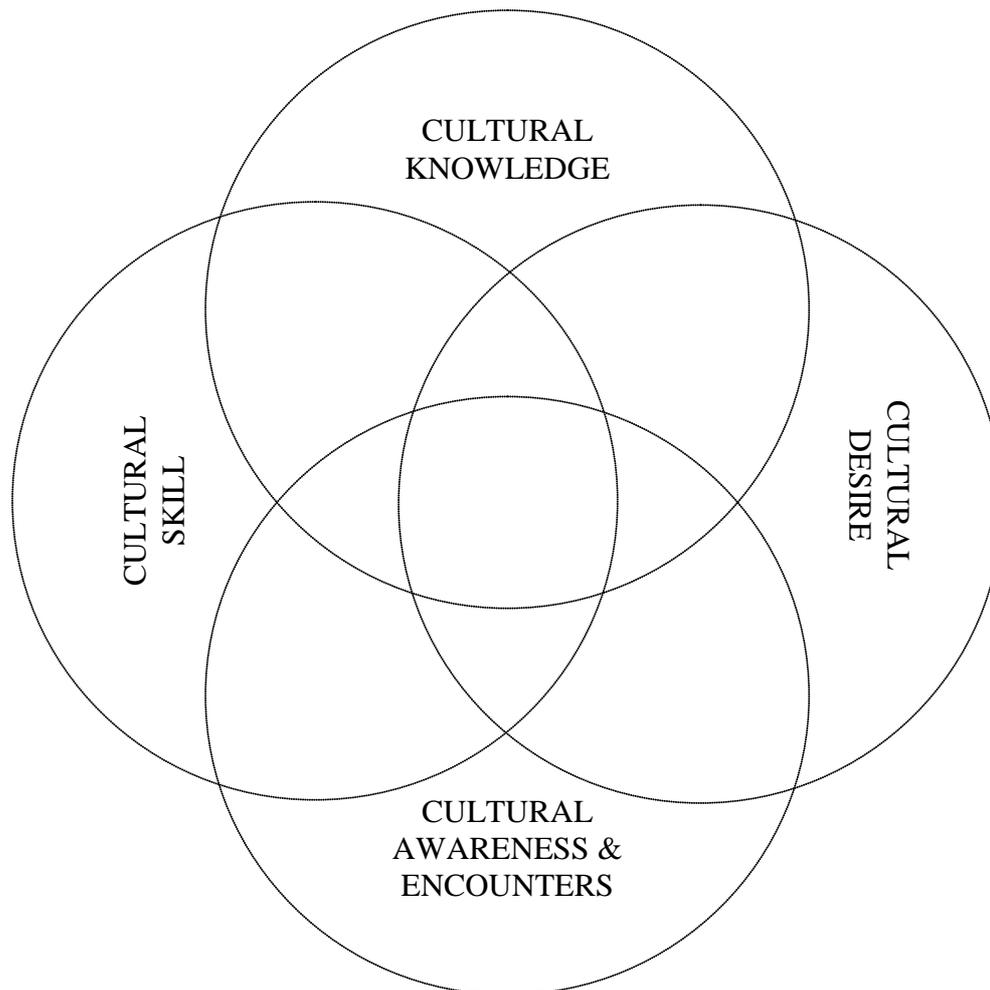


Figure 2: Adapted from Giger and Davidhizar's (2002) Transcultural Assessment Model.

### The Campinha-Bacote (2002) Cultural Competence Model

To develop their model (Figure 3) Josepha Campinha-Bacote (2002) blended the fields of transcultural nursing, medical anthropology, and multicultural counselling. It is a dynamic model that views cultural competence as an ongoing process. The healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the patient (individual, family, and community). The model is described from the viewpoint of the practitioner and requires healthcare providers to see themselves as becoming culturally competent rather than assuming they are already culturally competent.

Assumptions of Campinha-Bacote's (2002) model indicate that cultural competence is a process, not an event and that cultural competence consists of five integrated constructs: cultural knowledge, cultural skill, cultural desire, cultural awareness and cultural encounters. There is more variation within ethnic groups than across them, and there is a direct relationship between the level of competence of healthcare providers and their ability to provide culturally responsive healthcare services. Cultural competence is also an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse patients.



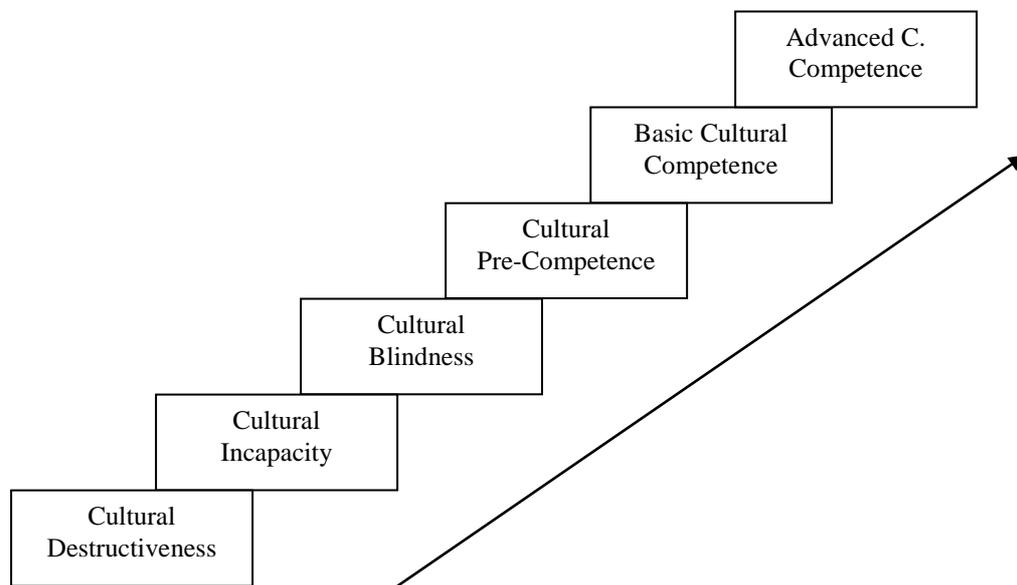
*Figure 3: The Process of Cultural Competence in the Delivery of Healthcare Services. Adapted from Campinha-Bacote's (2002) model.*

### **The Cross Model of Cultural Competence**

In the United States of America, Terry Cross created a commonly used and referenced cultural competence model. The *Cross Model of Cultural Competence* (Cross, 1988) in Figure 4 offers an institutional and individual framework to help gauge progress on various diversity initiatives. It describes cultural competency as movement along a continuum that is based on the premise of respect and appreciation of individuals and of cultural differences.

The Cross Model (Cross 1988) consists of six stages: Cultural destructiveness; Cultural incapacity; Cultural blindness; Cultural pre-competence; Basic cultural competence;

and Advanced cultural competence. Firstly, cultural destructiveness is at the most negative end of the continuum. Individuals in this phase view culture as a problem; believe that people should be more like the mainstream; and assume that one culture is superior. Secondly, cultural incapacity reflects an individual's lack of cultural awareness and skills. They may have been brought up in a homogeneous society and never questioned what they were taught. There is a paternalistic posture toward others. Thirdly, cultural blindness is where individuals claim that all people are exactly alike and they believe that culture makes no difference. The fourth stage, cultural pre-competence recognises there are cultural differences and individuals who start to educate themselves and others concerning these differences. They realize their shortcomings in interacting within a diverse environment, but may become complacent in their efforts. The fifth stage, basic cultural competence accepts, appreciates, and accommodates cultural differences. Individuals value diversity and also accept and respect differences. They accept the influence of their culture in relation to other cultures, and understand and manage the dynamics of difference when cultures intersect. Individuals are willing to examine components of cross-cultural interactions, such as communication and problem solving. Finally, advanced cultural competence is a stage where individuals move beyond accepting, appreciating, and accommodating cultural difference and begin actively to educate less informed individuals about cultural differences. They seek out knowledge about diverse cultures, develop skills to interact in diverse environments, and become allies with, and feel comfortable interacting with others in multicultural settings.



*Figure 4: The Cross Model (Cross 1988). A representation of the continuum.*

Table 1: *Common elements among four cultural competence models: Purnell; Giger and Davidhizar; Campinha-Bacote; and Cross.*

<i>Purnell Giger and Davidhizar</i>	<i>Campinha-Bacote</i>	<i>Cross</i>
<p>Verbal and nonverbal communication; eye contact; touch; proximity; gender, clock versus social time; orientation of time and belief systems; intimate; personal; social; consultative; and public spaces.</p>	<p><i>Cultural Knowledge:</i> Obtaining cultural knowledge; understanding worldview or lifeworld.  <i>Cultural Encounters:</i> Assessment of linguistic needs- use of formally trained interpreter.  <i>Cultural Skill:</i> Collection of relevant data; understanding cultural beliefs, values, and practices.</p>	
<p>Contextual use of communication; problems conveying meaning; healthcare problems and mental health barriers; fatalistic/ less belief in internal control and more in external control; acceptance of external factors, or proactivity about health based on what one knows.</p>	<p><i>Cultural Knowledge:</i> Obtaining cultural knowledge about the patient’s health-related beliefs and values.  <i>Cultural Encounters:</i> Assessment of the patient’s linguistic needs. <i>Cultural Encounters:</i> Directly engage in cross-cultural interactions with patients from culturally diverse backgrounds to refine or modify one’s existing beliefs, to prevent stereotyping.  <i>Cultural Desire:</i> Practitioner wanting to become culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters.</p>	<p><i>Advanced Cultural Competence:</i>  a) move beyond accepting, appreciating, and accommodating cultural difference and begin actively to educate less informed individuals about cultural differences; and  b) seek out knowledge about diverse cultures, develop skills to interact in diverse environments, and become allies with and feel comfortable interacting with others in multicultural settings.</p>

<p>Gender roles, social status; family structure and organization</p>	<p><i>Cultural Knowledge:</i> Obtaining cultural knowledge about the patient’s health-related beliefs and values involve understanding their worldview or lifeworld.</p>	
<p>Spirituality and health; religious beliefs, values, and practice; meaning of foods; meaning of life, use of prayer, spirituality and health</p>	<p><i>Cultural Knowledge:</i> Obtaining cultural knowledge about the patient’s health-related beliefs and values involve understanding their worldview or lifeworld.  <i>Cultural Skill:</i> Collection of relevant data; understanding cultural beliefs, values, and practices to determine explicit needs and intervention practices.  <i>Cultural Knowledge:</i> Seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups.</p>	<p><i>Advanced Cultural Competence:</i>  a) move beyond accepting, appreciating, and accommodating cultural difference and begin actively to educate less informed individuals about cultural differences; and  b) seek out knowledge about diverse cultures, develop skills to interact in diverse environments, and become allies with and feel comfortable interacting with others in multicultural settings.</p>
<p>Patient perception of practitioners, gender and healthcare, status; behavioural difficulties due to patient perception of practitioner</p>	<p><i>Cultural Desire:</i> Practitioner wanting to become culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters.</p>	
<p>Biocultural-hierarchy, skin colour, biological variation genetic, endemic</p>	<p><i>Cultural Skill:</i> Collection of relevant data; understanding cultural beliefs, values, and practices to determine explicit needs and intervention practices.  <i>Cultural Knowledge:</i> Seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups.</p>	

Furlong and Wright (2011) argue that some cultural competence models are static rather than dynamic in their intended function. With the view that a practitioner's capacity for "reflective self-scrutiny" (p.38) or critical reflexivity as a requirement for effective culturally competent practice, they believe there are cultural competence models that omit these important dynamic elements. However, Walker and Sonn (2010) note Campinha-Bacote's claims to "pose critically reflective questions regarding one's awareness, skill, knowledge, encounters and desire" (p. 173).

### **Complementary Theories of Practice**

#### **Patient-centred practice.**

The term *patient-centred practice* was attributed to Carl Rogers who coined the phrase "unconditional positive regard" (Rogers, 1987, p.486) to describe an approach to psychological practice focused on the patient. He believed in one's ability to respond empathically, to be able to enter the others' world, and to know that world as an understandable, acceptable part of reality (Lago, 2006). He also stressed the importance of self-actualisation in others. This single motivating factor in his theories was the notion of the actualizing tendency; that all living organisms, including a patient, are subject to this inherent tendency to maintain and enhance their own growth. This notion was at odds with a more authoritative practitioner-centred approach to healthcare. In this approach there are patterns of constriction in physician-patient relationships. As previously mentioned Mishler (1984) called this authoritative stance the voice of medicine. Hauser (1981) pointed out that other studies have described practitioner-centred approaches as "doctor-centred" and

“doctor dominated” (p.114). He regarded such extreme orientations to healthcare as purely biomedical approaches to understanding disease, and therefore limiting.

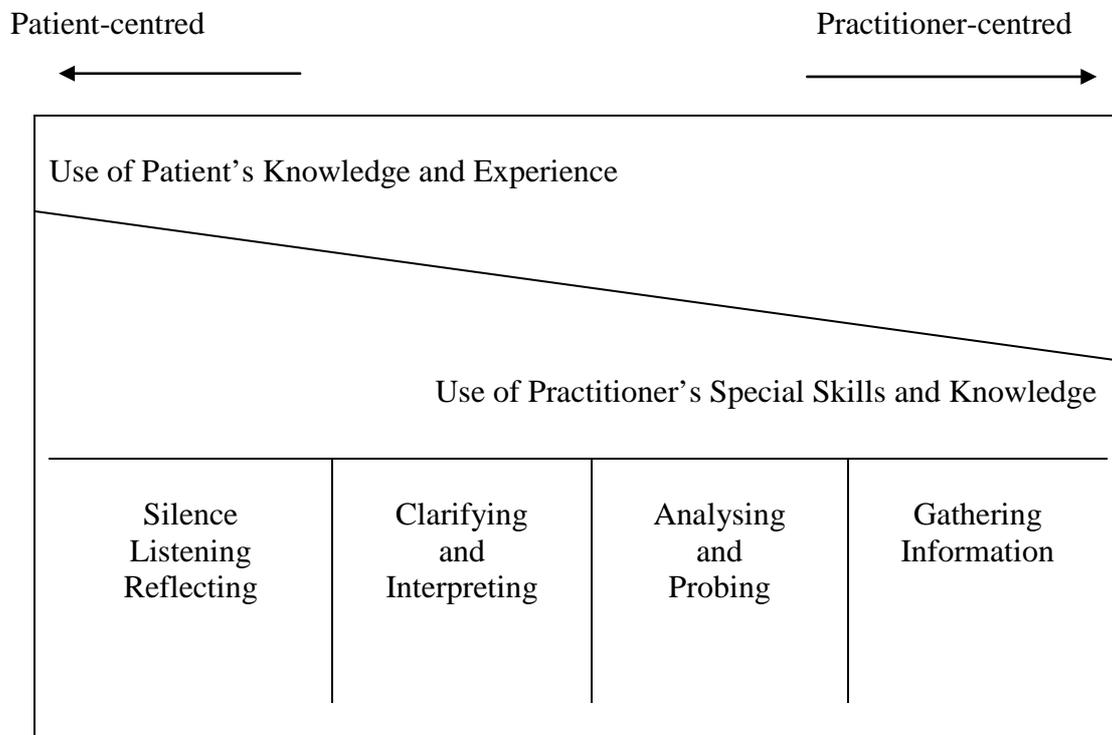


Figure 5. Practitioner communication styles. Adapted from (Hauser, 1981, p.112).

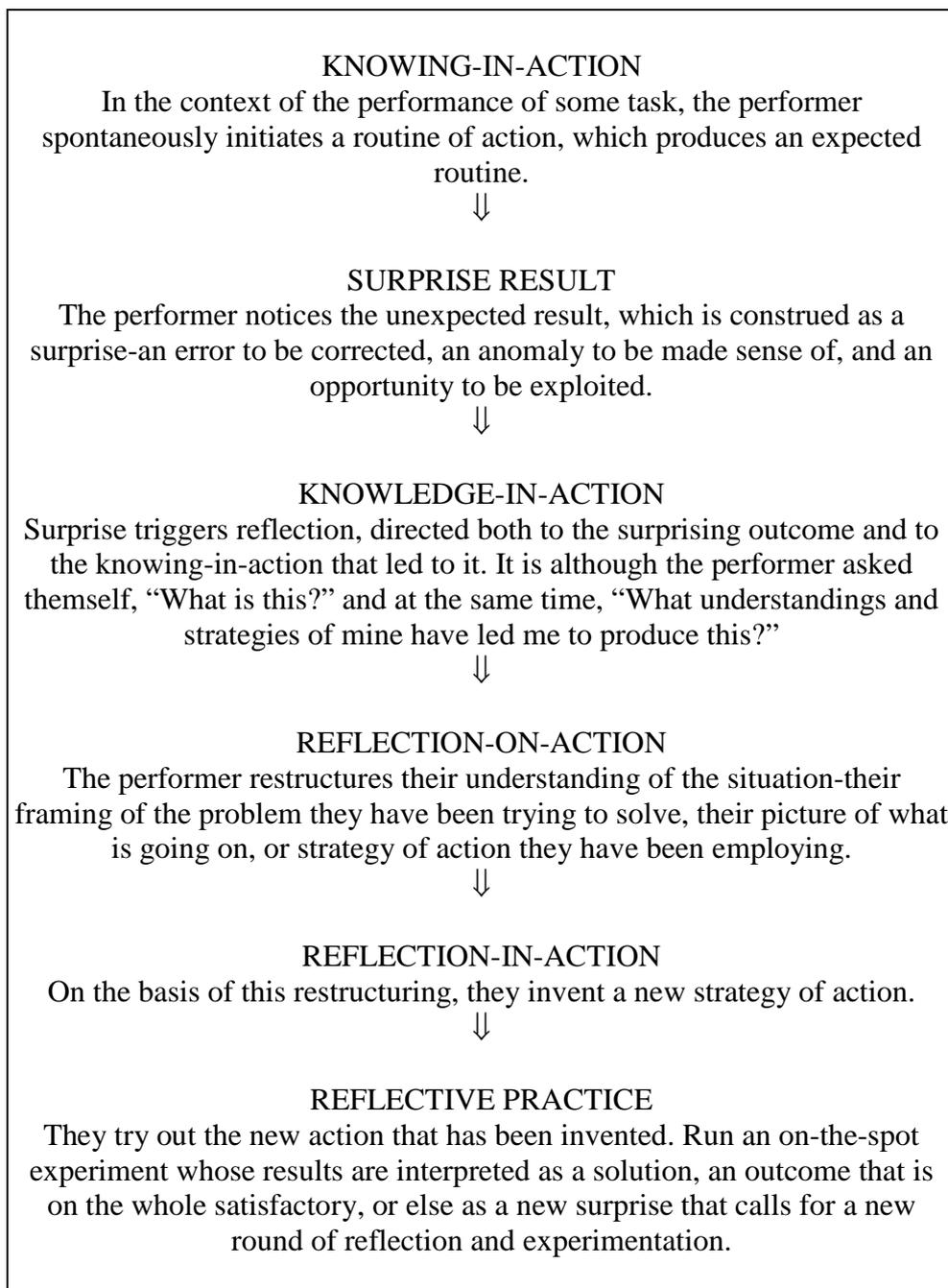
### **The reflective practitioner.**

There is now a tendency to look beyond evidence-based-practice and the delivery of services to clients. Donald Schön (1995) articulated the concept of the reflective practitioner as being different from the expert (see Table 2). In essence, he argued that the model of technical rationality, as posited by the positivist epistemology of practice, did not take into account a need to *inquire* into the epistemology of practice ... what people actually do. Schön assumed that practitioners usually knew more than what they could say and that they “reveal a capacity for reflection on their intuitive knowing in the midst of action” (Schön, 1995, viii). He made a distinction between Reflecting-in-Practice (looking back) and

*Reflection-in-Action* (in the midst of it) (Figure 6). He described the latter as a skill that is applied there and then, where thinking and doing are not separated, so implementation is built into practice. The practitioner approaches each problem as a unique case. One that is unique, complex, and uncertain so that no standard theory can be applied. Therefore, the practitioner's acquisition of competence is dynamic. This dynamic process begins with *appreciation*, followed by *action*, then *re-appreciation* (Schön, 1995). Consequently, there is regular *reframing* of what is understood and what needs to be done.

*Table 2: Practitioner perspectives: Differences in how practitioners' sources of satisfaction and demand for competence might be expressed. (Adapted from Schön (1995) and Redmond (2004)).*

Expert	Reflective Practitioner
I am presumed to know and must claim to do so regardless of my own insecurity.	I am presumed to know, but I'm not the only one in the situation to have important and relevant knowledge. My uncertainties may be a source of learning for me and for them.
Keep my distance from the client and hold onto the expert's role. Give the client a sense of my expertise, but convey a feeling of warmth and empathy as a "sweetener."	Seek out connections to the client's thoughts and feeling. Allow his respect for my knowledge to emerge from his discovery of it in the situation.
Look for deference and status in the client's response to my professional persona.	Look for the sense of freedom and of real connection to the client, as a consequence of no longer needing to maintain a professional façade.



*Figure 6: Reflective Practice Process: Adapted from Schön (1995) and Redmond (2004).*

Schön (1995) described the difference between traditional and reflective practitioner-patient interactions (Table 3) by proposing Model I and Model II descriptors.

*Table 3: Reflective Practice. Adapted from Schön's (1995) Client Perspectives.*

Traditional Contract Model I	Reflective Contract Model II
I put myself in the professional's hands, gaining a sense of security based on faith.	I join with the professional in making sense of my case. I gain a sense of increased involvement and action.
I have the comfort of being in good hands. All will be well due to me complying with the advice offered.	I can exercise some control over the situation and I am not completely dependent on the professional – they are also dependent on my information and actions.
I am pleased to be served by the best person available.	I am pleased to be able to test my judgments about the professional's competence. I enjoy discovering their knowledge, the phenomena of the practice, and also discovering about myself.

Schön was a main focus in this study due to his constructionist approach and for consistency to the focus of this study. However, the work of David Kolb and social realist Margaret S. Archer (a medical anthropologist) is relevant to understanding reflective practice. Kolb's Learning Style Inventory was developed to enhance experiential learning by a recursive cycle of experiencing, reflective observation, thinking, and acting (Kolb & Kolb, 2008). Archer (2003) argues for the self as having agency and selfhood as a continuing sense of self or reflexive self-consciousness, and the emergence of relational developments between people and societal structures. She also values the importance of self-monitoring for appropriate conversation, involving self-awareness, including reflective thoughts and it involves self-conscious recognition (Archer, 2100). It also relates to how we respond to

strangers so that we have the capacity to reflect on the appropriate socio-linguistic conversation.

### **Practice: Social and Psychological Viewpoints**

Healthcare training and practice takes into account not only scientific positivist approaches to health, but also constructionist approaches. A constructionist approach was described by Lauren Breen and Dawn Darlaston-Jones (2010) as the notion that “phenomena, including psychological phenomena, are interrelational, multiple, and dynamic, and that meanings are derived through our engagement with the social world and, as such, there is no one objective truth to be found” (p.72). This means that differing points of view and belief systems requires motivation to form equal partnerships. Participants engage one another in a reciprocal and equal communicative transaction. This opens up the possibility of considering social theory in some healthcare developments.

In her research on reflective practice, Redmond (2004) noted that German social theorist Jürgen Habermas revived Aristotle’s intellectual virtue *phronesis*. It was seen by many as reflecting his challenge to what he believed was the domination of scientism (McCarthy, 1984). Aristotle’s *phronesis* was compatible with Habermas’ determination of *practical and ethical knowledge*, and also *wisdom*. *Phronesis* is a skill used to deliberate about which social actions are good or bad for humans. It is also the capability to consider the mode of action in order to deliver change, especially to enhance the quality of life (Flyvbjerg, 2001). Habermas (1991b) believed that, “The Aristotelian determination of *phronesis* has a reflexive form. It is internalized as self-knowledge and insight. Practical knowledge orients one towards the rules of interaction and links up with and continues the process of socialization” (p.163) through positive or negative feedback from one’s actions.

Jürgen Habermas was considered by Lovat (2004) as one of the “intellectual architects of this moderately post-scientific age” (p.1). In theoretical terms, Habermas articulates a vision of equal partnerships through his *Theory of Communicative Action* and contributes to debate on ethical and humane practice in all forms of communication (Habermas, 1984; Monk, Winslade, & Sinclair, 2007). It is also relevant to healthcare professionals who work in a multicultural context. Habermas’ views on communication adequately questions healthcare practice and the voice of medicine when working with patients. A feature of a critical theory of society is generally to explain how a person, group or society has become engaged regularly in practices that are not in their interest as a result of some feature of that society. Consequently, Habermas regards the problems of misuse of power as elemental to his critical social theories (Braaten, 1991; Habermas, 1991a).

Similarly Bent Flyvbjerg, Professor of Major Programme Management at Oxford University’s Saïd Business School (Oxford University, 2011) offered a way of describing social science. He also took up a contemporary interpretation of Aristotle’s phronesis, which was considered one of his “three intellectual virtues phronesis, episteme and techne” (Flyvbjerg, 2001, p.2), to acquire knowledge in social enquiry. Flyvbjerg (2001) believed the concept of phronesis, variously translated as *prudence* or practical knowledge and wisdom, goes beyond both analytical, scientific knowledge (*episteme*), and technical knowledge or know-how (*techne*). In Aristotle's words, phronesis is a "true state, reasoned and capable of action with regard for things that are good or bad for man" (as cited in Flyvbjerg, 2001, p.2). It involves judgements and decisions made in the way of a “virtuoso social and political actor, which is beyond reducing social science to just evidence-based-practice or technical knowhow” (Flyvbjerg, 2001, p.2). Flyvbjerg argues that phronesis is commonly

involved in social practice and must be a part of social science and theory. In his conception of *phronesis*, Aristotle did not include explicit references to power. However, it is argued that those who practice social science and work with people inevitably need to understand *power relations* (Deetz, 1990; Flyvbjerg, 2001; Ruderman, 1997; Santhanam, 2008).

Unlike *episteme* or *techne*, *phronesis* is no longer found in our language. Flyvbjerg (2001) argues that the “absence of a modern word for *phronesis* is indicative of the degree to which thinking in the social sciences has allowed itself to be colonised or taken over, by natural and technical science” (p.3). Consequently, many practices including healthcare, are now challenged to modify their practice. Similarly, Hoshmand (2006) asserts that:

A cultural view of psychological practice requires us to engage in moral discourse and to acknowledge our role in a fundamentally moral enterprise. To bridge the divide in the field between a purely science-based definition of the enterprise and a moral, critical view, changes in the ideology and sociology of the profession are needed (p.34).

Dokecki (1996) also endorsed the Aristotelian position. This was consistent with the view of knowledge as a matter of Aristotelian practical reasoning, or *phronesis*, enacted in the community's social practices. He stated that prudence, meant as *phronesis*, was related to trustworthiness and was the ability to make competent decisions in real life situations. It allows, " letting the truth of real things determine what we do" (Lebacqz, 1985, p.104). Prudence also discerns valid reasons for engaging in interventions through a process of:

... perceiving the situation accurately, deliberating about it wisely, deciding what to do, and acting on that decision. A prudent practitioner can make the

right decision by inviting the patient to assume an active role in defining their problems and exploring avenues for intervention (Dokecki, 1996, p.99).

Westerman (2010) argues there is a "paucity of culturally derived empirical models" (p.212), which contributes to the resistance in the healthcare field to depart from mainstream or evidence-based practice. However, Sue (1998) suggested that an important ingredient in cultural competency is "scientific mindedness" [reflective of evidence-based practice] and "culture-specific expertise" (p.440).

While retaining evidence-based models for practice, culture still remains distant rather than close to the process of engagement with patients. Furthermore, culturally competent models of healthcare appear to be complex and difficult to define.

### **Research Questions**

1. What place did practitioners believe Evidence-Based Practice (EBP) held in their work?
2. Beyond EBP training, what knowledge gaps were identified as a result of working with a multicultural cohort of patients?
3. How did practitioners adapt their EBP training?

## Chapter 3

### Research Methodology

#### Chapter Overview

The previous chapter explained that diabetes is a chronic illness of major concern to healthcare organisations worldwide. Movement of individuals and families from country to country is increasingly common. Further, Australia is a popular destination for many refugees and immigrants from a wide range of cultural groups. Treatment of diabetes presents many unforeseen problems for Western medically trained practitioners with individuals who are new arrivals to Australia. This is also the case with Aboriginal people and Torres Strait Islanders where their high incidence of diabetes ranges over widely diverse cultural groups. Systems of belief and understanding of one's own health is often incompatible with Western medicine. Health practitioners in Western countries now need to find ways of "bridging this gap" by developing new models of practice that incorporate culture and cultural differences. To do so means to reflect on how Western medicine and healthcare might be viewed by others and the impact this has on healthcare outcomes.

The notion of dealing with difference respectfully and ethically is important to understanding and working with cultural groups. Diabetes healthcare practitioners were consulted to share their expertise in dealing with the challenges inherent with working with different cultures.

This chapter outlines the epistemological perspectives that underpin this research. In doing so it explains why *grounded theory* was used to manage the data and what type of grounded theory was utilised to address the three research questions which asked; What did practitioners think the place of EBP had in their work?

Beyond their EBP training, what knowledge was missing once they started practicing? How did they adapt their work to deal with those gaps?

As was discussed in the previous chapter, there are many policies that inform the moral and ethical framework that professionals undertake with their practice, especially with efforts to consider the needs of their clients. Studies researching the experience of the client can help with this endeavour. Researchers describe in detail the ways people in specific settings come to understand, account for, take action, and then manage particular phenomena. This process involves identifying and developing categories from the participant's own descriptive material, developing these to allow the researcher to contrast, then compare and analyse possible patterns or areas of interest (Miles & Huberman, 1984). Investigation of practice in health in a cultural context takes a deliberate attempt to be mindful and reflective of how that is done.

There are various methods to examine participants' experiences and this chapter explains ways of understanding phenomena that are used in this study. It is important to recognise the utility and relevance of not only an evidence-based-practice or *positivist* paradigm to understand our world, but also others, such as *modernist*, *postmodernist* and *constructionist* epistemological paradigms.

In this chapter my epistemological position is explained. It aligns with a constructionist perspective with methods of inquiry that acknowledge participants' reality as valid, and worthy of investigation, rather than looking only for a universal truth, or scientific argument that either supports or refutes that truth.

### **Situating the Researcher**

Prior to deciding on the focus of my project, my attention was drawn to Victoria University's research into the delivery of healthcare for diabetes patients, with particular reference to culture. It was relevant due to the high incidence of

diabetes and especially in the Western suburbs of Melbourne with its increasing and notably diverse multicultural population.

I began by focusing on the theme of diabetes because my wife has had Type I diabetes for many years and I was fully aware of the fact that this was a chronic disease needing constant attention and management. Fortunately, my wife manages her diabetes very well and so she enjoys very good health. Others are not so fortunate.

Rather than focusing on diabetes patients, the study took a different approach by investigating the professional experiences of diabetes health practitioners themselves. I asked practitioners what they actually did and what opinions they had about this experience.

Evidence-based positivist research and practical traditions appropriately contribute to increased understanding and management of diabetes. For example, reflecting on our own personal circumstances. These understandings need to be communicated to patients. In the past, diabetes practitioners who did not communicate competently or effectively had negatively affected my wife and especially those practitioners who had a paternalistic, “I know better because I am the expert” ... approach to practice. My wife found this as pervasive, unwelcome, and had an overall negative effect that surprised her. This experience confirmed that problems occur when a practitioner neglects or fails to consider how the patient’s identity or viewpoint is part of the clinical relationship. This lack of clinical skill and empathy focuses on power and control.

It is essential that evidence-based scientific research informs the treatment of diabetes. As a trainee psychologist, I am also naturally interested in the social determinants of health and effective, appropriate healthcare practice. I believe

whatever constitutes effective and appropriate communication will have an influence on healthy responses to care.

As an educator of at risk adolescents with behavioural and learning difficulties I know the importance of effective communication and sensitivity in forming relationships to facilitate successful educational outcomes. In other words, for personal and professional reasons I had an interest in working with stakeholders who were less empowered, without a voice, and who had difficulty fitting into the mainstream cultural and social structures. I wanted to know how particular professions work with minority groups, because of the different challenges that abound, compared to working in mainstream environments.

Overall, I saw myself as a practitioner with experience in both education, and to a lesser extent in psychology, and that the voices of education and health had a powerful role to play. This was not to the exclusion of stakeholders' viewpoints, power or sensibilities as recipients of a service. I believe that delivering services or conducting practice, as an "expert" in a one-way interaction, cannot always be effective or appropriate.

The existence of inappropriate power imbalances was brought home to me recently with my psychology training at a psychiatric hospital. I heard a psychiatrist debrief with colleagues and myself following a case meeting I was involved in. He complained that the parent (of a patient) was always interrupting and interfering with his process. This caught my attention, considering the fact that the parent was communicating her experience and lifeworld. I believed her contribution was relevant to the case and deserved to be listened to, respected and reflected upon. This also highlighted the importance of a shift of focus in areas of hospital health.

I have arrived at conducting this study due to some understanding of my wife's experience as a diabetes patient, combined with my professional and training experiences. I aim to investigate and report on the nature of professional practice, to consider evidence-based practice informed by evidence-based research, and to investigate what actually happens in practice. Especially with patients who may not understand or believe in the relevance of the healthcare available to them.

Discourse around cultural competence in professional practice implies that it is not static but is a *dynamic* process. This dynamic appears to be a more acceptable way of working with stakeholders, than by just merely administering scientific facts and professional knowledge in a one-way process. This has been necessary because unfortunately stakeholders are often viewed or "constructed" in terms that are considered mainstream, which is a limitation to ways of practicing healthcare.

### **Epistemology**

Burr (1995) describes epistemology as "the study of the nature of knowledge and the methods of obtaining it" (p.185). It is also about what and how we know the things that we know (Willig, 2001). Potter (1996) argued that researchers acknowledge their epistemological perspective in reporting research, otherwise "the reader is not given adequate basis for evaluating the study or knowing where to stand conceptually" (p.283). Therefore, indicating one's epistemological perspective assists the reader in understanding the lens that is orienting the approach to the research and the criteria by which judgements of the quality of the research can be made. It also accounts for choice of method and the way the findings of the research have been reported. This is because they are influenced by beliefs about what counts as knowledge and how one can best attain that knowledge.

Training, experience, and personal values tend to lead researchers to favour one epistemological perspective over others (Blaikie, 1993). Throughout my psychology training, I found clinical psychology trainers tended to orientate themselves in positivist epistemological frameworks. This is mainly due to the *scientist-practitioner model* as the required training method. It is traditional and dominant in the field of psychology. In this way, one is initially presented with a positivist perspective. For positivists, all knowledge is contained within the objective boundaries of science. However, positivism “is not defended in its strongest form by many contemporary scientists on the grounds that it places too many limitations on what can be legitimately included in a scientific program” (Reber, 1995, p.582).

Nevertheless, a positivist paradigm was important as it described and rationalised the theories that were being taught to psychology trainees, but it was to the exclusion of other paradigms. For in assuming there to be one overarching truth, a positivist paradigm has the tendency to marginalise those that are not part of the majority, who are seemingly “different,” and unfairly privilege whatever is considered “normal” or “mainstream”. It does so because the truth that is sought is arguably based on, and mostly constructed by, those who hold privileged positions in society, such as healthcare practitioners. Similarly, I recognise as an educator there are issues about power when working with marginalised and disenfranchised youth. These perspectives and experiences have been influential in my sensibilities and in the formation of my values prior to beginning this project.

### **Modernist and Postmodernist Perspectives**

*Constructionism* focuses on recognizing multiple possibilities for meaning and transformative action where some convention or taken-for-granted understanding or habit has held sway (Lock & Strong, 2010). This lens is set alongside Jürgen

Habermas' conceptualisation of *communicative rationality* that aims for mutual understanding within accepted parameters to interpret and express needs and interests or systems of belief (Braaten, 1991). Mutual understanding requires differing views to coexist despite power relationships and the presence of subjectivity in all communication. Similarly, Lock and Strong (2010) point out that Jürgen Habermas shares views compatible with social constructionists when he said, "objectivity, in the idealized sense of correct thing–word correspondence, is impossible" (p.77).

Jones (2001) argues that Habermas' work also supports a modernist view of validity statements that maintain some, but not all universal truths. Consequently, philosophically and theoretically, Habermas positions himself as a modernist, with its elaborations, rather than rejecting modernism entirely for a postmodern position. Not only do I accept Habermas' view that practical and ethical knowledge, and wisdom (phronesis) is valid and worthy of investigation, but I also accept the postmodern view asserting there are no universal truths. The world and our knowledge of it are socially constructed and therefore truths do not exist in isolation from us (Dahlberg, Moss, & Spence, 1999).

If truths or validity statements in communication are derived from our personal experience, and if they integrate with useful theoretical anchors to inform our analysis, then I take more than one position. This confirms for me my constructionist epistemological viewpoint. It describes what I mostly identify with because it takes a position, one that recognises viewpoints and dynamics that can be unique and valid to that situation or environment. I do not rule out the relevance of evidence-based knowledge in the delivery of healthcare. However, this knowledge needs to be complimented by informed reflective processes.

### **Critical Theory**

Critical theory is an important consideration for this study as it examines values, commitment to social justice, power and transformation. For example, a critical perspective of communication involves critical theory with its drive, desire, commitment to social justice, social change, and participation (Nelson & Prilleltensky, 2005). Critical theory also examines the inequalities in social structures that favour some and disadvantage others along the lines of culture and ethnicity. Although this may appear to be idealistic, it also supports the transformation of society to one where equality replaces a system promoting dominant-subordinate relationships (Mullaly, 2002). These views are also consistent with my values in my work with disadvantaged and disempowered adolescents. Critical theory also provides reference to a critical paradigm, which challenges the status quo. It also challenges systems and models of healthcare practice.

### **Grounded Theory**

To inform healthcare practice, it was decided research data would be handled according to grounded theory qualitative research methods. Overall, this would use a “personal, philosophical, theoretical and methodological background, to shape the research process and then ultimately the findings” (Willig, 2008, p.45). “Grounded theory is the method of choice when the researcher wants to discover the process of something” (Schmidt & Brown, 2008a, p.170).

In the mid 1960s, Barney Glaser and Anselm Strauss explored analytical themes in research and articulated the idea of developing theories from research grounded in data, rather than deducing testable hypotheses from existing theories. This approach is known as grounded theory (Glaser & Strauss, 1967). Stated simply, grounded theory methods consist of systematic, yet flexible guidelines for collecting

and analysing qualitative data to construct theories grounded in the data themselves. Furthermore, as a research method it provides guidelines on how to identify categories and establish links between them. So grounded theorists collect data to develop theoretical analyses from the beginning of a project, they study how participants explain their statements and actions and they ask what analytic sense can be made of them. Grounded theory was developed to counter the pervasiveness of a positivist paradigm with hypothesis testing where only existing theories were applied to new data (Breen & Darlaston-Jones, 2010). Willig (2008) sets out the complete grounded theory process as follows: Categories; Coding; Constant comparative analysis; Theoretical sampling; Theoretical saturation; and Memo writing. Categories identify patterns emerging from the data and move from descriptions to analytical interpretations. Coding is formulated early, initially comprising of descriptions. Constant comparative analysis identifies sub-categories. Theoretical sensitivity “asks questions” of the data, making comparisons, and looking for opposites. Theoretical sampling refines existing and newly generated analytic categories. Theoretical saturation occurs with sampling and coding till no more categories are found. Memo writing is undertaken to keep a record of the process development.

There is “movement” back and forth between the data and analysis. Due to both time and resource constraints in this project, an abbreviated version of grounded theory was used with the data gathered. This abbreviation consisted of categories, coding, and constant comparative analysis. Triangulation was followed up later. Triangulation included verifying the notes and coding of the transcripts with the first supervisor for coherence and consistency. It also involved receiving feedback from participants after their interviews to verify that the researcher accurately reported their experience and viewpoints.

**Terminology (constructionism and constructivism).**

Guba and Lincoln (1994) use the terms constructivism and interpretivism interchangeably. Crotty (1998) distinguishes between constructivism and constructionism, yet also uses the terms interchangeably. Gergen (1999) differentiates between constructivism, radical constructivism, social constructivism, social constructionism, and sociological constructionism. Despite these distinctions the terms are often used synonymously. Confusion as to the definition and language of the epistemology remains.

Both constructivism and constructionism (as I have described them) align with where I place myself as the researcher. Therefore the term constructivism will explain the orientation of grounded theory qualitative research I will be using as Charmaz's (2006) explanation resonates with my view. I will also use the term constructionism, as explained by Breen and Darlaston-Jones (2010).

**Constructivist grounded theory.**

A constructivist grounded theorist sees values and facts as linked. So their viewpoint rests on values. Thus, constructivist theorists attempt to become aware of their own presuppositions (Charmaz, 2006). Differences between people become visible as well as the hierarchies of power, communication, and opportunities that maintain and perpetuate such differences and distinctions. Charmaz (2006) explains change and difference as follows:

The constructivist view assumes an intransigent, yet ever-changing world, but recognises diverse local worlds, and multiple realities; and addresses how people's actions affect their local and larger worlds. Thus, they aim to show the complexities of particular worlds, views and actions (p.131).

*Constructivist grounded theory* recognises the active role of the researcher (Charmaz, 2006). It has been argued by Charmaz that categories and theories did not emerge from the data, but were constructed by the researcher through an interaction with it. Charmaz explains that constructivist theorists take on a reflexive stance and regard analysis as being contextually situated in time, place, culture and situation. Taking this view, then, a patient's unique cultural perspective in the eyes of the practitioner is of particular interest when choosing a methodology for this research.

### **Constructionist perspective.**

A modernist view acknowledges concepts and theoretical frameworks that reflect values and empower others (Parker, 2005). *Postmodern* theory argues that the self constantly changes in interaction with different contexts over time, rather than advocate for a single best theory or approach (Ivey, Ivey & Simek-Morgan, 1997). Positivist paradigms are useful for informing practice and treatment. So it is not surprising that this study is positioned to embrace a *constructionist* epistemology. It provides the framework for methodological pluralism and includes the perspective of the researcher in formulating knowledge statements (Breen & Darlaston-Jones, 2010). Papert and Harel (1991) describe constructionism as "learning-by-making" (p.1). It is based on *Verstehen* or *empathic understanding* of human behaviour (Weber, 1968). This stresses observation, description, understanding, and meaning. *Verstehen* holds that complexity of human phenomena requires different research methodologies to that of other natural phenomena (Breen & Darlaston-Jones, 2010). Cooperrider and Whitney (2003) optimistically explained constructionism as:

... an approach to human science and practice which replaces the individual with the relationship as the locus of knowledge. Thus it is built around a keen

appreciation of the power of language and discourse of all types to create our sense of reality-our sense of the true, the good, and the possible (p.176).

A constructionist perspective is valuable for the purpose of this thesis. It has a relationship to power that is not fixed in one place or with one person. Nevertheless, implicitly power is with the professional. I found that reflecting on what I know and do in practice has been a requisite for me to navigate complex communications as an educator. I found there was no single rule or theoretical position that could be applied to reach effective interaction with another individual. The task required *flexibility* and mindfulness of stakeholders' needs, because there was always something new to learn and reflect upon. It is also likely that a flexible and reflective professional approach will be helpful when working with patients whose understanding of a chronic disease varies from mainstream or traditional Western perspectives. Lock and Strong (2010) explained this well:

People live their lives in the lifeworld, and because we live in it, it is something very difficult to notice, and hence to investigate by the methods we have inherited from a very different tradition of objective methods. The sensibilities that inform social constructionism provide the necessary perspectives to reveal and clarify a new foundation for inquiring into, and understanding, human nature, which is both a paradoxical and exciting aspect of contemporary constructionism (p.7).

Pidgeon and Henwood (1997) substituted the term *theory generation* for discovery to capture the constructive element in this process. At the core of constructionist epistemology is the notion that phenomena, including psychological phenomena, are interrelational, multiple and dynamic. Meanings are derived through our engagement with the social world. As such, there is no one objective truth to be

found (Breen & Darlaston-Jones, 2010). The underlying assumption is that the relationship between the “knower” and what can be known is transactional and subjectivist, rather than objectivist. This means that knowledge is co-created through the interaction between the researcher and the researched (Guba & Lincoln, 1994). That position is dynamic, rather than being set by the rules of technocratic expertise provided to the grateful recipient. From this viewpoint, meaning-making which is imbedded in socio-cultural processes, will be specific to particular times and places. Consequently, our ways of understanding them will undoubtedly vary.

Overall, within the field of medical sociology there has long been a tradition of publishing in book form, themed collections of research. These themes draw out the contribution that the collection makes to knowledge and understanding in the field. The possibility that themes and concepts identified in individual qualitative studies could be further brought together or synthesised to derive *new concepts* and *theoretical insights* has begun to acquire some currency (Beard, Curry, Edwards, & Adams, 1997; Sandelowski, Doherty, & Emden, 1997). It is hoped that this study and its themes of culturally competent practice may contribute in some way to that growing body of knowledge and understanding.

## Chapter 4

### Methods, Data Analysis and Management

The previous chapter outlined the rationale for conducting this research and the researcher's epistemological position was explained. This position recognises the need for evidence-based healthcare practice based on sound scientific principles. It also resonates with a modernist viewpoint that reflects values and empowers others. As a result, the epistemological position is closely aligned with a constructionist viewpoint that provides a framework for methodological pluralism and includes the perspective of the researcher in forming statements around what knowledge emerges in the research process.

This chapter gives background information on participants' ethnicity, their specialist diabetes training, and the process involved in their recruitment. Reasons for selection of methodology and steps for data gathering were briefly explained. This includes an outline of the interview schedule development, management of data and analysis of the interview material, and also taken steps to ensure rigour of the data prior to setting out the findings and interpretation.

As stated in Chapter 3 it was intended that the present study might contribute to the growing body of qualitative research examining culturally competent health practice through detailed investigation of practitioners' interview dialogues. Those interviewed were in a position to comment on practice due to their experience working with a diverse multicultural mix of individuals. This study used grounded theory qualitative methods to investigate both the common and unique experiences of health practitioners working with diverse cultural groups. In Miles and Huberman's

(1984) words, whilst engaging in this qualitative research, the researcher “interprets data by finding out how the people being studied see the world, how they define the situation, or what it means for them” (p.335). Similarly, this study focused on uncovering the meaning of experiences of people working with diabetes patients from different cultures. As a result, this study focuses and reports on the experience from the practitioner’s perspective.

### **Participants and their Training**

Wide ranges of practitioners who had extensive experience working with non-Anglo Australian diabetes patients in the Western suburbs of Melbourne, were interviewed. The diabetes educators who participated in this project were originally trained as nurses then chose to specialise for practice with diabetes patients. Those participants who recently became diabetes specialist nurses (during the last 6 years) were trained in specifically designated courses. All diabetes educators were credentialed, as a result of fulfilling the requirements for membership of the Australian Diabetes Educators Association (ADEA). This membership usually involved undergoing a period of training in Melbourne at La Trobe University, Deakin University, or Mayfield Education (a private provider for the health and community services sector). Training was reportedly based on evidence-based Western pathophysiological research or “disordered physiological processes associated with disease” (The Australian Concise Oxford Dictionary of Current English, 1997, p.983).

Mayfield Education offers a Graduate Certificate in Diabetes Education and Healthcare over 25 days consisting of five one-week study blocks (Mayfield, 2009). Specialist diabetes training for nurses was usually one year’s training with two terms of education and one term of management.

Diabetes educators who began working with diabetes patients 15 to 25 years previously did not have specialised diabetes training available to them. They reported their training as less formal. It was an “apprentice-type” arrangement in hospital wards or in the community.

There were also three psychologists and one dietician, among a total of 22 participants, who volunteered to participate. They were able to offer insights from an allied professional perspective. Although their training was different from diabetes educators, their experiences were relevant to the focus of this study. Throughout the findings and interpretation and discussion chapters the term practitioners refers to all participants.

### **Recruitment of Participants**

Recruitment was a lengthy process to complete, as it was difficult to coordinate interview times with the researcher and participants’ work commitments. A purposive sample was recruited through Diabetes Australia and the Western General Hospital in Footscray Melbourne. Practitioners were recruited who worked with patients with diabetes in cross-cultural contexts. Firstly, contact was made with the convener of a local Australian Diabetes Educators Association (ADEA) network. This contact was made by email with a follow up telephone call organising an appointment to undertake the first recorded one-hour audio interview. Following this, a Plain Language Statement (Appendix A) describing the project was posted to the practitioner. At the conclusion of the interview, using a snowball technique, the first interviewee suggested names of relevant fellow diabetes educators that could be contacted. Permission was given for her name to be mentioned in this recruitment process. Further, an invitation was extended for me to give a presentation of my planned research project to her ADEA network meeting members.

At the ADEA network meeting presentation (Appendix B), practitioners were invited to participate by being interviewed for this study as participants. This was due to their capacity to be information-rich and illuminative (Patton, 2002). They also had the capacity to provide an insight into cultural competence with in their delivery of health services to diabetes patients. Interested participants were asked to contact the research supervisor or myself. Copies of the Invitation to Participate in Research (Appendix C) were then left for network members explaining the nature, purpose, aim and their role as volunteers.

Following the initial oral presentation, the written Plain Language Statement was mailed to those potential participants who later contacted the researcher for more information. If there were any difficulties recruiting participants following this presentation, the researcher would contact the ADEA network convener to ask the contact details of one other colleague and then follow up with the snowballing process of subsequent interview requests. The network convener offered to be interviewed first. The snowballing process was successfully utilised where needed afterwards.

## **Participants**

A total of 22 participants (twenty-one females and one male) volunteered to be involved in this study. This included 18 nurses specialising in diabetes care as diabetes educators, three psychologists, and one dietician. All participants worked with diabetes patients who came from a wide range of cultural groups. The ethnic backgrounds of participants were as follows: Anglo Australian, n=15; Chinese, n=5; Vietnamese, n=1; Egyptian, n=1; and Dutch, n=1. Their ages ranged from 27 years to 59 years; the Mean age was 45.7 years; 17 participants were in the 40-60 year age range. For the purposes of this study, the term Anglo Australian is understood to refer to any individual whose descendents were from the United Kingdom. All 18 diabetes

educators were members of the ADEA. This meant they were credentialed to work as specialists in this field and were also likely to be known to each other. This fact did not appear to be of concern to the participants who said they regularly met and shared information and resources.

## **Data Gathering**

### **The interview process.**

The process of conducting interviews was designed to investigate educators' understanding of their patients' specific beliefs and understandings within their culture and how these beliefs reportedly influenced patient understanding, treatment management, and ultimately their health outcomes in diabetes care.

Consenting health professionals were contacted by telephone to discuss all aspects of the research and the interview. They were also given opportunities to ask further questions and to discuss any issues of concern to them. If the educator was willing to participate, a convenient interview time was arranged. Each participant was asked to complete the Consent Form (Appendix D), in advance of the interview.

It was anticipated that all interviews would occur during work hours at interviewees' workplaces. Before the interview, the researcher would check that the written Consent Form had been completed. A Withdrawal of Consent Form (Appendix E) was given to the interviewee, which they could sign and contact the researcher if at any time following the interview they did not wish to have further involvement in the study. The Consent Form explained the fact that due to relatively few numbers of professionals working with diabetes patients in the Western suburbs of Melbourne, the anonymity of the participant may not necessarily be preserved in the documentation relating to the research. Participants were telephoned three to four

days prior to the scheduled interview to confirm the appointed time. With participants' consent, all interviews were audiotaped so that detailed analyses of verbatim transcriptions could be made. Audiotaped data were transcribed, thematically analysed and managed using QSR NVIVO 8.0 software.

### **Development of the interview schedule.**

The development of the Interview Schedule (Appendix F) was underpinned by research and theories pertaining to culturally competent professional practice in healthcare. It was planned that the transcript data for each interviewee would be first arranged under headings, according to the interview questions. The interview questions were grouped into the following general areas:

- a) Diabetes care and EBP.
- b) Culture and practice.
- c) Training, culture and practice.
- d) Personal relationships with patients.

Therefore, data was compiled to examine the meaning ascribed to these areas as elucidated by each interviewee. This process constituted segmentation of the interview data into three domains of enquiry: EBP and conventional preparation for practice; Bridging the gap in the real world between training, culture and practice; and, Real world interactions.

*EBP and conventional preparation for practice:* This inquiry was designed to orient the interviewee to experiences associated with their training as a professional working with diabetes patients. Specific emphasis was also placed on their training regarding the concepts of evidence-based-practice and the importance they placed on them.

*Bridging the gap in the real world between training, culture and practice:* The line of inquiry was towards patient-focused practice in a cultural context or “walking the talk”. This inquiry was designed to investigate their practical experiences of working in healthcare with diverse cultural groups to identify knowledge gaps in training.

*Real world interactions:* Finally, participants were asked to explain what they did to adapt their work from their training to their actual practice with different cultural groups. There was also flexibility for reflection and exploration of unexpected phenomena or themes if they emerged.

### **Data Management and Analysis**

Data analysis consisted of “examining, categorizing, tabulating, or otherwise recombining the evidence, to address the initial propositions of a study” (Yin, 1984, p.99). The original aims of the research drive the purpose of analysis (Krueger and Casey, 2009). Thus, in accordance with the research aims, the purpose of the analysis was to conceptualise the experiences and views of participants in the research process. A conceptual framework was generated through examining previous literature and research around the theme of cultural competence and its relevance to the delivery of health services.

An ethnological or phenomenological grounded theory was not relevant to this study because the researcher was not involved with the actual workplace processes as an observer or participant. Using a grounded theory approach as a beginning point, health practitioners were interviewed, key concepts and themes were identified and teased out in sentences and paragraphs, and then clusters were made. Material was examined to identify similar phrases, patterns, or themes. For *theoretical sensitivity*, generalisations were linked to a formalised body of knowledge. These links were then

compared to the focus of the research questions (Miles & Huberman, 1984; Willig, 2008). The questions collectively asked what was already understood to constitute effective healthcare; how practitioners' broader understanding of their patients related to their care; and what actually occurred in practice. If these links to formalised bodies of knowledge were "saturated," then questions were amended or deleted in the Interview Schedule (Amended) (Appendix G). New questions were generated according to the reflections made, resulting from examination of data as it emerged. For example, Q: "Around the theme of a cultural focus in the delivery of diabetes care, what would you like me to focus on in such a research project?" Q: "Is there something you would like to say that I'm not already asking you?"

Emerging themes were extracted from these interviews guided by the grounded theory strategies suggested by Charmaz (2006) to develop and extend current conceptualisations of culturally competence practice. These steps were: categories; coding; constant comparative analysis; theoretical sensitivity; theoretical saturation; and triangulation. The purpose of undertaking a series of interviews was to provide a unique description of practitioners' work with diabetes patients, which conveyed their subjective experience, aside from the required steps of treatment, as stipulated by their evidence-based training and knowledge in medicine.

Data was first analysed manually then electronically using QSR NVIVO 8.0 software. Data was generated through direct tape recordings of interviews, which were transcribed verbatim. Similar data were grouped together and given labels about concepts they represented. They were connected by statements indicating their relationship and then drawn from the insights and interpretations emerging during data collection. Once data was collected, research questions were removed from the interview schedule where there was saturation or overlap of information (Miles &

Huberman, 1984). Analysis occurred during data collection in order to help generate strategies for collecting new or better data as a corrective for built-in blind spots.

Overall, analysis consisted of two concurrent flows of activity, followed by a third: The first was the first intuitive response to the data. This involved data reduction into categories, involving thematic links and coding. Themes were teased out, clusters and partitions formed manually with hand notes over transcripts (Appendix H).

The second included data display through a preliminary schematic model with notes (Appendix I) using QSR NVIVO 8.0 software. This was created to visualize, explore and present connections in the data through comparative analysis. Emergent links demonstrating theoretical sensitivity and saturation were identified.

The third involved developing a number of exploratory NVIVO diagrammatical models (Appendix J), which were formulated through verification of the data. Conclusions were drawn from the data through triangulation with the first supervisor and interviewees. This last step involved consulting with participants (Appendix N) on the veracity of the researcher's conclusions arrived at in the data. The levels in these diagrammatical models were used throughout as a framework for handling the data (see stage 3 of Analysis below).

### **Analysis.**

Analysis of the data was organised in four stages:

1. Audio Transcript Organisation. All audio taped interviews with participants were typed onto separate word documents. The first typed transcript was read through. Using QSR NVIVO 8.0 software, sections of the text were identified and short descriptive headings were noted. For example, "learning at work" and "gender and hierarchy" were new headings created for analytical categories. As the second

transcript was read through, the same process was followed. When descriptive headings did not fit into the existing themes new themes were identified. Where common phenomena were identified the data was next grouped and listed alphabetically (Appendix K). These common themes were analysed further to review the appropriateness of the interview descriptors. Where a theme did not correspond with a descriptor it would be moved to an appropriate heading. Where a heading did not adequately capture the essential meaning of the themes grouped under it, it would be changed. Ultimately, a substantial list of themes was developed and coded. The emergent themes were collated in groups relating to each domain of enquiry, across interviewees, according to the interview structure.

2. Grouping of Themes. Using theme headings (QSR NVIVO Tree nodes) and transcript entries, a thematic matrix was constructed using QSR NVIVO 8.0 software. These matrices were categorised by interview question and by participant using numbers only to maintain anonymity and links to the original transcript (Appendix L). Cross-references were made to both categories. Each participant was assigned a number and so each participant was anonymously identified.

The list of themes provided access to original line numbers, which were embedded in the electronic document. These original line numbers were maintained throughout analysis to facilitate finding the statement's location in the transcript, should it be necessary to check the context of the statement at a later date. Common themes were then reorganised through the first of many static diagrammatical models created by the QSR NVIVO 8.0 software to show interrelationships between emergent themes and the original research questions.

3. Development of Diagrammatical Models for each Domain. Three separate coding domains made it possible to arrange and identify themes for coding (Appendix

M). They were EBP and conventional preparation for practice. Bridging the gap; and Real world interactions. Themes were grouped together according to what level of coding they corresponded to. For example, gender and hierarchy was assigned to Bridging the gap domain.

Themes from the raw data (type written transcripts) were verified for relevance by the first supervisor, who also reviewed and independently verified the relevance and integrity of the transcript coding. The complete list of specific targeted words and phrases along with their frequency were reviewed (see previous Appendix L). They were presented, discussed, and the appropriateness of new themes for coding agreed upon.

4. Final Stage: Generation of a Dynamic Model. A dynamic model representing an overview of the culturally competent dynamic as revealed by the data was developed (Figure 7). This culturally competent reflective model represented the final stages of the qualitative analysis findings relating to the research questions.

### **Ensuring Rigour**

Trustworthiness is equivalent to the notion of validity in positivist research. It is important in qualitative inquiry as a means of achieving methodological rigour (Lincoln & Guba, 1985). Interview data was captured on audiotape as well as by a “note-based” format. Brief notes were made at points that were of particular importance at the time. The reason for the dual data collection was to increase its trustworthiness and to provide a back-up should any communication by the participants not be understood by relying upon one method alone.

Trustworthiness of the data and the findings and interpretation were assessed using triangulation with the notes maintained by the researcher, available documents, debriefing, sharing perspectives with the research supervisor, and feedback from

participants. This was ascertained by telephone interviews with six participants (27% of participants) to comment on the accuracy of the findings and interpretation (Appendix N).

The use of a reflective journal by researchers has been identified as a means to verify rigour in qualitative inquiry (Lincoln & Guba, 1985). Therefore, a reflective journal (Appendix O) was used to document experiences during the research process. These included design decisions, comments made by participants, and personal reflections and recommendations on alternative or different approaches.

## Chapter 5

### Findings and Interpretation

*“Why should a culture run totally on our terms?”* (Diabetes practitioner).

*“Nurses are rescuers, and not everyone wants to be rescued”* (Diabetes practitioner).

*“If it was just simply sufficient to pass across the evidence-based information, then there would be declining rates of diabetes, and a healthier population”* (Diabetes practitioner).

### Chapter Summary

The previous chapter outlined how the data was organised along the lines of grounded theory methodology. Information was thematically arranged, coded and analysed around research questions to investigate healthcare practitioners’ actual experiences, and to develop explanations inductively drawn from the data. The findings and interpretation in this chapter set out to clarify the experiences of individual professional healthcare workers and to give an insight into the beliefs and experience of their practice. The qualitative findings and interpretation stated the practitioners’ views of EBP and perceived gaps in their training, along with what they did, so as they adapted to working with different cultural groups. Aristotle’s concepts of episteme (scientific knowledge), techne (practical knowledge), and phronesis (ethical knowledge and practical wisdom), were interspersed through Table 4. These concepts and additional findings were integrated into the culturally competent reflective practice model (Figure 7) presented in this chapter. They reflected how practitioners described their skills. Of these three ancient intellectual virtues the most prominent in this study is phronesis.

The findings and interpretation in this chapter were organised using the research questions below as a framework:

1. What place did practitioners believe Evidence-Based Practice (EBP) held in their work?

2. Beyond EBP training, what knowledge gaps were identified as a result of working with a multicultural cohort of patients?

3. How did practitioners adapt their EBP training?

Following each research question, identified themes and percentages in brackets signified the proportion of participants who held this viewpoint, or commented on it (see Table 4). Participants' comments are italicised and included to illustrate themes.

### Categories of Responses per Research Question

Table 4: Categories and percentages of responses per research question.

Research Question	Category (Response percentage frequency)
1. What place did practitioners believe Evidence-Based Practice (EBP) held in their work?	<p><b>Episteme and Techne</b> (EBP/ Scientific &amp; Technical knowledge)</p> <p><i>EBP Informs diabetes practice</i> 100%</p> <p><i>Practitioners views: EBP on its own</i> 100%</p>
2. Beyond EBP training, what knowledge gaps were identified as a result of working with a multicultural cohort of patients?	<p><b>Episteme and Techne</b> (Scientific &amp; Technical knowledge)</p> <p><i>Training: Level of Cultural Competence content in Diabetes Training</i> (Absent = 45%; Very little = 55%; and Comprehensive = nil %)</p> <p><i>Dietary knowledge</i> 100%</p> <p><b>Challenging the Status Quo</b></p> <p><i>Making Assumptions</i> 100%</p> <p><i>Recognition: Different Belief Systems</i> 100%</p> <p><b>Cultural Implications</b></p> <p><i>Translators</i> 48%</p> <p><i>Translators (criticisms)</i> 48%</p> <p><i>Religion/ Spirituality: Liaison - religious leaders in local community and internationally</i> 91%</p> <p><i>Family: Family and Hierarchy</i> 100%</p> <p><i>Power: Gender &amp; Culture</i> 68%</p> <p><i>Psychological Perspectives</i> 41%</p> <p><i>Healthcare Practices set by Policy</i> 14%</p>

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3. How did practitioners adapt their EBP training?	<b><i>EBP and Phronesis</i></b> (Integration of EBP and Ethical Knowledge)
	<i>Reflective Practice</i> 100%
	<i>Reflective Practice: Adapting EBP to suit</i> 100%
	<i>Forming Relationships</i> 95%
	<i>Communication Competence</i> 100%
	<i>Patient-Centred Practice: Patient Perception of Power; Locus of Control; Empowerment; and Empathy.</i> 100%
	<i>Patient-Centred Practice: Holistic approach</i> 27%
	<i>Community/ Engaging Community and Community Leaders</i> 73%

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### **Research question 1.**

What place did practitioners believe Evidence-Based Practice (EBP) held in their work?

#### **Episteme and techne.**

#### ***EBP informs the treatment of diabetes.***

Without exception, 100% of participants regarded core training based on EBP as an important requirement to prepare for their work. This knowledge was gathered through research and followed specified government and professional bodies' guidelines:

*EBP is important and informs practice, based on the best available evidence. It's usually gathered through research and we try to follow best practice through the guidelines of the National Health and Medical Research Council and also through the Australian Diabetes Educators Association (Diabetes practitioner).*

*... Knowledge through evidence-based research is very important in my practice because this is the information I need to have to be able to inform the patients that these are the indicators they should be watching and noticing, and making sure that they are actually complying to different exercises, or diet, or medication (Diabetes practitioner).*

#### ***Practitioners' views. EBP on its own.***

All participants agreed that EBP in training and practice was crucial to their knowledge base. Nevertheless, more was needed for appropriate and effective practice with multicultural groups. Importantly, it was argued that if EBP alone were

sufficient for successful treatment of diabetes, then the increasing rates of onset of diabetes would not be evident:

*It [EBP alone] might be relevant in more Anglicised suburban areas, but not in the Western suburbs of Melbourne. If it were sufficient to pass across the EBP information, then there would be declining rate of diabetes and a healthier population. ... A lot of it is direct translation, which is not necessarily enough or appropriate ... EBP and culture need to be together. There are few studies that look at the complex issues of working in communities with a large number of cultural groups (Diabetes practitioner).*

Schmidt and Brown (2008b) regarded nursing as the “artful use of a science to promote the health and wellbeing of others” (p.18). Similarly, practitioners regularly discussed the importance of working with their patients beyond the formal clinical delivery of medical knowledge. Furthermore, practitioners cited occasions where the efficacy of delivering clinical information via EBP was limited and in many cases it was irrelevant to some of their specific needs:

*... EBP research papers have a clinical language, but it is crucial that an empathic relationship is established with the patient (Diabetes practitioner). It's also important not to put pressure on the reluctant ones to change, but encourage them to keep an open mind and maintain an empathic relationship ... relationship is very important, so then we can get to the next stage. Success is measured in very small steps ... it's hard to maintain motivation because it [diabetes] is always there (Diabetes practitioner).*

Status and legitimacy as professionals in the field of diabetes healthcare was a concern to practitioners. In the healthcare field there was a requirement to use EBP in their work. One educator argued that to be taken more seriously diabetes educators needed to legitimise their work through formal EBP clinical research. She believed a requirement for employment was to follow government policy guidelines and so they were then seen as “legitimate” practitioners:

*It's quite scientific in the way we were taught ... we use this [EBP] knowledge to treat people, knowing that these are well-trialled and informed bits of information about the treatment of diabetes ... If you don't practice clinical-based programs, or guidelines initiated by the government bodies, you don't have a job. It's a requirement of being employed ... We diabetes educators had*

*to fight in our journals with more clinical research papers, rather than emphasising we care or we empathise ... We do our diabetes education practice with clients based on evidence-based programs. That's why we set benchmarks for clients based on research we read (Diabetes practitioner).*

Reasons for patients' lack of adequate diabetes management, were not considered to be all that clear cut. Practitioners put a high value on attending to the broader picture of a patient's lifeworld beyond focusing only on physical symptoms. They often discovered new knowledge in ways that were unexpected. There were times when this discovery was distressing:

*I saw a woman from an African background, from a war-torn country. I wanted to know why she wasn't eating properly ... that meat had lots of iron ... I didn't have time to check her background history, why she was a refugee ... and it wasn't till she started talking about how she couldn't eat meat, which she associated with rape and murder. She saw her family being murdered and she associated that with eating meat. That really affected me. I would have liked more time with that patient for the counselling side of things. That moment changed my practice in terms of being aware ... that if a person from a different ethnic and cultural background, to look at their social history. Because if something traumatic happened to someone, to be sensitive in how you choose your words and whether or not this treatment is a priority in their lives or not. These were the issues affecting what this patient was eating, but I was so set on meeting my goals that I neglected to check the whole picture before meeting the patient. I was quite affected by that experience (Diabetes practitioner).*

### **Research question 2.**

Beyond EBP training, what knowledge gaps were identified as a result of working with a multicultural cohort of patients?

### **Episteme and techne.**

As previously stated, practitioners commented on the importance of EBP and highlighted the inadequacy of EBP training alone, especially after their experiences working in the Western suburbs of Melbourne. In Habermas' (1987) *Theory of Communicative Action* he proposed that ethical and prudent communication, or phronesis, was a crucial element that must be reintroduced to practice as

communication competence. The absence of phronesis in our modern language appears to reflect the status of mainstream training and education, with its emphasis on analytical, scientific knowledge (episteme), and technical knowledge or know-how (techne) over the social.

***Training: Level of cultural competence content in diabetes training.***

(No Training = 45%; Very little = 55%; and Comprehensive = Nil).

As few practitioners reported culturally relevant content in their diabetes training curriculum, it was evident that most practitioners believed culture should be integrated into training. However, when it was present it was reported as being very brief. Samarasinghe, Fridlund and Arvidsson (2010) also concur with the practitioners' views that adequate knowledge regarding intercultural skills should be included in the education of nurses, both at under and postgraduate level. Practitioners indicated that cultural content presented in training was not integrated into the curriculum, but eventually became more prevalent in the latter year's training curricula. As a consequence of little culturally focused content in their training, they believed that they needed to learn at work when working with different cultural groups:

*What is right for the diabetes educator compared with what is right for the patient? In training we need practical ideas to handle religious, ethnic, ethical and moral issues that might arise with different cultures (Diabetes practitioner).*

*General information is given in training, but not relevant to the specific ethnic groups that we worked with. Maybe this can't be done and that learning at work is a requisite for working with a multitude of different cultural groups. Consideration of cultural diversity and cultural components in training are now less separate, but are becoming more integrated over the whole course. The concept of integration should be inbuilt. Resources are developed and translated on a need to know basis. Rather than just a template that is translated into relevant language, awareness of what can be included in delivery should be clinically effective and culturally sensitive at the same time. There is a need to integrate cultural aspects into the course, not as an add-on (Diabetes practitioner).*

Adhering to EBP information gained through training did not exclusively apply to their practice. Training content was widely considered to be general and limited in its application. It was deemed useful mostly for Anglo Australian populations:

*If it was a usual Anglo Saxon population and being trained in EBP, it would usually be easier to deliver the information. They have different levels of education in their understanding, so we can use that and apply it to the rest. I think when they are doing a presentation or teaching us, it should be pointed out that it is for more general situations (Diabetes practitioner).*

*This [cultural perspective] was not included in our training [in 2001]. Our diabetes training was for one year. Five sessions, each had a different theme or something. What is diabetes? Themes on diabetes, you know, on insulin, management, and complications. Then two terms of education and one term of management. It was general training (Diabetes practitioner).*

EBP was seen as essential, but appeared to be in the background to what they actually did. One hundred percent of participants identified gaps between content in their EBP training and the requirements of practice with different cultural groups. Shortfalls in available resources were considered to be widespread. Relevant resources often did not exist and practitioners created them to suit the specific needs of their workplace. Practitioners' identification of reciprocal knowledge-acquisition was also evident, as a result of responding to the "voice" of their patients:

*Every time you go to a conference there is new evidence, new research, saying how am I, how can I do something, what do I need to change? ... The ongoing use of EBP as a background to practice and to give patients specific data to explain what potential outcomes could occur ... so evidence comes from both directions. From research and from patients' experience themselves. ... The ADEA website has guidelines for management and guidelines for care ... and also something that I've tried to do here, and that is gap-analysis. Looking at what is not here and trying to fill the gaps. Trying being the operative word. It is very frustrating with lack of time and resources (Diabetes practitioner).*

Interpreters were highly valued by practitioners and many commented that they would have liked more training in how to effectively utilise translators' skills to navigate the complexities of the communication required:

*Training should include how to use interpreters, because it makes a difference to feel comfortable with interpreters. If there's a family member and they talk between each other, the interpreter is obliged to interpret what has been said between them (Diabetes practitioner).*

***Dietary knowledge.***

Following their training, 100% of practitioners commented that they needed to know which diets were culturally appropriate. This was done through their own research, resource development, and through the use of skilled interpreters. For example, over five years, diabetes educators created a Macedonian resource package focusing on their diet and other resources. But limited time and money made creation of this resource prohibitive. In many cases, widely available dietary information gained during and after training, was found to be irrelevant. Therefore, practitioners did not use it:

*Training was general. Information given may not apply to some cultures. There is nothing in training to say that Buddhists do not eat meat on designated days and so patients cannot respond (to us giving advice) about eating red meat. ... I was trained to give people a seven-day meal plan, but I don't give it because it's not relevant for the Egyptians, Greeks or Yugoslavs that I see (Diabetes practitioner).*

*... you might have access from ten to fifteen languages. A lot of it was direct translation but not culturally relevant in many cases. We tried to tackle that problem through district nursing because we've tried to develop a model that looks more at working with the community, to look at what is the level of health literacy or actual literacy. There are a couple of efforts around, but I don't think it's a consistent effort with all of those different groups. ... I could go to access bits and pieces, but there's no comprehensive package in the way there would be for an English speaker. One of us is putting together a Vietnamese package similar to the Macedonian package that was completed after 5 years. These packages are being put together because there isn't a comprehensive approach (Diabetes practitioner).*

There were also problems with general practitioners (GP) giving patients oversimplified strategies relating to diet. In the past they also gave incorrect responses to presenting symptoms, which have since been rectified due to the results of ongoing evidence-based research:

*I've found a change in the GPs. Their habit was to tell clients that it was only a little bit, just a little high on sugar, not full diabetes ... that they were borderline and not to worry about things at the moment. Just change their diet a bit. But now that's changing with the doctors and they're now saying you've got diabetes and you need to manage it. That makes it a lot easier for us. In the past that was hard for us. If doctors were telling someone who didn't understand English very well, that it's only a little bit, you needn't panic. So that's changed in the GPs training now that diabetes is on the rise (Diabetes practitioner).*

### **Challenging the status quo.**

#### ***Making assumptions.***

Importantly, 100% of practitioners demonstrated the capacity to recognise when they incorrectly assumed professional and personal knowledge relating to cultural information. As a consequence they address these views and preconceived ideas:

*It's important that I do not have a preconceived idea of what you (I) think they might understand or agree to. A woman said she had musical instruments in her body. It checked out that it was a way of describing depression and anxiety, rather than me originally believing she was delusional (Diabetes practitioner).*

*... Samoan and Arabic communities including Iraqis, Lebanese Muslim and Christians. They have their own traditions, so you have to be careful not to label people. You have to know where they are coming from in terms of their fasting and their religious beliefs and their practices. I found out that I had made a mistake when I mentioned Ramadan when I was seeing an Arabic woman without a headscarf and it should have alerted me that she wasn't Muslim ... she needed a Syrian or Arabic interpreter. So in a moment of inattentiveness I had assumed she was Muslim and they corrected me and said, no we were Christian. In our assessment process we ask them what country they come from. That's how we determine what sort of interpreter they need. This obviously doesn't work every time (Diabetes practitioner).*

*They don't know what they're buying, or where to buy it, or what it is ... they are given a fridge for the first time... they put their canned foods in the fridge ... just basic, basic stuff that we take for granted ... So it all takes a bit of stepping back and examining things in fine detail to work out what the assumptions we are making, and then changing from that (Diabetes practitioner).*

#### ***Differing belief systems.***

All practitioners (100%) were able to recognise *different belief systems* compared to a typical Western viewpoint, and were able to act on this. They discussed

incompatibility between EBP knowledge gained in training and the need for understanding and accommodating different cultural norms:

*Understanding people's different values and beliefs are important areas to examine ... looking at different cultural features and the notion of working with people with different beliefs. Because obviously if you're looking at some things that some people might consider as strange, might in fact be culturally appropriate in other places. You have to be careful because you're making a clinical decision and could be misled in what you think is clinically correct (Diabetes practitioner).*

Patients' lack of knowledge about their disease was reportedly a constant challenge. This difficulty was exacerbated by patients misunderstanding that the apparent lack of symptoms still meant they had a chronic disease. To manage their disease the challenge was to bring about awareness and change:

*It's a very sneaky disease. With a heart attack you normally feel quite ill. Unfortunately, with diabetes you don't. Very slow, sneaky, insidious diabetes. We're actually asking people to change their lifestyles, not just their diet. So trying to encourage someone to change their lifestyle or to look after themselves when they don't see any difference is quite a challenge, a huge challenge. They see no need to change when they don't feel any different (Diabetes practitioner).*

*If a client said to me that their condition was due to something they had done in the past, I would say yes you have done something wrong in the past. Then ask them what they think that might be. I let them bring it out without interfering with their systems of belief ... no matter what cultural background, I go to where they are and work with them from there and encourage them to feel they're not being judged (Diabetes practitioner).*

*If someone said it was voodoo and that this had affected the pancreas. First I wouldn't say they were crazy. I would respect their beliefs and everything else. But first I would try to find out why they believe that and whether they're depressed, or if there's increased anxiety because of what they believe (Diabetes practitioner).*

Practitioners knew the importance of not rejecting patients' points of view. They widely regarded the appropriateness of "meeting people where they were":

*You have to be careful to respect what the person perceives, whilst also offering a clinical view ... I came from that kind of culture myself where mysticism is part and parcel of the whole culture. I'm very sensitive to those things and I have to be very aware that this is what the person perceives. I've got to treat it very carefully. But definitely, if what they believe is possibly true, or even if it isn't, we can help them to understand that diabetes is also*

*part of the physiological process as well. So I don't discount what they believe (Diabetes practitioner).*

*If you discount what they already have in their mind, they'll be very difficult to work together with; and in terms of trying to educate them and counselling them better. ... If they brought it up [a curse or spell], by all means I would discuss it. It is a totally valid thing to be pursuing. You meet people where they are. You get lots of reasons why people have diabetes. You don't make assumptions; otherwise they'll never come back. Beliefs still exist where it is no longer culturally relevant. For instance, I worked with an African woman who wouldn't go out at night in Melbourne because she said she had to look out for elephants (Diabetes practitioner).*

### **Cultural Implications.**

#### ***Translators.***

“According to various studies, systems lacking interpreter services or culturally and linguistically appropriate health education materials lead to patient dissatisfaction, poor comprehension and adherence, and lower-quality care” (Betancourt et al., 2002, p.3).

Translators are considered more suitable interpreters than relatives, friends and children due to less emotional and more factual exchange, and also protection of patient privacy (Fatahi, Mattsson, Lundgren & Hellström, 2010). To do so enhances accurate and relevant exchange of culturally appropriate information. Interpreters were seen as crucial to their work, especially with difficult situations and patients who had difficulty understanding their practitioner's information. The terms translator and interpreter were used interchangeably and their role was highly regarded by all practitioners. Although some practitioners wanted their interpreting services to translate literally, others saw their work as more than just translating language. Through *intercultural interpreting* (Xu & Davidhizar, 2005), they saw themselves as facilitators of intercultural communication, where they translated into a “new space”. They were able to take into account their patients' cultural complexities and also

found ways of overcoming their frustration of not being able to properly “see” their patient:

*It's much harder to see the person when you are working through the interpreter. To get the character of the person, but with P the interpreter you get it more. He works with that. He's clearly a person who is very involved with that community. He really cares and he explains to me what he's doing. There was a general frustration of not being able to communicate directly with patients (Diabetes practitioner).*

*We have a good rapport with interpreters. The ones we have we ask them to come back. You may find the odd one (incompetent), but they're few and far between really. Those I've had seem to know me, so they know what I'm going to say next sentence (Diabetes practitioner).*

*It needs to be emphasised that, although family members can interpret for you, it's [important] not to be [family] members only. If family members come they are there to learn what you are teaching the patient, not necessarily to try to interpret for you. So it's useful to have the interpreter there as well as an English speaking family member. Sometimes a family member might, unwittingly, not translate objectively, but put in their interpretation. Occasionally an interpreter may not understand what I'm getting at; they'll say that to me. So I need to reword what I'm trying to get across. So they're not translators. Sometimes they need to understand the concepts too (Diabetes practitioner).*

*It's important to be aware that family translators can misunderstand or forget information, so professional interpreters are important ... No family members (should be) interpreters because they may incorrectly emphasise or generate anxiety that is not intended (Diabetes practitioner).*

*Translators (criticisms).*

There were no practitioners who were critical of translators as a whole, but 48% found inappropriate or inadequate translating skills by professionals as unexpected and detrimental to the processes involved in their work:

*There could be some problems with interpreters. I had a Cantonese interpreter even though I can understand Cantonese, but we were required to use an interpreter. I knew that the detail I was giving was not being translated, as I would want it, in terms of what I needed the patient to understand. A minor mistranslation can have a big effect. So now I sometimes think some interpreters, in languages I don't understand, haven't explained my words properly. Especially if I've gone into a lot of detail and their translation is just one sentence, it makes me wonder. I check with them to make sure the patient is not agreeing with me just to be polite (Diabetes practitioner).*

*If interpreters put in their own interpretations it's a problem ...there's a high risk of misinformation (Diabetes practitioner).*

*I had one interpreter answering their mobile during consultations. I do not want to have that interpreter again (Diabetes practitioner).*

### **Religion and spirituality.**

Practitioners widely reported their understanding of patients' needs and liaison with religious leaders in the local and wider community. Religious considerations were discussed by 91% of practitioners, such as the observation of fasting during Ramadan for Muslims. However, some patients wanted to keep strictly to the religious rules. As a result, religious leaders were approached by practitioners to negotiate on their behalf for ways to manage blood sugar levels within acceptable religious parameters. These meetings were fruitful especially when EBP information was given to religious leaders and religious information was exchanged. Consequently, informed decisions were made and compromises were negotiated around Ramadan for Muslim patients who wished to strictly observe fasting:

*I have gone to the heads of the church and informed them of the health concerns of diabetes patients. I tell them of the physical requirements that my patients need to enable them to manage. I have not seen Muslim groups, but I am now waiting to work with some Egyptian doctors whose patients are Muslim, so I'm going to begin to get into it in that area too. I will also approach Catholic and Egyptian Orthodox groups. I will also be thinking about the Greek Orthodox group as well. I need to know more about their religion to be able to work effectively with them. I [wasn't trained for that and] had to learn through my own experience (Diabetes practitioner).*

There were many occasions when practitioners needed to reflect and respond to religious and health beliefs. Those that varied from accepted scientific knowledge significantly influenced their clinical responses:

*You need to know about religion, which is a big thing also. Their beliefs about sickness; what causes sickness is really important. Whether [Western] medicine is accepted in their belief system because sometimes it isn't. Instead of taking medication, maybe they just trust in God. So you have to be able to reflect and be open to this (Diabetes practitioner).*

### **Family and hierarchy.**

All practitioners reported negotiating the different cultural norms related to family and hierarchy. There were questions relating to whom in the family decides whether the patient undertakes treatment or not; or about who in the family takes responsibility for managing the disease. Some men wanted to control their partner's treatment and appointments. In one extreme case, a husband refused to give his wife (the patient) permission to attend the clinic on her own, to the detriment of her treatment. Furthermore, many patients did not return for consultations until the practitioner met with the head of the family or a community leader. Treatment could only begin after those meetings:

*A male patient sends his wife [in his place]. He said for me to tell his wife as she was the one that looked after him ... his wife [usually] answers all the questions I directed to him, so I also have to deal with issues concerning her [compliance with his wishes] ... Sometimes there are families, Macedonian and Serbian, where the male is the head, the dominant one in the family and will not cooperate with me as he is not used to following a female's advice. It affects the management of the disease (Diabetes practitioner).*

***Power: Gender and culture.***

Males who had difficulties consulting a female professional, or were uncooperative, were cited by 71% of the female practitioners. They were overt in their expression of perceived higher status over women. For the purposes of successfully delivering treatment plans, practitioners "treaded a fine line" between promoting change and not alienating their patients:

*He kept saying, 'I'll check her temperature' [his wife was the patient, and was present]. This was not helping to detect blood sugar levels. I tried with an interpreter, but the husband screamed the whole place down. He got upset every time I said something that didn't agree with him. ... and then there was one time when her sugars were 30 something, where everyone's target is seven or less. She was sitting there and not saying a word. She let him do everything. So eventually I ... was speaking directly to her. But she wouldn't dare answer. I said to her I prefer to see her on her own, but he wouldn't let me. I contacted the GP and the GP actually gave up. The wife is sort of noncompliant as well, so it's not just the husband's fault. The GP found it was really hard. So in those cultures where the man controls, it's going to be very*

*hard, unless you can get through to him, because he is the one taking care of her ... he doesn't see how his behaviour is making his wife's diabetes much worse (Diabetes practitioner).*

There were issues concerning hierarchy and gender when casual conventions of communication by female practitioners caused offence:

*I tend to address patients by their first name. There was an older man, maybe late 60s or older, from an Eastern European country. This chap got very irritated with me because I presumed to call him by his first name. He said, 'You'll address me as Mr so and so.' Then it all went downhill from there. He just was not going to be addressed by this little girl. I think he actually called me a little girl. I wonder what he might have been like with a female doctor? He just didn't come back. He refused to come back and he wouldn't have a bar of it (Diabetes practitioner).*

*I had an African gentleman here who tended to give me (female practitioner) a bear hug every time we finished our consultation. I thought that was unusual ... because he was a Muslim gentleman and I'm thinking where's this coming from? I never did work that one out. He kept coming back. It was more of (for me) to keep my distance (Diabetes practitioner).*

*If there are some issues or reservations about me being a female, my usual view is that it is another barrier to be broken down, or overcome. Perhaps they might not want to come back, but on the whole it might take a little longer to form a level of rapport. I would acknowledge there are reservations, to put that out into the open and not try to be judgemental. I might say I appreciate what you're saying, but I can't offer you a male practitioner here. I think there be can many barriers, but as long as you talk about them with the person. There are communication skills that come into play (Diabetes practitioner).*

The practical implications of family hierarchies needed to be respected.

Practitioners were frequently challenged to come to terms with differing hierarchical partner-spouse power relationships:

*During consultations with both partners present, it was often the male that you had to direct your conversation to, even though he wasn't the patient. This was because he's being in charge of the female in the household and I know colleagues of mine who have told me stories where the male [partner of client] actually says, 'Tell me and then I'll tell her.' It's happened to me. A man has actually said, 'You speak to me and I'll tell her what to do.' You can't change what actually happens in the household, the lifestyle, or the household hierarchy (Diabetes practitioner).*

***Psychological perspectives.***

Cultural competence requires the ability to see the world through another's eyes or, at the very least, to recognize that others may view the world through different cultural lenses (Fitzgerald, 2000). Although empathy, rapport and relationship building were discussed extensively, 41% of practitioners commented on the actual importance of psychological factors as an adjunct to a wider, more holistic viewpoint of healthcare practice. Interestingly, practitioners often reassessed their initial analysis of patients' behaviour. For example, there were instances when they needed to decide whether behaviour that was a departure from the Western norm constituted a psychological problem, or a mental illness:

*A Chinese person was experiencing certain symptoms. It was hard to know if that was normal in Chinese culture, or whether it was a psychological problem. Whether the person was deluded in the type of symptoms that were being reported (Diabetes practitioner).*

*...With the older Arabic man whose wife had died, he's feeling very, very sad. He's saying, 'It's God's will. What can I do?' There are numerous things he can do and we're talking to him about re-engaging with people. The interpreter said to him, 'You are a man of great wisdom.' So then we were on to that. We said it was sad that he was sitting at home and nobody got to meet and talk and find out the things that he knew. So getting him to understand there was a place for him in the world, even though his wife has died. Then I said to him, 'What would your wife want you to do?' To bring her [his deceased wife] in and the interpreter said she would say, 'Get out there.' We all laughed and he laughed because we all knew his wife would say that. So although it wasn't planned, the interpreter and I found a way to engage and help this man who was feeling very sad (Diabetes practitioner).*

#### ***Healthcare practices set by policy.***

Policies were recognised as important to address gaps in training, practice and the rights of individuals. This was not widely discussed, but 14% said laws empowered individuals from countries who did not usually experience the same freedoms available in Australia. Practitioners also noted that they wanted to be consulted about policies affecting their work:

*I didn't learn about cultural competence or anything like that as part of our training. Cultural competence is now appearing in research papers and policy*

*writing. That exposed me to those concepts, but I wasn't formally taught as part of the training (Diabetes practitioner).*

*The government has clear guidelines. Experts in this field get together and discuss issues and say this is the way we'll do this, because we have had positive outcomes (Diabetes practitioner).*

*Cultural competence was not part of training, but is now in research papers and policy writing. ... It's important to get across that in Australia they have rights as some may have come from authoritarian regimes, or family structures (Diabetes practitioner).*

*Nursing is my background. They are cutting back on our times. It's the day-to-day people like me they have to keep in touch with; they are the ones. Policy makers need to consult those in direct contact those doing the groundwork (Diabetes practitioner).*

### **Research question 3**

How did practitioners adapt their EBP training?

#### **EBP and phronesis**

##### *Reflective practice.*

Although it was not referred to explicitly, reflective practice appeared to be employed extensively. All interviewees commented on how they were able to perceive, acknowledge and address assumptions made about their work and patients. An indicator of reflective practice is recognition of having made assumptions that need to be clarified; and that they are then acted upon (Schön, 1995). This action is clarified, or reframed, while it is occurring in the workplace.

##### *Reflective practice: EBP and learning at work.*

All practitioners commented on the capacity to reflect on their work. Responding through reflective practice was an inevitable direction to take, considering that practitioners initially had little relevant cultural knowledge, or experience, prior to their involvement in diabetes care. They were highly motivated to make a difference for their patients. The practitioners were very resourceful and conscientious in how they dealt with this shortfall in knowledge:

*I'm seeing a lot of people from different cultures and they've got different experiences. Coming from war ... from places where they've had problems. So I need to think again. They come over here and I often think what it would be like for me not understanding anybody. I would become quite isolated. It would be difficult for me to get on the tram or the bus. I thought why should a culture (be) run totally on our terms? ... It's our responsibility to understand their experiences (Diabetes practitioner).*

Reflecting on one's own cultural roots was important, especially if one was from a non-Anglo Australian background:

*... it was difficult for me when I was younger, because my father imposed Eastern cultural values because that was where he grew up. At the time I didn't really respect it as much as now and then trying to live in a Western society. But when I finished my studies and travelled overseas, I became more aware of ... I discovered that when people asked me where I was from, I thought to myself, where do I come from? I'm from Australia, but my parents came from ... so I became more aware of that. I would say I am Australian Chinese, so I respect both. I have come to appreciate the cultural values of both Australia and from where my parents come from and use them together (Diabetes practitioner).*

It was crucial to reflect on how to challenge behaviour that was detrimental to diabetes care and to keep patients engaged in treatment. Practitioners' capacity to reflect on their own beliefs was also evident. Beliefs that did not fit a Western scientific viewpoint were commonplace and were dealt with using EBP. In addition to this, less overt and subtler ways of advising and interacting with patients were found to be appropriate. These were successfully utilised:

*I needed to make certain decisions, as there were priorities that other cultures might make that are different to what I might do... You've got to be really careful you don't come across as being judgemental just because their way is different to your way. So you couldn't make it that she'd made a wrong choice, because to her, she'd made the only choice that she had. We see a lot of that type of thing where it's really hard to take that step back and realise they are my values, not her values. So I've got to respect where she's coming from and aware of where I am in this too (Diabetes practitioner).*

*I don't think we have a right to change other people's beliefs. They are comfortable in that and it's not my right to actually change that. It's finding a way that will keep them feeling comfortable with their beliefs, but get the outcome that you want (Diabetes practitioner).*

It was important for practitioners to find common ground with patients and to respond to their feedback rather than the other way round. This required reflection and *re-evaluation* of their work practices:

*You have to be mindful of what your values and beliefs are and that you don't put those onto somebody else and to be open to theirs. This relationship can be broken if you don't have their trust. They're less likely to do what you want them to, so you need to show respect for them if you want them to give you back that respect. Because they respect you, they're more likely to try to follow, rather than not (Diabetes practitioner).*

*I wouldn't try to impose my thoughts or beliefs on them. Again, I come back to that same thing: to work with what I've got in front of me. Does that view of their illness impede their ability to manage that condition, or their wellbeing? If they hold those views I work towards wellness, whilst being sensitive to their beliefs. I can harness those beliefs and find the discrepancies there and work with those. There is always scope to work with something, irrespective of whether I agree with their beliefs or not (Diabetes practitioner).*

*You can't generalise about one culture either. I think people from the same cultural backgrounds express different thoughts and beliefs. To me it's about the person and I need to rethink what I do. There will be some common themes, but it's those little individual differences, the way they relate to a culture, their beliefs about their illness. All those things intertwined. I can't make any general approaches, so I think it goes back to thinking and reflecting on what I do (Diabetes practitioner).*

***Reflective practice: Adapting EBP to suit appropriate cultural perspectives.***

This adaptive skill was employed by 100% of practitioners. They set out to adapt or modify their knowledge base acquired through training, because it was considered relatively inadequate. They used the feedback received from their patients, families and the community, whilst making adjustments through reflection. This new reflective knowledge was incorporated into their practice:

*I would definitely not regard the person just as an individual who has diabetes and that I needed to give them this specific bit of information. I think you need to look at the bigger picture of what makes that person; where they live; where they come from. I would ask myself if there were barriers that are stopping them from being concerned about their health and then put those strategies into practice (Diabetes practitioner).*

***Forming relationships.***

Relationship building was indicated by 95% of practitioners as one of the core elements in their practice, which is a cornerstone of reflective and patient-centred practice (Schön, 1995):

*... our podiatrist, who is part of our team, would cut nails or treat an ulcer, whereas I am providing a form of therapy. So it is really about working with the patient. It's about the relationship. That's the first thing to look at. It's not easy to say certain names. I have to practice to remember. I'm trying to show that I'm making an effort to get it right for them. It honours them and shows them respect by doing so ... I made the effort to say her real name and she appreciated that because people usually didn't make the effort to say it right. She did very well in the group and it may have had something to do with her being validated. Being personalised is always a good thing to do. It's relatively easy to do (Diabetes practitioner).*

For some patients, the practitioner's relationship with them was the only one having a positive impact on their health and wellbeing:

*She is 84 years old, lives on her own; she's like a hermit. Her husband died 16 years ago. She's not taking her tablets. She says, 'I just want to die. I've had enough.' ... So I go and do her weekly leg dressings and we have a chat and a cup of tea. But I can't force her to come in and have blood tests ... She still cooks for herself, she grumbles, she's wonderful. She's a sweetheart; and I did one leg dressing for her for 10 months ... There are people like that. My relationship with her may be helping keep her going. She's really a honey and a grumpy old thing. I would ring her up and ask her what she was doing and she would say to me, 'I'm not talking to you.' I'd ask what time are you free this afternoon. 'Humph, is the answer I would get. She's a honey. They keep you alive and the fact that everyone's different is great (Diabetes practitioner).*

*... But you know, they still come to my appointments, so that's good and I'm taking one step at a time. I told him to take both temperature and sugar. So if he wants to check the temperature, I say if he checks the temperature, then he can check this [blood sugar level] as well. He says, 'OK.' So we now have a relationship that we can move forward (Diabetes practitioner).*

### **Communication competence.**

All practitioners believed in the importance of developing appropriate communication skills. They appeared to have a capacity for highly developed micro skills with excellent verbal and nonverbal skills:

*When you don't know their language very well, you can tell from their body language, to help understand where they're coming from. It's important not to have a preconceived idea of what you think they might understand or agree to. [I try] to help understand where they're coming from (Diabetes practitioner). I check when I get a sense that their nonverbal communication is not quite congruent with my communication ... I want to know am I doing it right? When is eye contact not OK? (Diabetes practitioner).*

*It's important to understand their culture ... and use their beliefs to get the message across ... What words can we use that are not available or understood by us to describe certain phenomenon that we understand in other ways ... I want to be appropriate (Diabetes practitioner).*

***Patient-centred practice: patient perception of power; empowerment; and empathy.***

One hundred percent of practitioners clearly set out to encourage their patients to be in control of managing their disease. Practitioners empowered patients to make their own decisions and help them understand they were in control of the processes.

This generated movement towards their patient's autonomy and self-management:

*Some may come from authoritarian regimes or family structures ... to get across that in Australia they have rights, as some may have come from authoritarian regimes or family structures. It's important to empower people and encourage and support them in making choices about how to make a choice about their disease ... that's not just about me and what I'm going to get out of it. It's really about them. Where they are up to and where they are at. You can't teach that. I think you have to get that from your workplace ... they are in control and they make informed choices. They'll only move as far as they want to go. They are central ... instead of just dumping all the [EBP] information and then they have to follow that (Diabetes practitioner).*

All practitioners were required to focus on research and practice via EBP methods. Despite empathy and other psychological approaches being recognised as important behavioural characteristics, many reported these as having a low priority in science-based practice:

*We had a recent speaker at a conference who said that nursing is an empathic type of job, with love and caring.... and that diabetes educators reflected to him such attitudes and habits. I think he is correct and incorrect in some ways, because he would have done an internet search and would see that our journals reflect nurse's philosophies such as caring and empathy and so forth.*

*Whereas, we diabetes educators had to fight in our journals with more clinical research papers, rather than emphasising we care or we empathise. So we look at our clients' high or low sugar. I gave a talk at a recent conference to criticise this man to say that if I said I loved my client, do you think a medical journal would print it? No way. .... Most diabetes educators are nurses. A small fraction of them are dieticians or physiotherapists, but the majority are nurses. We are not going to forget what we are in there for. Let's face it. In clinical papers, you can't use those words. They will not be supported. Clients, whether you like it or not, have to have your empathy. If not, they don't come back. So it's important to have that relationship with them from the beginning. The same goes for doctors. People have more choice today. In the past people never questioned their doctors, but today we tend to question their actions (Diabetes practitioner).*

***Patient-centred practice: holistic approach.***

Although Indigenous people were not sought for this study, adopting a holistic approach to health is critical with Aboriginal people and Torres Strait Islanders (Zubrick, Kelly & Walker, 2010).

A holistic approach could be adopted for less willing families or individuals. This approach would require nurses to cooperate with other healthcare professionals, community authorities and family-focused practitioners. It also demands skills in intercultural communication paired with cultural self-awareness. (Samarasinghe, Fridlund & Arvidsson, 2010).

Although it was specifically discussed by 27% of practitioners, all practitioners described a holistic approach. They did not just treat presenting symptoms, but regarded the whole person or their lifeworld. Working this way often demanded acquisition of family and community knowledge, and liaison with allied professionals:

*We do our diabetes education practice with clients based on evidence-based programs. That's why we set benchmarks for clients based on research we read. On the other hand, we also work with clients on the basis that they are individuals ... we definitely need to know cultural information as we learn to gather information about their health and condition. But a large chunk should be from a cultural aspect; such as diet and more holistic information ... I look at people holistically. Not just look at HbA1c tests [The HbA1c test shows an average of blood glucose levels over 10-12 weeks. (Diabetes Australia,*

2011)], we must look at different ethnic and cultural backgrounds, personal social history. ... As a priority, we must look at the whole picture holistically, rather than just trying to reach treatment goals (Diabetes practitioner).

*Persuasion, trying to find out what is important to people, explanations, patience, chipping away, repetition, many, many times ... It's quite a challenge, but it's great because everyone's different. If everyone was the same, my job would be boring and I wouldn't be doing it. So it's not just evidence-based practice. You use your intuition, learn to read a person, try to find out what makes them tick, find out what's important to them (Diabetes practitioner).*

**Community: Engaging community and community leaders.**

Seventy-three percent of practitioners set out to engage not only individuals and families but also the broader ethnic community. One practitioner reported liaising internationally. This included contacting and meeting both civic and religious community leaders:

*I'm going through culturally appropriate channels of communication. I met with Melbourne's Bishop of that ethnic religious group and wrote to the main religious person in the country of origin, with positive results (Diabetes practitioner).*

*... but they (diabetes information pamphlets) never included non-English speaking people, because it was going to cost a lot to translate the actual handouts into multiple languages. So we decided we would run the program without materials. We had Mexican, Filipino, Turkish, and Spanish. It worked by us speaking, then they would go, 'hub, bub, bub,' and translate amongst themselves. It took a lot longer, but it was a very relaxing experience because you could see everyone was calming down. People had jokes and it was one of the warmest groups I had ever been in (Diabetes practitioner).*

**Comments on the future.**

Practitioners argued that it was not appropriate to adhere exclusively to scientific EBP approaches in future. Importantly, they argued for more research and verification of culturally based information:

*I would say there is lack of evidence in cultural aspects of education for the patients. I mean, the cultural perspectives would need to be verified as effective strategies for the patients. Nevertheless, there would be problems if we stuck strictly to the evidence-based practice approach when working with culturally and linguistically diverse communities. I would say more research and exploration on the cultural aspects of perceptions and other health issues*

*that influence the treatment and management of diabetes (Diabetes practitioner).*

All practitioners believed that diabetes specialist training had its limitations to adequately prepare them to work with multicultural patients. They said attention should be focused on finding out more about their patients, and to view people from a more global perspective. They believed this should be done in a reflective, explorative manner:

*At a seminar we had a presenter who came and talked to us for one hour about what she did with (an Eastern European community). But that really does not tell us about the culture, it just tells us what she did. But the world is a big world and I think a lot of things can't be taught at a school or training level. A lot will depend on experience. If you are prepared to learn from experience and you are prepared to explore the experience, then I think you stand a better chance of understanding clients. If you're going to say, 'Who cares? If they're black they're black, if they're white they're white. I'll give them the same thing.' Then it's your loss, not your gain. Globalisation has brought everything a lot closer. If you're not prepared to explore, then it's your problem (Diabetes practitioner).*

Community engagement was also very important for cultural groups. Without this many did not understand or know the existence of allied health disciplines. There were suggestions to explore the development of multi media in order to engage and communicate important healthcare information to patients and receive feedback about its effectiveness:

*You have to go out and have the core material and test it with the people you see as being the target users. We've got audio recordings rather than CDs because they (older people) were more familiar with that format. This is not us reading out the information sheet, but scripted plays done by people who are well-known in that community for doing acting, who participated in the recordings. If not as a video we could also use the script as a conversation prompter. In future we might be able to have it as a series of episodes on their community radio and use that as a community engagement strategy. They may think I don't need to see a GP if the information tells me what to do, so we need to educate people about that; and also put other messages in like stop smoking and encourage healthy eating for the whole family. So there are key health messages like that (Diabetes practitioner).*

Practitioners commented on the need to develop a community healthcare focus in future, with cooperation among allied health professionals. Also, there could be dissemination of information through public forums or informal community information sessions. Additionally, multidisciplinary services may run from one central location in the community:

*We need multi-layered systems to pick up the largest numbers and mixes of services to suit the widest range of people in the community ... To have community focus models, such as in Maribyrnong. They are medical services focused on community development with a big range of services. ... I would say, 'I'm a diabetes nurse and what that means is, I've done my nursing education, then I've gone off and done a course in diabetes care and I work with your doctor...' So you are emphasising the fact that you are working together with other professionals. A community service would combine a dental service, diabetes educator, dietician, podiatrist, and others. So it's not that you have to travel miles to the closest session. There is something happening in your local area. I think that would be a better way to run things. But that requires a high level of cooperation between various services spread all around the place. In future, I think this will happen more, but we're not quite there yet (Diabetes practitioner).*

*There is a need to network. Many are looking at a huge range of different issues. It's just enormous, especially working with different cultural groups. It might take a while; and in the meantime the diabetes educators in the region are already doing things; like a network meeting on a regular basis. So it's about being able to network, not necessarily through your employing organisation, but outside of that, with other professionals and stakeholders. So we all get to sit down and talk about what it is that we're doing (Diabetes practitioner).*

Those practitioners who worked in centres with allied professionals expressed the need for more psychologists to be attached to their services. This was due to many other issues that affected diabetes treatment requiring them to form complex relationships with their patients. Psychologists would help deal with the high frequency of mental health issues among patients:

*There are very few diabetes services that have the benefit of having psychologists attached to the team, that they can actually refer people to. So*

*there is a huge need, apart from us dabbling in it ourselves. They will also help us with ideas on how to approach people (Diabetes practitioner).*

*Then you've also got ... alcohol issues, that impact on their management. Also, because of their alcoholism they tend not to eat, so their overall diabetes management is severely affected. Then we also have a number of people with associated mental illnesses. That is a challenge in itself. There is one with schizophrenia who is quite a problem. There are also those who are living alone without any support people as well, so it's just a whole gamut of stuff (Diabetes practitioner).*

*I was surprised ... an apparent high incidence of depression and other mental illness that was high among the non-English speaking background diabetes patients. We have two fantastic psychologists here who are very busy all the time. She has given us a few lectures in ways to empower and how to talk to the patients. Unless you get their deep down issues sorted out, they're not necessarily going to move along. If there is substance abuse we have to deal with that. I was given permission to see a woman in the psychiatric ward here because I had seen her first. But usually not, we do not cover them. If I did in future, I think I would want to link in with the whole of the mental health services. This is because mental health and diabetes is such a big thing. If the patient agrees, I would refer to the psychologists (Diabetes practitioner).*

## **Summary of the Findings and Interpretation**

### **Patient-centred; reflective; and culturally competent reflective practice.**

The Culturally Competent Reflective Practice Model in Figure 7 below is a culmination of concepts and reported experiences of all practitioners in this study. It gives a schematic overview of the findings as described in the transcript excerpts and assumes a dynamic interaction between all of its components. Included at the base of this model is a four stage process of competence on a continuum of awareness moving from the position of not knowing (*unconscious incompetence*), knowing that one does not know (*conscious incompetence*), eventually through to knowing that one knows new skills (*conscious competence*). These skills are then assimilated in a way that is no longer conscious and considered to be more intuitive or automatic (*unconscious competence*). Despite this concept being used in training programmes, the origin of this four-stage learning process is not clear in the literature. However, Shenton (2007) describes a similar process in a sophisticated and expanded version.

All practitioners reported that evidence-based research material presented through the diabetes specialist-training curriculum was essential knowledge for their work. This information was gained by rigorous research methods forming the basis of their clinical practice. They were all guided by policies informed by evidence-based research in their approach to treatment.

Following their specialist diabetes training, practitioners began working in the Western suburbs of Melbourne with many differing cultural groups. Practitioners were unanimous in their view that gaps in their knowledge needed to be addressed

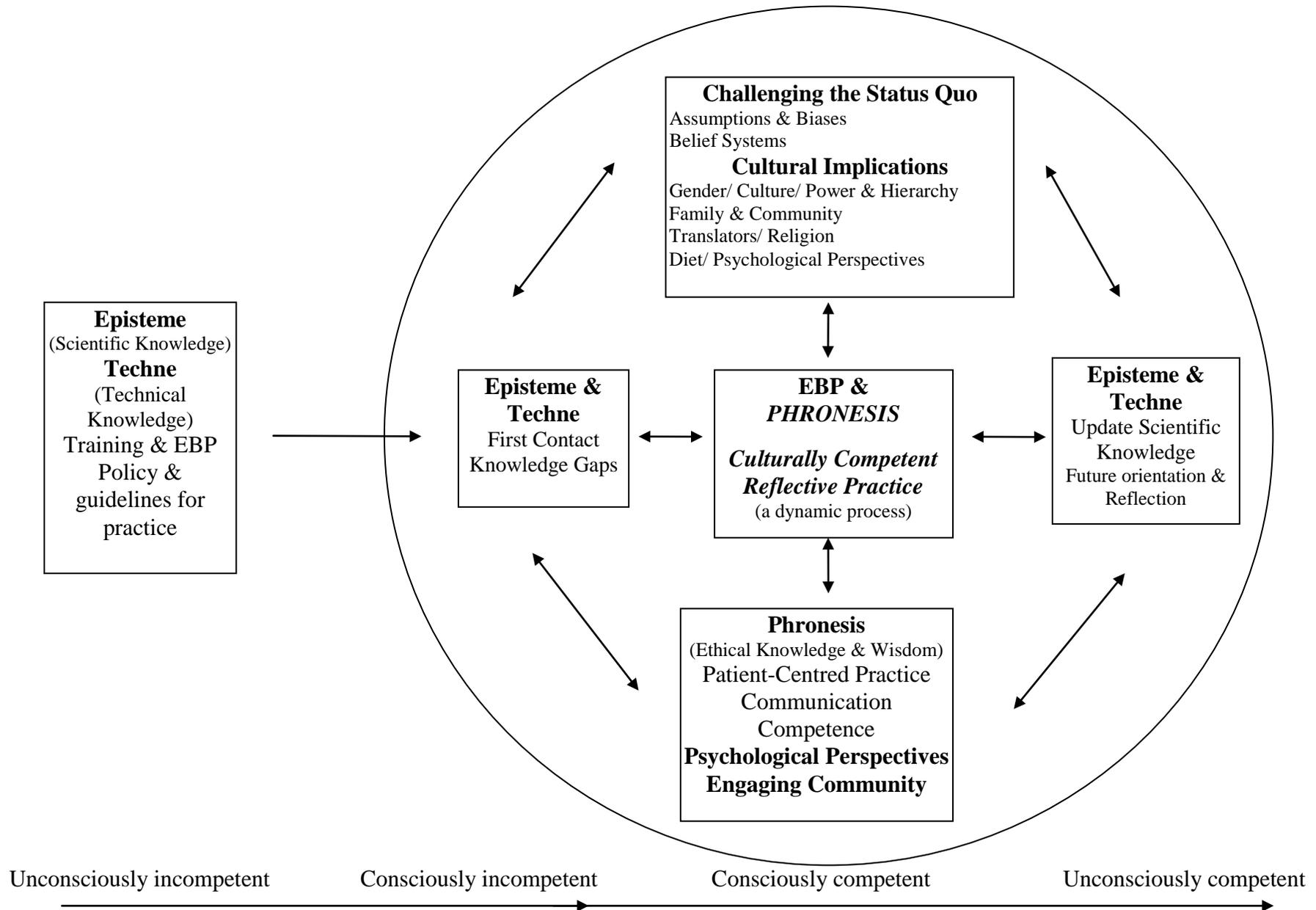


Figure 7: Model depicting Culturally Competent Reflective Practice in diabetes healthcare.

and they set out to do this themselves. They went about this in a general and case-by-case basis. By addressing these knowledge gaps practitioners were reflective in how they worked by responding to their patients' needs while still focusing on EBP. They became cognisant of cultural norms that were different from their own and also became aware of the differences within specific cultures.

A feature of their work was the ability for reflective practice with its dynamic nature. For example, they reported the capacity to "think on their feet" (also see Appendix N). They observed and modified their behaviour during and following consultation with their patients. Again, their initial training and knowledge of policies guided their practice. However, they remained conscious of, and sensitive to, understanding their patients' differing lifeworlds. This gave the educators a new perspective and re appraisal of their practice, which they changed according to what they believed needed to be done to achieve healthy treatment outcomes.

Throughout this dynamic reflective process practitioners reframed their practice in many ways. This included their capacity to be aware of and reflect on their assumptions and biases around different cultures, religions and individuals. Their biases were open to self-censorship as they challenged their own belief systems. This was paralleled by the inevitable immergence of their patients' belief systems, which were a constant challenge to them. Furthermore, practitioners comprehended and acted on new knowledge and feedback from their patients.

A clash of cultural attitudes influenced or complicated interpersonal communication. All educators who participated in the study (96% were women) worked with male patients from cultures where patriarchal values implied authority over females. They did not readily accept directions or professional expertise, which was an additional challenge to be appraised and acted upon.

For successful management of diabetes, patients needed to comply with practitioners educating them to understand the importance of taking responsibility for their own disease, where practical, by monitoring their own blood sugar levels. This often required educators to understand and help manage family dynamics. For example, engaging family members to help patients maintain effective diabetes management. Where possible, family and professional translators were engaged. However, professional translators were regarded as more appropriate and effective than family members.

Patients' religious beliefs often clashed with treatment regimes, which had a direct impact on effective diabetes management. Educators found they needed to understand, respect and achieve successful health outcomes with their patients through negotiation. At best, they left the individual to make up their own mind. On the other hand they "did what it takes" to achieve treatment goals and also maintain the patient-practitioner relationship. This included negotiating issues diet and the timing of food intake. Practitioners were made aware of the complexities of the difference in cultural beliefs around diet and the significance of eating certain types of food. In most cases this dietary knowledge was absent in training and certain diets clashed with EBP information. This had the potential to render many aspects of specialist training at odds with patients' cultural norms.

Practitioners' awareness of the importance of focusing on psychological perspectives was an added dimension to the effectiveness of their work. It was therapeutic in the sense that rapport building, empathic responses and positive regard for their patients produced a sense of comfort and engagement. Practitioners were highly motivated by their positive regard for their patients. Additionally, their regard for others was an impetus for them to reflect on their practice and engage in regular updating of their methods. As a result, prudent or wise decision-making and reflection produced more effective ways to work with a multicultural cohort of patients.

Updating practice included wide-ranging interpersonal skills that were enhanced in the workplace. For example, their high level of communication competence was instrumental in them forming relationships with their patients and their families. This involved achieving rapport with their patients and families to engage them in treatment regimes. This required competence in one's ability to communicate well, which involved many micro skills with awareness of nonverbal communication. These communication skills were consolidated and expanded on through patient-centred practice. Practitioners were presented with the complexities of new information. This was due to the wide-ranging differences in cultural norms as indicated by individual belief systems and the requirements of different religious groups. Consequently, for effective patient-centred practice, there needed to be a shift from an "EBP-driven" approach to one that focused attention on the needs of their patients. Thus, practitioners were required to consider their patients' lifeworlds as a priority. This ongoing process over time was a feature of reflective practice. The process involved action, appraisal and re-appraisal, followed by modified action. Practitioners reported undertaking these components of practice in a conscientious and competent manner. They also shared their information with colleagues through regularly convened network meetings.

This new and shared information was also supplemented by their own creativity and practicality as they created their own resources in their workplaces as the need arose. The content and nature of the new resources was guided by the inevitable challenges that emerged from their patients' individual and cultural needs. All practitioners felt their training did not furnish them with the cultural awareness or information and resources required in practice.

All practitioners believed that future training should incorporate more culturally focused material. However, more recent trainees noted the gradual inclusion of culturally focused content in training programs. Practitioners' future orientation was evident through follow up interviews on these findings (see Appendix N for excerpt) and through their

capacity and intention to reflect on their personal views and their practice in ways that always had the goal of empowering patients and remaining sensitive to their needs. By acknowledging their patients' lifeworlds as the highest priority in delivering healthcare, practitioners all indicated that EBP was core knowledge, but it was not exclusive to their work practice into the future.

In future, practitioners will continue to develop their own resources and unique, reflective ways of working with multicultural groups and individuals. It appears that the most important element in this ongoing process was critically reflective practice. This was essential to competent practice because it not only showed motivation and capacity to reflect on one's own values, attitudes and assumptions, but also the lifeworlds of those they were helping. Thus, culturally competent reflective practice is a dynamic process. It is critically reflected upon and re-appraised, then put into action in an ongoing cycle.

## Chapter 6

### Discussion

*“We ask people to change their life, not just their diet” (Diabetes practitioner).*

*“Social science never has, and probably never will, be able to develop the type of predictive and explanatory theory that is the ideal and hallmark of natural science” (Flyvbjerg, 2001, p.4).*

*“The observation of clinical practice bears directly on issues of value. ... The relationship between the patient and the practitioner is a basic element in healthcare” (Mishler, 1984, p.6).*

*“Animals lack one central characteristic of mankind’s, namely the ability to reflect” (Verhaeghe, 2004, p.54).*

### Chapter Overview

The findings and interpretation presented in the previous chapter were based on the thoughts, beliefs and experiences of the participants who were specialists working with diabetes patients from diverse cultural groups. Participants gave insights into their views of EBP and how they adapted to the different challenges facing them. Their motivation to deal with these challenges revealed a capacity to reflect. In explaining their motivations they described their ability to reflectively understand their cultural position in relation to others. This was interpreted as culturally competent reflective practice.

A brief summary of the findings and interpretation is presented and then expanded upon throughout this chapter. Sub headings are aligned with those in the findings and interpretation chapter and refer to the Culturally Competent Reflective Practice Model (Figure 7). Links are made to culturally competent reflective practice and Aristotle’s intellectual virtue phronesis through thinkers such as Jürgen Habermas and Bent Flyvbjerg. Then there is discussion of the findings and interpretation prompted by the research questions and the Culturally Competent Reflective Practice Model (Figure 7). Further interpretations are explored from reference points of episteme, techne, and phronesis as reference points.

Core ideas emerge from the findings as they related to the cultural competence models introduced in the literature review. As the changing relationships between healthcare and practice are explained, the emerging dynamic process of culturally competent reflective practice is highlighted. Pros, cons and limitations of methodology are discussed, followed by the implications of cultural competence in future research, education and practice.

### **Summary of the Findings and Interpretation**

The findings and interpretation revealed that practitioners described their process of change starting with evidence-based practice (EBP). From being medically adept and scientifically knowledgeable healthcare workers they began a process of culturally competent reflective practice. Responding to the complexity of their patients' lifeworlds they used broader skills. They moved from a position of authority in a medical sense and adopted a patient-centred and culturally appropriate position. This aligned with their reflective abilities. In effect, practitioners adapted EBP and transformed it into something unique to themselves and their patients.

Practitioners confirmed the importance of episteme and techne in their practice, but not exclusively so. Cultural implications became clearer for them as they responded to knowledge gaps in their training and practice.

Culturally competent reflective practice was brought about by the integration of EBP and phronesis. Forming relationships with ethical exchanges and delivery of practice served to highlight the concept of phronesis. Phronesis is argued to be an important element of culturally competent reflective practice. This practice appears to be ethically derived and delivered. For example, practitioners' values and knowledge were not imposed on others without being tempered by their patients' values and needs. This reciprocity was a characteristic of patient-focused practice, complimented by reflective practice, evolving into culturally competent reflective practice.

**Ethical Practice (Phronesis): Aristotle, Flyvbjerg and Habermas**

The ancient concepts of episteme, techne and phronesis originally articulated by Aristotle have a dynamic relationship with each other and still have meaning today. This is reiterated by Flyvbjerg (2001) who said phronesis is “commonly involved in social practice and attempts to reduce social science and theory to episteme or techne (elements in natural science), or to comprehend them in those terms, was misguided” (p.2). Both Jürgen Habermas (1990a) and Bent Flyvbjerg (2001) believe that phronesis represents respect for others. It involves *ethical* judgments that went beyond scientific and technical knowledge.

The point of introducing phronesis to this study was to investigate how its characteristics reflected the dynamics that were described by practitioners. It represents an “enrichment” of EBP to integrate it with value-based and ethical practice. Consequently, phronesis became elemental to the *Culturally Competent Reflective Practice Model* (Figure 7).

**What was Learnt? Addressing the Research Questions**

The chapter was set out based on the research questions and structure in table 4 and the *Culturally Competent Reflective Practice Model* (Figure 7):

**Research question 1.**

What place did practitioners believe Evidence-based Practice (EBP) held in their work?

**EBP, episteme and techne.*****EBP informs diabetes practice; EBP on its own; training and EBP.***

There was consensus among all practitioners that EBP was essential to diabetes healthcare practice. They all had the view that the guidelines of EBP alone did not sufficiently produce the expected health outcomes. This shortcoming occurred, it seemed

because science-based formal knowledge relies heavily on the biomedical model, which produces an “authority of medicine” (Mishler, 1984, p.122) or an implied position of power. This is important, but not sufficient for the complexity of engaging patients from different cultures. With an implied position of power, there is little scope for considering the viewpoint or systems of belief of patients. As a result, those from non-Western backgrounds may not necessarily relate or respond to treatment.

A paternal stance in healthcare delivery is deemed to be no longer appropriate. Furthermore, it does not always produce the required results. EBP can be complemented with knowledge that is exchanged from both directions rather than from the top down. This viewpoint or focus was not in the practitioners’ training, but emerged later as a dynamic in practice that they recognised when they developed it themselves. *Phronesis* in practice enriches the experience for both patient and practitioner. “Phronesis deals with value-based practice, a knowledge that is experiential, awareness-oriented, and context dependent. It requires consideration, judgment and choice” (Ruderman, 1997, p.124). Fortunately, cultural components are now becoming more integrated into training curricula in mental health and social sciences.

### **Research question 2.**

Beyond EBP training, what knowledge gaps were identified as a result of working with a multicultural cohort of patients?

### **Episteme and techne.**

#### ***Training and EBP; level of cultural competence in training; knowledge gaps.***

EBP did not appear in any of the cultural competence models presented in the literature review. Its exclusion might be under an assumption that it was already present or that EBP did not sufficiently “qualify” to be culturally orientated.

Nevertheless, all practitioners believed scientific knowledge provided an important background and foundation to work with patients from different cultures. Therefore, EBP, in the form of scientific (episteme) and technical (techne) knowledge, was crucial to their work. However, *gaps in training and knowledge* were claimed by 100% of practitioners. Training did not fully prepare them for all the complexities of working with different cultural groups. Rather than relying fully on their scientific knowledge and treating symptoms, practitioners reflected on what information they had or what was missing. They called on a wider scope of reference points to understand what was required to respond to the complexity of their patients' needs. Treatment plans were often compromised due to practitioners' lack of relevant cultural knowledge. Therefore, it was important for them to recognise and reflect on their potential to make false assumptions or to culturally stereotype their patients.

### **Challenging the status quo.**

#### ***Assumptions and biases; recognition of different belief systems.***

While some progress has been made, Dogra, Betancourt, Park, and Sprague-Martinez (2008) argue there is still work to be done in making cultural competency an integral part of the organizational fabric of healthcare. "National organizations need to consider their leadership role in helping health care organizations translate broad statements of cultural competence into meaningful action" (p.127).

Cultural competence requires a "sophisticated level of refinement of cognitive skills, attitudes and personal beliefs" (Giger and Davidhizar, 2002, p.187). Importantly, practitioners reported learning about their own cultural beliefs and attitudes, which interacted with information received from their patients. This self-knowledge challenged the status quo represented in the biomedical model, which does not address awareness and control of cultural bias. Consequently, patient-practitioner interactions were affected. As in the Purnell (2002) and Giger and Davidhizar (2002) models, practitioners dealt with assumptions about

their patients. This was achieved by activating by their acknowledgement of difference and their reflective ability. As a result they became aware of their own culture, values and biases, and the cultural norms of others. Spector (2002) highlights this dynamic interaction between one's cultural identity as a reference point and their patients to be accepting of different cultures:

It is possible to analyze health beliefs by determining a person's ties to his or her traditional heritage and culture, rather than to signs of acculturation into the dominant culture. The assumption is that there is a relationship in people between strong identities-either with one's heritage or the level at which one is acculturated into the dominant culture-and its health beliefs and practices (p.198).

### **Cultural implications.**

#### ***Translators and interpreters.***

As in Purnell's (2002) model, practitioners had difficulty in conveying meaning to their patients. Furthermore, the assessment of linguistic needs and the use of formally trained interpreters (Campinha-Bacote, 1999) were widely accepted as important. However, this study noted the differences between translation and intercultural interpreting (Xu & Davidhizar, 2005). Although practitioners used the word translator or interpreter interchangeably, the implications of the two are worthy of comment.

Interpreters who filtered their information through culture acquired knowledge about the complexities of that specific culture. Such cases contrasted with interpreters who translated literally. Direct translation was effective in exchanging biomedical knowledge. However, intercultural interpretation was far better for learning more about cultural norms and subtleties during the patient-practitioner interactions. Was this an advantage or disadvantage? Direct translation was important to assure them that scientific or technical

information was understood exactly as it was intended. However, this precision might have been at the expense of forming deeper relationships and the quality of treatment outcomes.

Practitioners described intercultural interpreting as successful. Those interpreters who had extensive knowledge of a specific culture could explain subtle cultural nuances. This improved communication competence, relationship development and the reflective process for practitioners. Consequently, more complex relationships could be formed and potential for including allied help such as psychological interventions was enabled.

***Power and hierarchy, gender and control.***

The empowerment of others was one ethical issue that practitioners navigated on a regular basis. Giger and Davidhizar's (2002) Cultural Competence Model raised questions of environmental control. That is the limited degree of control a patient perceives in the circumstances they find themselves. For example, practitioners recognised the power that patients vested in their roles. Culturally competent reflective practitioners would be required to provide ethically sound responses. For example, many patients reportedly did not know their rights. Unfortunately patients often acceded to the perceived and actual authority of the practitioners and the healthcare system. However, practitioners indicated awareness of their power in the patient-practitioner relationship, and sought to focus their service delivery with a patient-centred orientation. This may indicate their professional behaviour as ethically appropriate and therefore characteristic of phronesis.

Practitioners also found that attempting to change a patient's dietary regime was not something they could enforce. Where issues of quality of life were involved, especially with older patients in their 70s and 80s, change was much less likely to occur. Allied professionals such as psychologists were consulted to focus on these concerns.

There is the issue of gender. Historically, "the role of the nurse practitioner was subsumed under the role of the physician; much as if the work of women had been subsumed

under that of men” (Haddad, 2003, p.30). Nursing is not an inferior form of medicine, yet much of what nurses do and can contribute to patient welfare, remains hidden (Haddad, 2003). Practitioners reported being aware of their position of power and control, with refusal of treatment stemming from power issues around gender. Many males were reported as feeling vulnerable, and not able to cope with female practitioners. A male patient might refuse medical advice given by a female, especially one who is a nurse and not a medical doctor despite her considerable knowledge and skills. This lack of positive responses to female professionals advising them about their disease highlighted differing beliefs of social status around gender and professional roles. Practitioners reported finding these issues challenging, but not insurmountable.

These encounters were initially a source of frustration. Paradoxically, such encounters highlighted the role of the female practitioner as the medical authority. Consequently, practitioners needed to be mindful of the authority they had and how others might perceive them. Practitioners demonstrated the capacity to understand, respect and competently communicate to form and maintain relationships. Again, this behaviour is an example of *phronesis*.

Purnell (2002) and Giger and Davidhizar (2002) cited gender roles, social status, with family structure and organisation, as being relevant to culturally competent practice. This was shown in the findings and interpretation. Tannen (2007) explains that unlike women who communicate to form relationships, “for most men, talk is mainly a means to preserve independence, and negotiate, and maintain status in the hierarchical social order. This is done by exhibiting knowledge and skill” (p.180). Therefore, this could be a problem for male patients because they are in a passive and vulnerable role, receiving medical information from a female who was generally perceived as an expert or authority. Respectful practice

with older patients also considers the appropriateness of addressing older patients by their first name, or more formally.

***Religion and spirituality.***

Spirituality and social organisation needed to be understood and sensitively worked with in an ethical fashion, as in phronesis, which required letting go of preconceived ideas of how a patient should respond to treatment and biomedical information.

Practitioners set out to acquire culture-specific knowledge. The findings reflected both Giger and Davidhizar (2002) and Purnell (2002) cultural competence models' focus on social knowledge and spirituality. Practitioners familiarised themselves with their patients' religious practices, use of prayer, as well as behaviour that give meaning to life and individual sources of strength. Practitioners were in a position to do this and often negotiated with religious leaders to clarify any issues that might cause offence or confusion. Common to all participants was the observance of Ramadan by Muslim patients who fasted. The religious observance had a direct impact on diabetes management, could not be ignored and had to be dealt with sensitively.

**Research question 3.**

How did practitioners adapt their EBP training?

**EBP and phronesis.**

In response to their identified knowledge gaps following their training, practitioners reported integrating their biomedical knowledge with ethical knowledge, or phronesis. This meant that they developed a complex culturally interpersonal way to work differently with diverse cultural groups.

Practitioners modified the delivery of their medical knowledge and expanded their considerable relational skills and communicative capacities. They reinforced the ability of

their patients to articulate their own needs, by entering into their world through patient-centred practice. As they did this they began to reflect on their own beliefs and assumptions and reassessed how they worked. *Communication competence* incorporates complex, highly evolved communication skills, which are essential for working effectively. Communication was made more effective by the use of translators or interpreters, especially those who had knowledge of the culture and nuances unknown to practitioners. Practitioner's reporting of their communication skills with patients opened up the likelihood of forming relationships and for those relationships to be productive in achieving effective health outcomes.

Lauren Breen and Dawn Darlaston-Jones (2010) argued that meanings are derived through our engagement with the social world and therefore no one objective truth could be claimed. In spite of differing points of view and belief systems practitioners are required to form relationships, or equal partnerships. The findings reflected this view as practitioners aimed to engage their patients in reciprocal and equal communicative transactions. Through their reflective practice they were not relying entirely on theoretical absolutes to inform their communication and clinical interventions. Instead they derived meaning from their interactions with their patients through dynamic cognitive and emotional processes that were constantly reassessed. However, it has been pointed out that serious and unrecognised miscommunication is pervasive in non-Aboriginal doctor/ Aboriginal patient interactions (Morgan, 2006; Parker, 2009; Walker & Sonn, 2010). This lack of recognition may also extend to health practitioners working cross culturally in Australia with CALD groups.

“Health systems” argues Braaten (1991) “are to be set up as goal-directed” (p.3) using what Habermas (1991b) called “instrumental rationality” (p.163). This is a non-communicative and goal-directed activity where an organisation is arranged in such a way that its practitioners achieve the best possible outcome or success. Although this opinion

seems familiar and acceptable, the sensibilities of culturally competent reflective practice do not support this view. Instead, relationship building or patient-centred activity is a priority.

***Forming relationships.***

The Purnell (2002) and Giger and Davidhizar (2002) models share the view that culturally competent practice involved *forming relationships* that were sensitively intimate, personal, social and consultative. On a broader scale the practice also involves interacting with the community through public spaces.

Relationship sets the tone. It has a tremendous impact on the quality of patient-practitioner communication. A factor that influences the working relationship is power (Haddad, 2003). Although practitioners in this study are the most visible health professionals, they are not physicians who continue to exercise much power in the healthcare system. Unfortunately, many patients regarded the diabetes practitioners in this way too. Conversely, practitioners also reflected on their perceived professional authority and how it might affect their patients. On the face of it, this authority appears to be incompatible with the concept of patient-centred care. However, it is not inconceivable to direct a patient who is acting in ways that negatively influence their diabetes management. They reported having had the insight and skills to change their patient-practitioner dynamics and the potential for blocking and resisting treatment.

For a working relationship to function, it is important how patients believe practitioners should relate (Haddad, 2003) and respond to them. Their perception of a practitioner's role will influence their relationship and quality of communication (Haddad, 2003). A complication is how practitioners believe their patients should regard them. If, for example, practitioners saw their role as contributing directly to medical decision-making because of their evidence-based knowledge of individual patients, clinical experience and scientific training, then they will be more persistent in presenting what they know. If patients

did not see their own input as contributing directly to medical decision-making, they would be less interested in what the practitioner has to say. This is the point where practitioners need to be humble.

Practitioners also needed to have the capacity to become aware of their own unconscious biases as representatives of a healthcare institution. There would be few arguments to the contrary. There are differences in complexity, as explained by practitioners, of relationship formation. The mere application of scientific knowledge, or “imposition of the voice of medicine” (Mishler, 1984, p.6) was deemed ineffective, without consideration of the patient’s lifeworld. This is not to say EBP is ineffective. However, when there are potential complications in the relationship between the patient and practitioner that are not just mistranslations but issues relating to gender, hierarchy and power, then other strategies are required. As related by practitioners, the intention to “draw closer” to their patients involves knowing more about them and their lifeworlds. Despite any effort by patients to assimilate with the prevailing culture that exists, their systems of belief are still robust and healthcareers made it their practice to be aware of alternative belief systems. Achieving a relationship required a competent working knowledge of the complexities of communication.

***Communication competence and empowerment.***

When practitioners first started practice there were conceptual barriers to effective *intercultural communication*. These barriers were due to lack of previous experience or knowledge, because there was no perceived demand to consider other cultures other than Anglicised ones (Xu & Davidhizar, 2005). Teal and Street’s (2009) study pointed out a correlation between the acquisition of more skills and increasing complexity with *culturally competent communication*. Similarly, practitioners responded to the complexity of the challenges facing them and therefore developed a wide range of new skills that evolve as culturally competent reflective practice.

Habermas (1990) described the positive potential of *communication competence* for both practitioners and patients. His intention was for both to benefit and be empowered by this skill. Similarly, Allen, Chapman, O'Connor, and Francis (2007) stressed the importance of language in nursing, where “language elicits power and authority when educating and communicating with patients” (p.47). When one examines moral ways of working, especially with the vulnerable and sick, Habermas (1990) stressed:

Communication competence involves the ability to listen, to argue, and to give reasons for an opinion, understand what an opinion means, criticize a point of view, and ask what is being alleged. Openness is another important aspect of discourse ethics. We must reveal all reasons for our point of view and not hide any of them in order to make the *ethical* (italics added) dialogue reasonable. Conversely, if a patient is *communicatively competent* (italics added), they would have the ability and right to participate in actions that affected them (p.537).

Communication competence requires practitioners to exercise situational and cultural awareness. When practitioners encountered resistance to their work, they did not invoke the privileged voice of medical science, but listened and understood more about their patient in a respectful way. This willingness to listen brought about an ethical shift to patient-centred practice. Their effective practice did not impose Western values or the voice of medicine in their interactions. As a result, patients were not absorbed into the “framework of technical biomedicine” (Scambler, 2002, p.122), but it was reported their situation and position was respected through the practitioner’s use of contextual communication. This was from the perspective of the practitioner, so we cannot be certain that patients perceived this in the same way.

Contextual use of communication; verbal and nonverbal communication; eye contact; touch; and proximity were common to the Purnell (2002) and Giger and Davidhizar (2002)

cultural competence models and to the findings. Practitioners' ability to communicate well was an important factor to impress upon their patients the knowledge they needed to have to manage diabetes. They set out to empower their patients, so that they were motivated to self-manage their progress beyond the consulting room through phone calls and home visits and reflecting on how they can modify how they relate best in their approach to their patients.

Practitioners described competence in their ability to interact, which involved employing microskills, rapport building and awareness of nonverbal communication. Practitioners' repertoire of *culturally competent communication* included *self-awareness*. This needed a degree of sensitivity to others and a capacity for reflection. They were able to adapt their communication as they acquired new knowledge about their patients' core cultural issues.

#### ***Patient-centred practice.***

A holistic approach relates to patient-centred practice as it addresses not only a person's presenting symptoms but also takes into consideration their lifeworld. To have respect for the integrity of an individual requires the ethical use of power in the patient-practitioner relationship. It also means the patient is empowered to make their own healthcare choices.

Jürgen Habermas (1990) placed a great deal of importance on the *ethics of communication*, "... when the participants co-ordinate their plans of action consensually, ... where agreement is reached through explicit linguistic processes ..." (p.58). Practitioners were patient-centred and upheld this view as they worked and negotiated with their patients. Patient-centred practice also requires empathic responses and "unconditional positive regard" (Rogers, 1987, p.486), which allows patients to self-actualise, or maintain their own health. Mishler (1984) argued that if healthcare practitioners, "listened more, asked more open-ended questions, translated technical language into the voice of the lifeworld, and negotiated a

sharing of power; they would not only become more humane, but also become more effective practitioners” (p.6).

All practitioners focused not only on their patients’ symptoms, but respected the dignity of their patients as persons. Due to their patient-centred approach, practitioners learnt different cultural norms and nuances to engage their patients in an informed and ethical way. They recognised their problems within the context of their lifeworld of meanings, which implied an ethically oriented approach to gathering knowledge that respected the source of that information.

Patient-centred practice has a communication continuum that Hauser (1981) described as either *practitioner-centred* (analysing, probing and gathering information) or patient-centred (silence, listening, reflecting, clarifying and interpreting). The findings indicated a reported lack of constriction in practitioner-patient relationships and the absence of practitioner dominance. Further, they went beyond the exclusive use of a biomedical approach to understand disease. At various places along the treatment continuum, practitioners developed treatment plans informed by their patient’s unique understanding of their health.

### ***Reflective practice.***

John Dewey, a teacher, psychologist and philosopher argued that human experience was central to reflection. If an action took place without reflection, such an action was “reduced to a habitual or capricious impulse” (Redmond, 2004, p.9). Dewey’s seminal views on reflection were echoed by Jürgen Habermas whose communicative competence characterised reflection on background assumptions about the world. As a result, “basic norms are brought to the fore, questioned and negotiated” (Braaten, 1991, p.72).

The activities of practitioners and their capacity to adapt their practice resonated with Schön’s (1995) differentiation between traditional and reflective practice. Reflective practice

was a sophisticated interaction between practitioner and patient. Practitioners typically reframed potentially negative viewpoints by reporting their uncertainties as a source of learning for themselves and for their patients. They relied on EBP, though not exclusively. Engagement with patients was often unique to both of them and their situations. Further, practitioners had the maturity and capacity to acknowledge they were not the only ones to have important and relevant knowledge to communicate. Practitioners arrived at the point where they “reflected in action, and became researchers in the context of practice, where they were not dependent on the categories of established theory and technique” (Schön, 1995, p.68). For the benefit of the patients their unique clinical interactions constructed something new.

Giger and Davidhizar (2002) declared that, “... *cultural competence* connotes a higher, more sophisticated level of refinement of cognitive skills and psychomotor skills, attitudes, and personal beliefs” (p.187). These qualities were evident in the findings. Practitioners reported each experience as unique. As a result, they constantly reassessed what they needed to learn. Importantly, they reflected on information they received both in action and afterwards.

Subsequently, they adapted to the needs of their patients as they became privy to and acted on information that was unfamiliar to them. Most practitioners reported that they then reflected on and processed that information. This had the effect of altering the patient-practitioner relationship and of changing themselves as practitioners. They challenged their own beliefs and assumptions about culture. In doing so they continued to acquire cultural knowledge (NHMRC, 2006) and made a point of understanding their patients’ worldviews. This was all part of the reflective process. As a result, those practitioners who came from Anglo Australian backgrounds initiated the capacity to critically reflect on their own cultural

backgrounds. Consequently, they were well positioned to be empathic to others and to become increasingly more aware of their cultural competence with others.

Phronesis in reflective practice requires “consideration, judgment and choice” (Ruderman, 1997, p.124). It involves shared responsibility and joint exploration. Similarly, Bairbre Redmond’s (2004) view on reflective practice demands the capacity to constantly re-evaluate one’s position due to “infinitely new perspectives” (p.101) when interacting with the consumer. The practitioner behaves in an ethical manner as they impose an order of their own during consultations and take responsibility for the imposed order. They also hold themselves open, at the same time as they impose order, to the feedback received from their patients (Schön, 1995). Phronesis in reflective practice is an ethical two-way interaction that takes in all available cultural information. Therefore reflective practice is *cyclic* where information gathering is reciprocal. The power of the practitioner is kept in mind, but the needs of the patient are honoured.

***Culturally competent practice.***

Betancourt et al. (2002) argue that if clinical cultural competence is to be attained, healthcare providers:

Must be made aware of the impact of social and cultural factors on health beliefs and behaviours. They must be equipped with the tools and skills to manage these factors appropriately through training and education. They also need to empower their patients to be more of an active partner in the medical encounter (p.10).

Furthermore, “The relationship between a culture and its healing rituals is an intensely complex one ... current forms of health care are not responding adequately to the changing and contemporary needs of a multicultural society” (Lago, 2006, p.83).

Australia is a sought-after destination for many people from different cultures. This means that the cultural mix of the population is changing rapidly. Further, the manner in

which healthcare is implemented is changing. Change has not come that easily and there has been a lack of response due to the complex relationship between health and culture. Adequate responses required both understanding and communication of differences on many levels.

Monaghan and Goodman (2007) believe that “culture and communication were inseparable. We communicate culture, therefore it is dynamic” (p.3). Similarly, culturally competent practice in healthcare is a complex, dynamic process involving delivery of evidence-based treatment with many other ethical considerations. This complexity involves requirement to sensitively and ethically engage with patients who often struggle to comprehend the Western health system and treatment styles. All practitioners stated that they were confronted and challenged by patients who did not comprehend the notion of a chronic disease, particularly when diabetes patients experienced little pain and few symptoms.

Another complication and constant challenge was striving for patients to take responsibility for managing and monitoring their body’s functions for optimum short term and long-term health. Empowering their patients required sensitivity, respect for difference and awareness of the implied dominance of medicine that can undermine their capacity for self-regulation.

Consequently, it cannot be assumed that patients will readily respond to the medical information being given to them, even if it will save their lives. Therefore, the value in ethical considerations, or *phronesis*, is essential to *culturally competent* practice. This involves practitioners engaging patients in ways that help them adapt by *bridging the gap* between them to reach mutually acceptable goals in treatment. Campinha-Bacote (2002) asserted that cultural competence was not considered “an event” (p.181) or static attainment, but was a dynamic process. This appeared evident as practitioners reported reflecting on their work, which was required to reframe their understanding of how they interacted with their patients. They had the capacity to adapt and change due to their flexibility, openness and confidence,

and acceptance of fallibility. In this context, they did not regard themselves merely as experts. Consequently, reflection was made possible and their practice continued to evolve.

*Culturally competent reflective practice.*

Culturally competent reflective practice is an extension of reflective practice as it bases its reflective focus in the context of culture. It was found that practitioners needed to utilise more than their scientific or EBP knowledge as they reassessed and reframed their knowledge and practice based on cultural information. Habermas (1990) argued there needed to be a cultural tradition that reaches across the whole spectrum, not just the "fruits of science and technology" (p18). The implication here is that traditional healthcare practices need to embrace a broader frame of reference. Culturally competent reflective practice refers to professional interactions with different cultural groups and individuals. This involves being open to new ideas and theories and it takes into consideration the capacity for "knowing-in-action" (Schön, 1995, p.59). There was evidence for this as practitioners were required to generate new ideas, resources and strategies as they worked in action. For example, new resources needed to be created by practitioners that were not available, or apparently did not exist. Also, it was reported by practitioners that they reflected on appropriate ways of responding to male patients who were not familiar or comfortable with female healthcare practitioners.

Schön (1995) argued that a competent practitioner can "reveal a capacity for reflection on their intuitive knowing in the midst of action and sometimes use this capacity to cope with the unique, uncertain, and conflicted situations of practice" (p.8). Practitioners were continually faced with these uncertainties and described a multitude of different skills required to deal with them. Usually this response did not always involve EBP but something completely new. In effect, they resisted being "selectively inattentive" (Schön, 1995, p.59) to phenomena that did not fit their evidence-based knowledge. Instead they described having the

capacity to trust their own intuitive abilities, which was a counterpoint to their scientific training and knowledge.

Combined with evidence-based knowledge, culturally competent reflective practice includes a holistic perspective. Spector (2002) refers to a holistic view of health as “a complex, interrelated phenomena, the balance of all facets of the person - the body, mind, and spirit” (p.197). This includes not only their personal beliefs and circumstances, but also their cognitive processes such as thoughts, memories and knowledge of such emotional processes as feelings, defences and self-esteem. Practitioners learn from their patients directly or through their interpreters. They learn about spiritual practices and teachings, dreams, symbols, stories; gifts and intuition; and positive and negative meta-physical or innate forces (Spector, 2002). These facets are in constant flux and change over time. However, each is related to the other and to the individual’s overall context.

In spite of recent developments and implementation of cultural competence components in training programs, little is known about how cultural competence manifests itself in medical encounters (Teal & Street, 2009). However, culturally competent reflective practice is a dynamic process that was generated from participants’ professional experiences. This has been achieved without specific training to do so. It may be the case that this cannot be taught or implemented in the same way as EBP or medical procedures.

Reflection requires an inward focus and sensitivity to one’s own position in the patient-practitioner encounter. Equally, it requires external focus and sensitivity to the patient and their lifeworld. In other words reflective practitioners in this study were highly motivated to help others. To do so they were prepared to do what it takes for their patients to understand what they need them to know. They reflected on their behaviour, beliefs and emotional responses to their patients. They also made changes due to their self and situational

awareness. Their motivation to consider the broader needs of their patients was a high priority and an important characteristic of culturally competent reflective practice.

### **The Changing Relationship between Healthcare and Practice**

Although the following viewpoint is not new, the biomedical and constructivist approaches to healthcare practice do not seem to “fit” together. It appears that the latter is more appropriate for culturally competent reflective practice and can incorporate the former. Mishler’s (1981) comments on the relevance of constructivist approaches to healthcare describe this well:

The constructivist approach views health professionals as not being alone in the definition and control of illness, but as participants in a larger social process. To see the definition of illness as also socially produced, as the result of interaction among a number of participants including physicians, implies that a *wider range of information and interests must be taken into account* (italics added) in making medical decisions than is required by the biomedical model. The result appears to be a restriction in the scope of medical authority and a *loss of the social benefits of status and power* (italics added) that accompany medical dominance (p.165).

The above statement is not intended to devalue the role or efficacy of science or medicine. Nonetheless, Mishler’s views on the status of biomedicine points out that a shift in perception will not occur if a practitioner makes the assumption of being an inviolate scientific expert. This is especially relevant in the context of culture and the helping professions. Flyvbjerg (2001) believes that “social science's emulation of natural science is not going anywhere and that social and science theory is in need of reorientation” (p.4). Flyvbjerg might be meaning to say that a set of scientific biomedical facts are not always going to be sufficient for working in a social context and that we should not always be trying

to arrive at models to describe the processes. As this study is suggesting, perhaps a dynamic integration of both science and social theory would be useful in some practices.

To achieve clinical results that were healthy, practitioners employed a wider range of skills and strategies than they were required to have in training. They took it on themselves to make adjustments in how they perceived their patients and how they delivered their message. In effect, *practitioners became participants in the healthcare process* and engaged their patients in a more personal way than was previously required (as policy now requires cultural competence). They positioned themselves so that their use of personal power and control was ethical and respectful. The presence of phronesis in practice appeared to be present.

### **Limitations of Methodology**

To understand *culturally competent* healthcare practice, practitioners described what they actually did in their interactions with patients from their own perspective. Health practitioners working in the Western suburbs of Melbourne were chosen for this study, but the findings may or may not be consistent with the experiences of practitioners in other metropolitan areas of Melbourne that have more Anglicised populations. The sample was not completely representative although its purpose was to gain a better understanding of professional healthcare practice with patients from diverse cultural backgrounds. The findings were not derived from recipients of healthcare, which was a limitation of this study but from those who actually delivered it, so the breadth of sources was limited to the practitioners' points of view. Self-reporting has its limitations because it gives the view from one perspective and is highly subjective. However, in the context of this study reflective practice requires subjectivity as practitioners observe and process the phenomena that emerge in the space between themselves and their patients. Had there been a more even mix of males and females, then perspectives on power, hierarchy and gender would have been different. The result may have added complexity to the findings in general. If the experiences of

patients were included, it would have provided a deeper analysis of diabetes healthcare practice. Ideally, the study would have combined the two and produced and analysed results as they emerged.

Further, the study focused exclusively on CALD or ethnic groups, and did not include those practitioners working with Aboriginal or Torres Strait Island people. They are not only First Nation people, but they suffer a very high incidence of diabetes.

The current methodology was chosen due to limited resources and time availability. It would have been ideal to interview patients as well but would have required the services of interpreters in the interview process.

A limitation of this methodological approach was the difficulty of generalising the findings. The incorporation of a “Euro-Western concept such as reflective practice” into Australia is possible, however it may have “restraints” in other cultures, and in some cases it may be “contradictory” (Stockhausen & Serizawa, 2008, p.8). However, the study does demonstrate that culturally competent reflective practice may have the capacity to influence healthy management in diabetes healthcare with different cultural groups. Based on practitioners’ viewpoints, these findings support the efforts of those who assist people from different cultures who have recently been diagnosed or who have poor diabetes control.

### **Implications for Research, Education, and Practice**

#### **Implications for research.**

In Australia, practitioners need to be culturally responsive to all they work with, including ancient indigenous populations, immigrants and refugees. Fortunately, research into the cultural dimensions of healthcare is informing policies aimed to address this cultural diversity.

There will always be challenges and adaptations needed when research into evidence-based programs are trialled in “real-world” community settings. The dependability of culturally competent reflective practice could be very rigidly defined, or its dependability could be defined more freely, by allowing more flexibility in the implementation process. The implementation of culturally competent reflective practice should compliment practitioners’ ability to tailor their treatment strategies to their diverse settings and participants. The tailored approach would be superior to having a specific model imposed on a practice.

There is a social responsibility for diabetes educators, researchers and clinicians to be informed about the nature of poor diabetes management. This can be sourced and developed from multiple research methods, interdisciplinary sources and the experience of people from different cultural identities including indigenous populations in Australia who live with diabetes. The implications of this study for clinicians, researchers and academics are that cultural dimensions should not be ignored when investigating or assisting in the management of chronic illness.

### **Implications for education and training.**

Trainees in general tend to take for granted the understandings, assumptions and benefits associated with their group memberships. Sonn (2004) argued that it is important to raise issues with them about differences and experience of exclusion. However, the majority of practitioners clearly stated that their training institutions’ curricula had culturally-oriented components and there was some prior awareness about the implications of understanding difference. Nevertheless there was little integration of cultural awareness and practice into their overall training programs. This is surprising considering there are many diabetes patients in Australia from a wide range of cultural groups who are disenfranchised and are particularly vulnerable to having diabetes.

By focusing on reflective practice in training, educators would learn how to become culturally responsive and to especially to “sensitise themselves to cultural nuances” (Stockhausen & Serizawa, 2008, p.8). Reflective practice would also encourage practitioners to go beyond a biomedical model as a reference point and remind themselves of the need for cultural competence when introducing reflective practice within different cultures. It would be ideal to train practitioners by challenging their personal values and biases. This approach was present in my psychology training where it was not sufficient to be given lectures, or pass examinations. Challenging values and biases required a subjective involvement in skill acquisition and regular feedback on the quality of skill, performance, and unforeseen prejudices. My perception of myself in the learning milieu was challenged, observed, analysed, and critically appraised by my peers and supervisors in hospitals. It was not possible for me to be an objective observer in the educational process because my psychological training required learning and reflecting on how relationships were formed and how one ethically engaged others in complex ways. Diabetes healthcareers appeared to have these capacities. The distinction was that the constraints were self-imposed and reportedly not required as part of their specialist diabetes training. Nevertheless, carers skilfully acquired the necessary attributes.

The education of *culturally competent* practitioners will continue to evolve. Lack of resources may restrict the development of educational curricula that immerses the trainee in self-discovery in a cultural sense. And it may not yet be possible to run training programmes that take trainees through processes of discovering and reflecting on themselves and their assumptions and biases before they practise. Currently there is a strong push in training curricula focusing on culturally appropriate practice. Although we may need to accept that some of this learning will be acquired after training, programmes focusing on training professionals awareness and ability for reflection and critical reflexivity are central to

culturally competent practice. This is opposed to a view of a reflexivity that may be informed by “naïve applications of culture ... which unintentionally blame the patient’s culture for miscommunication, nonadherence to clinical recommendations, and other challenges to effective treatment” (Carpenter-Song, Schwallie & Longhofer, 2007, p. 1363). Practitioners need to be able to talk not only about their successes but also about their major transgressions in terms of providing healthcare. Although admission of transgressions by practitioners took place, this study highlights the dilemma of interviewing only healthcare providers.

### **Implications for practice.**

Health practitioners refer to policies as a guide to working with multicultural groups. There has been significant work done in this area through The National Health and Medical Research Council’s document, *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation* (NHMRC, 2006). Policy development continues in response to research conducted by various disciplines.

Practitioners challenged the assumption that effective diabetes treatment will rely entirely on EBP. Although there are many studies engaged in examining the importance of cultural perspectives in delivering healthcare, this study provided the opportunity for practitioners to report first-hand on how their belief systems and assumptions influenced their work. They all had the capacity to reflect on their beliefs in action and their capacity to shift their power position in relation to their patients was also made possible.

Implications for the future are broad for effective healthcare outcomes because culturally competent reflective practice is a constantly changing process. It is ethical inasmuch as it is oriented to the sensibilities of its consumers. Importantly, it is flexible in its delivery. This means that attention is given not only to the requirements of managing chronic disease in terms of EBP, but also attention is given to a dynamic process that takes treatment beyond EBP. Reflective practice also requires practitioners to continually reappraise

themselves and their work as they evolve as practitioners. They will reflect on their own assumptions and biases that are embedded in their own culture and their patients' culture. This dynamic process generates culturally competent and reflective practice.

These processes would also apply to other professions. The practical implications of the findings and interpretation offer a beginning point for more investigation and also the potential for immediate application to compliment other practices that are already taking place with diverse cultural groups, such as in *psychological* healthcare services. It places emphasis on the relationship with the patient and also positions the practitioner as a competent, flexible and reflective participant in the patient-practitioner relationship. This means that culturally competent reflective practitioners are tolerant of the need to constantly reappraise their work and their relationship with their patients.

***Practice: Psychological perspectives.***

Integration of different approaches to treatment in psychology is common now, but “integration has mainly involved the integration of Western models, with little attention to the body of knowledge on theory and practice from cross-cultural sources” (Hoshmand, 2006, p.30).

This study found that consideration of the psychological status of patients was effective in engaging patients and provided more options towards effective treatment. This was also indicated in the Purnell (2002) and Giger and Davidhizar (2002) models that cited healthcare problems and mental health barriers as highly relevant and appropriate to effective culturally competent practice. Similarly, Betancourt, Green, Carrillo, and Ananeh-Firempong (2003) pointed out “when cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, this leads to patient dissatisfaction, poor adherence (to both medications and health promotion/disease prevention interventions), and poorer health outcomes” (p.297).

Psychological perspectives appear to be an inevitable dimension to culturally competent reflective practice in as much as they involve the reappraisal of practitioners' and patients' cognitive schema. This means the reappraisal of what practitioners and patients both hold to be true: their values, attitudes, beliefs, and assumptions relating to their Euro-Western, Eastern or other beliefs. The practitioner re-integrates this new understanding into "culturally competent mental health practice by the degree of compatibility among community context, cultural characteristics of local populations, organizational infrastructure, and direct service support" (Hernandez et al., 2009, p.1046).

Practitioners needed to understand how cultural background, experiences, values, and attitudes influenced their patients' *psychological* processes. With the onset and management of diabetes it is inevitable that patients must consider significant changes, changes in their usual patterns of behaviour and changes in their perception of themselves. Identity formation is a complex and evolving process. Individuals are constantly discovering who they are in relation to others (Tilden et al., 2005). This formation is complicated for many by their personal cultural identity as minorities in a new country, and as a person with a chronic illness, which some people did not understand or recognise. Inevitably, resistance to change is present with the treatment of any chronic disease. This means that practitioners need to be not only scientifically minded (Sue, 1998), but also work on a deeper, more relational level than might be expected, or else engage the services of allied professionals.

### **Future Implications**

Practitioners in the study argued for more cultural awareness in their training curricula. There was an acknowledgement that this was emerging in many areas. With the continuing development of policies that inform culturally competent practice, there will be more culturally competent practitioners. Services will also be more oriented to addressing the needs of increasingly different cultural groups in Australia.

Healthcare models are highly effective, but need to change. Universal structures that are uncompromising may alienate people (Deleuze & Guattari, 2005; Monk, Winslade, & Sinclair, 2007) and this problem might apply to any healthcare practice based on EBP alone. This study supports the need to question the notion of an expert system in healthcare that is largely hierarchical or paternalistic. Due to the diverse nature of individuals, groups and systems, culturally competent reflective practice and its models should be dynamic and not static because the parameters that define it are as diverse as its stakeholders.

There will be tension between culture and biomedicine. To generate evidence-based models for culturally competent reflective practice would require testing of larger populations. This needs a great deal of financial backing and resources. However, this will not be realised unless its broader epistemological premise is made acceptable to evidence-based research and science in general.

Yet it is not out of our reach to educate practitioners to employ high-level cognitive and communication skills in a sensitive and ethical manner. The reintroduction of phronesis into our way of conducting healthcare is a meaningful and productive advance in any practice. It is worth investigating further and an adequate vehicle may be culturally competent reflective practice.

### Summary and Conclusions

Diabetes practitioners reported skills developed beyond their EBP training when working with different cultural groups. This thesis formulated the model *culturally competent reflective practice* to represent the skill acquisition and complexity of their interactions. The model illustrates their ethical behaviour and communication, relationship and rapport-building skill, which lead to practice that is holistic, patient-centred, and reflective. It assumes that “one size does not fit all” and the delivery of evidence-based treatments can be enhanced and adapted to the cultural context of all patients.

To bridge the gap between EBP training and actual practice, this study argued that Aristotle’s forgotten concept of *phronesis* was helpful. *Phronesis* represents ethical knowledge and practical wisdom. In this regard the work of Jürgen Habermas was an important point of reference. Through *phronesis*, he and many others pointed out the power of language and its ethical use. The model indicates that culturally competent reflective practice combines both EBP and *phronesis*. It cultivates a paradigm shift in practice that is value-based, oriented to self and other awareness, experiential, and dependent on context. Consequently, there is a shift in power relations from the “expert” practitioner to a reflective stance.

This reflective stance is more like a dynamic process than an outcome in itself. The process embodies the concept of *phronesis* where practitioners continually strive to adapt their interactions in an ethical and prudent way, thus improving them. However, culturally competent reflective practice cannot be externalised and packaged. Although increased cultural competence in providing healthcare services can reduce existing disparities is appealing, this study resonates with Derald Sue's (2001) and Hernandez et al.'s (2009) view

that cultural competence lacks a clear means of operationalization that can direct research and practice. Therefore, it is important to point out again that the culturally competent reflective model presented here is a dynamic process. It is not argued that a model of cultural competence can be applied prescriptively. Rather, the practitioner's reflective capacities and ethical considerations 'in action' are paramount. The culturally competent reflective practitioner model can offer guidelines, but the interactions between two individuals are unique and need to be constantly reassessed and refined. Further, the dynamic of culturally competent reflective practice may also be applied to other healthcare disciplines, including psychology.

Demographic changes anticipated in Australia over the next decade magnify the importance of addressing racial and ethnic disparities in healthcare. A framework that strengthens culturally competent reflective practice could help address these disparities and improve healthcare for the broader community in the Western suburbs of Melbourne.

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## Appendix A

### Plain Language Statement

VICTORIA UNIVERSITY

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PO Box 14428  
MELBOURNE CITY MC 8001



### PLAIN LANGUAGE STATEMENT

My name is Peter Abraham and I am a Doctor of Psychology (Clinical Psychology) student, at the Victoria University. My supervisor is Dr. Denise Charman, Senior Lecturer in the School of Psychology.

I am undertaking a volunteer research project focusing on cultural competence and diabetes healthcare. I would also like to invite you to help us explore this interface between culture and evidence-based practice in diabetes education. I am seeking to recruit a number of willing diabetes educators who may be members of the Australian Diabetes Educators Association (ADEA).

I will be asking you to agree to a semi-structured interview of approximately one hour, and to be audiotaped. The interview will ask you to communicate your views about cultural beliefs and the impact they have on diabetes care with CALDB patients. Interviews will ask how educators' understanding of patient's specific beliefs within a culture influences outcomes in diabetes care. Questions will be grouped under the following sub headings: Diabetes care and evidence-based practice; Culture and practice; Training, culture and practice; and Personal relationships with patients. Emerging themes will be extracted from these interviews using grounded theory to develop and extend current conceptualisations of cultural competence.

If you choose to participate, we will endeavour to ensure confidentiality and no identifying information will be used in the research or on the audiotape. However, you may wish to consider that anonymity cannot be guaranteed when disclosing confidential material and may be prejudicial to participants. Further, you will have the option of reviewing the transcripts of the interview, should you wish to do so.

Your support in participating in an interview will be greatly appreciated. It will help me to pass my university requirements and likely to help me in my future career as a clinical psychologist. It also provides you with the opportunity to help someone else and to contribute to academic research.

Participation is voluntary and if you request it, you may withdraw from the project at any time and your data will be withdrawn. If you feel distressed for any reason and if you are a member

of the Australian Diabetes Educators Association, you may contact them directly to access their support services. Alternatively, if you are distressed, you may contact Professor Sandra Lancaster who is a Clinical Psychologist and Co-ordinator of training in the Masters/ Doctorate in Clinical Psychology program in the School of Psychology at Victoria University (ph. 9919 2336).

In addition, for any queries or complaints about the way you have been treated, you may also contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MCMC, Melbourne, 8001 (ph. 03-9919 4710).

If you have questions that are not answered above, please feel free to send me an email [peter.abraham@research.vu.edu.au](mailto:peter.abraham@research.vu.edu.au) or phone Denise Charman on 9919 2536.

Yours sincerely,

Peter Abraham

## Appendix B

### Notes for ADEA Network Presentation

Presentation to Diabetes Educators

#### ABOUT ME

I teach at risk teenagers from the Western suburbs and I am undertaking this research project as part of my psychology training at Victoria University.

**NAME OF PROJECT:** *“Investigating Culturally Competent Reflective Practice in Diabetes Healthcare.”*

#### PROJECT IN CONTEXT:

- Australia’s CALD communities:

Type 2 diabetes is a major public health concern for Australia. It has been estimated that the incidence of Type 2 diabetes in those aged 25 years and older is approximately 7.5 per cent with one person undiagnosed for every person diagnosed. The health burden of diabetes is huge and it is estimated that the direct health costs for diabetes are likely to exceed \$2.3 billion dollars by the year 2010. According to the ABS 2002 Census of population and housing: selected social and housing.

- Previous: Diabetes Australia commissioned a report by the Dieticians Association of Australia and the Australian Diabetes Educators Association, as a contribution to its ongoing program of work to better meet the needs of CALD people with diabetes.

*Identification of Priority Needs for Nutrition Information Materials to Cater for Australia’s Culturally and Linguistically Diverse (CALD) Communities.* Professor Maurice Eisenbruch: Chairperson, Project Advisory Committee. UNSW had identified “Reinventing health – policy, practice and systems” as a key priority area of research focus. This achievement has been possible only as a result of the Australian Diabetes Educators Association (ADEA) and the Dieticians Association of Australia (DAA) working collaboratively towards the common goal ‘better diabetes services for all Australians’.

- For some time Diabetes Australia has been aware that the biggest problems experienced by clients from Australia’s culturally and linguistically diverse (CALD) community in managing their diabetes were of knowing the correct foods to eat, knowing how to manage diet and using medication. Two of the key lifestyle factors which are central to self-management of diabetes, diet and exercise, are heavily influenced by culture. It is therefore important to target information about diet to communities in terms of their own culinary practices, beliefs and preferences.

#### DIABETES CARE IN THE WEST: CONTEXT OF PROJECT:

- Past research focused on those communities with the highest prevalence rates of diabetes and consulted these communities about their own view of their needs. This project is to approach those who have direct contact with clients from CALD communities.
- This report will complement an epidemiological report by the Australian Institute of Health and Welfare (AIHW), designed to identify those CALD communities with the highest need for information ... greater risk of diabetes through genetic predisposition, relatively poor English language proficiency compared to other

immigrant communities, literacy difficulties, and an older than average population in Australia increasing the likelihood of developing Type 2 diabetes.

### **HOW PROJECT CONTRIBUTES TO THE BODY OF KNOWLEDGE AND CONTRIBUTES TO DIABETES CARE**

- Reinventing Health – Policy, Practice and Systems (after 2003. It was hoped the report would make a significant contribution to the provision of effective and appropriate diabetes and nutritional information for CALD communities in Australia.
- My project fits in here to help provide, initially from a research perspective, an investigation of perspectives as seen through the eyes of Diabetes Educators in the Western suburbs of Melbourne, which has the highest multicultural population concentration in the country.
- My project is to inform research through examination of your practice, because your experience with CALD communities in Western suburbs of Melbourne to deliver health messages is crucial in understanding that the messages to be perceived by patients are credible.

### **I WOULD LIKE TO ACKNOWLEDGE THE EXPERTISE YOU HAVE ACCUMULATED FROM DIRECT EXPERIENCE WITH CALD COMMUNITIES**

- Those of you who are working in the Western suburbs are the one of the most reliable sources of information to find out where CALD community members obtain their advice regarding diabetes care in Australia.

**OVERALL, MY PROJECT IS TO ASK, IN THE CONTEXT OF WORKING WITH PATIENTS FROM MANY DIFFERENT CULTURAL BACKGROUNDS, WHAT KNOWLEDGE YOU HAVE ACQUIRED THROUGH DIRECT EXPERIENCE AND TO DRAW OUT COMMON THEMES.**

## Appendix C

### Invitation to Participate in Research

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PO Box 14428  
MELBOURNE CITY MC 8001



#### **Request for research project interviewees.**

Dear Diabetes Educator,

My name is Peter Abraham and I am a Doctor of Psychology (Clinical Psychology) student, at the Victoria University. My supervisor is Dr. Denise Charman, Senior Lecturer, School of Psychology.

We are undertaking a research project into the links between evidence based practice and cultural understanding in diabetes education. The title of the project is *Investigating Culturally Competent Reflective Practice in Diabetes Healthcare*. We understand you face the challenge of care with individuals and families from different cultural groups whose diversity in the western suburbs of Melbourne is unique to Australia. We wish to understand your unique perception of how this diversity is dealt with and what effect it may have on the management of diabetes.

If you agree to participate, you will be asked to consent to be interviewed for about one hour, and for this interview to be audiotaped. The interview will explore the issues related to diabetes care and evidence based practice, culture and practice and training.

We believe that this research will contribute to our knowledge of cultural competence in the delivery of health services in the Western suburbs of Melbourne, especially in diabetes care. We do sincerely hope you decide to participate. If you do decide, please contact Peter on [peter.abraham@live.vu.edu.au](mailto:peter.abraham@live.vu.edu.au) to arrange a mutually acceptable time and place. Alternatively, you could phone Denise Charman on 9919 2536.

Yours sincerely,

Peter Abraham  
BEd; BA(Hons)(Psychology)  
Provisional Psychologist  
Victoria University

Dr. Denise Charman  
Senior Lecturer  
School of Psychology  
Victoria University

**Appendix D**

**Consent Form**

VICTORIA UNIVERSITY

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 Telephone: (03) 9919 2526

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 PO Box 14428  
 MELBOURNE CITY MC 8001



**CONSENT FORM**

**for Participants involved in Research**

We would like to invite you to help us explore the interface between culture and evidence based practice in diabetes education.

**CERTIFICATION BY PARTICIPANT**

I, .....  
 of .....  
 .....

Certify that I am at least 18 years old and that I am voluntarily giving my consent to participate in the study entitled: *‘Investigating Culturally Competent Reflective Practice in Diabetes Healthcare.’* being conducted at Victoria University by: **Peter Abraham** and **Dr. Denise Charman**

I certify that the objectives of the study, together with any risks and safeguards associated with the procedures listed hereunder to be carried out in the research, have been fully explained to me by one of the researchers (Peter Abraham) and that I freely consent to participation in an interview.

Procedures: **Semi-structured interview of approximately one hour, to be audiotaped.**

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential and identifying information will not be included in any publications.

Signed: ..... Date: .....

Contact Number ..... (For the purpose of ensuring accurate recording of the interview, if required).

Any queries about your participation in this project may be directed to the researcher (Name: Denise Charman, Senior Lecturer, School of Psychology, Victoria University ph. 03-9919 2536). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MCMC, Melbourne, 8001 (ph. 03-9919 4710).

**Appendix E**

**Withdrawal of Consent Form**

VICTORIA UNIVERSITY

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PO Box 14428  
MELBOURNE CITY MC 8001



**WITHDRAWAL OF CONSENT FORM  
for Participants involved in Research**

**CERTIFICATION BY PARTICIPANT**

I, .....  
of .....  
.....

wish to withdraw from this project and understand that my data will not be included in this project, without specific consent. I understand that my withdrawal is without prejudice or obligation to the researchers or to Victoria University associated with the project,.

I withdraw my consent to participate in the study entitled:  
*'Investigating Culturally Competent Reflective Practice in Diabetes Healthcare.'*

being conducted at Victoria University by: **Peter Abraham and Dr. Denise Charman**

Signed: .....

Date: .....

Contact Number .....

Queries about your participation in this project may be directed to the research supervisor (Dr. Denise Charman, Senior Lecturer, School of Psychology, Victoria University ph. 03-9919 2536). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University, PO Box 14428 MCMC, Melbourne, 8001 (ph. 03-9919 4710).

## Appendix F

### Interview Schedule

Diabetes Care and Evidence Based Practice:

*Diabetes care and evidence-based-practice:*

1. Q: What do you understand evidence based practice (EBP) to be?
2. Q: How is evidence based practice adapted to suit diabetes patients in their cultural context?
3. Q: What sorts of considerations would you take into account that would be indicative of effective diabetes care?
4. Q: All diabetes patients would face the challenge of managing numerous behaviour changes. In working with patients were there elements in your training to address cultural differences in approaching that challenge?

Culture and practice:

5. Q: How would dealing differently with different cultural backgrounds have an impact on the effectiveness of your work with diabetes patients?
6. Q: Can you identify areas where there is less evidence of systematic research about management of diabetes within specific cultural groups?
7. Q: To what extent would you take into consideration the family perspective as a component of cultural considerations in diabetes care?

Training, culture and practice

8. Q: Does your training or current work practice include consideration of diabetes patients from culturally and linguistically diverse backgrounds?
9. Q: To what extent does your training incorporate a cultural perspective when delivering your services?
10. Q: How different does culturally based training compare to the more traditional evidence based practice, in terms of treatment outcomes?
11. Q: In what way does your training as a diabetes educator focus on the implications of the cultural background of your patients?

Personal relationship with patients

12. Q: Are there certain facts relating to cultural background that you believe a diabetes educator needs to know about a patient before working with them?
13. Q: To what extent would you consider the involvement of the whole family in the diabetes care of one of its members?
14. Q: To what extent would you consider social support to be a salient feature of effective diabetes care?
15. Q: Would you see the relevance in asking a diabetes patient about whether they believe their body is out of balance (eg yin/yang, hot/cold, wind, fire, water,

earth), astrological destiny, or a person's soul temporarily leaving the body, someone wanting to hurt the person and casting a spell (eg the evil eye), someone seeing, hearing or feeling something ominous?

16. Q: Can you give a specific example of your personal experience with a diabetes patient from CALDB demonstrating how you worked with them that had an impact on their treatment outcome?
17. Q: Around the theme of a cultural focus in the delivery of diabetes care, what would you like me to focus on in such a research project?
18. Q: Was there a defining moment when it struck you that you needed to work differently than you were originally trained, that was separate from EBP?
19. Q: What is the most challenging thing about working with people from diverse cultural backgrounds?

## Appendix G

### Interview Schedule (Ammended)

#### *Research questions*

Diabetes Care and Evidence Based Practice:

Demographics: Gender/ age/ ethnicity/ other

Training: Deakin/ Mayfield/ other

1. Q: What do you understand evidence based practice (EBP) to be?
2. ~~Q: How is evidence based practice adapted to suit diabetes patients in their cultural context?~~
3. ~~Q: What sorts of considerations would you take into account that would be indicative of effective diabetes care?~~
4. Q: Were there elements in your training to address cultural differences?

#### Culture and practice:

5. Q: How would dealing differently with different cultural backgrounds have an impact on the effectiveness of your work with diabetes patients?
6. Q: Can you identify areas where there is less evidence of systematic research about management of diabetes within specific cultural groups?
7. Q: To what extent would you take into consideration the family perspective as a component of cultural considerations in diabetes care?

#### Training, culture and practice

8. Q: Does your training or current work practice include consideration of diabetes patients from culturally and linguistically diverse backgrounds?
9. Q: To what extent did your training incorporate a cultural perspective that influenced delivery of your services?
10. Q: How differently would culturally based training compare to the more traditional evidence based practice, in terms of treatment outcomes?
11. Q: In what way would your training as a diabetes educator focus on the implications of the cultural background of your patients?
- 11a. Q: What would you include in a training course for diabetes educators relating to cultural perspectives and CALDB groups?

#### Personal relationship with patients

12. Q: Are there certain facts relating to cultural background that you believe a diabetes educator needs to know about a patient before working with them?
13. Q: To what extent would you consider the involvement of the whole family in the diabetes care of one of its members?

14. ~~Q: To what extent would you consider social support to be a salient feature of effective diabetes care?~~
- 15 Q: Would you see the relevance in having a diabetes patient describe the cause of their illness as their body being out of balance (eg yin/yang, hot/cold, wind, fire, water, earth), astrological destiny, or a person's soul temporarily leaving the body, someone wanting to hurt the person and casting a spell (eg the evil eye), someone seeing, hearing or feeling something ominous?
- 16 Q: Can you give a specific example of your personal experience with a diabetes patient from CALD background as having an impact on their treatment outcomes?
- 17 Q: Around the theme of a cultural focus in the delivery of diabetes care, what would you like me to focus on in such a research project? (Is there something you would like to say that I'm not already asking you?)
- 18 Q: Was there a defining moment when it struck you that you needed to work differently than you were originally trained, that was separate from EBP?
- 19 Q: What is the most challenging thing about working with people from diverse cultural backgrounds?

Appendix H

Initial Coding and Categories

*Communication*  
*Patient Satisfaction*  
*Adherence*  
*Health Outcomes*

*Cultural Competency*  
 Wade et al (2000) J Gen Intern Med 15(1) *Linked Learning Form*

**INTERVIEWS**  
 Diabetes Educators

*Total time 4:21:50*  
*Reliability of text*

# CS (Anglo Australian): 11/09/06 interview (and 14/11/06 with diabetes educator colleague Jude Wilkinson from Shepparton present, but not interviewed- suggested a Gloria Kilmarfen in Shepparton gloria.kilmarfen@gvhealth.org.au). ADEA or Diabetes Australia cultural advisor is Cello Wizek.

*1*  
*4*  
*5*  
*7*  
*10*  
*11*  
*11a*  
*12*  
*13*  
*15*

*EBP*  
*Relates to NH+M&A ADEA*

*Gap analysis*

**3 Q:** What do you understand evidence based practice (EBP) to be?  
 It's practice based on the best available evidence. It's usually gathered through research and we try to follow best practice through the guidelines of the National Health and Medical Research Council (NH&MRC) and also through the Australian Diabetes Educators Association (ADEA). The ADEA website has guidelines for management and guidelines for care of the elderly, and also something that I've tried to do here, and that is gap analysis. Looking at what is not here and trying to fill the gaps. Trying being the operative word. It is very frustrating with lack of time, resources.

**4 Q:** All diabetes patients would face the challenge of managing numerous behaviour changes. In working with patients were there elements in your training to address cultural differences in approaching that challenge?  
 Using the Flinders Model. It does not work well with ethnic groups. There was an elderly Chinese man ... Sometimes being maternal telling some to "lift your game" to some teens and early 20s. Nurses are rescuers, and not everyone wants to be rescued.

*Flinders Model not effective with ethnic groups*  
*not everyone wants to be rescued.*

**5 Q:** How would dealing differently with different cultural backgrounds have an impact on the effectiveness of your work with diabetes patients?  
 It's actually very challenging because different cultures have a very different understanding about what diabetes is, and they also place varying importance on the mode of treatment, so you need to be very careful. First of all that, depending on their ethnicity, that they understand what diabetes is, and grasp that concept and think it's something serious. Because it may not be a disease that occurs in their own country. They may have known people who have had it, but there may not be a word for it in their language. You can't assume that someone would even understand the concept of what diabetes is. Also, based on peoples past experiences. For example, Macedonians come very quickly to mind. Older people have the only experience of it as something that occurs when someone is close to death, as something occurring accompanying palliative care. You can tell from their body language (see DC interview about reading people's communication to you and each other when don't know language very well) to help understand where they're coming from. It's important not to have a preconceived idea of what you think they might understand or agree to. Association breaks down barriers. Important to get across to clients that in Australia they have rights. Some may come from authoritarian regimes or family structures. I think it's important to empower them and encourage and support them in making a choice about how they manage their disease. Vietnamese patients are passive and are compliant. Australians are the opposite and tend not to cooperate. There was one Australian man, a truck driver who would not manage his levels by self administering insulin because he said that he was dirty and it would not be clean enough to inject himself. The hardest are those who are illiterate in their own country. - *8. A. But for those who are illiterate in their own country*  
 Pakistani Muslim Kooris go to St Vincents, but not Footscray Hospital

*in this regard it's important to understand what it is and how it is used in various*  
*body language*  
*preconceived ideas about what is required or agreed on*

*Not aware of how different approaches to cultural groups*  
*you don't really understand it*  
*Not aware of how different approaches to cultural groups*  
*in 02 they have rights - empower*  
*Not passive/ compliant - not aware*  
*but that's how that patient. The wife looks after him. In 1/2 year*

**7 Q:** To what extent would you take into consideration the family perspective as a component of cultural considerations in diabetes care?  
 It's extremely important to do so. There was an instance when I was seeing a male patient who said to me that if there was anything he needed to know, then to ask the missus. She will know as the wife, she looked after him. *8. A. But for those who are illiterate in their own country*  
 Siblings also can benefit by knowledge of what a chronic disease is and what is needed to manage it.

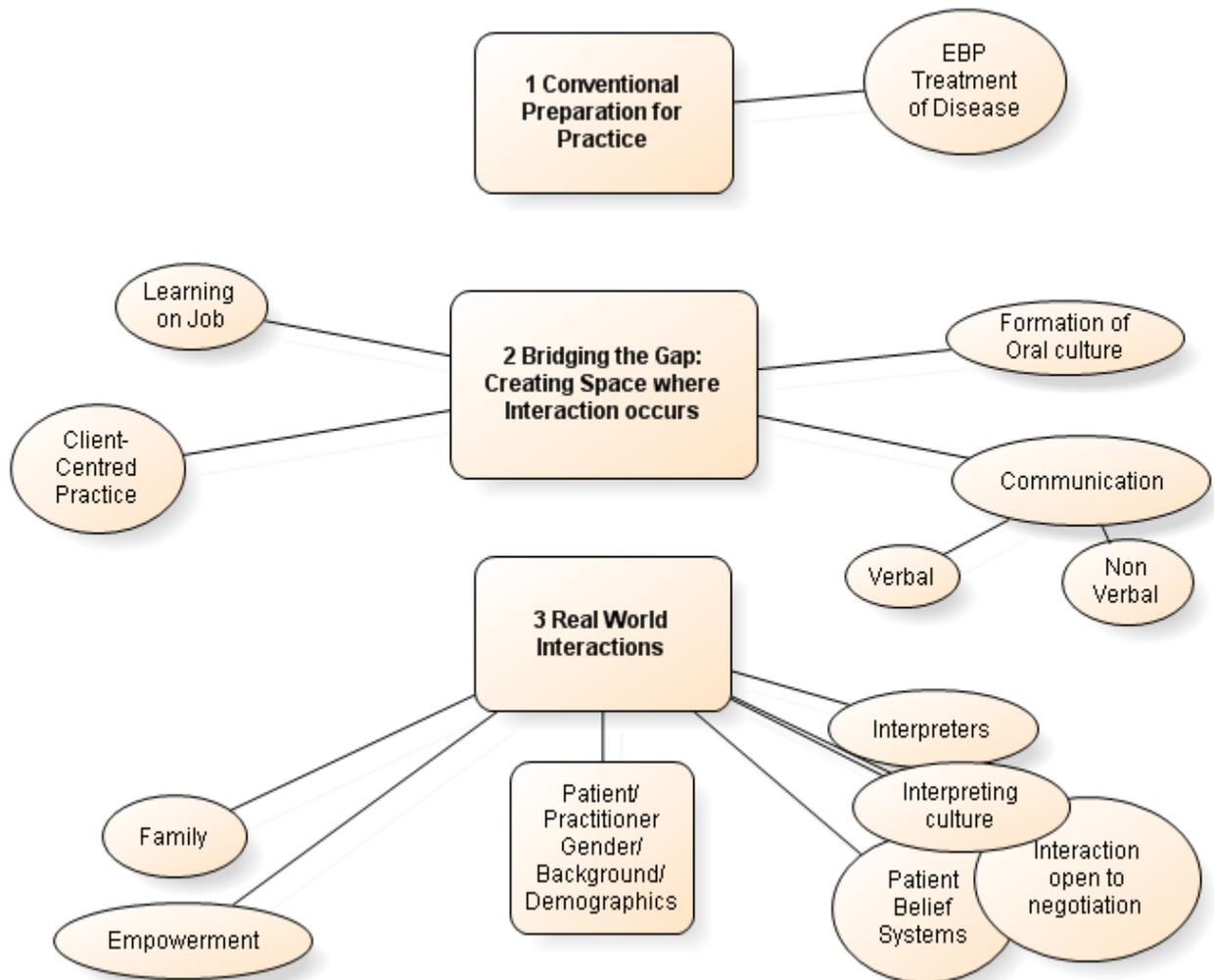
**10 Q:** How different does culturally based training compare to the more traditional evidence based practice, in terms of treatment outcomes?  
 Training in the 1990s did not include a lot about ethnicity. It is only a Graduate Certificate.

41 1



**Appendix J**

**Exploratory NVIVO 8.0 Models**





Diet/ Food Paradox

T	EBP	
	EBP As mandatory	
	EBP Assumptions	
	EBP Benefits	EBP
T	EBP deemed effective	
T	EBP deemed not effective	
T	EBP Limitations	

EBP Relevance

EBP Research & Ed Knowledge

T EBPEBP Criticism

F Educator flexibility

Educator Insight

T Educators need to know

Empowerment

Empowerment of Direction

Encourage Change

Equal Treatment

F Evidence Based Practice EBP

Family

\* Family & Culture

Family Gender & Control

F Family Model & Community Focus Model

Future/ All services in one place

Future/ Early Intervention

Future/ Outreach to African Communities

Gender

Gender & Control

Gender & Hierarchy

Gender Barriers to Treatment

Gender/ Family Gender & Resistance to Treatment not by Culture

Gender/ Family/ Gender & Resistance to Treatment

Groups & Education

Hierarchy & Family/ Gender

Hierarchy of Needs

Hierarchy Perception

Hierarchy Social Structure

HOLISTIC

Interpreters

Interpreters in Family

Interpreters/ Assumptions

Language

Level of Education

Levels of Education/ Innumeracy

F Making assumptions

Mindfulness

Models Used

Motivation

Motivational Interviewing

Non compliance

On job CC

On job learning

F Openness to difference

Poverty

*Educator qualities*

*Empowerment of patients*

*Family*

*Future*

*EBP place*

*Interpreters*

*Non Compliance*

*Put in interpreters*

The diagram consists of several handwritten notes and arrows. At the top, 'Gender' is written with an arrow pointing right. Below it, 'Hierarchy' is written with a double-headed arrow connecting it to 'Gender'. To the right, 'EBP place' is written with an arrow pointing left towards 'Interpreters'. Below 'Interpreters', 'Non Compliance' is written and circled, with an arrow pointing down from it. A large curved arrow starts from the 'HOLISTIC' section and points towards the 'Interpreters' area. There are also some bracket-like symbols on the left side of the page.

Practice & Cultural Competence  
 Practice & Cultural Competence Assumptions  
 Practice & Cultural Competence over the years  
 Practice & Cultural Competence Own research  
 Practice & Cultural Competence/ Cultural Pride  
 Practice & Cultural Competence/ Disorientation  
 Practice & Cultural Competence/ Imposition of Cultural Terms  
 Practice & Cultural Competence/ Ineffective practices  
 Practice & Cultural Competence/ In low demand Nationality  
 Practice & Cultural Competence/ Patient-Oriented  
 Practice & Cultural Competence/ Respect Client Wishes  
 Practice & Cultural Competence/ Trauma  
 Practice & Cultural Competence/Attitude to CC  
 Practice & Cultural Competence/Educators CC skills identified  
 Practice & Cultural Competence/educators Degree of CC knowledge  
 Psychological Issues  
 Quality of Life  
 Relationship-Recalcitrant patients  
 Relationship Building  
 Relationship Clinical  
 Relationship Establishment  
 Relationships  
 Relationships Gender  
 Relationships GPs & Educators  
 Relationships Limitations  
 Resource Development  
 Resource Development/ Translation  
 Respect Acknowledge Identity  
 Structure Change in Diabetes Health  
 Teaching Aids/ Visual  
 Training & Cultural Competence  
 Training & Cultural Competence/ Consumer not Clinician Centred  
 Training & Cultural Competence/ ~~elsewhere~~ on the job  
 Training & Cultural Competence/ grown over the years  
 Training & Cultural Competence/ Interpreters  
 Training & Cultural Competence/ Lifestyle, Language, Values & Traditions  
 Training & Cultural Competence/ Limited  
 Training & Cultural Competence/ N  
 Training & Cultural Competence/ Sensitivity to Cultural Beliefs  
 Training & Cultural Competence/ suggestions  
 Training & Cultural Competence/ Wish List  
 Training & Cultural Competence/ Y  
 Translated Resources  
 Translation direct  
 Trauma  
 Visual Information  
 War & Conflict  
 Wish list for CC research

*CC in practice*  
*Learning on the job*  
*Pro advice*

*HOUSTON* → *Relationships*

*Client-centred*  
*report to community & team*

*Training*

*Wish*

*1st/2nd/3rd Negative case example*  
*→ makes them more aware*

Appendix L

NVIVO 8.0 Matrices Categorised by Question (Excerpt)

*1 of 20 Research Q.3 What do we know about how EBP is adapted to suit the diabetes patient in their cultural context?*

*is EBP adapted?? Maybe not. Something happens in the space between.*

*in the way they communicate. To meet where at a belief, then bring in EBP when relative to that. Communication with actions - Ham one. -> meet them where they are at. -> attitude of not making assumptions.*

*BELIEFS AROUND HEALTH*

**Name:** Tree Nodes\REAL WORLD INTERACTIONS\Belief Systems

<Internals\Interview transcripts\070801 #19 Sarah Price> - § 1 reference coded [2.99% Coverage]

Reference 1 - 2.99% Coverage

It would be good to know how different people view different disorders because I was working with an interpreter and saying different words to describe being depressed and the person was saying no to all of them.

<Internals\Precis Table-per Question\Diabetes Eds precis matrix\_1question> - § 24 references coded [8.56% Coverage]

Reference 1 - 0.27% Coverage

Q	%	Line	
1	8	48,49	<b>Barriers other than culture.</b> May be also other factors other than culture, <b>such as socio economic factors.</b> It may be that the information that is being presented doesn't sit comfortably with their understanding of their health.

Reference 1 - 0.26% Coverage

4	9,10	24 26	Some new arrival <b>Africans are innumerate.</b> Ethiopian, Sudanese, Somali, Dinka? This <b>affects ability to self manage:</b> to read glucometers and to transfer pictures on the screen, numbers, and put into a record book.
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*Africans innumerate - can't use equipment or monitor progress over time*

Reference 2 - 1.01% Coverage

4	9,10	41	Concept of chronic illness and ongoing medication is quite alien to many Africans have spent 10 years in refugee camps.
4	9,10	50	<b>Africans find it difficult to take on the responsibility for their own health and management</b> rather than be treated and managed by a doctor. If left to their own resources they go off their medication.
4	9,10	53	<b>CULTURES DIFFERENT FROM THE TRADITION WESTERN VIEW.</b> Problem with <b>no motivation</b> bc there is <b>no pain, not feeling sick.</b> So <b>problem of understanding prevention is very difficult.</b>
4	9,10	55	<b>Can't make assumptions.</b> Often say <b>yes to be polite</b> but don't understand. <b>Be open minded.</b>
4	9,10	58	<b>Older</b> people across all cultures tend to be <b>less flexible</b> about change, and more fixed in their ways. Terms of reference are from within their community, which may <b>negatively reinforce their beliefs</b> , which may not be

*Western culture different*

1 / 6

2

2

NO EXPERIENCE OF STRATEGIC CHANGE

• Dealing with  
 • Ready for  
 CHANGE 1/2

**Name:** Tree Nodes\IREAL WORLD INTERACTIONS\Belief Systems\Barriers & Perception of Resistance

<Internals\Precis Table-per Question\Diabetes Eds precis matrix\_1question> - § 41 references coded [10.87% Coverage]

Reference 1 - 0.27% Coverage

4	9,10	58	Older people across all cultures tend to be <b>less flexible</b> about change, and more fixed in their ways. Terms of reference are from within their community, which may <b>negatively reinforce their beliefs</b> , which may not be helpful.
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Reference 2 - 0.30% Coverage

4	9,10	7,10	<b>Motivational interviewing</b> and picking up where people are at from what their health beliefs: Whether ready to make a change or not. If many barriers <b>then more energy goes into those who are moving into the stage when they are ready for change.</b>
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Reference 3 - 0.32% Coverage

4	9,10	26	<b>Hard to maintain motivation because it is always there.</b> So need to introduce a new incentive or take to a new point. For example, an older non compliant patient had upgrading a meter to latest, for free. Changed his attitude and became more interested in using it.
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Reference 4 - 0.32% Coverage

5	1	46	<b>My experience of Australians is they tend not to cooperate.</b> A truckie who refused to manage his levels by self administering insulin, because he had dirt on him. Most difficult are those who are illiterate in own country; include Pakistani, Kooris, and many Muslim groups.
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Reference 5 - 0.19% Coverage

5	2	36	<b>African</b> groups come in but have <b>no idea</b> what it is. Often seen to last after housing and other issues are attended to because <b>no pain</b> or obvious symptoms.
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Reference 6 - 0.75% Coverage

POWER 2/3 + GENDER 3/4

Older + set in ways. ↓ flexibility ↓ CHANGE

spend more energy on their roads for change

hard ways to motivate for CHANGE

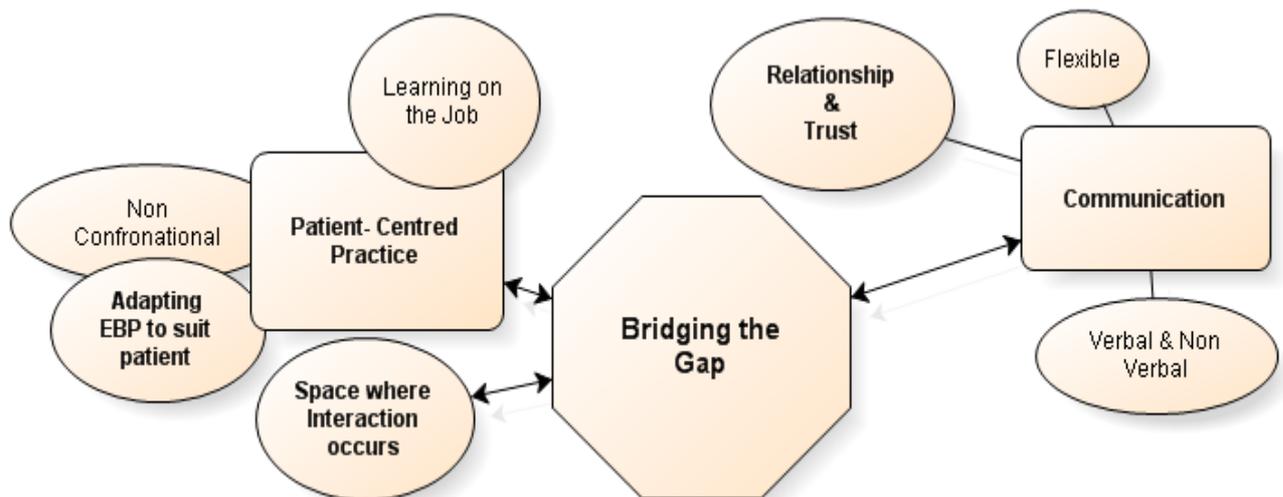
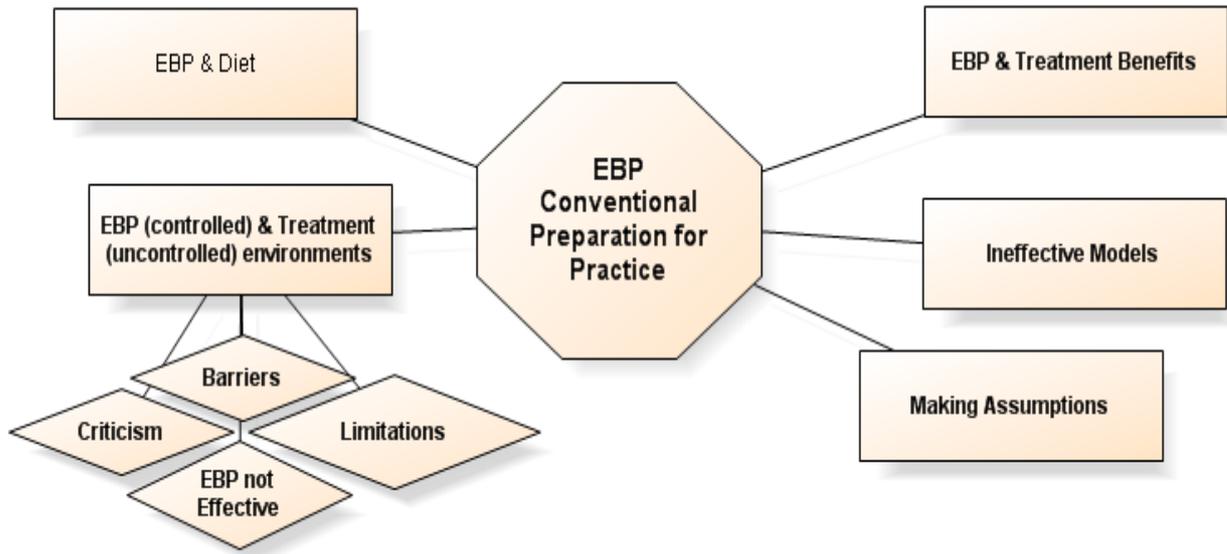
(CHANGE) of illiterate in own country

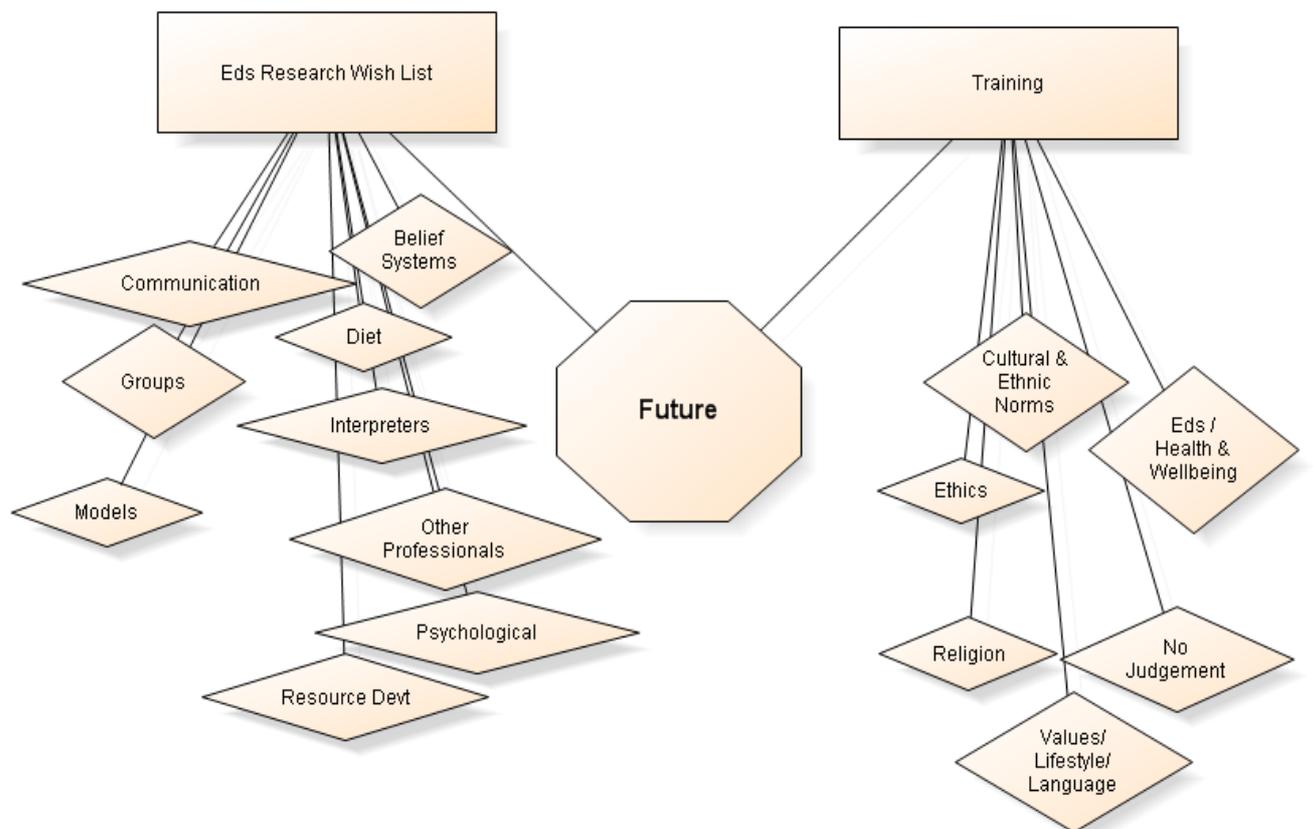
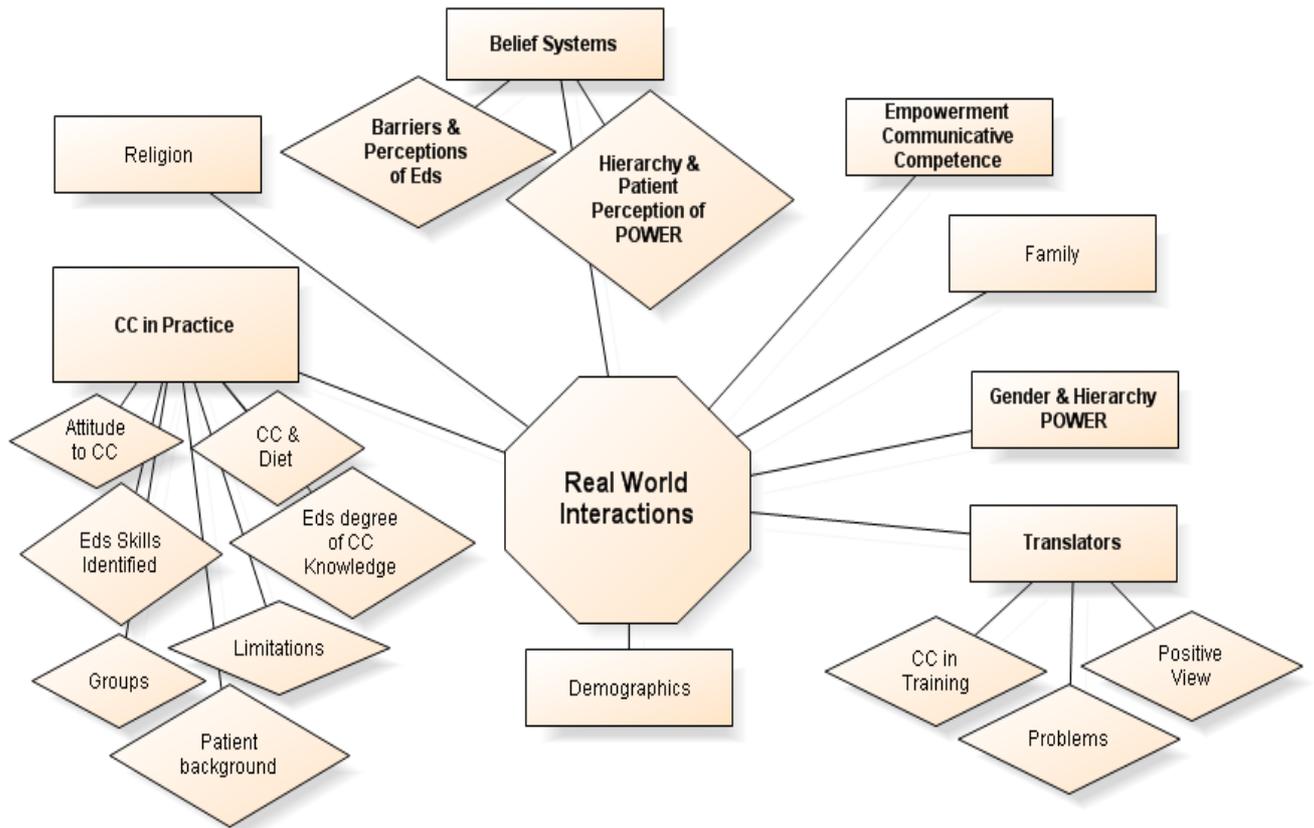
African: no idea of Diabetes / no pain or obvious symptoms

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Appendix M

NVIVO 8.0 Diagrammatical Analysis





## Appendix N

### Participant Feedback (Excerpt)

(Follow-up telephone interviews 15 mins)

Process of triangulation (Verification of data). Participant #18-précis of interview 2010.

*Q1: (The thesis findings indicated that ...) You had the intention of looking not only addressing symptoms but considering your own and your patients' cultural differences and them as a whole person. What are your thoughts on this?*

*Q2: (The thesis findings indicated that ...) Your ability to be reflective. Being aware of difference and having a capacity to be aware of your own assumptions or biases. What are your thoughts on this?*

#### Q1. CULTURALLY COMPETENT BEHAVIOUR

*Self-awareness:* Through feedback from patients became aware of own shortcomings and ignorance of systems of belief. Patient's views were very different from Western beliefs and way of living. At first was uncomfortable with lack of compliance and power relations. They were very vulnerable and needed to be aware of this especially with a "disease that did not seem that obvious." In network meetings to reinforce the importance of us learning about culture and its effect on treatment. To think of the person as a whole because they are coming from a different way and "world of operating."

*Awareness of the other:* A desire to do this properly, to make a difference. There are so many reasons and beliefs that we need to consider. We can't assume that all patients interact with professionals in the same way. Sometimes it's a problem if a male patient and female professional doesn't have the status of a GP. Noticing lack of eye contact. Understood this. Initial reaction was shyness, but realised this was not the case when patient took offence and began to behave differently and there was less rapport.

#### Q2. CAPACITY TO REFLECT AND ACT DURING AND AFTER CONSULTATIONS

*In action:* We all have to be able to "think of our feet." Awareness that needed to change perception of how relating to other. Lack of rapport, or comprehension by patient often resulted in adverse outcomes in short term. Having a sense that something is "not quite right" and changed how relating to patient to find another way. Constantly having to do that. It was constantly learning something new and making adjustments. A lot of it involved a range of different ways of communicating. We have to get to know as quickly as we can where the patient is coming from.

*Post consultation:* Consult allied professionals individually and during case meetings. Information was gathered relating to cultural knowledge, norms and nuances. Set out to find my own information by researching diabetes literature. Sharing information through network meetings. I thought about how I worked and what I needed to change. In a way this was intuitive. I don't think I deliberate stopped and reflected, it seemed to happen because I wanted to do the best I could to help. You get to know them better and find out more about their world. Being able to get hold of interpreters is often difficult. But those who know about their culture are going to be able to give more information to help me understand how best to work.

## Appendix O

### Reflective Journal (Excerpt)

The examination and reporting of diabetes practice. What do they do to deliver their service? How do they deliver their service? Their experience and communication with different groups will help inform and contribute to the enhancement and effectiveness of the delivery of diabetes and mental health care to patients from diverse cultures.

The beginning point for this study was from a grounded theory perspective. Not compelled to confine myself to this. Unlike the more popular quantitative approach to research in the human sciences, a qualitative approach more appealing- opportunity to reflect on interactions with the participants involved. Their points of view were key in establishing a basis for examining practice in health care.

Explore culturally competent practice in health care, with specific reference to: Diabetes practitioners' experience in the delivery of diabetes care. WHY? Experience with specific CALD groups and EBP. WHY? To examine practice undertaken when working with patients from different cultures other than Anglo Australian. Hypothesising that there are differences. Examination of practitioner's experiences working with culturally and linguistically diverse (CALD) populations. WHY? To distil what diabetes practitioners do in practice. What are covert/ overt problems? Experiences include: Practice. Does everyone think about culture?

#### *Thoughts and Questions*

What are covert/ overt problems?

Does everyone think about culture?

Context. What are the surrounding conditions: the circumstances or events that form the environment within which something exists or takes place?

How does EBP play out in an uncontrolled environment?

How do people talk about cultural competence?

What are the encounters between practitioners and patients doing?

Knowing as compared to being and doing.

Practitioners' experiences are myriad.

Keep in mind to be thinking about the sophistication of detail in this research project.

Culture and Practice.

Includes power and empowerment of others.

Culturally Competent interaction (what is this?).

Cultural Competence in interaction for participants. *Expand* interaction occurring in the space between the participants and the patient with interpreter as facilitator.

Communicative behaviour is embedded in wider structures of power. Language plays a dynamic and creative role in the construction of social reality (Monaghan & Goodman, 2007).

How different was it when working with different cultural backgrounds?

Asked whether training looked the cultural background of patients.

EBP is where a distinct and specific approach to treatment is undertaken and I was interested in how practitioners deviate from this.

What problems might arise if the patient is not being understood?

network meetings. Was very informative. I tended to hope that the names of different cultures would come up so I could identify if there were specific characteristics inherent in specific cultures.

By interviewing I don't claim to describe the interviewee's experience. It may well be about experience, but it is an experience rendered into language, an account of how one practices health care, and I am working with that account as they "language it".

Change of supervisor was disconcerting ... no prior warning; promotion for supervisor ... hard for me to pick up momentum again. I lost nearly a year in this changeover.

Insert question in interviews: Were there defining moments when experience was different from EBP?

Stay focused on culture and practice culture and ethnicity

14/5/07 Started new enquiry -Was there a defining moment when it struck practitioners that they needed to be culturally competent in their practice? Not getting anywhere with this question.

14/6/07 No defining moment cited by any practitioner. Question not very useful. Having a dilemma about best way to decide how to analyse data in this project. After reading about constructionist viewpoints it seemed most like what I relate to and what I am doing here. Remaining totally objective seems unlikely. I am actually part of the process, and so are the participants I'm interviewing here.

1/7/07 Critical reflexivity, can offer a way to explore the power relations in this study, where otherwise they might have been ignored (Parker, 2005). Critical reflexivity also provides an opportunity to conceptualise my own role in this project with a view to learning how I can be of most use as a researcher, and how I can question and offer viewpoints in the development of humane and relevant professional practice.

8/7/07 Time commitment on hospital clinical placement and my work commitments taking toll on momentum. Power with professions ... psychiatrist in a debriefing saying that patient's parent was "interfering." Appalling ... taking a long time to refocus attention back onto patient.

Qualitative research can be a precarious pathway to take, as the demands of logic and scientific thinking are not often regarded as compatible to research by some.

Look for patterns. What is the crux of the work? Who appears to be doing it better? What's lacking/ not lacking? Similarities in practice (What language defines that?). How is this manifested? Diet/ training/gender/EBP.

Practitioners want to be appropriate -Not to offend [humane as in Aristotle's phronesis] Ethical protocols? See links to Habermas. There is a strong sense here that ethics is a core issue in all of this.

*Jürgen Habermas*

Links between Ethnicity and Culture: Habermas? -Adopt certain behaviours due to the experiences of our elders and environment

*Communication competence is a position of power.*

*Empowerment: what does it look like? Respect comes into it.*

Bent Flyvbjerg

Social science is important. Theory and technical knowledge need to come together (check Flyvbjerg) When there is uneven power, the practitioners take a position.

Flyvbjerg is a negotiator of power relationships. How is it done? How did the nurses do it?

Possible themes to think about. Educator training; resistance; previous experience; motivation for interpersonal skills; openness to difference; gender issues; relevance of client relationship; openness to difference; teaching strategies; resource availability; resource development; power relationship.

16/7/07 What do practitioners do outside EBP with multicultural patients? What outcome can I see or am I seeking? To articulate thoughts/ feelings/ behaviours that are valued to work with multicultural patients.

30/7/07 How important is EBP on its own? EBP plus visual and culturally appropriate information. It is Western medicine being promoted and not Eastern beliefs. Western information may not be culturally relevant to understanding of health.

Culture. This issue matters. Why? What are they? For example, instead of a variable such as interpreters, I could have clarity of communication and knowledge of culture in sharing of patient information and education in treatment. Communication and power is highly relevant here. Is counterpoint with ethical and prudent practice - vulnerable patients who do not know the country or its systems.

6/8/07 Practitioners respect others beliefs. They explained how they worked to have a positive impact on their patient's lives.

Respect older patients' decision not to change even if it shortens their life by 5-10 years. If have been living this way for 70-85 years, then it is hard to change patterns.

Should we? Older patients are less flexible about change, which is difficult to deal with. Whose issue is that?

19/8/07 EBP is needed because of the structure, but also empirical knowledge is important. But it doesn't seem to be a good argument to back the rigorous nature of evidence-based practice. Especially if you're dealing with different cultures and systems of belief.

Practitioners are quite special. An authority figure that shares power. There is something about the diabetes practitioners that makes the interaction with their multi cultural patients work very well.

Diabetes practitioners' communication in the 'space' is a core component.

Phrase CC as a dynamic for example, culturally competent interaction.

CC in interaction for participants. *Expand*

Interaction occurring in the space between the participants and the patient with interpreter as facilitator. Interpreting culture is very important.

Knowledge Values and Awareness

Values-Notion of *protecting another's culture* implies lack of ability to do so. Not to lose face or dignity.

Interpreters. Beliefs. World view-time-relationships. Social organisation.

Ethical protocols?

### *Educator Qualities*

Despite EBP material, started with patients without judgment. No preconceived ideas of one's understanding [willingness to be wrong and accommodate the other].

### *Communication*

Information needs to be simplified from EBP. Use visual information.

EBP delivered but empathy essential.

Benchmarks are set by EBP, which provides information about the disease and for healthy blood sugar levels there is a need to tailor the work to fit and sensitive to their needs. [They are very creative and innovative and sensitive practitioners]

EBP important, but empowerment is important [‘voice of medicine’ vs client-centred/lifeworld].

In general throughout concentrate on the concepts of culture, and culturally competent activity in delivery of health. If can’t form relationship then have problems. (Broadmeadows islanders not returning) If the practitioner is not able to form a relationship, then there will be problems. For example, islanders not returning for follow up consultations, and that AB was expected to make contact with the community leader before this would happen.

What do we know? What don’t we know?

Find theoretical anchor- human relations. Jürgen Habermas’ theory has strong ethical positions on communication, power relations across many areas.

There are also links to *Aristotle and phronesis*: Is this too provocative to question EBP on its own, as I have been trained that evidence-based material is crucial. This study questions this premise. EBP limits itself in the context of what is coming up in the interviews. EBP material is gained through a controlled environment. In the field no such reality exists. EBP can inform, but that is its limitation. Have to follow EBP. There is the limitation of facts only. Preventative long-term management is difficult to get across: it is counter intuitive to continue taking medication for the rest of your life when you have no sense of being sick. 4/9/07 Culturally competent practice is an ethical imperative, and a right. Phronesis is ethical knowledge and behaviour. How to make practice inclusive? Drawn to qualitative approach, as it requires reflection and flexibility as it also takes into consideration the immediate experience and opinions of participants.

11/9/07 Make a connection between sociology and health practitioner.

Back to literature review-Culture in terms of policy (why a need? what is it? what responsibility to?)

25/9/07 Where has cultural competence come from? Is it a realisation that we do not have insular societies in the western world and that medical knowledge is born out of compartmental, reductionist, scientific thinking? Qualitative allows me to do many things. It also talks about people.

6/10/07 Practitioners needed to think about different cultural groups and creating relevant resources for them.

My analysis is evolving into a critical reflection of the practice of health practitioners. I expect this view can be broadened from practice with diabetes patients, but to psychologists working with patients from different cultures and ethnic backgrounds. I have a sense that the views of health care professionals around culturally competent practice, in the absence of formal training dependent will be valuable for all practitioners in health care.

In working with diabetes patients, EBP is crucial to inform the practical aspects of management of blood sugar, but humane delivery of this information is likely to impact on the effectiveness of learning to participate in its management. Thus, deviance from the biomedical view, is important in terms of respect for personal power and basic human rights.

### *Diabetes Training*

Seems argument is that CC in training not actually practical anyway, and that profession relies on practitioners in the field to create material, then share it.

Cultural competent practice is to enlighten, motivate, empower and encourage patients. Put in CC models briefly and what they are about.

### Knowledge Values and Awareness

Values: The notion of *protecting another's culture* implies lack of ability to do so. People should not be put in a position to lose face or dignity.

Ethnocentricity.

Interpreters interpreting culture is very important. Interpreters as facilitators.

Beliefs; World view- time- relationships; Social organisation.

Transference responses to practitioners; Practitioner as an admonishing mother.

[Consideration of psychodynamic approach with relationship compared with no relationship, directive or paternalistic]

### *Methodological thinking and reference material*

Dilemma about best way to analyse data. Beginning with grounded theory.

Reading a lot of Parker (2005) - has me thinking ... argues that grounded theory was a tactical intervention that formalised proposals for research funding, but had become a complete strategy for research using positivist style procedures and techniques, that the discovery of theory from the data was not tainted by subjectivity. I need to accept my own subjectivity. Objectivity: when the knowledge is assumed to be out there to be grasped if only the researcher can put aside all their preconceptions. This leads to a version of objectivity that requires that the subjectivity of the researcher is made absolutely blank. You can pretend to be blank and empty, but that pretence will just stop you from making use of what you know (Parker, 2005, p57). [Maybe too much to put in]. Parker (2005) expressed caution that "reflexivity should not be a self-indulgent and reductive exercise that psychologises phenomena and psychologises your own part in producing them" (p.35).

There is a mix of viewing the data from a modernist perspective through the lens of Habermas' model, alongside a critical postmodern perspective. This allows for an exploration into areas that might have remained unexplored, were I to have adopted a positivist approach. It provides a space to reveal and explore the more murky challenges and the tensions of the research process. Critical reflexivity, can offer a way to explore the power relations in this study, where otherwise they might have been ignored (Parker, 2005).

Critical reflexivity also provides an opportunity to conceptualise my own role in this project with a view to learning how I can be of most use as a researcher, and how I can question and offer viewpoints in the development of humane and relevant professional practice.