

*Paramedic Practice and the Cultural and Religious Needs
of Pre-Hospital Patients in Victoria.*

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Abstract

Religion and culture can impact profoundly on healthcare practices and health outcomes. The Australian community is rich and diverse in differing cultures and religions, and at times of medical emergency the paramedic increasingly will be required to respond to healthcare needs of this diverse community. This study is designed to investigate current paramedic practices as they relate to an awareness of the cultural and religious needs of community groups as a holistic approach. It also incorporates the voices of these community groups from their experiences with emergency paramedics during pre-hospital health care for those living in Melbourne, Australia. Narrative Enquiry and Thematic Analysis were used to identify common threads in responses from two independent volunteer groups: community groups (n=20) incorporating representatives from the Africa, Asian, Middle Eastern, Muslim, Jewish and Indigenous Australian communities, and paramedic practitioners (n=20). The purpose and nature of, and satisfaction with, the paramedic callout were investigated using semi-structured interviews during a 90-minute focus group with the individual community groups and individual 30-minute face-to-face interviews with the paramedic group. Themes indicate that the paramedics had both a deficit of knowledge and a presence of incorrect knowledge about cultural practices that impact directly on professional practice. In relation to suggestions from the community group participants to ambulance paramedics, communication and respect were the strongest themes. Whilst the paramedics acknowledged the importance of cultural and religious values and preparedness in pre-hospital practice, themes of frustration and increased anxiety as well as a lack of useful cross-cultural education and training were consistent throughout. This study recommends strategies to improve interventions with diverse community groups in the pre-hospital setting, and identifies areas of cross-cultural curricula that should be incorporated into paramedic education. The flow-on from these recommendations will result in an improvement in the overall health outcomes for community members and better informed, and more culturally prepared, emergency paramedics.

Authenticity Declaration

I, Peter Hartley, declare that the PhD thesis entitled *Paramedic Practice and the Cultural and Religious Needs of the Pre-Hospital Patients in Victoria* is no more than 100, 000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. 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.

Signed: _____

/ /

Peter Hartley

Date

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Chapter 1

Introduction

I have often thought about why topics of research are undertaken. Why some people choose subject areas that others find less interesting? We are all individuals and as such the research that emanates from the countless studies that are undertaken are representative of this. I have speculated in my own mind over the years as to the reasons why people choose an area of research, I guess there are many.

I recently had the opportunity to attend a workshop with twenty (20) other students undertaking their doctoral studies in varying universities across this nation. I was surprised to learn that many of these students had had their topics chosen for them, almost forced upon them, regardless of their interest. I was thankful for the opportunity afforded me to choose my own topic, or, at least, I tend to believe that it chose me. Of course, given my long career in pre-hospital emergency care as a paramedic, it was important for me that the topic of my doctoral research produced new knowledge for this discipline.

As a paramedic of nearly twenty – seven (27) years, I have had a long and lasting interest in many aspects that a holistic approach to patient care can offer. As a very junior academic, some twenty (20) years ago, I was considered a ‘pioneer’ in my quest to attempt to bring in sociology-themed subjects into the paramedic curriculum, a crusade which still exists to this

very day. In those early 'pioneering' times that I reflect on now, my focus was much broader than it is today. Back then, I was not so acutely aware of the cultural and religious needs of the Victorian community in pre-hospital care. From my early days on the road as a paramedic practitioner, I always knew that there was something missing from the care that I was able to offer my patients, yet it was not clear to me exactly what that was.

I was a paramedic, charged with the responsibility of responding to the public at times of medical and surgical emergencies. I was proud of my vocation, and believed that I performed my role with compassion and understanding. Like other paramedics in Victoria, I also had a degree of medical skills that was to be admired by our interstate and international counterparts. Yet aside from this, I still felt there was an underlying aspect to my care that was missing.

Discussing this, at times, with my then senior colleagues, I was advised repeatedly that I was expecting far too much from my role as a paramedic. The responses from them were always the same; I was looking too deeply into the needs of our patients, that our role was to get them to hospital as quickly as possible and move onto the next job at hand.

The yearning to do more, yet not knowing exactly what that was, intensified over the years. On reflection, I now know, and understand, what this yearning was. In those earlier years of working predominately in the north-eastern suburbs of Melbourne, my encounters with

patients of differing cultural or religious backgrounds were rare, certainly not enough to make me aware that there were any potential issues.

Like all paramedics, there was the occasional requirement to fulfil overtime shifts in locations that were short staffed. This often required attendance at a branch location some distance from my own home branch. It was at these times that I had the fortunate opportunity to work in locations that had significantly different population demographics from those I was usually assigned to work. I recall being astounded at what I had learned from attending these locations and the desire to comprehend more about the individual requirements of patients whilst in our care.

Being sent to areas such as Caulfield, with a high proportion of members of the Jewish community, and Sunshine, where the mix of cultural backgrounds was so varied, was exciting; not knowing what challenges were facing you on the very next call out and what you could learn from the experiences of being exposed to the diversity of cultures. It was during this time that I began to realise exactly what aspect of my care was missing.

However, it was not until I was exposed to a series of specific events that were encountered that I really became aware of what this entailed.

The first was a series of patients from varying but very specific cultural backgrounds. During this time it was explicitly clear to me that I held no knowledge of how to address them. I recall that, at that time, I was embarrassed that I was unable to deliver the level of care that

I believed the patients deserved, particularly when my patients' cultural or religious needs were beyond my capacity to understand or respond to.

The second was exposure to some of my colleagues' discussions. These discussions gave me some insight into their distinct lack of cultural preparedness and their lack of desire to develop these skills. There was no definitive moment for me that I realised that many of our patients required more than what we could offer. It was definitely a more gradual awareness that we could offer so much more for community groups who appeared to have such strong religious and cultural beliefs, the very belief systems that they turned to for support and guidance at times of illness.

Being involved on a social level with friends and family from varying health disciplines, I often engaged in conversations with them about their knowledge of dealing with patients of differing cultural or religious backgrounds. I wondered whether or not this posed any issues in their respective workplaces. I recall that I was continually astonished at the level of knowledge other healthcare professionals had in this area. Discussions also evolved about the varying education and training programs that they had undertaken which had enabled them to gain this insight. They often commented that they were equally astonished that paramedics were not exposed to the same level of training in this area as they had been.

Many of my social group of friends at that time worked in the hospital setting and they had frequent encounters with paramedics in dealing with patient care. In particular, they were

involved in handing over the care of the patient from the paramedic to the hospitals' emergency departments. At times, comments from some of these friends would often include concerns that paramedics had failed to recognise their patients' religious or cultural requirements. They added that after the paramedics had left, discussions with the patient indicated that the paramedics concerned had failed to establish any rapport with the patient. To this day, I clearly recall a statement made by a nurse colleague when discussing these very issues. She said that 'with knowledge comes respect', indicating that without required knowledge there may be disrespect.

Over the ensuing years, I attempted to read as much as I could that related to the cultural or religious needs of patients. This was frustrating as all the information that was available related to in-patient services, incorporating issues that held little relevance to paramedic practice in the out of hospital setting. The information that I was able to ascertain related only to in-hospital services, making arrangements for private prayer times and spaces for their patients and capacity to provide meals congruent to religious needs. Additionally, there was information relating to some religious and cultural groups not sharing the same hospital rooms. None of this information was applicable to paramedic practice.

After several encounters with patients from varying religious and cultural backgrounds, I had made the assumption that those from the Muslim community appeared to be the most devout in their customs and, from my experience, held the most challenges for paramedics. For this reason the focus of my Master of Health Science research was titled 'Are the

Cultural and Religious Needs of the Islamic Community Being Met by the Metropolitan Ambulance Service, Melbourne Australia During Times of Emergency?' Hartley (2006).

The results of this study incorporating twelve (12) participants gave clear indications that there was a large religious / cultural group within Melbourne whose specific needs relating to their religion and culture were not being met by the then Metropolitan Ambulance Service, now known as Ambulance Victoria. This study also identified significant gaps in the knowledge of paramedics in relation to their understanding of Islam and the impact this had on themselves as paramedics, as well as on their patients.

The results of my Master's study (Hartley, 2006), were not dissimilar to those evidenced by Purnell & Paulanka (1998), who argue that global diversity and multicultural populations have far-reaching implications for health care practitioners and the delivery of health care services and health care organisations. Throughout their research, Purnell & Paulanka claim that the many different immigration patterns have led to unique multicultural societies; economic, technological, and social changes have prompted the need for modifications in health care practices to address these changes. Not unlike the findings in my own Master's research, (Hartley, 2006), they also conclude that educational and human service organisations need to be increasingly culturally sensitive and culturally congruent so that individuals, families, and communities are provided culturally competent care. Health care is in a unique category and must reflect a unique understanding of the values of diverse populations and individual acculturation patterns.

In their study Sheikh & Gatrad (2001), make the case that religion, culture and health share a rich and intricate past. Their interrelationship however, is arguably more intriguing. This is particularly so with increasing diversity amongst communities occurring in very recent times that place more demand for services to be culturally and religiously congruent. They note that not only do religion, culture and health meet at the great turning points in life, at the junctures of birth and death, but continue to profoundly influence and shape notions of well-being and disease for many people throughout their lives. These two junctures are heavily intertwined for many people and cannot be viewed in isolation. I believe that this is the very core of why a holistic approach to health care is important not only for patients but also for improved patient outcomes. This was also identified also in my Master's research (Hartley, 2006).

My previous research also showed that the Muslim cultural group within Melbourne retained their cultural and belief systems long after arriving in Australia. It also highlighted that the retention of these practices exponentially increased with the level of devoutness they held in their faith. Further, the study revealed that for many Islamic patients, their reliance on their belief system was far more powerful during times of illness or medical emergencies. My Master's research (Hartley, 2006), gave me considerable insight into the Muslim community's experiences in dealing with paramedics in Melbourne as this related to their cultural and religious requirements. I believed that similar experiences existed in other cultural and religious groups given the diverse demographics of Victoria, and I was keen to hear their stories.

Melbourne is a multicultural city. It has people from 223 countries, speaking more than 180 languages and dialects that identify with 116 religions. Today, 43.5% of the total Melbourne population were either born abroad or is of foreign origin. Melbourne's population has a high concentration of Greeks and Italians. More recently people from other countries like Cambodia, Vietnam, India, the Philippines, and Malaysia have also settled in this city. Over the past decade there has been an influx of immigrants from the Middle East and from the African countries as, especially from Sudan. Melbourne has the highest concentration of Jewish people in Oceania and it also has a large Muslim population. (Australian Bureau of Statistics, 2007)

To give a clearer picture of the religious and cultural diversity of Melbourne, the following two tables from the Australian Bureau of Statistics (2007) details how diverse this city is. Table A details the number of people living within Melbourne via ancestry; Table B details the number of people living in Melbourne via religious identity.

Table 1 Melbourne Population by Ancestry

Australian	1,076,831
Australian Aboriginal	2,226
American	9,744
Chinese	182,550
Croatian	32,354
Dutch	60,737
English	916,832
Filipino	32,196
French	19,101
German	109,177
Greek	149,195
Hungarian	18,338
Indian	67,405
Irish	299,271
Italian	260,956
Lebanese	33,685
Macedonian	35,097
Maltese	57,897
Maori	11,785
New Zealander	22,883
Polish	44,433
Russian	18,114
Scottish	238,306
Serbian	25,534
Sinhalese	36,118
South African	14,153
Spanish	16,118
Turkish	29,364
Vietnamese	62,688
Welsh	16,254
Other	315,917
Unstated	291,758

Source: Australian Bureau of Statistics (2007)

Table 2 Melbourne Population by Religious Identity

Anglican	433,544
Assyrian Apostolic	1,066
Australian Aboriginal Traditional Religions	154
Baha'i	1,888
Baptist	51,307
Brethren	2,678
Buddhism	126,082
Catholic	1,018,117
Chinese Religions	1,040
Christian	50,651
Churches of Christ	10,013
Druse / Druze	945
Eastern Orthodox	212,884
Hinduism	40,639
Islam	103,187
Japanese Religions	223
Jehovah's Witnesses	9,663
Judaism	40,546
Latter Day Saints	7,824
Lutheran	24,153
Miscellaneous Religions	3,132
Nature Religions	4,772
No Religion	717,718
Oriental Orthodox	8,835
Other Christian	4,566
Other Protestant	9,936
Pentecostal	29,940
Presbyterian and Reformed	83,763
Salvation Army	8,169
Seventh-day Adventist	6,678
Sikhism	8,591
Spiritualism	1,732
Uniting Church	143,551

Source: Australian Bureau of Statistics (2007)

A further outcome of my Master's study (Hartley, 2006), identified that paramedics in Victoria held strong Australian beliefs, failing to understand, or value, the non-Australian traditions of their patients. According to Engel (1997), throughout the latter part of the twentieth century health care provision was primarily based on western needs, with the assumption that the needs were essentially physiological and that the biomedical and biopsychosocial models adequately underpinned service delivery. He concludes that, unfortunately, these essentially western-derived approaches were incompatible with meeting the needs of patients from diverse cultural and religious backgrounds.

Engel goes on to argue that it is only in more recent times that we have seen a shift in approaches to address this disparity in some healthcare professions, such as medicine and nursing. His study also includes that the adoption of a more holistic approach to patient care, that consideration of religious and cultural needs, which is more likely to bring about more positive outcomes for the patient.

My earlier study within the Muslim community, however, showed that the adoption of this approach is confined mainly to tertiary care facilities, i.e., those providing in-patient continuing care, and is not seen in the primary health-care services provided by paramedics in the pre-hospital practice environment.

Pre-hospital care is, by industry definition, the provision of professional emergency care delivered by paramedics before the patient reaches the hospital. In Melbourne the

statutory authority for the delivery of these services rests solely with Ambulance Victoria as a single state-wide service.

According to the Ambulance Victoria's 2010-2011 Annual Report, paramedics in Melbourne are responsible for the initial attendance at medical emergencies and accidents. The service is required to assess, treat, and stabilise patients, first at the scene and then continuously on the way to hospital. Given the diverse demographics of the population of Melbourne outlined earlier in this chapter, paramedics will increasingly be required to attend to patients who are of different religious and cultural backgrounds to themselves.

As briefly mentioned earlier in this chapter, when accepting the next challenge in my career as an academic, to complete my PhD, the decision on which area of research to undertake was not a difficult one. It seemed a natural progression to me to take my Master's study (Hartley, 2006), further, to look beyond just the one community group, the Muslim community. I had for some time been interested in the experiences of paramedics in dealing with various cultural and religious groups during the course of their work throughout Victoria. I was also specifically interested in the impact, if any, these experiences had on them personally.

This study is an investigation of paramedic practice and the cultural and religious needs of pre-hospital patients in Victoria. This study is especially concerned with whether improvements in the services provided by paramedics are possible, and, if so, how and

where improvements can be made to the services provided by paramedics to the community they serve.

Religious beliefs and health-care

Given my long-term interest in this subject matter, it is obvious that I believe that religious beliefs can impact very profoundly on healthcare practices and health outcomes. When healthcare professionals are from entirely different religious or cultural groups to those of the patient, I don't believe that the importance of religious beliefs can be underestimated. My Master's study (Hartley, 2006), showed that such misunderstandings, or even ignorance of religious beliefs, can have harmful consequences for the patient and leave negative impressions with both the paramedic and their patient, often resulting in considerable damage to the paramedic / patient relationship. This in turn can impact on quality of care and short-term and long-term health outcomes. The critical point here is that good healthcare depends on the healthcare provider's ability to be sensitive toward such differing needs.

At times of medical emergency, the Australian paramedic practitioner will be increasingly required to respond to the emergency healthcare needs of patients from differing cultural and religious backgrounds. Emergency paramedic care is often the first point of call and, since patients can be especially vulnerable during these times, paramedics in Melbourne who, in the main, have Australian approaches, ought to be aware of cross-cultural issues that are likely to impact on the provision of their care.

As western awareness of cultural and religious beliefs, values, and daily living practices are in general, just beginning to develop, caring for these community members poses some real challenge to most health care workers. My Master's research (Hartley, 2006), showed that Muslim religious values and the worldview of Islam are markedly different from the values that underpin life in the Australian world. It could be presumed then that this is the case for other cultural and religious groups, something this study hopes to clarify. Understanding any set of values requires that health care workers know about religious and cultural factors, social structure, and health care features, otherwise any real understanding of a patient's overall needs cannot be met. I believe that the central and important goal of cross-cultural healthcare necessitates learning about the culture and then developing care practices that are culturally congruent, i.e. meaningful and useful in the values of both groups of people, the patient and the health-care provider. Leininger & McFarland (2002), state that delivering culturally congruent care requires becoming aware of one's own culturally learned assumptions. To be unaware of our own culturally aware assumptions is not consistent with the notion of culturally competent care and trans-cultural healthcare practices

My Master's study (Hartley, 2006), highlighted that understanding the different cultural and religious aspects of patient care can be difficult for paramedics in relation to treating Muslim patients. When seeking to relate to the Muslim patient, a number of substantive barriers were identified. First, there was arguably the problem of social institutional intolerance embedded firmly in Australian culture. Secondly, the difficulty of how, and to what degree, those educated in a secular biomedical model of healthcare could relate to, and understand

those who bring with them very different notions and expectations. And thirdly, but not finally, widespread Islamophobia, manifesting as overt and covert hostilities directed against Muslims and their property, has not been without consequence. This study hopes to investigate these and other related themes across the broader multicultural community.

This situation is further compounded by misunderstandings and misinformation by those who do wish to deliver culturally competent and sensitive care. Communication is often the key to the first step in bridging the gap. Take for example, the elderly Afghani, on being made aware of the animal gelatine component of his antibiotics, who asked how his general practitioner could have made such an important mistake; or the middle-aged Kenyan car mechanic who, wiping a tear from his eye, inquired why the medical profession had subjected his elderly mother to the pains of a post-mortem. Was the caring profession really so insensitive asked Sheikh & Gatrad (2001)?

With all good intent, such misunderstandings or insensitivities still occur within most areas of the western medical profession. As my Master's study (Hartley, 2006) indicated, care offered from within the pre-hospital phase by paramedic practitioners is not exempt, and this is most likely largely due to a lack of content relating to cultural diversity that exists within the paramedic academic curriculum. This study intends to further examine this concept beyond that of the Muslim community and incorporate the wider multicultural community of Victoria.

Significance of this study

The most challenging, and exciting, aspect of this study is the potential contribution it can have in creating a new body of knowledge. Very little has been undertaken that deals with cultural or religious preparedness of paramedics at either local or international levels. To my knowledge there is no study that exists that has incorporated data directly from paramedics or community members detailing lived experiences on this subject.

This research will make a significant contribution to the cross-cultural knowledge within the discipline of paramedic science by ascertaining the key religious and cultural needs of the community. It also intends to address key issues facing both paramedics and the wider community. Additionally, this study will develop a new body of knowledge on cross-cultural and religious issues into professional paramedic education and curriculum design.

The more specific aim of this project is to raise paramedics' awareness in relation to religious and cultural preparedness issues. This is set within the context associated with the community receiving emergency paramedic care.

This study aims to identify the religious and cultural needs of the sample cohort in relation to pre-hospital care. The underpinning research question investigates the overall set of philosophical beliefs in specific religious and cultural groups that may impact upon effective pre-hospital care. This study is especially interested in whether improvements to pre-hospital care are possible, and, if so, how and where improvements can be made to the services provided by paramedics to the communities it serves.

The specific longer term aims of this project are to:

- raise awareness of cultural issues associated with patients receiving emergency paramedic care;
- inform the development of educational material on cross-cultural and religious issues into professional paramedic education curriculum;
- broaden the understanding of paramedic practitioners to enable them to better respond to the religious and cultural needs of diverse communities.

The research will contribute to the cross-cultural knowledge within the discipline of paramedic science. Additionally, by ascertaining the key religious and cultural needs of the Australian community, this knowledge will culminate in cultural competence for paramedics and other pre-hospital health care workers.

Finally, this study will enhance the level of effectiveness of paramedic work in pre-hospital practice when dealing with the multicultural community they serve. This has the potential to lead to an improvement in the overall healthcare, and the potential recovery of, the patient as well as decreased levels of stress for paramedics working in an environment where patient needs go beyond merely just the physiological, and begin to incorporate the biopsychosocial.

The next chapter will discuss a recent study tour I completed, visiting paramedic education programs and ambulance services across the United Kingdom, United States of America and

Canada. The chapter will present an international perspective on this study through descriptions of the various centres visited. As such, it presents a window on day to day practice in a range of paramedic organisations and educational facilities, which supplement the literature review which follows in chapter 3.

Chapter 2

Reflecting on Practice – An International Perspective

There are many reasons why people travel; be it vacation, work related, the need to visit friends and relatives; travel comes with the complexities of challenges, pleasure, leisure, and for many, excitement of new opportunities and learning. When travelling in other countries, we expect to meet different people, see different sights and do different things. However, the most valuable learning that comes from travel is not that we are different but that we share so many common needs and feelings. Travel for me, therefore, provides an ideal opportunity to see, do, hear, evaluate, gain insights, connect with colleagues, and develop hypothesis and conclusions.

For many years now, the Australian Emergency Medical Service providers, incorporating both ambulance services and ambulance authorities, have widely been recognised within the international arena as centres of excellence in service provision, education and training. Travelling to other nations to investigate practices relating to cultural and religious preparedness of their paramedics afforded the opportunity to consider global practices.

Recently I was fortunate to undertake a three-month study tour, allowing me to travel and visit universities offering paramedic programs and ambulance services throughout the United Kingdom, United States of America and Canada. I was especially interested to gain a more global perspective in the levels of cultural and religious preparedness that were

incorporated in international universities' paramedic curriculums. I was also interested to explore whether there had been any initiatives relating to cultural or religious awareness that had been instigated by any of the international ambulance services. This was an opportunity to gain some insight into international practices specifically relevant to this study.

It has long been accepted that study tours greatly enhance the ability to gain first-hand insight into leading organisations and their practices, expand networks, and begin building relationships with major international organisations. There were four distinct domains to this tour, however, the one domain that is relevant to this thesis is that of cross-cultural issues as they relate to the provision of Emergency Medical Services (EMS) in other nations. This chapter outlines the information obtained from these visits. The information obtained from other nations during these visits holds specific relevance to this thesis. It clearly outlines international perspectives on cultural and religious preparedness of paramedics, experiences of international services and higher education paramedic programs in delivering culturally competent care, and presents programs of best practice.

At times of medical emergency, the Australian paramedic practitioner will be increasingly required to respond to the emergency healthcare needs of the growing diverse population. Emergency paramedic care is often the first point of call, and since patients can be especially vulnerable during these times paramedics ought to be aware of cross-cultural issues that are likely to impact on provision of emergency care. Overseas models of a more

culturally congruent approach to patient care may offer the Australian industry some insight into the benefits of this approach.

There is a wide range of call-out categories for a paramedic crew^{*}. Each of these categories is presumed to be demarcated according to physiological parameters of the patient event, even though there is considerable diversity within each of those categories.

Notwithstanding, the Australian paramedic is generally well-placed to respond to the needs of the patients in each of these categories.

Unfortunately those needs generally only extend to the anatomical and physiological, and often ignore the cultural and religious components, which impact so powerfully on these 'science' components.

Many EMS service providers overseas have recognised the need for a holistic care approach, acknowledging that spirituality and improvement in health are, indeed, intertwined.

Implementing sensitive and appropriate approaches by overseas paramedics have enhanced positive health outcomes and assisted in a more rapid recovery, where this has been possible.

^{*} Paramedics in Victoria usually respond to an incident as a team of two commonly referred to as a crew.

The study tour identified specific EMS programs that have been developed and adopted in the UK and the US by EMS providers that appear to have similar aims to:

- raise awareness of cultural issues associated with patients receiving emergency paramedic care;
- inform the development of educational material on cross-cultural and religious issues into professional paramedic education curriculum;
- broaden the understanding of paramedic practitioners enabling them to provide better health care to the diverse communities they serve.
- decrease the levels of stress for paramedics working in an environment where patient needs go beyond just the physiological, and begin to incorporate the biopsychosocial.

I intend to approach my findings from this study tour by way of reflective practice in a chronological manner, detailing thoughts and processes as they occur; I wrote a virtual travel diary that will relate my experiences and insights throughout the study tour as they relate to, and offer, an international perspective into this study. The process is intended to incorporate my own personal judgments and hopes for a greater insight into programs claiming excellence in this domain, this giving a greater international perspective to this thesis.

Considerable planning was undertaken when formulating this study tour. It was essential that places visited were able to have relevance and inform this study. The following places

of interest were specifically chosen based upon claims of best practice, both in relation to academic programs and service delivery incorporating cultural and religious inclusion.

London Ambulance Service – London – United Kingdom

Arriving in London is much more of a culture shock than I had anticipated. Although the January weather is incredibly bleak, the coldest in over a century, the city struck me as the most culturally diverse as I had ever seen. Having not been to London before, I had not given much thought to my expectations. I had perhaps expected it to be not unlike Melbourne. Travelling from the airport to the centre of London, there were stark differences, perhaps more on geographical size as opposed to actual demographic differences. Observations permitted me to determine that low socio-economic communities (SES) are widespread; it seems that the areas around London that house these communities extend over massive regions. I could not help but wonder if the actual number of low SES communities in and around London is far greater than in Melbourne, or is it related per capita, and therefore appearing greater, given the density of the population in this city.

Walking around these areas provided a greater insight into the communities. There seems to be a disproportionately high representation of new arrivals to the United Kingdom in these areas. Whilst it is often determined that cultural diversity brings richness to communities, I could not help but wonder if the oppressive nature of the physical surroundings stripped these communities of such richness. I also wondered what impact

this has on the centuries of cultural values inherited by the families living in these neighbourhoods. Everywhere I walked, the cultural and religious diversity of these communities became more apparent. Designated community centres for specific cultural or religious groups, places of worship, markets, and the very community representations themselves actively displayed the diversity. Given the large distribution of cultural and religious miscellany, I hold high hopes for the London Ambulance Service and its programs addressing these issues.

The London Ambulance Service (LAS) is one of the largest and busiest EMS providers in the world. The service has 5000 employees and 70 ambulance branch locations throughout London, covering an area of 620 square miles (998 square kilometres). The Service responds to an average of 1.2 million incidents per year.

I had lengthy discussions with the LAS senior operations manager around the delivery of education to the LAS paramedics, both during the initial phase of the qualification and continuing educations programs. The LAS is exceptionally proud of its achievements and is well recognised for its excellence in the provision of emergency care to the community in and around the London area. LAS boasts numerous initiatives inclusive of programs incorporating the non-traditional roles of the paramedic, best service practice in meeting the needs of the population, and integration with other health agencies. The front line paramedic workforce has an under representation of new arrivals to the United Kingdom, so the question arises as to how does this major organisation meet the cultural and religious

needs of the community it serves? LAS report that cultural diversity programs have been considered by the organisation for some time now. There is little content in the initial training phases of the LAS paramedic, and no provision, to date, for in-service education programs. LAS senior personnel acknowledge that we live in a time where communities are becoming increasingly demanding of having their individual values met, particularly as these values relate to strong religious and cultural requirements, and the demographic area the LAS serves is typical of such a community. Like most ambulance services, LAS struggles to work within budgetary requirements. Priorities are considered when allocating funds that have a direct impact on the provision of service. Innovative programs that have impact on service delivery, that is value for the dollar, higher level of service for reduced dollar value is the focus of many large organisations that rely on government funding as the primary source of funds to cover operational demands.

A more holistic approach towards patient care is on LAS's agenda. Programs directly dealing with cultural and religious issues have been considered. There is acknowledgement that the need is there, and there are increasing demands from the community to have these needs met. Priorities, unfortunately are a reality of ambulance services worldwide. With limited funding, priorities will always be given to the primary focus of ambulance services, the culture of which is embedded in the provision of service that deals with the physiological parameters of patient care. The LAS is hopeful that as the education of paramedics continues to move from the post-employment service model to higher education

institutions, and that areas, such as the biopsychosocial needs of patient care, will be incorporated into the curriculum.

Kingston University – London – United Kingdom

Kingston University is one of many tertiary education facilities in the United Kingdom that deliver pre-employment and post-employment models of education for paramedics. Unlike most academic programs in the tertiary sector, paramedic courses are still heavily embedded in industry relationships. There is a strong focus on delivering work ready graduates, without, it seems really holding an understanding of what work ready relates to. The question that arises is who determines work readiness? Is work ready related to the ability of the graduate paramedic to meet the needs of the organisation they will be employed by or is it determined by the capacity of the graduate to meet the overall needs of the patient they will be attending? Kingston University holds strong relationships with the LAS and, as such, delivers its programs in accordance with the needs of that organisation.

The LAS has input into curriculum content and graduate attributes. Whilst strong industry relationships for university courses are to be applauded, there seems to be a significant difference between industry engagement, collaboration and the desire for ambulance services to maintain the status quo with the key stakeholder's determination of where the industry is heading.

To place this into some context, the United Kingdom model of paramedic education is somewhat mirroring what has occurred over the past decade or so in Australia. Paramedic education in Australia and specifically Victoria, has undergone considerable change this past decade. As EMS providers are faced with increasing public demand for services, the paramedic education system is equally challenged to respond to such needs, whilst, in many ways it is still 'cutting its teeth' in the realms of academia. This environment necessarily requires that consistently improved models of paramedic education are essential to ensure that graduate paramedics are prepared for the ever increasing demand for higher, and more complex skills sets and growing requirements for autonomy in practice, and greater challenges as a result of increasing community demands.

This change is not only confined to paramedic education but also incorporates the EMS providers of out of hospital clinical care, the relevant authorities, and the on road paramedic. The Council of Ambulance Authorities submission to the Australian Government Department of Education, Science and Technology (2006) stated that paramedic higher education programs must produce not just work-ready graduate paramedics with appropriate clinical ability but multi skilled practitioners who are responsible for the out of hospital clinical care and safety of their patients, and the community as a whole. This in essence, is in contrast to the higher education mandate of university graduates. As the paramedic higher education system struggles to establish itself in the dominion of academia, coupled with the complexities and contrasts of its established roots in vocational

education, the major challenge emerging appears to be the definitions and expectations of 'work ready'.

This disparity of work readiness is not only confined to the key stakeholders, the EMS providers and the higher education system, but is also endemic within the individual organisations. Higher education places great emphasis on developing graduates as critical thinkers; they are asked to question beyond the expected, to challenge and forge beyond the conventional. It is no surprise that conflict arises when graduate paramedics enter a working environment that is steeped in clinical practice guidelines and specific work instructions. The question that fundamentally arises from this is whether critical pedagogy is appropriate in higher education paramedic programs. This would of course require EMS to undergo considerable change in its current ethos and shed the embedded foundations steeped in the military backgrounds of its founders.

Further to these challenges are the multifaceted ideologies formed from basic underlying principles of who leads, who follows, and who collaborates. Holding a strong focus on having developed relationships with the ambulance industry, paramedic academic programs face the dilemma of accepting pressures from their industry partnerships to develop programs that specifically meet evolving industry needs. The impact is a loss of autonomy in their program development. Obtaining a balance becomes the key.

Kingston University is no exception. The program is specifically developed around industry requirements, and has formal arrangements with the LAS to do so. The program has a strong emphasis on clinical expertise, and is modelled on previous vocational training programs. The university is working closely with the LAS to incorporate areas that support the principles of the service that surround community paramedicine. Interestingly, the term community paramedic conjures up thoughts that this new role and focus is represented by a provision of service that is more aligned to community needs. In recent times the term has become the catch cry of services across the world and captures the changing roles of the profession, which has moved away from the non-traditional aspects. That is, paramedics who undertake work outside of the usual role of ambulance service provision such as community health centres have advanced clinical skills sets enabling them to operate in rural communities in lieu of medical practitioners.

The Kingston University program is not inclusive of curriculum content relating to a holistic approach to patient care. Whilst it incorporates some aspect related to sociology, nothing is delivered that equips graduates with a knowledge or skill set to deal with the cultural or religious issues they will be facing once they become operational paramedics.

South East Coast Ambulance Service – United Kingdom

The South East Coast Ambulance Service (SECAM) is not unlike the LAS, although they argue they are, by far, the more progressive service. They are located about 45 minutes out of London; however, in many respects, the demographics, the physical surroundings, and the

density of the population seem identical, except for the high rise buildings, which are not apparent in this area. SECAM again holds a strong emphasis on the clinical aspect of service provision. This is not surprising, and, perhaps, is as it should be. The clinical needs of patient care in a medical emergency should hold the utmost priority for any EMS provider. As with the LAS, SECAM is also developing programs that permit paramedics to work beyond the accepted scope of practice. These programs are specifically designed, however, to alleviate the financial burden on the health care system, freeing up resources to meet increasing operational demands.

The SECAM service operates in an area that has a high Muslim representation. As such, I had hoped to be able to obtain some firsthand knowledge of how this service has developed programs that equip paramedics with an understanding of the special requirements of Islamic patients. Like the LAS, the SECAM service is acutely aware of the need to address issue pertaining to the cultural and religious requirements of patient care. However, again like the LAS, due to the priorities with limited resources, clinical aspects relating to the biophysical approach hold the focus. The ability of this service to meet the cultural and religious needs of the community it serves is limited to an agreement reached by the service and the local mosques, that paramedics will cover (not remove) their footwear on entering.

Plymouth University – Plymouth – United Kingdom

Making the five-hour drive towards Plymouth, I was somewhat glad to be leaving the density of London. The English countryside covered in deep snow was somehow calming,

despite the ice-covered roadways and my complete lack of knowledge as to where I was heading or how to get there.

Plymouth is the first university in the United Kingdom to offer a stand-alone degree program for paramedics. Other university programs are heavily intertwined with the ambulance service that their graduates will be employed by, therefore requiring collaborative agreements between the organisations that see student paramedics being employed by the EMS provider and undertaking all, or a component of their education with the university. Whilst Plymouth University still works closely with the West Midlands Ambulance Service, they hold no such agreement.

The program offered is a three-year degree, after which graduates can obtain employment with any of the service providers in the NHS. The curriculum content for the degree is not specifically inclusive of cultural or religious components as they relate to paramedic practice. There is, however, a subject that deals with the sociology and psychology of patient care. The program coordinator holds an extensive nursing background and, as such, is acutely aware of the overall needs of patient care being met as best practice. She advises that throughout her nursing career there was always a strong emphasis on the holistic approach, with cultural and religious components being incorporated into nursing programs and postgraduate courses. The same emphasis has not been brought into the realms of paramedic programs.

A common thread seems to be emerging. Whilst it is acknowledged that the cultural and religious needs of the community are becoming increasingly important as the community demand for such recognition escalates, such incorporation into education and practice does not hold a high priority in relation to clinical needs. There is an element that many have described to date that surrounds the obligations of paramedics towards their patients and overall patient care. Many of the EMS operational managers that I have spoken to argued that because patients are in the care of a paramedic for such a short period of time, that considerations of their religious and cultural needs are not required and have little impact on outcomes. Such issues surrounding a holistic approach hold little place in pre-hospital care and are best left to the tertiary care providers, that is the hospital medical and nursing teams. I wonder if the community feels the same way? There appears to be little insight into the consequences of patient outcomes when such basic elements of patient care are ignored, and what are the longer-term effects this has not only on patient recovery but also the impression and faith the patient holds of the service providers.

If paramedics are serious about obtaining professional recognition and status, then EMS providers and educators need to address any disparity that exists in the level of delivery of service and those of community expectations.

Exeter (West Midlands) Ambulance Service control room – United Kingdom

The West Midlands Ambulance Service is again reflective of both the LAS and the SECAM service. Whilst geographically the location is in stark contrast, the area is comparatively

rural, with smaller cities such as Exeter located within the region. I was fortunate enough to be permitted to spend some time in the control room. These ambulance service communication and control centres are often referred to as the 'heart' of the organisation. Indeed, as for the operational requirements, everything goes through these facilities in real time.

The West Midlands service houses a well-established and respected referral service. That is, a senior clinician will intercept requests for call outs and after a series of specific questions determines whether the request is best served by another health care agency. This in turn frees up the paramedics for, what is deemed, more appropriate responses. It seems it is all about rationalising service delivery. Call takers in this facility have no specific training in dealing with cultural or religious aspects related to patient care, the standard questions asked are only to determine the priority status of the request. The senior clinician's responses to any language difficulties are to utilise an interpreting service, however this is where the expectation of dealing with the cultural aspects of the community ends.

Birmingham City University / West Midlands Ambulance Service – United Kingdom.

Birmingham City University provides the education and training for paramedics in collaboration with the West Midlands Ambulance Service. As such, it is under contractual obligations to ensure graduates from the program meet the requirements of the service. The academic staff of this program are employees of the ambulance service chartered to ensure course content is reflective of the service's requirements. There seems no

autonomy in the development of the curriculum and academic creativity is stifled by the vocational approach to paramedic education. The program offers no content that relates to cultural diversity or preparedness and has a complete biophysical approach.

The more I am exposed to both university programs and ambulance services throughout the world, the more disconsolate I am becoming with my findings. I am feeling like a lone voice and wondering if, in fact, my quest for cultural and religious congruent care in the pre-hospital setting is sufficient to bring about change. I begin to question the notion that all patients in pre-hospital care should be receiving an approach that is reflective of health industry standards. It continues to astound me that whilst ambulance services and educational facilities that offer paramedic education recognise the need to address the religious and cultural issues of their patients, there have been no further developments, no active moves towards actually obtaining that goal.

Liverpool John Moore University – United Kingdom

Unlike Birmingham City University, Liverpool John Moore University (LJMU) is independent from the ambulance services and the university, whilst still reflective of the ambulance industry needs and attributes determined by the NHS, develops curriculum content. Whilst LJMU does not have units of study dedicated to the cultural aspects of patient care, they are however embedded throughout the curriculum. I begin to feel like perhaps I am not the isolated advocate for a holistic approach to patient care, that there are some programs that have incorporated this successfully.

LJMU's curriculum frequently refers to respect of the cultural needs of the patient, and that paramedics ought to be aware that some patients have strong cultural influences that can dictate individual responses that may take a paramedic from a different cultural background by surprise. There are many references outlining the need for paramedics to take culturally sensitive approaches to their patient care, and that responses from specific cultural and religious groups given a set of circumstances can be predicted. However, there was nothing delivered that could offer paramedic students anything that could equip them with knowledge on how to be culturally prepared and responsive to their patients' needs

It seems that it may be one thing to have such content incorporated into the curriculum, but just stating that there is a need does not really provide paramedic students with the knowledge or skill sets to either determine or deliver culturally sensitive care. The metaphor that comes to mind here is that while I can offer a student the information that the bleeding from a laceration needs to be stemmed, without the 'how to', is this information really helpful?

Halifax, Nova Scotia, Canada

It is very late at night and my flight arrives at Halifax airport, Nova Scotia, Canada. The temperature outside is minus 42 degrees Celsius and I must say I find it somewhat unnerving that the plane is landing on a runway covered in snow. There is a stark contrast to the United Kingdom; perhaps it is the different nation, perhaps it is the fact that Halifax is a relatively small rural city, or a combination of these.

The ambulance industry in Halifax is quite unique in that a private company under contract to the government has responsibility for service delivery. This company then subcontracts out the operational side of EMS to a service provider who in turn employs the paramedics. The company owns the infrastructure, which means the actual service provider holds no ownership of any assets apart from its employees.

Nova Scotia is the seventh most populous province in Canada with an estimated 946,397 residents as of January 1, 2011. It accounts for 3% of the population of Canada. Roughly 60% of the population live in rural parts of the province. The 2006 Canadian census counted a total of 45,195 immigrants living in Nova Scotia. The delivery of EMS to this province holds considerable challenges, given the vastness of the Nova Scotia and the fact that a high percentage of the province's population resides out of the urban areas. This, coupled with the often harsh and isolated terrain and severe weather, is a high focus of concern for the service providers.

The ambulance service in Nova Scotia boasts one of the world's most successful community paramedic programs. The Long and Brier Island Community Paramedic Program was established due to the remote nature of the area, the inability of these two communities to attract general practitioners, and the under-utilisation of paramedics stationed there. Intensive community consultation occurred to determine specific needs related to service delivery. The program was then established to ensure community needs were met. Again,

this is reflective of the biophysical needs, inclusive of some sociological aspects as they relate to aged care, mental illness and isolation.

The service acknowledges that the program is unique and that it would not be possible simply to replicate this program and deliver it to another isolated region of the province.

The reason behind this is the recognition that community needs differ from one community to the next due to differing demographics, differing social requirements, and differing cultural requirements.

If there is such recognition, then why is it that the cultural issues are not addressed? The Long and Brier Island program has little need to address religious and cultural values given the demographics of this community. However, further program considerations are seeking input from community representatives. Whilst this consultative process is in its early phase, no consideration has been given to include the specific cultural or religious needs of the community according to the service's operational managers.

The urban area of Nova Scotia Halifax is a busy metropolis with a strong representation of cultural and religious backgrounds. The service employs paramedics who are eligible for registration under the Canadian registration scheme. As such the paramedic workforce in this service comes from numerous Canadian provinces and educational facilities. The service provider offers in-service training programs, however, these relate to changing and

developing clinical practices. The service does not provide any programs that assist paramedics in dealing with patients from culturally diverse backgrounds.

St Louis, Missouri

I was fortunate enough to be able to attend a national event involving the chiefs* of EMS providers from across the United States of America. This gave me the opportunity to meet a number of chiefs of ambulance services in the one place, enabling me to obtain information from service representatives that would otherwise not have been possible. The overwhelming impact obtained from meeting with these chiefs was that the services are as individual as the communities they serve. The heads of these services impress on the future developments of paramedic practice America wide, and their organisations' commitment to deliver high quality patient care with paramedic skill sets is equal to none. There is significant pride displayed when discussing their individual services coupled with a component of competitiveness and ownership.

Paramedic education throughout the United States tends to be predominantly a model of post-employment, that is training occurs under the delivery of the ambulance service after the paramedic is employed. This vocational model operated in Australia some years ago until paramedic education was transferred to the higher education sector.

* The official term used to identify the heads of ambulance services.

Throughout my discussions with these heads of services, it became clear that there has been no consideration given to the inclusion of cultural or religious diversity within either their training programs or service delivery. I find this very disappointing given the diversity of American communities. Once again, there was a strong focus on the biophysical model, with advances in paramedic practice limited only to skill sets that addressed advances in medical and surgical emergencies. This excluded any knowledge or skill sets that even remotely deal with any psychosocial issues pertaining to patient care.

There was an acknowledgment from the chiefs of EMS that there is a definite need for EMS providers to be more culturally and religiously prepared and responsive to community need, and that this need is becoming more apparent. However competing priorities dictate that budgetary constraints limit advances in paramedic practice to the needs of the majority of the community. Whilst minority groups are often vocal in expressing their individual needs, it is not possible to rationalise funds to address such needs when the greater community could benefit from such allocation of funds.

I question the motivation behind statements relating to budget constraints. Is this argument valid? Whilst competing funds are always an issue for ambulance service providers, it is not uncommon that funds and grants can be obtained to develop and increase culturally sensitive services and programs. I wonder how much longer minority community groups will accept this argument before they commence demanding that ambulance services commit to meeting their specific religious or cultural needs as a matter

of human rights. I am becoming increasingly frustrated with the common notion of ambulance service providers recognising the need for a culturally sensitive approach of paramedics, while achieving nothing. I wonder how the typical paramedic at the vanguard is dealing with patients whose cultural or religious needs are superseding their physiological requirements.

BC Ambulance Service – Vancouver, British Columbia, Canada

Justice Institute of British Columbia – Vancouver, British Columbia, Canada

The BC Ambulance Service (BCAS) and the Justice Institute are heavily entwined. BCAS is the service provider, whilst the institute is responsible for the training and education of paramedics. BCAS also has a comprehensive in-service education department that accepts responsibility for the competency standards of paramedics employed by the service, as well as continuing education programs identified by service need. Much of the curriculum at the Justice Institute is determined by the needs of BCAS with any gaps picked up by the services education unit.

Vancouver is a coastal city located in the Lower Mainland of British Columbia and is the largest metropolitan area in Western Canada. Vancouver is the third largest city in the country and the city proper ranks eighth. According to the 2006 census, Vancouver had a population of 578,041 and its metropolitan area exceeded 2.1 million people. Its residents are ethnically and linguistically diverse; 52% of whom do not speak English as their first language. (Canadian Federal Bureau of Statistics, 2009).

Given these statistics, that the large percentage of the population that do not have English as their first language, one could assume that health service providers would deem a holistic approach to patient care a priority, inclusive of pre-hospital care providers. Yet there is nothing in either the curriculum content of the program offered by the Justice Institute or in the continuing education programs delivered by BCAS.

Educators within the BCAS education unit state that they are acutely aware of the need; however, they struggle to keep up with the demands of this large organisation's requirement to deliver optimal service to the community, which is the provision of emergency medical care. I find the terminology used here is contrary to the outcome. Optimal service delivery surely encompasses not only meeting the needs of the whole community, but also the whole needs of the community as per the organisation's charter. The provision of emergency medical care must be inclusive of a culturally sensitive approach.

MD Ambulance – Saskatoon, Saskatchewan , Canada

MD Ambulance Service (MD Ambulance) is a relatively small organisation servicing the Saskatoon region of the Saskatchewan province. The city has a population of almost 250,000 with a higher than average representation of first nation people.

MD Ambulance has a 'family' feel about it, with the organisation's management team fostering a nurturing environment for the employees. The service also has a strong

community commitment, actively seeking community input into the development of their programs. Like all EMS providers throughout Canada, MD Ambulance employs paramedics who have obtained registration by completing academic programs in institutions throughout the nation. The service also has its own education unit that delivers continuing education programs. It also has a range of initiatives that are inclusive of paramedic input into the development of the service itself and their continuing education programs.

After much community consultation, MD Ambulance commenced the Health Bus concept of bringing healthcare directly to the patient. The Health Bus is a mobile health service that operates seven days per week, at a specified location for each day. The provision of service is not limited only to the usual skills sets of a paramedic, but is also inclusive of health education, patient empowerment, sexually transmitted illness testing and counselling, and chronic health management. Many patients are of low socio-economic status and, as such, rely heavily on this free and confidential service.

One paramedic and one nurse practitioner staff the Health Bus at any one time. Staff working in the Health Bus undergo specific training and ongoing education programs that are inclusive of diversity training. The program has a heavy focus on the needs of the first nation people; however, it is also inclusive of cultural and religious awareness and sensitivity of other community groups. As staff working in the Health Bus do so only for one day per week, with the rest of their workload being undertaken in normal ambulance duties, these skill sets are naturally carried over to that role.

Spending a day in this organisation and, fortunately, some time in the Health Bus talking to patients, it became obvious as to the high regard community members have of the MD Ambulance service. If a service of this size is able to make considerable in-roads into a holistic approach to patient care, and is dedicated to be inclusive of cultural and religious preparedness of its paramedics, then it continues to astound me that the larger services, whilst acknowledging the need, are unable to implement strategies to address them.

It saddened me somewhat to leave an organisation that is so progressive in its policies to deliver optimal patient care. I felt a considerable attachment to this service in just the very brief period of time that I visited. I believe that there is much more I could have learned from this service, had more time permitted.

Toronto EMS – Ontario, Canada

Toronto EMS is the only service in the Toronto area. Again, the service employs paramedics that hold registration status in Canada after successful completion of an education program undertaken at one of the country's institutes.

Toronto, as a city, is not unlike Melbourne. It is about the same geographical size, has a similar population, and is as culturally diverse. Walking around, this city has an incredible familiarity; I could be walking the streets of Melbourne's CBD. Again, like Melbourne, the cultural diversity of this city is obvious. It is hard to obtain a clear picture of the

representation, but what is clear is the high percentage in this city of new arrivals as compared to other Canadian cities visited thus far.

Toronto EMS, like many of the Canadian services has a dedicated education unit that delivers continuing education programs. This service does, however, have an internationally recognised community paramedic program. What makes the Toronto EMS program so unique is that the program is delivered within the city of Toronto, whereas community paramedic programs are usually confined to rural and remote areas.

The Toronto EMS Community Paramedic Program was originally designed to reduce the workload of the organisation. This was especially the case for patients who call for ambulance attendance on a regular basis mainly for social reasons as opposed to medical issues. The community paramedic undertakes a visit to the patient's home and, after making assessments, arranges appropriate referrals to service providers that best match the patient's needs. This highly successful program has been extended to incorporate paramedic referrals. Paramedics who attend a patient's home who believe that there are some social issues affecting the patient's ability to sustain independent living, make the referral to the coordinator of the community paramedic program. A home visit is undertaken, usually within 24 hours.

The community paramedics have extensive education in the social sciences, inclusive of content that incorporates cultural diversity training. Added to this, the service itself

sponsors and chairs a consultative group on matters pertaining to the cultural and religious needs of the greater Toronto Community. The chief of the Toronto EMS chairs a panel consisting of representatives of cultural and religious groups, which meet regularly. The charter of this group is to identify any specific needs of their individual communities that can be incorporated into future in-service education programs provided to Toronto EMS paramedics, and to account for any issues that individual community member may have experienced during delivery of service by paramedics. The latter is deemed as a tool of information exchange for improvement of service delivery as opposed to disciplinary action.

One interesting fact about the Toronto EMS Community Paramedic Program is that each community paramedic costs the service \$80,000 per annum, but saves the service \$750,000 per annum in service reduction. It would seem that other services could learn some lessons from this model and appropriately redirect funds. Excuses of lack of financial resources and competing budgets, despite the acknowledgment of the need for a more culturally and religiously congruent service, would become redundant.

University of Toronto - Centennial College – Ontario, Canada

The University of Toronto houses its paramedic program at Centennial College, and is the main provider of paramedics to the Toronto EMS. As such, the two organisations work closely to develop a collaborative curriculum, however, Centennial College maintains autonomy over the program and ultimately the content.

The program coordinator at Centennial College is acutely aware of the need for paramedics to undertake a holistic approach to patient care, and has created a specific unit of study dedicated to the preparation of paramedic students to be culturally prepared and sensitive. The coordinator reported that the main issue in the development of this unit was sourcing appropriate texts to support student learning. Texts that deal with cultural issues pertaining to the healthcare needs of patients were directly referring to nursing and in-hospital care, with the emphasis being on recognition of dietary requirements, observation of religious rituals etc. There was nothing available that specifically dealt with the pre-hospital setting that paramedic students could relate to their field of practice. The paramedic team was therefore forced to write a discipline-specific manuscript for student use.

It would be an interesting exercise to measure the cultural preparedness of the paramedic students attending Centennial College both before and after undertaking this unit, and perhaps undertake a comparative study with their Australian counterparts.

Georgian College – Barrie, Ontario, Canada

Georgian College delivers both basic and advanced programs aimed specifically at graduates obtaining employment with any of the Canadian services. Whilst they have some affiliation with the Toronto EMS, the collaboration is not linked to determining curriculum activities. Georgian has a strong emphasis on the clinical development of their student's practical skills sets, and, in many ways, is reflective of a vocational approach to paramedic education.

There are no specifically dedicated units of study that deliver cultural diversity aspects in the program; rather it is an adjunct to one of the units. The content delivered primarily relates to intercultural communication and utilises a text of the same name, *Understanding Intercultural Communication* by Jane Suderman (2006). This publication serves as a comprehensive introduction to cultural communication styles; however it fails to address any of the specific needs of the different cultural communities as they relate to health care in the pre-hospital setting.

It seems that, perhaps, there are opportunities here, groundbreaking opportunities that could discover a wealth of new information that can only enhance the level of patient care for communities of differing cultural and religious backgrounds. The lack of relevant reference material is of concern and perhaps may be reflective of the disassociation thus far that the pre-hospital emergency care industry has with the psychosocial aspects of patient care. On the other hand, however, the opportunity to write such a text is overwhelmingly tempting.

Cambrian College – Ontario, Canada

Cambrian College is located in Sudbury, some four hours drive from Toronto. This is a large rural town with a high percentage of residents of French background. The percentage of French students attending Cambrian was, in fact, so high that a separate college was formed to deliver the program entirely in French, hence Boreal College was formed and located in

close proximity to Cambrian. Like other colleges in Canada, Cambrian offers paramedic education allowing graduates to obtain registration within North America.

Cambrian does not include cultural diversity education in the curriculum in either of their paramedic or advanced care paramedic programs. Interestingly, the advanced care paramedic program is designed to address specific community needs due to the ageing population, increased coverage of health care plans, and new technological advancements. Graduates from this program are specifically directed towards the non-traditional roles of the paramedic, including municipal and regional Emergency Medical Services, base hospitals, and private industry (mining companies). Whilst the target for these graduates holds a much stronger community focus, there is still no inclusion of cultural awareness housed within the content delivered.

It seems that the Canadian paramedic education programs deliver content to enable graduates to obtain registration within North America. Given the lack of inclusion of issues pertaining to cultural or religious diversity and community need, one can, rightly, make the assumption that the accrediting authorities do not require such inclusion into the curriculum. If change is going to occur, then perhaps it needs to occur at this level and focused downward, that is, forcibly apply the requirement from the accrediting body. Not unlike EMS providers, the clinical focus takes precedence over all else, and a holistic approach to patient care is not considered, generally speaking. The paramedic industry is actively seeking professional recognition, citing their nursing counterparts and other allied

health professionals as reflective examples. However, I would argue that if you look closer, and begin to delve beyond the surface of what paramedics do, and incorporate the aspects of curriculum content, level of service delivery to patient care, then compare this to the likes of nursing, then you would find considerable differences.

Boreal College – Ontario, Canada

Boreal college was established as a derivative of Cambrian to cater for students of French background. The college offers almost identical curriculum to that of Cambridge, with the only significant difference being that all program content is delivered in French. The sense of French identity is high, as indeed is the respect for French culture, but this is where it ends. Similarly to Cambrian College, Boreal offers no content relating to cultural diversity or preparedness in its paramedic program.

Boston EMS – Boston, Massachusetts - USA

Boston Emergency Medical Services (Boston EMS) is one of the nation's oldest providers of pre-hospital care, tracing its roots back more than 100 years, and is regarded as one of the strongest emergency medical services in the country. The Department employs over 350 paramedics who respond to an average of 300 emergencies per day and more than 100,000 per year, making Boston EMS one of the busiest services in the country

In addition to preparing the city for large-scale emergencies, Boston EMS also delivers enriching community programming designed to strengthen the health and well-being of the

city's residents. These community initiatives are designed to educate the community about EMS response and local public health issues; however they are not reflective of a consultative process to determine community need.

The notion that EMS providers 'know best' and advise the community what it is they need appears consistently throughout the world. There appears to be minimal consultation or inclusion of community members in the development of EMS, despite the continued acknowledgment that EMS providers need to offer greater consideration to community issues such as cultural requirements.

Boston EMS trains its own paramedics and has a comprehensive education unit and curriculum, the content of which does not incorporate issues pertaining to the cultural or religious needs of the community it proudly serves.

Conclusion

Overall, the study tour was remarkably enlightening and had a profound impact on me both personally and professionally. There were many times that I felt a sense of "déjà vu" as the information offered from so many of the agencies and universities visited were not only similar to, but in many instances mirrored, what we see here in Australia. I was especially surprised to note that while the inclusion of culturally responsive care in the pre-hospital setting was on many agendas of the organisations visited, it had not been actioned. This appears to be as a result of resources and competing organisational priorities, which is not

dissimilar to what is seen here in Australia. The information obtained from this study tour gave me a clear indication that despite some claims as to innovative programs aimed to increase paramedics' cultural sensitivities, there was little apparent data to suggest this had been effective. The few programs that appeared to have achieved the goal of meeting their respective communities' religious or cultural requirements in the pre-hospital setting had achieved this by continued commitment from the organisation, and the dedication of paramedics, in the belief that it would make a difference. None the less, I believe it was an opportunity to gain a more global perspective and held considerable relevance to this study in underpinning the evidence and data produced in this thesis.

The following chapter will present the review of the literature relevant to this study and discusses where this study positions itself within the literature.

Chapter 3

Reviewing the Literature

Reviewing the literature relating to cultural and religious preparedness in the pre-hospital setting proved to be the most challenging aspect of this thesis. It has always been my understanding that the literature review is incorporated into a study to 'position' the contents of the thesis within the specific area of study. The literature review should, therefore, draw on existing knowledge, and then add to, change or challenge this by the research presented. I have always understood that the literature review incorporates the concept of existing knowledge plus new knowledge via the thesis results with an outcome of achieving a more robust understanding of the knowledge presented.

Through exhaustive searches of the literature, I have discovered that almost nothing exists that discusses the particular issues presented in this study. It is apparent that, to date, the literature relating to culturally and religiously responsive health care is limited primarily to nursing and medicine and excludes pre-hospital care and some of the other allied health services.

The methodology utilised for this literature review was traditional and included review and critique in summarizing the limited body of literature related to this study generally and the research question specifically. The body of literature included is made up of the relevant studies and knowledge that address the subject area. This approach to the literature review

was chosen with the focus on gathering together the volume of literature in a specific subject area and summarizing and synthesizing it. A further focus of this method was to provide the reader with a comprehensive background for understanding current knowledge and highlighting the significance of new research. It also enabled identification of gaps or inconsistencies thus helping to determine and define the particular research questions (Coughlan et al, 2007).

Key words such as cultural / religious preparedness, inclusive healthcare, cultural / religious inclusive curriculum, paramedic education, diversity in healthcare practices, cultural / religious inclusive paramedic practice, cultural / religious responsive allied healthcare were utilised in searches of web based peer journals and data bases inclusive of British Nursing Index, CINAHL (Cumulative Index of Nursing and Allied Health Literature), Cochrane Library, Pubmed / MEDLINE, and PsycINFO.

Articles were selected based on combining keywords, the Boolean operators of 'and', 'or', and 'not'. That is articles were selected based on the inclusion of all or any of the keywords, and excluded if no key words were apparent.

Ethnography of culture, religion and rituals is complex, and incorporates what roles each might play in the study of contemporary society and culture. Cultural and religious rituals have long been a cornerstone of anthropological thought and have been built into many aspects of human life.

Culturally and religiously based rituals are arguably a universal feature of human social existence: just as one cannot envision a society without language or exchange, one would be equally hard-pressed to imagine a society without respective rituals. And while the word “ritual” commonly brings to mind exoticized images of primitive others diligently engaged in mystical activities, one can find rituals, both sacred and secular, throughout “modern” society. Culturally and religiously based rituals are in fact an inevitable component of all cultures, extending from the largest-scale social and political processes to the most intimate aspects of our self-experience. Yet within this universality, the inherent multiplicity of ritual practices, both between and within cultures, also reflects the full diversity of the human experience.

Cultural and religious ritual situations draw from a wide array of cultural contexts, and serve to bring people together and pull people apart; they frame experience or are themselves re-framed; they help people see who they are and who they are not; they exercise power and resist power. But no matter the culture or the religion, rituals demonstrate the continued relevance and insights for individual communities (Jeffreys, 2006).

Communication with patients can be improved and patient care enhanced if health care providers can bridge the divide between the culture of paramedic delivery and the beliefs and practices that make up patients' value systems, based on ethnic heritage, nationality of family origin, religion, and other social indicators such as age, sexual orientation, disability, or socioeconomic status. Every health care encounter provides an opportunity to have a

positive effect on patient health. Health care providers like paramedics can maximize this potential by learning more about patients' cultures.

When an individual's culture is at odds with that of the treating medical system, the patient's culture generally will prevail, often straining the healthcare provider–patient relationships. Healthcare providers can minimize such situations by increasing their understanding and awareness of the cultures they serve or by being open minded and educating themselves regarding those that they do not know.

Cultural and religious preparedness, cultural competency, cultural and religious responsiveness, or cultural awareness and sensitivity, can be defined as, the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences, self-awareness, knowledge of a patient's culture, and adaptation of skills Cross (1989).

The 2005 National Health and Medical Research Council (NHMRC) enquiry into the health care needs of the culturally and linguistically diverse (CALD) communities of Australia found that there were many gaps in the evidence base, both in terms of research on interventions as well as the more serious issue, that individuals and groups from CALD backgrounds are being systematically excluded in research due to the challenges and additional investments required to ensure their participation. The NHMRC enquiry found that research frequently

excluded consideration of people from CALD backgrounds and their health issues. The national consultations that formed part of this enquiry found that much work is underway across the nation, in culturally appropriate health promotion and health interventions, but research issues, methodologies, and rigour varied widely. At a local level, the NHMRC enquiry found that it is common for projects to be constrained by funding, so that they exclude harder to reach population groups, are either not appropriately evaluated, or the results not published or disseminated (NHMRC, 2005).

Throughout this thesis reference is made to Australian values in the context of “western norms”. Australian values broadly refer to the western civilization / European civilization that has exemplified this country since European settlement, and is used very broadly to refer to the heritage of social norms, ethical values, traditional customs, religious beliefs, political systems that are in direct conflict with those of other nationalities / cultures / religions.

Western approaches to health / promotion, healthcare delivery and education have consistently failed to ground its professional (both philosophical and practical) praxis adequately in such areas of humanities as philosophy, history, and cultural studies. The result has been the absence of meaningful participation of people and their cultures considered to be ‘non-western’. It has become common practice in the field of public health and in the social and behavioural sciences to pay lip service to the importance of culture and the understanding of health behaviours. Health promotion and disease prevention practices

continue to operate under the strong and direct influence of the Westernised model of prevention. Although benefits are derived from such an influence, it seems unconscionable that western professions that anchor themselves in the ability to influence human wellbeing have consistently undermined and in most cases ignored the importance of the recognition of culture in healthcare practices. There continues to be a strong reliance on medicine having a western focus, even though such an orientation has been constantly challenged for its limitations, which are driven by monocentrism and often result in cultural inappropriateness.” (Beilharz and Hogan 2002)

This again, emphasises the location of individual paramedics within an institutional context that of itself has a distinctive western medicine flavour. Out of its history it has also a military, hierarchical orientation of uniforms, titles for units etc. As such, the organisation may be at odds with those to whom it provides medical care.

It is the intention of this chapter to therefore ‘position’ the new knowledge created by the research from this study by presenting where it fits with what is already known, and how the literature informs this current study. This essentially requires the literature to be drawn from other disciplines such as nursing and medicine, as this study deals with facets that have not been previously explored in depth within the paramedic discipline.

Ambulance Services in Australia – An Historical Overview

To understand the ethos of any organisation, it is important to gain an understanding of how the organisation came into being, its developing history and challenges, and the constraints that have moulded its present existence. The principle of 'what we are today is because of who were we yesterday' is an important paradigm here.

As a paramedic of more than 27 years, it is hard to determine where the line is drawn that distinguishes the history of the ambulance service from the present. On reflection, the ambulance service has undergone many transformations during my association. I look back at when I first commenced with the service and recall how militarised it seemed to be, everything from the ethos down to the presentation of the paramedics and their classifications.

During my early training days, my very first lesson incorporated respect for superior 'officers'. Whenever an officer walked into the room, we were instructed to stand, and place our right hand over our left chest as a sign of reverence, almost a salute. When I was allocated my first clinical round at Melbourne's central city branch, it was no surprise, therefore, that senior officers' attention to detail was paramount. The vehicle (ambulance) was the main tool of trade, and the focus was to ensure its pristine status at all times. Polishing hubcaps and blackening tyres were the standard rigor of the first morning tasks. I recalled back to my earlier nursing training where the then 'Charge Sister' would run regular ward inspections, focusing never on patient care but the alignment of pillows, bed linen,

and, of course, those hospital corners, as if tucking in the ends of the sheets and blankets would aid in the speedy recovery of the patients in our care. It occurred to me then that this service was perhaps some 20 years behind its nursing counterparts.

The uniform itself had a strong military style, complete with epaulettes and insignias signifying rank, shoes always highly polished. Dependent upon who the senior officer was on the roster allocation, there was at times, an inspection parade of vehicles and officers to ensure all conformed to regulation. Titles of the then ambulance officers (now paramedics) were also inclusive of military, and included titles such as 'station officers' and 'area command'. The organisation consisted of only males, including administrative staff. It is not surprising that when I joined the ambulance service back then, there was such a strong military feel about the organisation, which left no doubt in my mind that the service had strong roots in the military.

Ambulance services worldwide have developed from warfare. As early as 1766, during the Napoleonic wars, horse drawn wagons were being used to collect the wounded from the battlefield and transport them to surgeons who had set up nearby makeshift hospitals specifically to support those fighting at the front (Greaves, Porter, and Smith, 2011).

Over the ensuing years, the plight of the victims of warfare was increasingly recognised, which led to the call of international recognition in 1864 with the first Geneva Convention, giving neutrality to medical personnel on the battlefield. This also led to the formation of

various national aid societies such as the International Red Cross (Greaves, Porter, and Smith, 2011).

Industrialisation throughout the latter half of the 19th Century saw a marked increase in the number of accident rates, particularly in the mining industries throughout the United Kingdom. As a result of this, the first ambulance service was established in 1889 by the Order of St John, now commonly known as the St John Ambulance Brigade (Greaves, Porter, and Smith, 2011).

Wars continued to provide a stimulus to pre-hospital care and transportation of the sick and wounded, particularly the First and Second World Wars. It was during the First World War that motorised vehicles replaced horse-drawn ambulances. In the Second World War, these were again replaced by aero medical evacuations, mainly helicopters. It was not until the Vietnam War that pre-hospital care established itself through rapid transportation of the sick and injured with the measurable outcome of increasing survival rates (Greaves, Porter, and Smith, 2011).

Australia's ambulance service began in 1881, with a group of army medical troops being trained by a St John syllabus, and began using horse-drawn ambulance wagons. This service began to expand to incorporate the training of other official personnel, such as police officers and firemen, who were most likely to respond to accident incidents. The first

'established' ambulance service in Australia commenced in Melbourne in 1883 with the development of the first 'permanent' ambulance station by St John (Howie-Willis, 2009).

Not unlike Melbourne's international counterparts, industrialisation brought about a dramatic increase in the number of serious accidents in the city. As a consequence the St John movement thrived. It was not until 1896 however that the St John Ambulance Centre placed an Ashford Litter (two-wheeled stretcher bed) at Melbourne's main fire station; this was replaced in 1899 by a horse drawn ambulance (Howie-Willis, 2009).

In 1907 the first suburban ambulance branch station was opened in Prahran as public expectations grew for a more rapid response to incidents. Melbourne now had two ambulance branch locations servicing the entire community with four horse-drawn ambulances. In 1910, the first motorised vehicle commenced operating, and in 1916 the St John Ambulance Brigade split its functions into community first aid and ambulance transport thought the renamed Victorian Civil Ambulance Service (VCAS) (Ambulance Victoria, 2012). Not unlike more modern times, economic constraints and public need forged a major influence on the development and redefining of the ambulance service at this time. Following the split of its functions, the VCAS was experiencing major difficulties in financing its operational requirements and was insolvent by mid-1916 (Ambulance Victoria, 2012).

Melbourne experienced a severe influenza outbreak in 1918, and the need for an ambulance service became essential. The then Public Health Department funded the services requirements with marked increases in staffing and vehicles (Ambulance Victoria, 2012). In 1948, the newly formed Hospitals and Charities Commission took over responsibility for Melbourne's ambulance service, and determined separate responsibilities for Metropolitan and Rural communities. The rationale for this proposal was to ensure a 24-hour a day service by fully trained ambulance personnel to all communities of Victoria. This resulted in the VCAS servicing metropolitan Melbourne, and the establishment of 16 individual rural services. In 1988, these 16 rural services were amalgamated into five separate regions based on the then Health Commission's regional boundaries. There was, however, one exception; a small community ambulance service was established to serve the Alexandra region, which evolved as a purely community owned and run entity, servicing their own community without any government funding.

Again, financial pressures were having a significant impact on rural services, and following a commission into rural ambulance services the Minister for Health announced the amalgamation of the five regions into one in 1998. This saw the establishment of Rural Ambulance Victoria, which continued to serve all rural communities outside of metropolitan Melbourne. (Bird, 1999). From 1998, Victoria experienced a two-service approach to ambulance care, which remained until 1 July 2008, when all three services, Metropolitan Ambulance Service, Rural Ambulance Victoria, and the Alexandra and District Ambulance

Service, were amalgamated into the present state-wide single service, Ambulance Victoria (AV) (Ambulance Victoria – History of Ambulance Victoria, 2012).

Culture of the Paramedic Profession / Organisations

A particular focus of this thesis has included aspects of culture, religion, and rituals. This, however, has been mainly confined to these aspects from a community perspective. This thesis also addresses the ethos that is embedded within the ambulance organisational context, which impacts on paramedic practice.

Yen (2009) argues that organisations provide structure, resources, and systems that influence the work people do. She maintains that an organisation implies that there is a specific purpose, specific duties, and specific functions that govern peoples' work, which is overseen by superiors within that organisation. There is no question that such a definition is explicit within the organisational structure of Ambulance Victoria.

The history of ambulance, as previously discussed, is steeped in military traditions. It was not until relatively recent times, in 1987, that the first female student paramedic joined the then Metropolitan Ambulance Service. Up until that time, the male dominated service resulted in a masculine approach to the structure and ethos of the organisation. Whilst females have been consistently recruited since this time, as late as 2007 The Council of Ambulance Authorities noted in its annual report that the ambulance workforce consisted primarily of males. In his research, Boyle (1997) argues that a conflict exists in this male

dominated workforce with that of the actual work undertaken. He contends that whilst the ethos is masculine, actual paramedic practice requires the performance of caring and emotional work, traits traditionally seen as feminine. Yen (2009) notes that ambulance workers, and workplace hold a distinctive culture with beliefs, values and rituals embedded in its military background. She also adds that ambulance work is often depicted in the media as heroic and masculine. It is not surprising then that when a television show commences that typically glorifies paramedic work as adrenalin rushing, trauma rescuing, helicopter-jumping occurrence in the daily life of a paramedic, there is a marked increase in the enquiry into paramedic courses at the university programs I coordinate.

There has been much written about the stressors that face paramedics, many referring to the job requirements of dealing with severe accident victims. In more recent times there have been an increasing number of studies relating to the stress encountered by paramedics as a result of the organisations that employ them. Ambulance Victoria is a large organisation, with some 3,300 staff (Ambulance Victoria 2011). Within the organisation, there is a complex set of systems, structures, policies, and guidelines that must be followed. In his study Glendon (1991), found that many of the stressors paramedics faced related directly to the organisational culture. He noted that if paramedics are to perform to the best of their ability, then the support of the organisation is essential; however, he found that very few paramedics actually felt supported by the organisation that employed them. He contends that there is a disconnect between what is seen as a caring and compassionate

role with that of an organisational structure that houses a strong masculine, military and often non-caring ethos.

Paramedic Education, an Historical Perspective

The past three decades has seen a significant change in ambulance education. It has emerged from an ad hoc system of non-formalised training programs (Reynolds & O'Donnell, 2009), delivered by individual services, through to semi-structured industry-driven vocational programs, to the, now autonomous, university degree programs.

In Melbourne, as late as the 1960s, there was no formalised training for ambulance officers. On their first day, ambulance staff were given a first aid book which was first written in 1878 by a British army surgeon, P. Shepherd (Wilde, 1999). Up until this time, ambulance officers were expected to learn from their on-road exposure. Whilst most ambulance officers held a first aid qualification from St John, the remainder of their knowledge and skills was acquired as they worked. This required many ambulance officers to form close relationships with local medical and nursing staff who would often advise them on skills and knowledge on how to improve the level of care they gave their patients (Wilde, 1999).

Many ambulance officers of this time were of the opinion that patients were not offered the correct treatment, and believed that, as a result of this, many of their patients suffered unnecessarily. There was a growing opinion amongst the officers that patients would benefit further if the ambulance officers were better trained. There was mounting pressure

from within the ranks of the then Victorian Civil Ambulance Service to address this (Wilde, 1999). It seems that as early as those initial days of ambulance practice, those actually delivering patient care were determining the training needs of ambulance officers to some extent. Industrial unrest was also a factor that facilitated change at this time. There was a shift from the primarily volunteer workforce towards paid professionals (Reynolds & O'Donnell, 2009).

The superintendents of each of the regional ambulance services in Victoria used to meet on an annual basis. In 1957, these meetings were formalised with a newly created organisation, the focus of which was to reflect the links that had developed between the regional services. This newly formed organisation was the Victorian Ambulance Services Association (VASA), and comprised executive members of the individual services' committees of management.

There was no ambulance officer representation on VASA. Amongst the many motions that were passed at their inaugural meeting in 1957, was one that VASA write to the Hospitals and Charities Commission requesting the formation of a school specifically designated as a training facility for ambulance officers. One of the VASA committee members was Dr. Ric Bouvier who had developed a course syllabus, which in 1959 was further developed into a course outline. Bouvier's original proposed course went for four days, with lectures in the morning, and hospital rounds in the afternoon, and further lectures in the evening (Wilde,

1999). On 18 September 1961 medical and nursing staff of the Geelong Hospital delivered the first training course in Australia for ambulance officers.

In 1963, Melbourne's School of Nursing moved from its Mayfield Street, Malvern location, and the Hospitals and Charities Commission deemed this vacated space as a general education centre, known for many years as the Mayfield Centre. The centre offered a variety of courses including classes for flower arranging, medical secretaries and aged care. In 1964, the training for ambulance officers was moved to the Mayfield Centre, a move that many at the time viewed as an acknowledgment of the Hospitals and Charities Commission of the low status of the training of ambulance officers in Victoria.

By 1965, the Ambulance Services Wages Board set in place a series of classifications. These classifications required specific training requirements to achieve promotion and wage increases. There were a series of courses and examinations put into place that enabled ambulance officers to progress from new recruits at Ambulance Officer Grade 1, through to Grade 3. In May 1965 it was determined that there were some 400 ambulance officers Victoria wide who were seeking these newly formed, and mandatory, qualifications. These new courses were of four week's duration and required that attendees live in at the Mayfield Centre whilst attending (Wilde, 1999).

Up until this time, the desire for training of ambulance officers had come primarily from within the industry itself. Throughout the 1960s and 1970s, there had been considerable

advancement worldwide in emergency medicine, and a flood of research detailing the correlation between patient outcomes in the pre-hospital setting and the level of knowledge and skills of ambulance officers. This was particularly relevant to patients suffering heart attacks. Emergency medicine as a stand-alone discipline began to emerge in the early 1960s, largely as a result of the Vietnam War and, at a more local level the increasingly serious injuries sustained in motor traffic accidents (Wilde, 1999).

The Royal Australasian College of Surgeons held a seminar in Melbourne in October 1969. The seminar's focus was on the management of road traffic casualties. There were many outcomes from this seminar; the most notable of which was the formation of new laws governing the compulsory wearing of seatbelts. A less notable outcome of this seminar, however, were the call for more training of ambulance officers, improved status of ambulance officers, and the recognition and value of ambulance officer skills by the medical profession (Wilde, 1999).

Throughout the latter part of the 1960s and early 1970s, the focus of the work of ambulance officers in Victoria had changed greatly often more by accident than by plan. The needs of the community were seeing ambulance officers being called to medical emergencies where early treatment was critical as opposed to road trauma, as had been seen previously. This had considerable implications for the ambulance industry in Victoria and the need for expanded education to meet community demand. In 1974, there were governance amendments made to colleges offering vocational education, which resulted in the

development of a diverse range of vocational programs under the umbrella of Technical and Further Education (TAFE). These changes allowed for the development of an accredited vocational certified qualification for ambulance officers, the Certificate of Applied Science (Ambulance Officer), which commenced in 1978. To enable this course to meet TAFE accreditation requirements, the previously known programs that were being delivered through the Mayfield Centre had to be considerably restructured. The curriculum design at this time primarily consisted of two overriding principles, the preparation of ambulance officers for specialised clinical skills and to ensure compliance requirements for recognised qualifications (Reynolds & O'Donnell, 2009). In 1977, the course was moved to new premises, which saw the birth of the Ambulance Officers Training Centre (AOTC), the first stand-alone educational facility dedicated to the training of ambulance officers for the State of Victoria (Wilde, 1999).

The new premises had somewhat of a military feel about them, as the majority of the staff at the facility had strong (some decades) of military experience (Wilde, 1999). Although this was a civilian establishment, uniforms and males dominated it. The course was modelled on a post-employment apprenticeship style. Students undertaking the certificate program were employed by their relevant ambulance service and attended the AOTC for approximately ten weeks a year, compared to the previous program of four weeks. This mode of delivery allowed students to spend most of their time working for their services in between their study release blocks. This lasted for a period of three years, when students graduated with their certificate qualification (Wilde, 1999).

In September 1982, an independent consultant was engaged to review the certificate program. The review was problematic given that it had no terms of reference and, as such, confused information from students undertaking the certificate course and those previously trained at the Mayfield Centre. There was also some criticism of the AOTC by the regional ambulance services who could not come to a common agreement as to the expectations of a graduate ambulance officer, a phenomenon that still exists today. Other criticisms of the program were that medical and nursing staff primarily undertook the teaching, neither of which had experience in the unpredictable world of pre-hospital care. In 1982, this was addressed, and the AOTC had a multidisciplinary staff inclusive of qualified ambulance officers (Wilde, 1999).

In 1987, The Certificate of Applied Science (Ambulance Officer) was due for re-accreditation. This was an opportunity for a curriculum review resulting in the establishment of the Associate Diploma of Paramedic Science (Ambulance Officer) (ADHS), although the overall structure of delivery and length of the program remained relatively unchanged.

A review of the AOTC was initiated in 1993 by the then state government Department of Human Services and Health. The review's final determination was handed down in March 1994, recommending that the AOTC close in December of that year and transfer responsibilities to the TAFE sector. This was, no doubt, a cost driven exercise, and followed many other disciplines. The early 1980s saw the transfer of nurse education from the post-employment model of in-hospital training to the higher education programs within

universities that exist today. Many saw this is a cost saving exercise (Wilde, 1999), as student nurses attending universities were not required to be paid, as opposed to the post-employment model where they were on full pay during the three years of their education.

Similarly, the transfer of education of ambulance officers to the TAFE sector also brought about a change in student status from the previously known post-employment, apprenticeship style, to what is known today, pre-employment unpaid student status for the duration of their education. Prior to these events, Victoria University had developed and commenced delivering a paramedic program as a professional development opportunity for current qualified ambulance officers, specifically designed to update their Certificate and Associate Diploma status to that of a degree.

In 1991, the Council of Ambulance Authorities (CAA), being the peak body for ambulance in Australia, advanced further initiatives in ambulance education by determining that the training of ambulance officers be conducted by universities (Reynolds & O'Donnell, 2009).

There was a strong push from within the AOTC to partner with a university as opposed to a TAFE college. The government agreed, which bought the AOTC more time, and the AOTC called for formal proposals from education institutions. In 1997, the AOTC entered into a formal arrangement with Monash University to deliver the ADHS, which commenced in 1999, some five years after the original recommendations (Wilde, 1999). This new program was commonly known as the Diploma of Ambulance Paramedic Studies (DAPS), and was the

contracted program for Victoria's ambulance services. The Monash DAPS was still a post-employment mode, with students attending from their relative employing services for their formal education and returning in between these times to work. These students were on full wages whilst studying, so not a great deal had changed.

Meanwhile, Victoria University developed the State's first pre-employment model of ambulance qualifications and commenced accepting students into the Bachelor of Health Science – Paramedic program in February 1999. This was a significant change in ambulance education, not only due to its pre-employment student status, but also because the program had degree status.

Today, the only way to gain employment as a paramedic within Victoria is to first achieve the degree qualification. Whilst Victoria University was the pioneer of this program there are currently five universities in the state that now deliver this qualification. The DAPS course at Monash received its last student intake in 2005, with a further single graduate intake occurring in 2006 to meet industry resource demands.

The Role of the Paramedic in Today's Society

In Victoria, the roles and functions of a paramedic are determined through state government legislation via the Ambulance Services Act (Vic) 1986. The term paramedic has been adopted by ambulance services Australia-wide only in recent times; previously their title was that of Ambulance Officer (Reynolds & O'Donnell, 2009).

Today, a paramedic's primary responsibility is to deliver patient care in the pre-hospital setting. The nature of the paramedic workload is considerably varied, and can include a wide number of facets, including road, industrial, and domestic trauma, as well as medical emergencies associated with almost any aspect of the human body.

In recent years there has been a dramatic increase in the skill levels of paramedics (Reynolds & O'Donnell, 2009). The days of first aid approaches have given way to advanced technology and a shift in ethos arising from the 'How' to deal with patient care situations (competency based vocational education) to the present 'Why' patient care actions are required, brought about, predominantly, by higher education philosophies (Reynolds & O'Donnell, 2009).

Victoria's paramedics are highly skilled at working in what, at times, can be an uncontrolled environment, exposed to weather, darkened locations, industrial settings, and other physical challenges. They are equipped with an expanded clinical knowledge and practical skill sets arising from their university education, and have access to advanced technology in the way of equipment and drug therapies to aid almost any physiological presentation their patients have. The primary focus is that of patient care in the pre-hospital setting, inclusive of assessment, treatment, stabilisation and transport to a medical facility for ongoing care. Today's paramedics are widely recognised as an important link in the health care team, alongside nursing, medicine and other allied health and wellbeing disciplines.

Paramedicine, Medicine, and Nursing; the interrelationships.

As the literature review for this thesis draws on other disciplines, particularly nursing and medicine, it is important to gain an insight into the interrelationships that exist between them and paramedicine.

The three disciplines of paramedic, medicine and nursing appear to be similar, in that each provides patient care and invokes treatment modalities that promote (hopefully) an improvement in the patient's health status at that time (Reynolds & O'Donnell, 2009).

In the provision of emergency care, the relationship between paramedicine and medicine is intrinsic (Reynolds & O'Donnell, 2009). Both disciplines provide emergency care to the sick and injured with the ultimate aim of preserving life. Paramedics may very well operate autonomously in their decision-making and practical skills applications; they are none the less governed by strict clinical guidelines derived from evidence-based medicine. It is not uncommon in some instances for paramedics to contact physicians to obtain advice about a particular treatment regime whilst with a patient.

The environment in which the paramedic operates, however, differs from that of medicine and nursing. Paramedics usually work in pairs, (crew) and are removed from the support systems of controlled hospital environments, specialist referrals, pathology testing and medical imaging on which nursing and doctors rely so heavily (Reynolds & O'Donnell, 2009). Paramedics deliver health care to wherever the patient is, irrespective of environmental constraints.

The relationship between paramedicine, medicine, and nursing, however, is rapidly drawing closer as the roles and functions of each merge. In recent times, there has been increasing collaboration between the disciplines in research (Reynolds & O'Donnell, 2009). The expanding role of the paramedic has also seen opportunities arise in recent times.

Paramedics can operate now as independent practitioners in industrial settings, in-hospital as physician assistants, and in a range of other 'non-traditional' roles which have seen paramedics working far more closely with their nursing colleagues in both hospital and community settings. The similarity in the roles of nurses and paramedics is being increasingly recognised by universities, with some combining their courses into a double degree. Despite this, the paramedic discipline stands fast in its belief that the roles and functions of paramedics and those of nurses are considerably different, and that the blurring of these serves no purpose but to dilute the specialised field of paramedicine.

Paramedicine as a Profession

Over the last century, the paramedic discipline in Australia has undergone significant transformation and has been influential on many fronts, including health, social, political, economic, and professional (Williams, Onsman, & Brown, 2009). Paramedic practices in the last ten years have seen considerable change in most aspects of the discipline, including the scope of practice, education, and research. This has been seen to strengthen the paramedicine discipline as it strives for professional recognition (O'Meara 2009).

However, the formal recognition of paramedicine as a profession is yet to be achieved. Whilst the debate relating to professional status has been raging for some time, it has reached new peaks in recent times following the Federal Government's movement to a unified national registration scheme for health professionals. Paramedicine, to date, has failed to gain entry into the scheme, as the discipline failed to gain recognition or acknowledgement as an emerging profession (O'Meara, 2009). The debate today is still robust, and paramedic academics, leading practitioners, and policy makers are exploring options to paving the way to gain professional status. Some believe the discipline has achieved this; others are of the opinion that there are still hurdles to overcome. (O'Meara 2009). The common thread here appears to be that most are of the belief that it is intrinsically linked to national registration of paramedics, as is the case with other health professions such as medicine and nursing.

Up until the 1980s, paramedicine in Victoria had been linked strongly within the emergency services, as is still the case today in the United States of America. As a strategic move towards professional recognition, the industry in Australia aligned itself with the medical profession, drawing on medicines' influence, history, and scope of practice. This resulted in the recognition of, and acceptance by, other professional groups (Molony, 1986). The development of university-based education brings with it a unique body of knowledge and scholarship leading towards professional status (Williams, Onsmann & Brown, 2009).

Despite these moves, the industry itself is still fragmented across geographical boundaries. The individual state authorities govern the organisational structure and accountability of each of the ambulance services in Australia. Similarly, there are no registration requirements for paramedics, and no standardised scope of practice, resulting in considerable difficulties for paramedics in having their qualifications accepted across state borders. This means many are required to return to student status to obtain positions with interstate services.

There are currently 15 university programs in Australia offering paramedic programs for graduates wanting to become emergency paramedics. Whilst this offers the discipline greater capacity for research, increasingly changes in medical approaches resulting from evidence based studies, and growth in the body of knowledge, the lack of a national curriculum approach does nothing to progress the discipline's professional status (Williams, Onsman, & Brown, 2009).

To seek professional status requires the development of professional attitudes. Professional practice features include the visible and invisible, and draw on the tensions that exist between the technical skills (science based) and the caring attributes (social based). The incorporation of patient collaborative decision-making within evidence-based practice, and social issues, such as e-health and cultural competence, whilst increasingly more complex, shape the very definition of professionalism (Trede, 2009). Intrinsic to gaining professional

status is the capacity of the profession to meet the needs of the organisation's customers, in this case the patients. (Reynolds, 2004).

Human Rights – Legislative Frameworks Recognising Culturally and Religiously Diverse Communities.

Papadopoulos (2006), notes that there is an inextricable link between human rights and health care. Australia is becoming more responsive to the needs of people from diverse backgrounds, and policies exist at National and State and Territory levels that enshrine the rights of all Australians to equal access to health services that meet all their needs.

It is the duty of the state, regardless of political, economic, or cultural systems, to promote and protect all human rights and fundamental freedoms (Marks & Clapham, 2005). The human right to “freely participate in the cultural life of the community” is asserted in the Universal Declaration of Human Rights (Nie’c, 1998. p 27). The right to take part in ones cultural life is a fundamental one, and is protected under a number of human rights systems (Marks & Clapham, 2005).

Despite these policies, the health system in Australia is challenged to meet the needs of a population with a broad range of cultural, linguistic and religious backgrounds. As a result, health inequalities exist for many CALD background communities, and those of some religious faiths. Implementing policies effectively to ensure equity and access to health promotion and health care services for a diverse population will require action at every level of the health system in this country (NHMRC, 2005).

There has been a long history of pressure for minority community groups to assimilate with what can be viewed as mainstream communities. Such minority communities should be protected from this pressure, and it is this protection that underpins the many minority treaties that have been formed worldwide since the Second World War (Kymlicka, 1995). In essence, it is these very treaties that deem where ethnic, religious or linguistic minorities exist. Any persons belonging to these groups shall not be denied the right to enjoy their own culture, practice their own religion, and use their own language.

The right to equal justice, equal opportunity, and equal dignity; these words have indeed become the very basis of human rights' law in Australian civilisation. Australia as a nation values such rights, upholding the very nature of the principles of equity and anti-discrimination. Gender, ethnicity, and religion, all hold equal standing, equal rights, and equal respect, as reaffirmed by the Australian Human Rights policy introduced in the December 1993 Vienna Declaration (Department of Foreign Affairs and Trade, 2004).

Human rights law recognises the right to take part in, and carry forward, cultural practices (Marks & Clapham, 2005). However, writing in 1983, Williams (a 20th Century British cultural studies writer and critic) declared 'culture' one of the two or three most complicated words in the English language (Williams, 1983).

The human right 'freely to participate in the cultural life of the community' is asserted in the Universal Declaration of Human Rights. The right to partake in cultural life is understood

both as a right of access to cultural activities and as a right to create cultural works. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) upholds such rights, affirming cultural recognition.

The obligation is established. Infrastructure such as the health care system in Australia holds an obligation not only to recognise the culturally-diverse nature of the community it serves, but also to provide culturally sensitive services and programs aimed at meeting ethno-specific needs.

In states in which ethnic, religious, or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with other members of their group, to enjoy their own culture, profess and practise their own religion, or to use their own language.

The right to the highest attainable standard of health was first enunciated in 1946 in the Constitution of the World Health Organisation (WHO), and is reiterated in numerous WHO sponsored declarations, including the 1978 Almata Declaration on Primary Health Care and in the 1998 World Health Declaration. It is also recognised in the International Covenant on Economic, Social and Cultural Rights (Marks & Clapham, 2005).

The right to freedom of religion is recognised in article 18 of the Human Rights Declaration: Everyone has the right to freedom of thought, conscience and religion; this right includes

freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance. Freedom of religion is likewise guaranteed in the International Covenant of Civil and Political Rights (Kymlicka, 1995). Human rights propose that the concept of religious manifestations should be understood, inclusive of ritual and ceremonial acts, symbols and objects, the wearing of particular clothing or head coverings (Marks & Clapham, 2005).

Whilst it is recognised that many of the existing and established services providing health care in Australia endorse such basic human rights, address inequalities that may exist in service delivery, and offer programs that have an ethno-specific identity, such services have evolved from agencies that have grown from the very foundations of health care programs. Institutionally, health services have generally evolved from established hospital-based programs. Even today, health services, community health centres, and home health care programs are attached to, or at least have strong affiliations with a hospital facility. Such strong links have seen philosophies such as equity and social justice maintained throughout service delivery. Paramedic science, however, is a new and evolving discipline, with its roots based in the military as has been discussed earlier in this chapter. Paramedic science has not grown through the same professional evolution that has brought the more established health facilities to where they are today. Although pre-hospital emergency care is now very much aligned with the more traditional health care services, the emphasis is still very much focused on a patient's physiological status, managed through precise regimented protocols.

Undergraduate paramedics attending their program at Monash University were involved in a program designed specifically to cultivate an awareness of the way culture impacts on health and health care (Spencer & Archer, 2006). It was noted that these students expressed scepticism and portrayed dismissive attitudes about cultural influences in health care. By casting aside cultural diversity, these students perceived the patient as a 'universal body' rather than an 'individual person', illustrating how health care in the pre-hospital setting is protocol driven with disregard for the inherent cultural ambiguities of patients. (Spencer & Archer, 2006).

Paramedics are taught to assess according to physiological needs; treatment modalities are all based on physiological needs and information to referral agencies is also based on physiological needs. It is only in recent times that the ambulance service has begun to become aware of its obligations to meet the human rights' needs of the community it serves. It is, also, only in recent times that the ambulance service has seen the need to grow and develop the paramedic science discipline to become more aligned to other professional health care providers such as hospitals.

Culturally and Religiously Responsive Health Care Practices

Today's societies are becoming increasingly borderless, and, as a consequence, healthcare practitioners are being forced to recognise and pay greater attention to issues related to racial and religious differences, ethnicity, and diversity when providing care in a

multicultural society. Health care professionals must meet the needs of their ethnic, racial, and culturally and religiously diverse communities (Purnell & Paulanka 2008).

Patients have the right to be understood, respected, and treated as individuals despite their differences. In addition, they have the right to expect health care providers to realise that they are different and that their perspectives on the interpretations of health are legitimate (Kelleher & Hillier, 1996).

If patients are forced to relinquish their personal ideologies and cultural beliefs, resentment, anger, and noncompliance may result. The challenge this presents healthcare practitioners is to understand the patient's perspective. This requires health care practitioners to develop open styles of communication, be receptive to learning from their multicultural patients, and demonstrate a tolerance of ambiguities inherent in cultural norms (Purnell & Paulanka, 2008).

A health system that is culturally competent has four requirements according to the NHMRC (NHMRC, 2005). It must (a) acknowledge the benefits that diversity brings to the Australian society, (b) assist health providers and consumers to achieve the best, most appropriate care and services, (c) enable self-determination and ensure a commitment to reciprocity for culturally and linguistically diverse consumers and their communities, and (d) hold governments, health organisations and managers accountable for meeting the needs of all members of the communities they serve (NHMRC, 2005).

As identified by The Lewin Group, there is international consensus about the nature and importance of cultural competence “as an essential component of accessible, responsive, and high quality care (The Lewin Group, 2002). Cultural competence is much more than an awareness of cultural differences, as it focuses on the capacity of the health care system to improve health and wellbeing by integrating culture into the delivery of health services (NHMRC, 2005). Cultural competence has been classically defined by Cross et al (1989), as:

“A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals that enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behaviour that included thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. A cultural competent system of care acknowledges and incorporates – at all levels – the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansions of cultural knowledge, and the adaption of services to meet culturally-unique needs” (Cross et al, 1989, pp, 4-5).

Cross (1989) goes on to elaborate that ‘cultural competence’ may be viewed as a goal toward which professionals, agencies, and systems can strive, and that becoming culturally competent is a developmental process. He contends that a culturally competent system of care is made up of culturally competent institutions, agencies, and professionals that value

diversity, have the capacity for cultural self-assessment, are conscious of the dynamics inherent when cultures interact, have institutionalised cultural knowledge and have developed adaptations to diversity.

A culturally competent individual, however, appears to be more complex. The NHMRC has broadened this definition and included in its summary that a culturally competent health care practitioner:

- Acknowledges the importance of cultural understanding to achieve effective communication.
- Feels confident in his / her abilities to communicate effectively with CALD background groups.
- Can advocate with / and / or on the behalf of patients and their communities.
- Recognises and respects that communities are their own cultural experts and is able to facilitate a community development approach.
- Appreciates that many people from CALD backgrounds need to involve family and community in discussions about health related issues.
- Feels comfortable about involving an interpreter where there is a language barrier.
- Understands how differences in culture, language, and migration experience may have an impact on the way health programs are developed.
- Shares experiences with other health professionals whilst respecting confidentiality,
- Has undergone a process of self-reflection to understand the impact of personal cultural identity on his / her practice.
- Undertakes continuing professional development to develop the necessary skill set to foster culturally competent practice (NHMRC, 2005).

Despite these definitions, cultural competence the related standards for health care systems, and the increasing attention in acceptance of these standards, there is no formal agreement across different health care professions on what specifically constitutes individual cultural competence or how it is best measured (Johnstone & Kanitsaki, 2005). Camphinha-Bacote (2002), did however produce a culturally competent model of care involving five independent constructs to make up cultural competence: The constructs incorporate:

Cultural Awareness –the deliberate, cognitive process in which health care providers become appreciative of, and sensitive to the values, beliefs, life-ways, practices and problem solving strategies of patients’ cultures. This awareness process must involve examination of one’s own prejudices and biases towards other cultures and in-depth exploration of one’s own cultural background.

Cultural Knowledge – the process of seeking and obtaining a sound educational foundation concerning the various worldviews of different cultures.

Cultural Skill – the ability to collect relevant cultural data regarding the clients’ health histories and presenting problems, as well as accurately performing a culturally specific physical assessment. Health care providers when conducting an assessment must use a culturally sensitive approach and elicit cultural content in a culturally appropriate manner.

Cultural Encounters – the process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds' versus relying on text book learning about different cultures and their possible stereotypical portrayal.

Cultural Desire – is the motivation of health care providers to want to engage in the process of cultural competence. As well as having cultural awareness, cultural knowledge, cultural skills, and cultural encounters, health care providers must also have a genuine desire and motivation to work with culturally different patients.

The benefits of a culturally competent approach have been recognised increasingly by health care practitioners, policy makers, governments, academics, and health services managers, acknowledging that culture can have a profound influence on people's experiences and perceptions of health and health care, and patient compliance with treatment recommendations and treatment outcomes (Chong, 2002). Also it is also being recognised increasingly that the delivery of culturally competent health care is inextricably linked to good patient outcomes (Betancourt, 2003). Culturally specific and responsive health care practices have a powerful influence on patient outcomes (Purnell & Paulanka 2008). Not only does culturally responsive health care practice improve patient outcomes, the lack of acknowledgement of a patient's cultural or religious requirements may impede recovery, and in some instances become a greater issue for the patient than their

presenting problems (Kelleher & Hillier, 1996). Valuing diversity in health care enhances the delivery and effectiveness of care, both physically and symbolically (Chong, 2002).

Nursing

Culturally responsive nursing has a long and significant history. Florence Nightingale became the first known trans-cultural nurse when she reported on the specific health needs of the Australian Aboriginal community in 1865. Since this time the nursing profession has made important contributions to cross-cultural work by utilising the flexibility that nursing provides to ensure responsiveness to their patients' requirements (Morse, 1999).

Over the last six decades, thousands of nurses worldwide have worked diligently to establish cross-cultural nursing practices as a formal area of academic study. A substantial and important body of knowledge on trans-cultural theoretical, research, and evidence-based knowledge has been generated by nurse scholars throughout the world (Andrews & Boyle, 2012).

Since the 1980s there have been significant changes to nursing curricula worldwide, both undergraduate and post graduate, ensuring that cultural aspects of patient care are incorporated (Papadopoulos, 2006). Throughout this time, nurses have focused on cross-cultural issues in their practice to enhance the provision of effective, safe, and efficient culturally competent and responsive care (Andrews & Boyle, 2012).

Culturally responsive nursing has been soundly established with theories and guidelines to provide culturally competent health care to the community's nurses serve (Morse, 1999). Trans-cultural nursing is acknowledged and recognised by many nurse leaders and other health care disciplines as the first recognised discipline with research findings to support direct trans-cultural health care practice. This has been a major breakthrough in nursing and in health disciplines generally (Andrews & Boyle, 2012).

The National League of Nursing is the peak body for nursing worldwide. The organisation has formally acknowledged a professional mandate for culturally and religiously competent care, inclusive of the inclusion of cultural concepts on the educational preparation of nurses (Munoz & Luckmann, 2005).

The literature reviewed indicates that there have been several factors that have influenced and underpinned the establishment of culturally and religiously responsive nursing practices that exist today. Some of these factors are identified by Leininger (1995), Andrews & Boyle (2012), Morse (1999), Purnell & Paulanka (2008):

- The marked increase in the migratory population of the world within, and between, countries. Culturally and religiously responsive nursing has been essential because of the growing diversity that now populates global communities.

- There has been a significant increase in multicultural identities with people expecting their cultural and religious beliefs, values, and life-ways to be understood and respected by nurses and other health care professionals.
- The increased use of health care technology sometimes conflicting with cultural values of patients.
- Worldwide, there are cultural and religious conflicts, clashes, and violence that have an impact on health care as more cultures and religions interact with each other.
- There has been an increase in the amount of litigation resulting from cultural and religious conflicts within the health care system, including those related to negligence, ignorance, and imposition of health care practitioners.
- There has been an increased demand for community and culturally based health care services in diverse environments.

Trans-cultural nursing care, however, has been criticised for its definitional, theoretical, and, particularly, its practical limitations such as the focus on the provision of the physical aspects of cultural sensitivities such as food and prayer requirements (Andrews & Boyle, 2012). The nursing profession has faced many challenges in achieving clear and concise concepts around cultural sensitivity, cultural competence, and cultural congruence (Mullholland, 1995). Colour, religion, and, at times, geographical locations are most often used in the nursing context to define culture, and highlight cultural diversity (Andrews &

Boyle, 2012). These are often portrayed as minority versus majority issues, and fail to recognise that every person has a cultural heritage (Talabere, 1996).

Cultural and religious diversity in nursing is itself an ethnocentric term because it focuses on how one person is different from the nurse practitioner, as opposed to how different the nurse practitioner is from their patient (Andrews & Boyle, 2012). In essence, using the term cultural or religious diversity within the nursing context is frequently viewed as the norm against which everyone else who is different is measured against.

A further criticism of trans-cultural nursing is that models fail to recognise the relationships between knowledge and power associated with prejudice, discrimination and racism (Culley, 1996). Similarly, there is the power relationship that exists between groups (Talabere, 1996). This can be noted in instances where patients from a traditionally underrepresented group fail to behave as a nurse expects; the behaviour is sometimes referred to as 'noncompliant' (Leininger, 2002).

A final criticism of culturally and religiously responsive nursing practice arises from nursing embracing models based on assumptions that one's own culture and the culture of others creates tolerance and respect from people of diverse backgrounds (Andrews & Boyle, 2012). It has become apparent that the mere awareness of one's own culture and that of others is insufficient to alleviate the potential presence of prejudice, bigotry, and racial, ethnic or cultural conflicts (Campinha-Bacote, 2007). Nurses and other health care providers must

have positive experiences with members of other cultures and learn to genuinely value the contributions all cultures can make to our multicultural society. None the less, becoming aware of one's own culture and that of others is a starting point for developing the sensitivity, skills, and knowledge necessary to provide culturally and religiously competent nursing care (Purnell & Paulanka, 2008).

Notwithstanding these criticisms, the nursing profession is well equipped to respond to the religious and cultural needs of their patients. Not only have there been considerable gains made in the education, research, and ethos within the nursing profession to achieve culturally and religiously competent care, the institutional structure of most hospitals lends itself to nurses being able to care for a patient of the same cultural or religious background as their own (Dobson, 1991). This of course is not the case with paramedics where the institutional structure constrains culturally responsive care at even the core levels of ethos, research, and logistics by means of the incapacity of the organisation to align the culture or religion of the paramedic with that of their patient.

Medicine

As discussed earlier, nursing and medicine are closely aligned. However, the literature suggests that medicine has also gone through a series of changes and self-examinations to incorporate culturally and religiously competent care in their field. Not unlike its nursing counterpart, there has been an evolution that has brought the discipline to where it is today.

Much of the literature that discusses culturally competent medicine incorporates a definition that differs slightly from nursing, and is heavily focused within the United States. Medicine, in its true scientific fashion, has taken a 'scalpel' approach to dissecting the terminology. The end result is that there are a series of individual facets that define cultural competence in medicine. The Association of American Medical Colleges (AAMC) has incorporated a national definition which refers to cultural and linguistic competence as being a set of congruent behaviours, knowledge, attitudes, and policies that come together in a system, organisation, or among professionals that enables effective work in cross-cultural situations (AAMC, 2005).

The AAMC separates definitions of culture and competency stating that 'culture' refers to integrated patterns of human behaviour that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. For the AAMC, 'competence' implies having the capacity to function effectively as an individual or an organisation within the context of the cultural beliefs, practices, and needs presented by patients and their communities (AAMC, 2005).

There are overriding principles, however, that appear to be common between the two disciplines. Both agree that cultural competence in health care combines the belief of patient/family-centred care with an understanding of the social and cultural influences that affect the quality of medical services and treatment. Again, both disciplines acknowledge

that there is strong evidence to suggest that it is critically important that health care professionals are educated specifically to address issues of culture in an effective manner.

The literature suggests, however, that the emergence of cultural and religious competence in medicine, unlike nursing, has occurred only in very recent times. It has been as recently as the late 1990s that this has emerged as an important issue (Betancourt, et al, 2005).

Despite this late acknowledgment, the medical fraternity lists the same rationale for the requirements of a culturally responsive profession as nursing had done some decades earlier. The rationale for a culturally responsive approach for physicians has been determined by the increasing diversity of the community the profession serves, often with health requirements influenced by their social or cultural backgrounds. Interestingly, one of the main reasons noted for such changes was the potential for some patients to present to the physician with symptoms that differed from the “textbook recommendations” (Berger, 1998).

The other reasons relate to research findings being suggestive of culturally responsive care being linked to patient satisfaction, adherence to medical instructions, and health improved health outcomes. Further research highlighted the importance of patient-centered care and cultural competence in improving quality and eliminating racial/ethnic health care disparities (Stewart, 1999). It is important to note here that the research which brought about change was discipline focused; that is, it was undertaken within the medical profession, and tended not to draw upon established research within nursing.

The largest push for culturally competent approaches in medicine came in 2000, with the Liaison Committee on Medical Education (LCME) introducing a standardised approach for cultural competence to be implemented in all faculties of medicine. This approach added momentum to medical schools throughout the United States introducing cultural competence into all undergraduate medical curricula:

“The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering the overall health of the patient.” (Smedley, 2003. Pp 26 – 28).

In moving forward to ensure cultural competence was embedded in all medical curricula, further internal legislative frameworks were developed to ensure a standardised approach (AAMC, 2005). Not only did the LCME commence the governing process related to the need for curricula to include cultural competence content, the next phase specified how this was to be done. The specificity and the content ensured that culturally competent curricula should not be an add-on to the present medical school curriculum. The framework specified that, if issues such as culture, professionalism, and ethics are presented separately from other content areas, they risk becoming de-emphasised as fringe elements of marginal importance. The intent of a cultural competent curriculum was to specifically enhance the patient-physician interaction and assure that students had the knowledge, skills, and attitudes that allow them to work effectively with patients and their families, as well as with other members of the medical community (AAMC, 2005). The literature seems to be

indicative of the medical discipline taking some heed of the established nursing criticisms of cultural competence discussed earlier.

The Liaison Committee on Medical Education considered that it was not enough just to embed cultural competence into the undergraduate curricula. They noted that there was also some change required in the ethos of some of the academies, and established a list of institutional requirements to ensure the effectiveness of a culturally competent curriculum (Smedley, 2003). The AAMC considered the requirements onerous, nonetheless, these were adopted as practice. In summary the requirements of the academies were to ensure that:

- The curriculum must have the institutional support of the leadership, faculty, and students.
- Institutional and community resources must be committed to the curriculum.
- Community leaders must be sought out, and involved in, designing the curriculum and providing feedback.
- The institution and its faculty need to commit to providing integrated educational interventions appropriate to the level of the learner.
- A cultural competence curriculum must have a clearly defined evaluation process that includes accountability and evaluation, specific student feedback, and consideration of outcomes assessment (AAMC, 2005).

To assist medical schools in their efforts to integrate cultural competence content into their curricula, the AAMC developed the Tool for Assessing Cultural Competence Training

(TACCT). The TACCT reflects the input of experts in cultural competence and medical education. The instrument provides validated recommendations on curriculum content and is used in conjunction with materials that identify optimal educational methods and evaluation strategies (AAMC, 2005). This offers some potential for this to commence the debate on paramedic curriculum content relating to cultural and religious content.

It was not a smooth transition; however there were many tensions that existed throughout the process. Physicians-in-training are part of a cultural group that has its own beliefs, practices, customs and rituals. These include definitions of health and illness, the superiority of technology prevention through annual exams, compliance, procedure and systematic approaches not unlike what is seen in paramedicine. Medical students engage in customs of professionalism and courtesy and have rituals like the physical exam, visiting hours and surgical procedures (Spector, 1996). Medical school teaches students scientific rationality and an emphasis on objectivity; they value numeric measurement and physiological and chemical data and tend to separate the mind and body (Kleinman, 1999). Medical students may reduce patients to individual diseases and body parts without seeing the patient as a part of a family or community. In this way, physicians in training represent an ethnocentric culture of their own, one that values its own culture above others, inevitably leading to conflicts with the patient's culture (Spector, 1996). Initially, there was strong resistance from faculty and students who were entrenched in the systems approach and scientific ethos. Had it not been for the LCME governance framework, it is doubtful much would have been achieved (AAMC, 2005).

Similarities between the disciplines of medicine and paramedicine, in an historical, ethos, and practical approaches are evident. Culturally responsive care within an established discipline does not occur overnight. It is an evolution that commences with the establishment of industry governance from the top levels, and developing programs aimed at the education of new undergraduates at the lower level. It has a multi-layered approach, not only with the development of a new body of knowledge, but also structures put into place specifically aimed to change the very culture of the institution of the discipline itself.

The Australian Medical Association (AMA) is currently developing a position paper on cultural competence in health care for Australian physicians, however it is not due for release until late 2012.

Allied Health

Allied health professionals are professional health care workers who are not associated with medicine, nursing, or dentistry. The list of allied health care professionals is extensive and ranges from medical technicians, pharmacists, physiotherapists, and Audiologists, just to name a few.

Little has been written about cultural competence approaches within the allied health sector, and it would appear from the literature that is available, the evolutionary trend relating to culturally competent approaches in both nursing and medicine is still commencing. The few articles that have been published relate to definitions, and research

beginning to show the need. The literature identifies trends such as migratory populations, increasing diversity in communities, and the positive outcomes that culturally sensitive approaches bring. Not unlike what has been discussed previously with medicine, the allied health group is presently establishing its own body of knowledge rather than utilising what exists within the disciplines of medicine and nursing, although the knowledge that is being formulated is, of course often, indistinguishable.

Not unlike paramedicine, allied health care professionals are relatively new as a discipline when compared to medicine and nursing, with some still emerging as new technology, and increasing community needs arise. The advancement of new technology and equipment requires that someone learns how to operate / administer this, and a new allied health care discipline is born.

In this early phase of culturally competent development within allied health, there is one very notable piece of literature that stands aside from nursing and medicine. A large study of allied health care education programs within California was undertaken to determine which were inclusive of cultural and religious competent care in their curricula. The study found that, of the 341 programs surveyed, 37.5% included some component that related to the cultural preparedness of their graduates (Chapman, et al, 2008). A further interesting fact that arose from this study relevant to this thesis was the data relating to paramedic programs. There were 25 paramedic programs reviewed in the study, with only four (4),

(16%) that had incorporated cultural and religious responsive care into the curriculum. This was well below the studies average of 37.5% (Chapman, et al, 2008).

It is difficult to ascertain why the allied health professional disciplines are some years behind the other medically related fields when it comes to culturally responsive healthcare practices. My own hypothesis is that for most of these health care services, patients have the opportunity for choice. If one is requiring the services of a myotherapist or podiatrist, for example, and if the patient has specific religious or cultural requirements, then there is the capacity to engage the services of a practitioner from either within the community they belong or, at the very least, one which their community recommends. This may mean that culturally responsive healthcare within the allied health sector is a mute point. This will not always be the case. In some instances, such as during periods of hospitalisation, allied health services will be allocated to the patient without such a choice. Similarly, this is not the case with paramedicine; patients have no choice in the allocation of a paramedic crew who attends their needs.

Incorporating Cultural and Religious Competence into Curriculum

In 1990, the Commonwealth Department of Employment, Education and Training (DEET) produced and distributed a discussion paper supporting the concept of "a fair chance for all" in higher education. Specifically, the document set out national equity objectives and targets for each of six groups identified as disadvantaged in gaining access to higher education. The six groups included one focused on Non English Speaking Background (NESB)

students. The document also identified the responsibilities of both the Commonwealth and individual higher education facilities in achieving the national equity objectives and suggested a range of strategies to assist institutions in their planning in this regard. The strategies in relation to NESB students included "multicultural curriculum development" and "cross-cultural awareness" (DEET, 1990, p. 38).

This strategy resulted in the formation of the "Cross-Cultural Education Network". This group was active in the development of a Cross-Cultural Education Policy, which amongst other things encourages academic staff and students to develop an understanding of both their own cultures and those of others. It also advocates professional development opportunities and incentives to assist academic staff to become more effective in cross-cultural teaching situations.

Fundamental to the operationalisation is a recognition of the ethnocentric nature of the current curriculum in higher education, in terms of both content and delivery, and of the need for higher education curriculum to become more "culturally inclusive", in ways that are beneficial to all cultural groups within the higher education context.

Thus, a genuinely "cross-cultural curriculum" is seen as one which incorporates, values and extends the prior experiences and learnings, the current interests, needs and concerns, and the preferred learning and assessment styles of students of all cultures represented in higher education classrooms.

In the sense of inclusivity, the concept of a "cross-cultural curriculum" is parallel, in many ways, to the concept of a "gender-inclusive curriculum" which had been advocated and implemented for a number of years by committed feminist educators (see, for example, Hildebrand, 1990; Harding & Parker, 1995).

Thus, it appears likely that conceptual tools which have been effective in relation to gender-inclusivity may be helpful to those engaging with cultural-inclusivity. One such set of tools is derived from what has become known as "stage theory" as proposed, for example, by Schuster and Van Dyne (1984).

Schuster and Van Dyne (1984) charted curriculum change processes in terms of six stages of incorporation of women in the curriculum. The stages moved from the first, essentially masculinist situation, in which the absence of women from the curriculum was not seen as a cause for concern, through a second stage, in which there was a "search for the missing women". Frequently, such a search resulted in the addition of some identifiable "exceptional" women to a still predominantly masculinist syllabus. It did not impinge at all upon the teaching or assessment strategies associated with the syllabus.

In the third stage, women were conceptualised as a disadvantaged group, and questions involving reasons for the paucity of women leaders and the devaluation of women's roles were answered, typically, with the assistance of strategies which focused on changing women. Examples of such strategies are those focused on improving women's self-esteem

and/or providing them with attributes such as assertiveness which were seen as critical to the definition of leadership.

The fourth stage involved the study of women "on their own terms" (Schuster & Van Dyne, p. 419), and the acknowledgment of the validity of women's experiences and ways of knowing as a basis for the curriculum.

The fifth stage was more challenging, characterised by questions regarding the validity of current definitions of knowledge and the search for alternative paradigms.

The sixth, final stage envisaged a "balanced curriculum", in which women's and men's experience could be understood together, and the students could be empowered through an "inclusive vision of human experience based on difference, diversity, not sameness, generalization" (p. 419).

Those working to implement culturally inclusive curricula in a number of disciplines have applied Schuster and Van Dyne's framework with some success. In history, for example, Tetreault (1985, 1987) presents "phases of thinking about women in history, ranging from "male-defined history", through "contribution history", "bifocal history" and "histories of women", to "histories of gender". Similarly, Willis, E., Reynolds, L. and, Keleher, H. (2009) have adapted the framework to chart progress towards a gender-inclusive curriculum in

science and have developed a similar typology in the context of culturally inclusive education.

The Willis, E., Reynolds, L. and, Keleher, H. (2009) framework typifies in a number of ways the advances which have been made over the past decade in the application of stage theories to curriculum reform. As implied earlier in this discussion, early applications focused predominantly on curriculum content. In the more recent applications, however, there has been recognition that cross cultural curriculum inclusiveness extends well beyond merely the content of the curriculum and that there is a need to consider teaching processes and assessment strategies at the same time as curriculum content if the full potential of cross cultural inclusivity is to be realised. Indeed, Willis, E., Reynolds, L. and, Keleher, H. (2009) goes even further than "inclusivity", presenting a "socially critical" perspective, within which practitioners aim for students to understand the manner in which people (including themselves) are positioned by the curriculum and to use the curriculum as a vehicle for achieving social justice.

Operationally, tools such as those of Schuster and Van Dyne, Tetreault, Kreinberg and Lewis, and Willis are used to help clarify the perspectives of those engaging in curriculum reform. As Willis, E., Reynolds, L. and, Keleher, H. (2009) writes of their experiences dealing with a wide variety of situations and groups in mathematics education:

In each of the situations they have described that it became clear that there were widely disparate views about what, if any, relationship the mathematics curriculum has to cultural inclusion and, consequently, about whether and how the mathematics curriculum should change. Whether at national consultative meetings, in the higher education staffroom or talking to publishers, dealing with differences in viewpoint was severely hampered because participants did not share a common framework or language and hence had difficulty recognising, let alone understanding, each others' points of view. Often the very same words meant quite different things to people with unfortunate consequences in loss of faith when an agreement of one meeting appeared to be broken by the next. Equally often, choices of words that caused offence masked an underlying commonality of viewpoint which would eventually become apparent although not without considerable stress.

With respect to such situations, the success of frameworks such as those discussed here appears to lie in their capacity to, in the words of Willis, E., Reynolds, L. and, Keleher, H. (2009) "provide a vehicle for the development of better understanding between participants". In many ways, the work of educators such as Tetreault, Kreinberg and Lewis and Willis in curriculum transformation has realised the vision of Schuster and Van Dyne (1984), demonstrating that using "gender as a category of analysis enriches and illuminates traditional subjects" (p. 426).

To some extent, the application of stage theories to cross-cultural curriculum development was foreshadowed by Schuster and Van Dyne (1984), when they hypothesised that the use

of "gender, race and class as primary categories of analysis will transform our perspective on familiar data and concepts as well as reveal new material to be studied" (p. 426). Indeed, following the initial work on gender in this area, a small number of educators concerned with the interaction of culture and ethnicity within classrooms have proposed frameworks which reflect stage theory approaches. Although these frameworks are not necessarily connected explicitly to the work of Schuster and Van Dyne and were not always developed in the context of curriculum transformation, they nevertheless had significant influence. Banks (1987) for example, proposed a typology of ethnicity, identifying the stages, which he considered an individual must pass through in order to become an effective, culturally sensitive educator. Within this context, Martin and Atwater (1992), have summarised the stages along the following lines:

- "ethnic psychological captivity", in which individuals act on the basis of internalised beliefs about particular ethnic groups;
- "ethnic encapsulation", in which people are ethnocentric and practise ethnic separatism;
- "ethnic identity clarification", where people have clarified their attitudes towards various ethnic groups;
- "biethnicity", where individuals have the attitudes, skills and commitment to participate in their own or other ethnic groups;
- "multiethnicity", where an individual has a reflective ethnic and national identification;

- "globalism and global competency", within which a person's capacity for multiethnicity transcends national barriers.

Although Martin and Atwater's approach has been found to be useful in the context of the development of ethnic identity by science teachers, it appears to have only limited application to cross-cultural curriculum development. A more promising approach is found in the work of Bennett and Stillings (1993, as quoted by Timpson, 1995), which posits six stages of:

- "denial", conceived as a form of ethnocentrism or parochialism;
- "defense", associated with negative stereotyping and an assumption of cultural superiority;
- "minimisation", where differences are often trivialised;
- "acceptance", where cultural differences are acknowledged and respected;
- "adaptation", reflecting a culturally pluralist view and a certain fluidity of world view;
- "integration", where "differences are perceived as an essential and joyful aspect of all life" (Timpson, 1995, p. 3).

While the Bennett and Stillings framework is helpful, it appears to lack the third important stage of Schuster and Van Dyne's typology, namely that in which the problem is seen to lie in the attributes of the "minority" group and the solution is seen to lie in changing this minority group to be more like the dominant group. It is possible that this stage is incorporated in that identified above as "defense".

However, given that, historically, the stage has been of such significance in progress towards a gender-inclusive curriculum, it would appear to be desirable for it to be more explicit in any framework to be used in relation to cultural inclusivity.

Clearly, however, there is a need for further exploration and development of frameworks proposed for use in cross-cultural education, in order to maximise their effectiveness as tools for use by staff developers and academics in universities.

Scholarship, research and collegiality are the hallmarks of any higher education institution. Providing a learning and research environment that enables students and staff to engage in responsible social and cultural analysis and debate will produce ethical and cross-culturally competent graduates who can engage with multiple perspectives, operate in socially, culturally and linguistically diverse environments, and work in multicultural teams.

Higher education institutions should seek to foster excellence in scholarship, innovation and social responsibility and show a committed to providing an educational environment in which inclusivity is a benchmark of excellence.

Respect and valuing all students will promote inclusivity on campus. This will be reflected by an increased access to higher education and the social and economic benefits it provides to segments of the community traditionally excluded.

An inclusive culture will enrich the educational experience of all students. Students and academics need to engage with and accommodate diversity in building knowledge, values, skills, abilities and personal qualities that will equip them to be effective professionals and citizens.

The pragmatic benefits in developing professionals who can interact and operate effectively and creatively with a wide variety of others and in rapidly changing globally oriented workplace contexts will be evident both within the higher education realm and the wider community. Such rounded and grounded professionals will have been exposed to knowledge which enriches or challenges by acknowledging different sources of knowledge production, differing claims as legitimacy for knowledge, and differing applications of knowledge.

Inclusive curricula use teaching, learning and assessment arrangements which facilitate engagement with these broad notions of the curriculum by students who bring diverse abilities, interests and backgrounds to their studies. These teaching, learning and assessment arrangements are focused on the development of professionals who are able to make an immediate and ongoing contribution in their chosen professions and fields in both local and global contexts.

In an inclusive higher education culture of teaching and learning and assessment where teachers and students alike are encouraged to reflect on their diverse abilities, interests and

backgrounds and acknowledge how such diversity impacts on their life generally and their education specifically. Such a learning and teaching environment will in turn enhance and promote further respect and valuing of others and reinforce and foster the growth of a community of inclusion.

An inclusive curriculum will advance, disseminate and preserve knowledge, foster scholarship, facilitate research and enhance the spirit of collegiality all of which bears witness to sound educational practice.

Inclusive curricula make evident those criteria and the basis of the selection and encourage debate about these criteria. This debate permits exploration of the ability of such curricula to be inclusive, to demonstrate respect for and the valuing of students of varying ability, cultural or social backgrounds.

Furthermore, inclusive curricula use teaching, learning and assessment arrangements, which facilitate engagement with these broad notions of the curriculum by students who bring diverse interests, abilities and backgrounds to their studies. These teaching, learning and assessment arrangements are focused on the development of professionals who are able to make an immediate and ongoing contribution in their chosen professions and fields in both local and global contexts.

Many higher education institutions have advanced in developing programs that are culturally inclusive in terms of their course design, curriculum content and teaching methodologies.

Some of the key indicators of an inclusive curriculum are advised by Marshall (2010). He states that there are at least seven indicators of an inclusive curriculum: knowledge, attitudes, professional excellence and practice, creative problem solving, social responsibility, communication and international.

Knowledge indicators

Demonstrated understanding of:

- the potential of the theories and perspectives of non-dominant groups to contribute to the field;
- how particular ideas within a field of study have privileged some above others;
- the identification of the potential of the theories, content and methodological approaches of the field to influence the needs, interests and perspectives of non-dominant groups; and
- the way the accepted approaches to, and outcomes of, research have the potential to differentially affect or inform various ability, social and cultural groups.

Application of knowledge to a range of social and cultural contexts;

Recognition of the social and historical influences on the development of the field and in particular the effects on specific ability, social and cultural groups.

Attitude indicators

Demonstration of:

- a personal ethical position which includes the recognition and valuing of social and cultural diversity; and
- the links between 'value-free' and 'merit-based' decision making and social inequality.

Recognition of:

- the dynamic relationship between construction of privilege and/or disadvantage; and
- the ability of discipline knowledge to perpetuate and/or dismantle social inequality

Professional excellence and practice indicators

Understanding of:

- the social and cultural dimensions of networks of knowledge and be able to recognise their implications in locating, evaluating, managing and using information; and/or
- the partial and relative nature of their own knowledge and its construction in relation to their historical, social and cultural experiences.

Recognition:

- of the potential for enlarging their repertoire of learning styles to include strategies appropriate in a range of ability, cultural or social groups; and/or
- that self direction may involve fundamental differences in approach for individuals from different groups.

Maintenance of a concept of self in relation to, and which is informed by, wider social and cultural perspectives;

Sustaining an intellectual approach, which embraces the changing social and cultural professional context;

Awareness of the social and cultural factors in constructing arguments and negotiating with others; and

Work collaboratively in groups and teams which comprise members from varying ability, social and cultural backgrounds.

Creative problem solving indicators

Utilisation of analysis and synthesis techniques which are relevant to particular ability, social and cultural contexts;

Definition and analysis of researchable questions from a range of ability, social and cultural perspectives and positions of interest ;

Recognition of the cultural and social embeddedness of problems with respect to both their conceptualisation and solution.

Social responsibility indicators

Demonstration of the social and cultural dimensions of community responsibility.

Contextualisation of the social and cultural origins of technologies and demonstration of their differential impact on particular groups in society

Recognition of the social and cultural issues associated with environmental sustainability.

Communication indicators

Demonstration of an understanding of:

- the links between literacy's, and social and cultural experience ;
- the relevant social, cultural and interpersonal communication issues with audiences of diverse ability, and/or social and cultural backgrounds .

Understanding, respecting and valuing forms of communication from less dominant groups.

International indicators

Demonstration of:

- a global understanding of issues which involve considerations relevant to particular social groups such as women and indigenous people;
- an awareness of the complexity of decision making with respect to various sub-groups within an international context.

Appreciation of:

- the similarities and differences between their own and others' constructions of social, economic and cultural aspects of community and citizenship;
- the importance of historical and socioeconomic contexts in the articulation and valuing of professional practices locally and elsewhere;
- the intersecting and sometimes conflicting value positions of multicultural Australia in professional practice;
- the complex interplay of language, history and cultural institutions that operate within and between cultures;

Ability and willingness to:

- seek out and identify a range of cultural expectations and interpretations relevant to their professional practice;
- understand the social issues associated with particular cultural and international contexts;
- critically reflect on international standards and practices within the notions of good practice of a profession;

The aim to provide culturally congruent health care and multicultural workplace harmony can only be achieved by preparing health care professionals to actively engage in the process of cultural competence through active learning processes (Jeffreys, 2006).

Meeting the needs of culturally diverse students is a growing challenge in academia as well as in the professional workplace and within professional associations. Some of these challenges arise from within the student groups themselves. Health care students will enter the professional education arena bringing with them their cultural heritage inclusive of learned values, beliefs, and behaviours. These are the very values that are powerful directive forces that give order and meaning to peoples thinking, decisions and actions (Leininger, 1995).

Health care has its own sets of values and its own unique culture, reflecting its own cultural style and often reflecting dominant societal values (Jeffreys, 2006). Although increases in culturally diverse students have been noted in higher education health programs such as nursing and medicine in recent times, the values, beliefs and underlying education have been slow to change in accordance with changing student population needs (Munoz & Luckmann, 2005). Ethnocentric tendencies and cultural blindness have been major obstacles to the needed changes in health care education. The ethnocentric responses of health care education programs uphold the beliefs and values that traditionally applied to healthcare education are supreme. The result of this is that the traditional teaching and learning practices are often upheld and are contraindicative to cultural competent education (Jeffreys, 2006).

The teaching – learning process of cultural competence must consider the various philosophies and approaches to learning outside of the traditional practices. Whether the

educator is perceived to be an authority figure, coach, mentor, professional, or member of the health care occupation being taught, all will influence the teaching – learning process (Munoz & Luckmann, 2005). Teaching approaches, therefore, need to be carefully considered and varied in accordance with the individual learning needs of students. This is particularly important where the student group is representative of differing cultural backgrounds (Smart & Smart 2002).

Teaching and learning strategies perceived as competitive fun, for example, can be seen as aggressive and threatening by others. Perceived barriers to learning, mismatches in teacher – student expectations, and poor learning experiences will do little more than hinder the learning processes of cultural competence (Lim, Downey & Nathan, 2004). It is imperative to meet the needs of students if cultural competence is to be successfully delivered within health care education programs. Students representing diversity in age, ethnicity, religion, race, and gender, for example means embracing a broader, inclusive worldview that appreciates all the varying forms of diversity (Jeffreys, 2006).

Despite these complexities, changes, and challenges faced by health care education programs, there is a strong commitment by many to the goal of a culturally competent health care system and the inclusion of culturally responsive curriculum. Any educational setting has the capacity to provide ongoing opportunities for promoting cultural competence, however, the higher education academic setting has the potential to make the greatest impact (Jeffreys, 2006). The main function of the higher education academic

setting is education, and the primary student role is learning, setting the environment for good cultural learning practices (Leininger, 1995). Learning in the higher education academies can be maximised through well-planned, coordinated approaches aimed at maximising cultural competence outcomes (Smart & Smart, 2002).

A planned approach for the delivery of a culturally competent curriculum should be inclusive of four approaches for effective integration of culturally competent health care within the higher education academic setting, having the potential to positively affect the greatest number of student groups (Leininger, 1995).

1. Trans-cultural concepts, skills, and principles integrated within an existing curriculum.
2. Select cultural care modules incorporated within a curriculum
3. A series of coordinated, substantive trans-cultural health care courses with field experiences
4. A major degree program or stream in trans-cultural health care at graduate level (Leininger, 1995).

However, culturally competent learning should not end with the conclusion of the formal education setting (Munro, 2005). Lifelong, ongoing cultural competence development needs to be an essential professional expectation. Lifelong learning principles are embedded into

higher education curricula and, as such are well positioned to commence this ethos (Jeffreys, 2006).

Entry-level higher education offers the greatest possibilities for addressing culturally competent health care within health care programs (Jeffreys, 2006). Such entry-level courses provide the foundation for professional practice and, numerically, these programs have the potential to make enormous strides in cultural competence development because enrolment in these programs is usually greater than in other degree programs (Leininger, 1995).

Health care educators are empowered to make a significant difference by introducing, fostering, and nurturing cultural competence development (Munoz & Luckmann, 2005). Each individual health care academic is empowered to make a positive difference; however, the greatest impact will be achieved through a coordinated, holistic group effort that thoughtfully weaves together health care course components, health care curriculum, and supplementary resources (Papadopoulos, 2006).

Promoting cultural competency in academia requires considerable, sincere effort that must begin with self-assessment. This self-assessment requires the health care academic to systematically appraise the varying dimensions that can impact on the educational processes and the achievement of the educational outcomes (Jeffreys, 2006). Academic self-assessment, can be overwhelming and confronting (Morse, 1999), however the

evaluation of variables that impact on the student – teacher interaction are essential before developing culturally congruent educational approaches (Jeffreys, 2006). At times, health care educators may be unconsciously incompetent in their educational approaches with culturally diverse students. One is unconsciously incompetent when they are not aware of cultural differences or when they unknowingly carry out actions that are not culturally competent (Purnell, 2003). Behaviours, such as cultural blindness, cultural imposition, and culturally incongruent actions can cause cultural pain to others unknowingly (Leinginger & McFarland, 2002). Consciously attempting to implement culturally congruent behaviours and avoiding incompetence is a key component in facilitating cultural competence development among culturally diverse learners (Jeffreys, 2006).

A model for academic self-assessment has been developed by Jeffreys (2006). The model requires that all academic staff involved in the delivery of cultural competence in higher education health care programs self evaluate their suitability to do so by reflecting on the following key questions relating to cultural values and beliefs:

- What are my own cultural values and beliefs?
- What do I know about students' cultural values and beliefs?
- What values and beliefs do I expect from students?
- How do I feel when a student's cultural values and beliefs are different to mine?
- What actions do I take when a student's cultural values and beliefs are different to mine?

- How do / could different cultural values and beliefs affect the student relationship with academics, other peers, and me?
- How do / could different cultural values and beliefs affect the student's cultural competence development, academic outcomes, satisfaction, stress, persistence and retention?
- How confident am I about my cultural knowledge, skills, values, and attitudes when interacting with, teaching, and advising culturally diverse students?
- What is my motivation for engaging in the process of becoming culturally competent?
- What is my level of commitment in developing cultural competence in peers, administrators, students, and myself?
- What are my strengths, weaknesses, gaps in knowledge and skills, values, goals, and priorities concerning cultural competence development?
- How confident am I about learning new trans-cultural health care skills when interacting with teaching, and advising culturally different students?
- How confident am I about performing new trans-cultural health care skills when interacting with, teaching, and advising culturally different students?
- How confident am I that I will actively advocate for cultural competence development in the academic setting?

(Jeffreys, 2006. p. 78).

Embedded in this self-assessment is the appraisal of one's understanding about the multidimensional factors influencing health care students' learning, achievement, retention, success and cultural competence development. Unless health care educators conduct a

systematic appraisal of all multidimensional components, full understanding will not be achieved (Jeffreys 2006). Health care educators must assess their own cultural desire or motivation for engaging in the process of becoming culturally competent (Campinha-Bacote, 2003).

The Clinical Learning Environment

There are many different types of clinical settings; however, all provide significant and varied learning opportunities, particularly those in the health care setting (Campinha-Bacote, 2003). Unfortunately within most health care clinical practicum, student learning is often stifled by the constraints of specific curriculum requirements focusing on physiological learning outcomes and the performance of practical skills (Jeffreys, 2006). Many clinical learning environments provide enormous opportunities for students to learn beyond conventional curricula; however, this is rarely achieved due to the lack of content focus permitting this. A major consideration of student's clinical learning environments should be the exposure students have to the diversity of the health care recipients their clinical learning offers (Purnell, 2003).

Interaction with culturally diverse patients, families, communities, and other health care providers in the clinical learning environment can offer a wealth of learning opportunities for students. However, providing opportunities for students to interact with culturally diverse patients and personnel must be appropriately partnered with cultural competence development as an integral course and curriculum component. Students need to have the

general trans-cultural health care skills, knowledge and values to successfully achieve positive learning outcomes for cultural competence development within the clinical learning environment (Leininger & McFarland, 2002).

Clinical instructors within the clinical learning environment have unlimited opportunities to effectively weave cultural competence development activities throughout the clinical learning experience (Jeffreys, 2006). Clinical instructors must be prepared to be flexible and to adapt learning objectives to the ever changing situation. Because the clinical setting particularly in pre-hospital care, is not 'controlled', clinical instructors must always be ready to expect the unexpected (Tabi & Mukherjee, 2003). Unexpected situations present new learning opportunities for students' professional growth; some of these unexpected situations may be rich opportunities for expanding cultural competence (Jeffreys, 2006). Despite the cultural diversity within the health care setting, the clinical instructor is pivotal in guiding students to new levels of cultural competence development. The clinical instructor can supplement actual clinical experiences with case studies representing different cultural groups, values, beliefs, behaviours, and / or practices (Tabi & Mukherjee, 2003).

Students can also benefit from the awareness that academic staff are also learning and developing cultural competency skills within ethnic communities (Leininger & McFarland, 2002). By reaching out to surrounding communities, community based curricula have the

potential to provide students with a wealth of valuable experiences if accompanied by other substantial curricular components that embrace a wide diversity of cultures (Baldwin, 1999). It is clear that the health profession's literature supports a growing consensus that cultural curricula content should be included in health care higher education programs. Once this is achieved, however, there is a continuing obligation for these programs to ensure competency (Marshall, 2010). A cultural competence curriculum must have a clearly defined evaluation process that includes accountability and evaluation (Jeffreys, 2006).

Many university-based health care programs have developed tools to assess the level of cultural competence amongst their student groups, but reliable and valid tools that evaluate the curriculum are still needed (Marshall, 2010). As discussed earlier in this chapter, the Association of American Medical Colleges (AAMC, 2005) has developed the TACCT. Although developed to evaluate medical schools' efforts to integrate cultural competence content into their curricula, other health professions, such as nursing, paramedicine, and allied health care, can easily adapt and use this evaluation tool (Marshall, 2010).

The following chapter will discuss the methodology used for this study.

Chapter 4

Methodology

When deciding on the methodology to use for this research, I was mindful of the fact that the study was about the lived experiences of paramedics and the community members they served. I believed that the essential underpinning requirement was three-fold.

Highlighting my own voice in this research was, of course, necessary, offering an indication of where my place as a researcher was in this study. The remaining two requirements were the voices, narratives, and lived experiences of both subgroups of participants. The subgroups were made up of the paramedic subgroup and the community subgroup. The critical aspect for me, here, when deciding on a methodology, was to ensure all sets of voices were heard and given justice to.

In March 2005, I attended my first American Education Research Association (AERA) conference in Montreal. I was fortunate enough to attend a workshop and separate presentation by Professor Mara Sapon-Shevin from Syracuse University, New York. Sapon-Shevin is a social justice advocate and has a drive for acceptance, tolerance, equity and understanding of minority groups and others. She is well respected and published in this area with many of her studies and publications focusing on inclusion and otherness.

Since attending that conference much of my work has been inspired by Sapon-Shevin and her capacity to capture the very essence of the 'voice' in her work. Sapon-Shevin's work, her

ability to encapsulate the narrative with fervour, and validity, also influenced my decision on which methodology to use for this study. Many of Sapon-Shevin's writings are not just about the written word, they validate communities, empower individuals, and give voice to the 'others'.

Sapon-Shevin (1999) identifies six principles when discussing inclusiveness in communities. She refers to these principles as 'CIVICS': incorporating courage, inclusion, value, integrity, cooperation, and safety. Whilst her work in this area is primarily aimed at teaching and classroom communities, these same principles are a well-established framework for any organisation that holds a genuine desire to address inequities within minority communities.

It became clear to me that to rely on a single methodology would not serve the study with integrity or enable the data to be captured and related in a meaningful manner. To ensure that no thread of the virtual tapestry would be lost I decided to utilise a mix of qualitative methodologies that best suit the requirements of this study.

This is a qualitative study that is inspired by Sapon-Shevin's work and it draws on a range of methods including narrative enquiry, phenomenology, and ethnographic research. The underpinning data examination is undertaken using a thematic analysis approach. This is discussed further in this chapter.

Ethnography and Narrative Enquiry were specifically chosen as the theoretical and research approaches in this study, as I believed that they addressed the underpinning research questions. This study's research questions investigated philosophical beliefs in specific religious and cultural groups that may impact upon effective pre-hospital care. This study was especially interested in whether improvements to pre-hospital care are possible, and, if so, how and where improvements can be made to the services provided by paramedics to the communities they serve. This study therefore required the exploration of cultural phenomena, which reflect the knowledge and system of meanings guiding the life of varying cultural groups, and of the paramedics. This is a study of people, their ethnogenesis, community and institutional composition, and their religious culture. This study incorporates the voices of paramedics, and their experiences / stories of delivering healthcare to the diverse communities in Melbourne.

Narrative Enquiry was specifically chosen to inform the research questions, as this research method aids in understanding and researching the way people create meaning of their lives as narratives. Narrative Enquiry permitted me as an investigator to not focus on what happened so much as what meaning people made of what happened.

Narrative Enquiry is based firmly on the premise that, as human beings, we come to understand and give meaning to our lives through story (Andrews, Squire & Tamboukou, 2008). Grounded in interpretive hermeneutics and phenomenology, it is a form of qualitative research that involves the gathering of narratives—written, oral, visual—focusing

on the meanings that people ascribe to their experiences, seeking to provide "insight that (befits) the complexity of human lives" (Josselson, 2006, p.4). Narrative enquiry is more than the uncritical gathering of stories. Narrative enquirers strive to attend to the ways in which a story is constructed, for whom and why, as well as the cultural discourses that it draws upon. Narrative enquiry holds immense value in the stories themselves (SooHoo, 2006).

Narrative Enquiry runs deeper than being a research tool and rests on the epistemological assumption that we as human beings make sense of random experiences by the imposition of story structures. This is likely to be especially the case in times of stress and anxiety such as those described by participants in this study. Narratives are not productions of individuals alone, but rather are shaped by social, cultural, and historical conventions. Therefore, the details of story structures and contents reveal much about the social and cultural context in which the story-teller exists. Narrative Enquiry is conducted with the understanding that stories people tell are often at the surface of a more complex underlying story. As such, in this study, Narrative Enquiry draws from a range of theoretical perspectives, including "otherness" as defined by SooHoo (2006). A focus of this study is the coming together of two groups of individuals, often perceived by another as "other".

Instruments

Qualitative Research

Qualitative research involves analysis of data, such as words from interviews, pictures from video, or objects and artefacts. Quantitative research primarily involves analysis of numerical data. As such, qualitative research methodology has been chosen given the

nature of the data to be collected in this research. The data will present areas such as feelings, perceptions, beliefs and opinions; all difficult, I believe, to be ascertained through surveys.

Bouma (2004) states that qualitative approaches offer impressions and provoke feelings, not attainable by quantitative methods which may focus on census type data. He adds that in the provision of feelings about a particular situation, qualitative research seeks to answer the question, 'What is going on here?' The aim of qualitative research is, often, to describe in detail what is happening in a group, in a conversation, or in a community. My research is focused on gathering data of this genre from differing communities by the use of conversation, individual narratives of lived experience, which aims to determine 'What is going on here?'

Denscombe (2010), additionally, argues that qualitative methods tend to be associated with words rather than numbers and are associated with description. He adds that this methodology incorporates a holistic perspective and is better suited to description and dealing with meanings or patterns of behaviour.

Qualitative researchers often use words in their analysis, and they often collect or construct stories about those they are studying.

What narrative researchers hold in common is the study of stories or narratives or descriptions of a series of events. Narrative research usually embraces the assumption that the story is one if not the fundamental unit that accounts for human experience. Within the framework of narrative research, researchers use a number of research approaches, strategies, and methods (Lieblich, Mashiach-Tuval, & Zilber, 1998).

Narrative researchers might also study the impact of particular narratives on experience. Other narrative researchers may code narratives, translate the codes to numbers, and use statistical analysis, or they may analyse the factors involved during a storytelling event as a predictor of some phenomenon of interest (Pasupathi, 2003).

Narrative researchers use narrative throughout their research. Narrative inquiry embraces narrative as both the method and phenomena of study. Through the attention to methods for analysing and understanding stories lived and told, it can be connected and placed under the label of qualitative research methodology. Narrative inquiry begins in experience as expressed in lived and told stories. The method and the inquiry always have experiential starting points that are informed by and intertwined with theoretical literature that informs either the methodology or an understanding of the experiences with which the inquirer began (Clandinin & Connelly, 2000). In essence, narrative inquiry involves the reconstruction of a person's experience in relationship both to the other and to a social milieu, and is the most compelling and appropriate way to study human interaction (Clandinin & Connelly, 2000).

The purpose of the phenomenological approach is to illuminate the specific, to identify phenomena through how they are perceived by the actors in a situation. In the human sphere this normally translates into gathering 'deep' information and perceptions through inductive, qualitative methods such as interviews, discussions and participant observation, and representing it from the perspective of the research participant(s). Phenomenology is concerned with the study of experience from the perspective of the individual, 'bracketing' taken-for-granted assumptions and usual ways of perceiving. Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and subjectivity, and emphasise the importance of personal perspective and interpretation. As such they are powerful for understanding subjective experience, gaining insights into people's motivations and actions, and cutting through the clutter of taken-for-granted assumptions and conventional wisdom.

Phenomenological research overlaps with other essentially qualitative approaches including ethnography, hermeneutics and symbolic interactionism. Pure phenomenological research seeks essentially to describe rather than explain, and to start from a perspective free from hypotheses or preconceptions (Husserl 2009). More recent humanist and feminist researchers refute the possibility of starting without preconceptions or bias, and emphasise the importance of making clear how interpretations and meanings have been placed on findings, as well as making the researcher visible in the 'frame' of the research as an interested and subjective actor rather than a detached and impartial observer (Plummer 1983, Stanley & Wise 1993).

This study utilises Phenomenological methodology as it is particularly effective at bringing to the fore the experiences and perceptions of individuals from their own perspectives, and therefore at challenging structural or normative assumptions. Adding an interpretive dimension to phenomenological research, enabling it to be used as the basis for practical theory, and allowing it to inform, support or challenge policy and action.

As part of this qualitative research approach, focus groups and semi-structured interviews were utilised to gain the stories of the lived experiences of community group members and of paramedic experiences. The focus groups with community groups were conducted by utilising a specific framework of questions as detailed in this chapter. Similarly the semi-structured interviews with paramedics utilised a set of questions relevant to their practice that is also detailed later in this chapter. (Refer interview questions).

Ethnography

This study required me to focus on cultural systems with identifiable features. It is inclusive of the diverse cultural and religious norms within a subsection of the community as well as the cultural systems of Ambulance Victoria's paramedics involved in this study. The study necessarily, needed to include lived experiences and explore the relationship that may exist between all participants. Padgett (2012), states that ethnography adopts a holistic perspective viewing all aspects of the phenomenon as parts of an interrelated whole.

This thesis is also a study of interpersonal relationships amongst community, and family, and the professional relationship between these groups and paramedics. This thesis is also a study of the voices arising from these relationships, as in many instances the lived experiences spoken of are inclusive of a loved one. According to Goodall (2000), ethnography is based on interpersonal relationships. He argues that these relationships gain authenticity from the quality of personal experiences, the richness and depth of individual voices, and a balance between engagements with others and self-reflexive considerations of those engagements.

Tedlock (2000) states that ethnographic research has been enshrined as a method, a theoretical orientation, and, even, a philosophical paradigm. Aronson (1992) adds that ethnographic interviews have become a commonly used qualitative methodology for collecting data, and are commonly used by research clinicians. From the conversations that take place in a therapy session, or those that are encouraged for the sake of researching a process, ideas emerge that can be better understood under the control of ethnographic methodology.

When deciding on the use of ethnography, one of the aspects that I needed to consider was how this methodology was positioned within a study where the focus included health provision. Wolcott (1990) supports the use of ethnography within the health setting. He states that whilst the focus of ethnography is culture, it is well applied in contemporary

settings inclusive of health and communities, especially where the study is of belief systems and religious frameworks.

The more recent innovations in ethnography continue to focus on conveying the cultural experiences of another, particularly in the field of health care according to Hammersley & Atkinson (2007). They argue that ethnography forms the very basis for detailed descriptions of the social world, particularly where conflicts of individual interests seem opposed and social forces are present. Wolcott (1990) supports Hammersley & Atkinson by adding that ethnographic approaches are continually applied in a range of contemporary health care settings, including hospitals and community-based services. He further contends that regardless of the setting, the focus of ethnography remains on culture and is useful to the study of systems of beliefs, religious frameworks, and of worldwide views.

Leininger (1995) adds that ethnographic approaches move beyond the focus of communities, and provide a robust methodology for researching health care professionals within the natural setting, and viewed within the context in which it occurs, as well as studying areas that have not been previously explored.

Further supporting the use of ethnography methodology within the health setting are Griffiths & Mooney (2012). They argue that the central tenet of ethnography is the phenomenon of culture, and that ethnography is an approach that permits the research of

society's culture in order to understand how people's behaviour is shaped and determined by the culture in which they live.

Griffiths & Mooney (2012) cite Palmer's use of ethnography for his 1983 research exploring the cultural influences on occupational behaviour in paramedics. Although Palmer's research was published 28 years ago, it is notable how certain aspects of the study are still relevant today, for example, what type of emergency call is valued and what is seen as inappropriate use of emergency ambulance services.

Narrative Enquiry

'Stories until are secrets' (SooHoo 2006 p. 16).

This study is of the spoken word.

The collection of data for this study is taken from the story telling of the lived experience, incorporating 'otherness'. This forms a necessary aspect to the data as many of the participants are perceived as being different in some way; they are seen as not belonging by other groups who see themselves as the norm and judge those who do not meet that norm. Otherness takes many forms; it could be that the 'other' is of a different race or nationality, different religion or social class, or different sexual orientation. Similar to SooHoo's (2006) definition, this study uses the term the 'otherness' as relating to different cultures and religions than the norm, as perceived by paramedics. This study recognises

that conversations are full of meaning and the need to encourage participants to respond to questions unreservedly about their lived experiences. It was essential to this study that the many layers of these stories were able to be discovered.

SooHoo (2006) discusses the transformation of power' in the narrative. She states that there is a critical source of knowledge in the lived stories of diverse human beings in relationships 'with' and 'to' each other. She also maintains that stories, in the form of personal narratives, challenge the reification of textbooks as the primary source of knowledge. The benefits of this is the first hand exposure of the lived experiences of others; the capacity to view, feel, hear, sense the emotions expressed from individuals. This cannot be achieved from textbooks.

Schwandt's (1997) definition of narrative enquiry draws attention to the 'centrality' of the story, and is concerned with the means of generating data from the stories in a meaningful manner. He reminds us that narrative research strives to preserve the complexity of what it means to be human and to locate these observations of people and phenomena in society. As a qualitative research method, narrative enquiry (Riessman 2007) has been used extensively in the discipline of sociology by social researchers over the past two decades. Riessman (2007) adds that the significance of narrative enquiry, as a method to investigate phenomena important to healthcare has widely been recognised by nurse researchers and has resulted in its continued application as a qualitative research approach. Narrative research methodology permits the researcher to see differing, and sometimes contradictory

layers of meaning, to bring them into useful dialogue with each other, and to understand more about individual and social change (Andrews, Squire & Tamboukou 2008).

This study required considerable focus on multiculturalism, diverse communities and in many instances, the perceptions by the community group participants tied to the disparity of power that exists between themselves and paramedics. The data collection was of personal narratives, stories of lived experiences from these diverse communities. I believe the critical element of this study is the narrative. Whilst I do not reject that knowledge can be gained by texts, it was important for this study to hear the narratives first hand. SooHoo (2006) contends that personal narratives are valuable resources in multiculturalism because we hear stories by the person(s) who are members of specific social groups rather than reading stories 'about' individuals by detached authors.

Semi Structured Interviews

Interviewing is rather like a marriage. Everybody knows what it is, an awful lot of people do it, and yet behind each closed front door there is a world of secrets (Oakley 2009, p. 276).

This study relied on semi-structured interviews to stimulate discussion and generate material for analysis, as the data are reliant on feelings and beliefs which are more aligned with qualitative methodology. I believed that, in order to gain the data with integrity, the participants in this study needed to express their stories in their own words. Whilst it was clear to me that I needed to have questions in place to guide the interviews, I was also conscious of the need to permit the participants freedom to narrate their own stories. It was important therefore that my questions

did not shape or steer participant responses in a certain way. Patton (1990) supports this approach. He states that the goal of semi-structured interviews is to explore a topic more openly and to allow interviewees to express their opinions and ideas in their own words. He reminds us that we interview people to understand what life is like from perspectives other than our own, and that there is a freer exchange between the interviewer and interviewee, thus permitting the interviewee to shape the order and structure of the interview.

Semi-structured interviews also enact a fluid power relationship that enables participants to disclose thoughts, beliefs, and emotions readily, as the power rests with them for some of the time. Enosh and Buchbinder (2005) in their studies reveal that neither party is devoid of power during the interviews; that power shifts constantly amongst all participants inclusive of the facilitator. They add that overall power is indirectly disbursed. This concept felt comfortable for the aims of this research.

The key needs of the community participants were formally identified in this study using semi-structured interviews in focus groups and case studies. In addition to this, sections in this research incorporated recommendations which highlight the potential benefits on health care outcomes for patients should their cultural and religious needs be considered in a holistic approach by pre-hospital health care workers.

Focus groups

My approach to data collection for this study also incorporated focus groups. My overall aim was to create an atmosphere that permitted a range of views and opinions to be conveyed in a moderated setting. When selecting this approach, I was mindful of Liamputtong's (2010) work that clearly indicates that focus groups allow access to research participants who may find individual interviewing intimidating. This approach, according to Liamputtong, is also useful when it may not be culturally appropriate to interview individuals alone. He also suggests that focus groups are particularly valid for studies that incorporate underrepresented and marginalised populations, and particularly suited for research investigating cultural perspectives. It was critical for me to ensure that I was able to meet any of the participants' religious or cultural requirements and was constantly mindful of my own cultural preparedness.

According to Bouma (2004), focus groups combine the strengths of interviewing and observation. He adds that focus groups are used increasingly as a way of learning about public opinion on a variety of issues, and allow a varied range of opinions to be expressed.

Bryman (2004) ascertains that focus groups allow the researcher to develop an understanding about why people feel the way they do. He adds that the focus group approach offers the opportunity of allowing participants to probe each other's reasons for holding a certain view. Further, Bryman (2004) states that focus groups offers the researcher the opportunity to study the ways in which individuals collectively make sense of

a phenomenon and construct meanings around it, and are particularly useful to obtain varied views and beliefs.

Work Examples and Case Studies (Emerging from Focus Groups and Interviews)

To enable this study to encapsulate the essence of the narrative, case study examples were used as presented by the community group representatives. Similarly, narratives in the form of work examples of paramedic practice have been included from the narratives of the paramedic participants. Whilst in many instances, single narratives in response to discussions were pertinent and recorded as such, in some instances I chose specifically to relate these case studies and work examples to give the narrative context. On occasions, I also determined the need to unpack the contents to closely examine individual cases to enable relevance and relationships to other cases.

The stories from the community group participants and from the paramedic group allowed the examination of a number of variables as single instances as well as common phenomena. Stories provided a systematic way of looking at events encountered by both these groups, and allowed the researcher to recognise the overlapping of commonly encountered experiences. The stories were therefore essentially examples of experiences offered by the participants during the focus groups and interviews. This tool also permitted the collection of these experiences in a format that gave access to analysing this information, and reporting the results. This process allowed me as the researcher to gain and report on a greater understanding of what happened as it did, and what might become important to

look at more extensively in future research. Stories lend themselves to both generating and testing hypotheses, and present the information in a more meaningful and enriched format.

Reissman (2007) places case studies in the context of narrative enquiry by stating that case studies produce context-dependent knowledge that is essential to the development of a field or discipline.

Denscombe (2010) states that the use of case studies has become extremely widespread in social research, enabling data to be connected from varied sources, and often brings validity. Babbie (2007) supports the use of case studies as a qualitative methodology, contending that the chief purpose of case studies is descriptive, and particularly useful when anthropologists describe culture or to gain an understanding of the structure and process of social stratification. De Vaus (2004) adds that case studies have been fundamental to the substantive and methodological development of the social sciences. He further states that educational research, evaluation research and organisational research have all made extensive use of case studies to foster their development.

Thematic Analysis

Collection of the data was only one aspect of this study. The challenge was how to interpret the data in a manner that ensured the stories remained rich in content and that the analysis did not dilute them in any way. The ability to determine patterns and trends emerging from the differing lived experiences of both subgroups of participants was essential to this

research. Thematic analysis is a method for identifying, analysing, and reporting themes (patterns) within the data according to Braun and Clarke (2006), and is perceived as a foundational method of qualitative analysis. This methodology also permits the consideration of implications of the 'meeting' of these two sets of perceptions.

Data from the interviews and focus groups were transcribed to form a collective set. Each transcript was then read several times and examined closely to make sense of what was being relayed by participants. Notes were taken simultaneously to record pauses, emotions, and changes in pitch against the narratives.

Coding was then used to deconstruct the data and determine links between the codes.

Axial coding was then used extensively to connect the different codes and organise the data by making connections to categories, themes, and subthemes. Axial coding permits a greater level of abstraction from the data according to Liamputtong (2010). She recommends axial coding, as it allows the breaking down of data into systematic codes, which are then able to be reassembled or reorganised. Axial coding then permits the process of these reorganised codes being collapsed into categories, allowing the emerging of themes. She concludes that axial coding plays a major part in constructing the themes as interrelationships, revealing further subthemes.

Thematic analysis was used throughout the data analysis process as a recognised practice in qualitative research. This involved searching through data to identify any recurrent patterns,

themes, which were then placed into clusters of linked categories conveying similar meanings and usually emerged through the inductive analytic process, which characterises the qualitative paradigm.

Thematic analysis provided the analytic framework but the manner in which themes concepts and categories were managed. This method permitted the systematic working through of the data (narratives) to identify topics that were progressively integrated into higher order themes, via processes of de-contextualisation and re-contextualisation. The analytical process required several stages.

1. Interviews were transcribed into text and the document was formatted so the margin could be used for identifying individual bits of data. This was done to assign line numbers as identifiers for cross-referencing.

2. The text was read, noting items of interest, major themes (macro). This inductive approach to thematic analysis allowed themes to emerge from the data, rather than searching for pre-defined themes. During the first reading notes of major issues as they came to mind were made in order to acquire a sense of the various topics embedded in the data.

The text was then re-read and any thoughts were annotated in the margin. The text was then examined closely, line by line, to facilitate a microanalysis of the data. This also

promoted open coding which identified any new information by de-contextualising bits of data embedded within the primary material. This also enhanced the axial coding process.

3. The text was then sorted as items of interest into proto-themes. This is where themes began to emerge by organising items relating to similar topics into categories. This was a fluid process so categories could be modified, developed and new ones allowed to emerge freely. At this stage keeping the themes as simple as possible assisted the flexibility in the categorisation process whereby any re-ordering of the clusters of categories helped in creating and re-defining the initial themes.

4. Examination of the proto-themes was then undertaken with a focus on gathering the initial definitions arising from the themes. This required a further 'trawling back' through the data examining how information was assigned to each proto-theme in order to evaluate its current meaning. A provisional name and flexible definition was then created for each emerging theme.

5. Axial coding was then utilised by re-examining the text carefully for relevant incidents of data for each proto-theme. This involved re-contextualisation whereby any data were now considered in terms of the categories developed through this analysis. Taking each theme separately and re-examining the original data for information relating to that theme was a vital stage in the analytic process because human perception is selective and the relevance

of data could have been easily overlooked. Furthermore, pieces of data previously assigned to a theme were investigated for contradictory elements.

6. Constructing the final form of each theme followed. The name, definition and supporting data were re-examined for the final construction of each theme, using all the material relating to it. This stage of re-contextualisation focused more closely upon the underlying meaning of each theme.

7. Report of each theme could then be constructed. The name of each theme was finalised including its description and illustration enhanced by a few quotations from the original text to help communicate its meaning to the reader.

I believe that thematic analysis provided me with the capacity to undertake the analysis of the data in this study. Braun and Clarke (2006) indicate that thematic analysis involves searching across a data set, be it a number of interviews or focus groups, or a range of texts, to find repeated patterns of meaning. Liamputtong (2010) acknowledges that thematic analysis allows the researchers to find themes in the data in a way that makes sense.

Ryan & Bernard (2003) believe that without thematic analysis, investigators have nothing to describe, nothing to compare, and nothing to explain. They argue that words are more powerful than numbers, and thematic analysis is a method for identifying, analysing and reporting themes within the data.

The Process / Procedures

Victoria University Human Research Ethics Committee (VUHREC) approval has been granted for this study.

The Participants - Community Representatives

This study relied on two separate groups of people for data: the patient group (community group representatives) (n = 20), and the paramedic group (n = 20). The total number of participants in this study (N=40) was determined by two primary factors. The first factor was directly related to the data collected in the previous Masters study undertaken by Hartley (2007). The data in this study reached saturation levels with 6 community participants, and 6 paramedic participants.

The number of participants in the present study was increased to twenty from each of the participant groups to ensure the capture of the more diverse cultural and religious groups, and to allow for equal representation from both of the participating groups.

The second factor that was taken into consideration when determining the numbers of participants was the manageable amount of data that would be generated from such a diverse group of participants.

The study recruited two separate convenient samples of participants. These were purposefully selected to ensure that they met the eligibility criteria. For the community group representatives, initial recruitment was led by the researcher and was undertaken through community agencies relevant to the specific or religious cultural groups. This was

necessary to ensure that the sample group who volunteered to participate were selected through a process anonymous to me as the researcher, thereby ensuring no bias. This process was also undertaken to ensure that participants did not feel coerced to be involved. There was also the belief that they were more likely to give permission to participate due to the tacit support and trust with the relevant agency, and the implicit trust and support from the agency of the study.

In order to gain a cross and diverse representation of cultures and religions, this study sought to recruit delegates from the following community groups:

- African (Eritrea, Somali, Sudan, Nigeria, Ethiopia)
- Asian (Indonesia, Philippines, Malaysia, China, Thailand, Laos, Cambodia, Vietnam, India)
- Middle Eastern (Iraq, Afghanistan, Pakistan, Iran, Lebanon, Turkey, UAE)
- Muslim / Islam
- Jewish
- Indigenous Australian

Several community groups were approached to act as a conduit in the recruitment process and consisted of:

- Afghan Welfare Association of Australia
- African Australian Welfare Council
- African Welfare Service Organisation of Melbourne
- Australian Jewish Welfare Society
- Australian Lebanese Welfare Association
- Australian Somali Society
- Australian Turkish Association
- Australian Turkish Cultural Association
- Chinese Association of Victoria

Chinese Community Resource Centre
Chinese Community Social Services Centre
Collingwood Turkish Welfare Association
Diversity Connect International - Melbourne
Ethiopian Community Association in Victoria
Indigenous Social Justice Association - Melbourne
Iranian Society of Victoria
Iraqi Welfare Association
Islamic Council of Victoria
Jewish Community Council Victoria
Kurdish Association of Victoria
Somali Community of Victoria
Somali Digil and Mirifile Association in Australia
Sudanese Community Welfare Association
Victorian Arabic Social Services
Victorian Aboriginal Health Service
Vietnamese Community in Australia - Victoria Chapter
Vietnamese Welfare Resource Centre

These agencies were approached to assist with calling for volunteers who met the inclusion criteria, and were chosen to ensure a broad representation of religious and cultural groups. The criterion was that either they or a family had utilised the services of Ambulance Victoria in the previous five years with an even mix of gender. The assistance of these agencies was originally sought via mail correspondence outlining the focus of the study and the inclusion criteria. This was later followed up by phone contact by myself. This phone contact enabled confirmation of receipt of the letter, and also permitted the opportunity for a less formal introduction and allowed any of the community groups to convey any questions. In some

instances, the request was required to be presented at the organisation's committee of management before the call for volunteers could be made.

Seven focus groups were conducted with the community representatives, with consideration given to cultural and religious diversity ensuring broad cultural and religious responsiveness. This required that some of the focus groups were gender specific, and others were respectful of preferences for cultural separateness. In all instances, the focus groups were undertaken at the location requested by the focus group members, usually in the offices or community house location of the community group body that assisted with the recruitment.

All twenty interviews with the paramedics were undertaken in places most suitable for the interviews, with an even mix of private homes of the paramedics who were off duty, and in the branch locations of those paramedics who were on roster. Interviews undertaken at branch locations were conducted in private office locations.

The researcher, to assist with recruiting volunteers, approached these community representative groups with differing cultural and religious backgrounds. These agencies then assisted in selecting participants based upon the inclusion criteria; however permission to proceed was not required from these organisations, as the agencies, as a third party could not provide participant permission.

These community agencies by means of their usual communication processes, including notice boards, newsletters, and general announcements, undertook the call for volunteers for this study. For those members of the community who responded with a desire to consider participation, a discussion was then held with them individually to determine an appropriate venue, date and time that was convenient to all. All prospective participants were provided with full disclosure information sheets and the opportunity to have any questions answered. They were then invited to sign the consent form.

There was some potential for bias due to the possibility of only community group members who had negative stories to present in relation to their use of the ambulance service choosing to participate in the research. This potential for bias was minimised by ensuring that all correspondence inclusive of the information to participants was generalised, and incorporated no language, which suggested that only negative experiences would be of interest. The only inclusion criterion was the use of the service in the previous 2 years.

The process described above seemed to be relatively straightforward to me, although what I was not prepared for were the inevitable delays in the majority of the community agencies responding to my requests for recruiting assistance. I had envisaged that letters would be sent out in the first instance and, within a day or two, emails would commence rolling in. I also believed that my phone would commence ringing from all the agencies displaying overwhelming enthusiasm to take part. For me, the lack of response was confronting and concerning. I wondered at the time if the data from the community representatives was going to be possible to

obtain. Despite constant reassurance from my supervisors, I was definitely alarmed. After several weeks had passed I commenced follow up phone calls and emails to ensure that my original correspondence had been received. In most cases, I discovered that the delay in responses had nothing to do with lack of interest, or otherwise, in my study; it appeared quite the contrary. It seems that even these small community group agencies, mostly run by volunteers, have their own internal mechanisms in place by means of correspondence being referred to the next committee meeting for action. The wait continued, as did the delays. I have never thought of myself as an impatient person, but perhaps I am.

Slowly, over many weeks (a veritable brief moment in time in research my supervisor advised) the responses were forthcoming, and focus groups were commenced for some of the community groups. As for others, considerable negotiation was involved, as the community agencies expressed concern about possible repercussions against not only the agency itself, but also, more importantly, members of their relative communities. I found this a surprising response, yet I should not have. My own Australian ethos, influencing my expectations of responses, was the very essence of 'otherness'. On reflection, many of these community groups view themselves as powerless against authority; they are minority groups, some of which have significant fears of government agencies for very sound reasons. The concerns expressed by the community agencies are addressed in more detail within chapter five. This has been done intentionally, as I believe it holds more relevance and context in that section given the content presented.

The original intent was to hold small focus groups of three or four people, taking into consideration a balance of mixed gender and potential cultural or religious conflicts. However, on arrival to some of these focus groups, the number had grown considerably, as a snowball effect had occurred through the communities. I thought this was a clear statement in itself; people wanted to be a part of this study; they had a story to be told and wanted it to be heard. This meant, though, that on each of these occasions, there was considerable time spent at the beginning of the focus group to ensure informed consent was obtained.

These group discussions facilitated data collection and case studies via the individual narrative story telling (SooHoo S., 2008) that assisted in identifying and clarifying specific religious and cultural needs of the Australian community and their lived experiences with the use of Ambulance Victoria. The groups were asked about their experiences with using the ambulance service. This set the topics for discussion under guidance from me as the researcher. The topics included the reasons that the ambulance service was required, the gender of the paramedics who attended, consultation of the paramedic crew with the patient or family members relating to specific cultural practices or requirements, satisfaction of the service, and recommendations. The group members were also able to develop the topics and raise additional topics considered important, such as whether they would utilise the ambulance service again.

These discussion groups were audio taped following approval of all participants. All participants in this project were de-identified and given a code to enable accurate transcription.

Transcriptions were not made available to people not associated with the data analysis and

interpretation components of this project. This was inclusive of the community agencies, although in some instances representatives of the agencies self-recruited into the study after meeting the inclusion criteria.

The discussion groups were guided by ground rules established prior to any discussion. Ground rules focused on the freedom to speak, confidentiality, and the rights of non-disclosure. This was important for the participants, as many of them had come from a background where 'authorities' had treated them harshly. This specific issue will be discussed in more detail later in this chapter, particularly in relation to government agencies and fear of loss of financial benefits.

As indicated earlier in this chapter, the focus groups were run as semi-structured interviews, hence offering a series of questions specifically designed to evoke open discussions and elicit responses for this study. It was important for the integrity of the data that all focus groups be asked the same set of questions. It is noteworthy, that the order in which these questions was delivered varied as directed by the conversations of the group.

The length of time that the focus groups ran varied considerably, although there was no apparent reason as to why this was the case, apart from some of the groups having a more robust discussion emanating from all or some of the questions. Focus groups for community representatives were held to facilitate a greater sense of wellbeing and ease given group participation. The briefest focus group meeting was of sixty minutes duration, however several

groups ran for almost 2 hours, with continued general discussion beyond conclusion of the formal group.

Interview Questions – Community Group representatives.

The Interview questions that were included in the focus groups were:

1. Tell me about the reason for the ambulance call, and who made the call (Assessment)
2. Tell me whether or not you felt that the paramedic crew recognised any of your religious or cultural needs or requirements. (Needs met)
3. Tell me about any of the features of the paramedic attendance that you liked in relation to their recognition of your religious or cultural needs? (Needs met)
4. Were there any aspects that related to your specific religious or cultural needs that you believe were not met. (Needs not met, with reasons)
5. What would you have preferred for the paramedic crew to do? (Preferences with reasons, recommendations)
6. Tell me what you would advise or comment on, to other members of your community about your experiences with the ambulance service? (Impressions)

The above questions were trialled in a pilot study as part of a Masters by Research by Hartley (2007). In this research these questions proved to be highly successful in obtaining the narratives required for rich data collection specific to the study's requirements. Whilst this PhD participant group was more diverse than that in the previous Masters study, the underpinning research questions were identical.

Although not central to this study, some specific areas of interest that were incorporated into the focus group discussions aimed at identifying and clarifying beliefs and values to instigate discussion for each of the religious or cultural groups included:

Spiritual / Pastoral Care
Psychiatric Illness / Counselling
Medical Consultation
Life after Death / Fate
Religious Observations
Gender
Childbirth
Death and Dying
Transfusions / Blood Products / Organ Transplants – Donations
Elderly
Suicide
Drug Administration

Specific matters pertaining to the above were not asked of the community participants in terms of their individual health histories. These issues were raised from the questions asked to the group, in that they may highlight the general differing needs of the varying religious and cultural groups within the same theme.

It is important to note that for this study, participants were not required or encouraged to discuss their own personal health or illnesses. The focus of this study was to collect research data on the community's religious and cultural needs as they relate to the use of Ambulance Victoria, and how they may differ from perceived Australian norms.

The above focus is supported by the principles outlined in the Australian Government National Health and Medical Research Council (NHMRC, 2006) 'Cultural Competency in Health: A Guide

for Policy, Partnerships and Participation’. The policy contends that a culturally competent health system:

- acknowledges cultural competency as integral to core business;
- recognises that consumers move around the health system and that the whole system should support cultural competency and aspire to a seamless approach;
- resources the capacity and policy infrastructure to foster culturally competent practice;
- defines and disseminates information on core cultural competencies across the system;
- facilitates consistent and culturally competent research and data collection across jurisdictions to improve knowledge and monitoring;
- provides for increased utilisation of language services to support culturally competent practice;
- identifies a skill set for culturally competent practice and supports health organisations and individuals to value and achieve culturally competent practice;
- encourages a broader view of culturally competent practice through the promotion and marketing of health departments and health services, the built environment, and institutional respect for cultural traditions (eg diet, social customs); and
- supports community development as a key strategy to increase cultural competency for healthier living and environments (Cultural Competency in Health: A Guide for Policy, Partnerships and Participation, NHMRC, 2006, p.31).

These focus groups proved to be the most challenging, aspect of this study, but not in a way that I could have predicted. I instigated the most challenging component of the focus groups for me, by me. I had completed most of the paramedic interviews first, and heard their stories. In some ways, I related to them. I recall that, during these interviews, the narratives from the paramedics were so robust with Australian values and expectations. Throughout many of the focus groups I also felt that, at times, it was my own Australian values and beliefs that impeded

the process. I was consistently mindful of this, but none more so than during one of the focus groups with an African group of women.

The African group of community representatives posed the most challenges for data collection. Due to a lack of response from the 'official' community groups representing this particular region, I chose to request permission to attend an established self help / social craft group for African women who meet on a weekly basis at the local primary school. The group fluctuates in size from week to week, is very informal, and is led by a school representative who facilitates more than constructs or leads.

The meeting of this group and me was primarily to take the form of a focus group, where I would present the questions and record the responses for data collection. The challenges presented, however, were unexpected and, in themselves, posed some insight for me as to my own cultural understandings, or misunderstandings, of this cultural group of women which was steeped in tradition.

The group had not been informed of my attendance and, on arrival, I as the facilitator, gave the reason for my being there. Initially, I was able to ascertain that of the nine women that were present, there were representatives of the Somali (2), Sudanese (2), Eritrean (1), Ethiopian (1), Djiboutian (1), and Nigerian (2), communities. As the group had not previously been made aware of my attendance that day, I delivered my brief as to why I was there and offered to return at another time should they prefer to discuss my presence

amongst themselves or their family members. All participants in the group agreed to continue.

After the initial challenge of my attendance not being forewarned to the group had been addressed and resolved, a further challenge was to arise, this being that there were language barriers resulting in a considerable amount of time being required to explain and obtain consent. Within the group, the only person who had a good understanding of the English language was their usual facilitator who was used as the sole interpreter. Within the group there were three subgroups pertaining to language, so translation was often required to go via the interpreter to one member of the group, then reinterpreted to another.

A lengthy discussion ensued around the reason for my presence, as I wanted to ensure that all participants had a clear understanding of the basis of the research as well as providing informed consent. While all participants agreed what was surprising to me was that they all refused to sign the consent form. On further investigation via the facilitator, she explained that this was most likely due to the fear of official paperwork of any description being traced back to Centrelink* or any other government agencies. The participants also confirmed this fear of loss of entitlements.

Initially, most of the participants presented as being reserved, unsure, and even fearful of my being there. One of the participants made it clearly known that, whilst she had no

* Australian Federal Government agency delivers a range of payments and services for retirees, the unemployed, families, carers, parents, people with disabilities, Indigenous Australians, and people from diverse cultural and linguistic backgrounds.

objection to the focus group taking place, she was happy to be in attendance and observe, but preferred not to participate.

I was feeling somewhat anxious, picking up on non-verbal cues of anxiety, fear, trepidation and reservation from this group of women. These women were clearly giving me a strong indication that they did not want me prying into their lives, their families, seeing me as an authority figure. They resented my interference with their social gathering despite all the time and energy I had expended getting the information across to them.

I considered aborting the focus group; it seemed to go against many of the principles I have developed as a researcher about informed consent and willingness as a participant to be involved. I looked at these women and recalled all the comments made from the paramedic group about the African culture, their misinterpretation of verbal cues, the judgments made of their nationality. The silent question arose as to my own judgments, my own expectations of this group, my values not being met, my non-verbal interpretation based on Australian standards. Was I really as culturally unprepared to undertake this task as was the paramedic subgroup? Were my own Australian values clouding my reasoning? This became the critical turning point for this focus group. I had to remove any of my own preconceived notions of this group of women; I had to consciously put aside my Australian values that had been steeped in my psyche, and reject years of my own Australian and privileged cultural values and preconceived notions of how people 'should' respond. In clearing these perceptions from my thinking I began to wonder what had brought these women here? To

this group via their different nations? Why here? Why this suburb in Melbourne? What had these women been exposed to, what had they seen? Has this had any impact on they way they bonded together as a group, how they viewed me, how they, ultimately, relatde on all levels?

The conversation was somewhat fragmented due to having to use the facilitator as the interpreter. However, a rhythm soon developed, and the conversations began to flow like the 'sounds of an African drum beating'. As the discussions progressed, the women, themselves, seemed more relaxed, more at ease, and more willing to participate. Their body language did not alter the entire time the focus group ran, they still appeared 'closed' and 'disengaged'; however ignoring these Australian standardised non-verbal cues, other indicators gave me the impression that in fact this was not so. Open verbal communication, constant vocal engagement, participants interjecting to get their voices heard were all indicators to me that these women welcomed the opportunity to get their stories heard, and heard they were. The woman, who with such determination in the early stages of the focus group made it clear that she did wish to participate but observe, soon became an active and vocal participant, interjecting, contributing, even appearing agitated waiting for the chance to jump in to offer her next viewpoint.

In conclusion the women involved in the focus group appeared to have achieved something, their narrative, their stories, their voices on a common subject were noted, detailed, recorded. Most importantly for them, a knowledge that they had contributed to an

academic process that will hopefully bring about improvement for their community. As I was about to leave, I was invited back to the group any time. I left feeling somewhat humble, pleased with the achievements, and, most importantly, the opportunity these women gave me to obtain just this tiny piece of insight into their culture.

The next two sets of focus groups were as diverse from each other as one could imagine.

The first set was with Asian community representatives, incorporating those from Indonesia, the Philippines, Malaysia, China, Thailand, Laos, Cambodia, Vietnam, and India. I was mindful of the fact that within this 'group' there were, in fact, significant cultural and religious differences. This was not dissimilar to the second set, being representatives from the Middle East inclusive of Iraq, Afghanistan, Pakistan, Iran, Lebanon, Turkey, and the United Arab Emirates.

From very early into the focus groups with the Asian representatives, it became clear to me that I needed to change my approach to enhance the process of the focus group. This was not a case of 'one size fits all' in the approach that I was making. This is a study about cultural diversity; meeting, recognising, acknowledging, and respecting differing cultural and religious values and beliefs. I was asking them about their lived experiences with Ambulance Victoria as they related to cultural and religious requirements. I had to be as culturally and religiously prepared as possible to ensure the efficacy of these focus groups given the nature of the conversations. I found this daunting in the first instance. If I were

not able to display cultural and religious sensitivities, then this would surely hamper the process.

It suddenly occurred to me that perhaps being an 'expert' on cultural and religious sensitivities across the diverse Melbourne community was not required of me by them. Merely an acknowledgment and respect of them was enough. I found this to be the case in these focus groups, to my relief.

The Middle Eastern set of focus groups was different again. I found it interesting that although the set questions were asked of each of the groups, the group dynamics were significantly different. In hindsight this should not have been a surprise. Of course the dynamics within the Middle Eastern groups was going to be different to the Asian set, and equally different again from the Indigenous Australian group and that of the Jewish group. These people came from diverse nations, and had considerably different lived experiences. Some chose to come to this country as a life opportunity, others were forced from their country of origin for humanitarian reasons. Irrespective of this, their rich cultural and religious ancestry has shaped who they are today, and as such presented this way in the focus groups.

The easy part for me was to recognise this; the more challenging aspect for me was to ensure that I could facilitate these focus groups to gain the outcomes required. I believe that I have achieved this. In previous focus groups that I have been involved in, it has been

customary to thank the participants for their involvement on conclusion of the group meeting. It has been my experience that participants tend to acknowledge this by a nod of the head and / or a handshake on departing. During this study, in all instances members of the focus groups thanked me for the opportunity to tell their stories, to share their experiences. Participants were very vocal throughout the focus groups, with conversations on many occurrences still robustly occurring after the focus group had ceased where I was invited to make contact at anytime in the future should I require any further data. In some instances focus group members applauded me at the end of the group for addressing issues that had been of concern to their communities for some time.

Emotions were often at the forefront of the focus groups. For many their experiences with pre-hospital healthcare in Victoria has had profound impacts on either themselves or a loved one; in some cases the wounds are deep and have longevity. Some of the stories that were told were hard for me to hear, and at times caused me considerable distress. Whilst I believe that this was not shown at the time by me, there was the need to offer empathic responses, which did not cloud the data presentation. The stories that did cause me the most anguish arose from those that told of lived experiences prior to coming to Australia, and were not representative of the narratives arising from experiences with Ambulance Victoria.

The Participants – Paramedic Representatives

The second group of participants in this study was the group of the paramedics. Their knowledge of cultural and religious requirements of their patients, cultural preparedness, and experiences in dealing with a community as culturally and religiously diverse as is in Victoria is at the very centre of this study.

Paramedic units were approached for volunteers who held a desire to participate in this study. For those paramedics who volunteered to participate, a discussion ensued to determine an appropriate venue, date and time that was convenient to all. All prospective participants were provided with full disclosure information sheets and the opportunity to have any questions answered. They were then invited to sign the consent form.

The paramedic group was comprised of paramedics from within Ambulance Victoria who met the inclusion criteria. There was an even mix of men and women with the inclusion criteria being primarily working in geographical locations known to have high-density representations of varying cultural and / or religious groups. The paramedics were chosen on the basis of:

- a) recent graduates – less than five years experience (n = 10),
- b) more than 5 years paramedic experience (n = 10).

This was done specifically to capture both modes of paramedic graduates. The paramedics with less than five years experience will have had some clinical exposure since graduation and would

be more likely to be representative of undertaking their undergraduate studies within a university setting. The paramedics having more than five years experience will have had significantly more time exposed to the diversity of patient care, and will have undertaken their studies under the post-employment model of employer (service) provider education.

The paramedics were interviewed individually at a time convenient to themselves, given availability and shift work requirements. The interviews were audio taped following approval by each of the participants. Each of the interviews with the twenty paramedics were of approximately 1 hour in duration. Interviews were held with the paramedic group as it was considered that paramedics were less likely to feel ill at ease than community group members. Individual interviews also accommodated paramedic participants' work patterns.

Interview Questions – Paramedic Representatives

As with the community group representatives, set interview questions were formulated to meet the requirements of semi-structured interviewing. Again these questions were designed to evoke open discussions, and elicit responses appropriate for the data collection of this study. The questions asked of the paramedic participants were:

1. Tell me about the education / training you have undergone, either during your training, or in service education programs, that specifically related to cultural or religious awareness.
2. Tell me about any call out you have gone to that has involved you attending a patient where you have noted them being from a different religious or cultural background to yourself.

3. Tell me about the feelings you had at that time as they related to your attendance and treatment as a paramedic.

The questions above were trialled in a pilot study as part of a Masters by Research in 2007.

Beyond the focus groups, demographic information of Ambulance Victoria paramedics inclusive of religious and cultural backgrounds was attempted to be obtained to gain a clearer picture of the religious and cultural backgrounds of the service's workforce. Further, a documentation analysis of Ambulance Victoria was undertaken to review the ambulance service's policies in relation to cultural preparedness, and the extent that they are mandated in continuing education programs, or influence the institutional culture.

The demographic data of the paramedic group of participants has been intentionally placed within the data analysis section of this thesis in chapter five. This has been done to validate the data, personalise the narratives and ensure the stories have context. A table detailing the paramedic participants' demographics has also been included in chapter 5.

This study does not intend to address issues pertaining to the diverse backgrounds of paramedics. The research focus is intended to be more reflective of how paramedics deal with the religious and cultural needs of their patients.

A third and final cluster of information presented in this thesis was obtained from my study tour as discussed in chapter two. Face to face discussions were held with universities offering paramedic programs throughout the United Kingdom, the United States of America, and Canada. Similar discussions were also held with senior operational and education managers of ambulance services in these three countries. Participants of these discussions were aware that the purpose of these discussions was not to collect data, but to reflect on international practice. The information obtained from these discussions is presented in the form of a travel diary of travel of a reflection of international practice to inform my methodology and substantiate the relevance of this research from an international perspective.

The next chapter will present the data findings from the paramedic group participants and discuss their experiences in dealing with patients who are of differing cultural and religious backgrounds to themselves.

Chapter 5

Data Findings Paramedic Subgroup

Introduction

As indicated in previous chapters in this thesis, the focus of this study has come about by my own interest in the potential benefits a holistic approach can bring to patient care in the pre-hospital setting, with a particular emphasis on acknowledging patients' cultural and religious needs. This thesis has already established, through a review of the literature, that many other medical and allied health disciplines have incorporated such an approach as routine in dealing with patients, and documented the improved outcomes for patient and healthcare practitioners alike.

The literature review also discovered there was a lack of research literature that was specifically relevant in the cultural and religious preparedness of paramedics in the pre-hospital setting. This next chapter presents the data findings of the paramedic subgroup and identifies themes arising from this data specifically in relation to their education and training relating to cultural and religious preparedness. This chapter also presents the paramedics' individual experiences in dealing with patients of differing cultural or religious backgrounds to themselves.

It was easier to collect data from the paramedic subgroup than it was from the community subgroups, which will be discussed in the next chapter. Paramedics, by nature, are

passionate about their careers and eager to talk about all aspects of the work they undertake. When designing the questions that guided the semi-structured interviews I was conscious of the need to ensure that paramedic participants viewed these questions through a paramedic practitioner lens rather than interpreting their experiences through a purely cultural or religious lens. I was mindful of the need for this study to ensure that the paramedic participants' responses were from their own professional perceptions without unintentionally shaping their replies by preconceived notions of what they thought their responses should be.

The interviews of the paramedic participants posed some challenges. On the one hand my own professional background as a paramedic of 28 years gave me credibility with this group of participants. Being seen as an 'insider' of the organisation had the probable outcome of automatically placing the paramedics at ease. They would know that I have an intimate understanding of their roles, functions and the organisation they worked for. They would also know and trust that I had no hidden agenda or was trying to extract answers from them that could be misinterpreted. On the other hand, my own background bringing the advantages that come with credibility, also has its disadvantages. I was constantly aware of the need for the voices of the paramedics to be clearly heard without any preconceptions of what was being said by them being clouded by my own past experiences.

This, in turn, presented a significant challenge in analysing the data without losing the very rich nature of the paramedic voices. The paramedic subgroup, in general, was initially

perplexed about the questions being asked. They were hesitant in their responses. They needed time to gather their thoughts. Some even commented that they are not used to being questioned on areas of their profession that were not directly clinically related. But as the flow of questions began to enable them to relate the topic to their daily work, they had a great deal to say. Capturing the dialogue, the narrative, their stories became a primary consideration in how I presented the outcomes of the interviews, and this chapter represents an attempt to retain their voice in the text.

Group Demographics

The paramedic subgroup comprised twenty (n=20) paramedics, the diverse demographics of which fulfilled the inclusion criteria. The interviews with this subgroup were conducted on an individual basis, either in my office or at branch locations where the paramedics were working. Fortunately at no time did a paramedic get a call out midway through an interview, ensuring the data collection was not compromised.

The subgroup demographics comprised an equal mix of gender (ten (n=10) male, ten (n=10) female). The male group comprised six (n=6) participants who had graduated greater than five (5) years, the longest being 17 years, and the average number of years since graduation being 9.8 years. The four (n=4) remaining participants having less than five years since graduation comprised an average of 3.2 years. Of the male group there was an equal mix of participants relating to educational background. Five (n=5) participants had undergone their paramedic education under the previously known DAPS (Diploma of Ambulance

Paramedic Studies) program, whilst the remaining five (n=5) had received their paramedic education through the university higher education sector.

The female paramedic participants comprised an equal mix of those who had been working greater than five years since graduation, and those less than five years. The mean average of those greater than five years was 9.2 years clinical experience, whilst the remaining cohort had an average of 2.8 years on road experience since graduating. Again, there was an equal mix (5/5) of DAPS graduates and those who had received their degrees via university education.

Paramedic Group - Demographics

Gender	Participants	> 5 years	< 5 years	University	DAPS*
Male	10	6	4	5	5
Female	10	5	5	5	5

* DAPS = Diploma of Ambulance Paramedic Studies (as opposed to higher education degree)

All participants in the paramedic subgroup had extensive exposure to patients of different cultural and religious backgrounds from their own. Of the twenty (n=20) paramedic participants, eighteen (n=18) had worked predominately in the west of Melbourne, within the boundaries of Sunshine, St Albans, Keilor, through to Epping and Northcote. One (n=1) participant had worked predominantly in the inner south (Caulfield) and the remaining participant worked mainly in the outer west, in Werribee and Hoppers Crossing. All these

geographical locations have a higher representation within their communities of cultural and religious backgrounds other than Australian / Anglo-Saxon.

Participants' responses are likely to be influenced by their educational background, hence it was important to note the educational experience each had encountered. Historically paramedics in Victoria had been trained by their employer as a post-employment model of education within the vocational education system, similar to the apprenticeship model that still exists today. Over the past decade paramedic education has moved into the university sector under the realms of higher education. This transition was completed some three years ago resulting in the current model of entirely higher education degree graduates entering the paramedic workforce. As this is now the only way to obtain a paramedic position, it was important to delineate the educational backgrounds of the paramedic participants given the recent emphasis placed on educational input relating to culture and religion during their education. That is, it is in the educational background of paramedics that one would expect to receive the necessary knowledge and 'sensitivity' relating to such issues as cultural preparedness. It is the vehicle by which authorised professional knowledge is conveyed.

It is for this reason that the focus of this research relating to paramedics' awareness of cultural and religious issues pertaining to patient care is around the social variable of their education. Whilst acknowledging there are many social variables, such as class, ethnicity, gender, sexuality, and wellness, just to name a few, that may influence participants'

responses, given the limitations of this single thesis, and the research focus, education is seen to hold most relevance.

In recording the dialogue from the paramedic subgroup, it is important to note that it was the diverse nature of the transcripts that interested me. That is it was important for me to relay the intended meaning of the transcripts by the paramedics or what their narratives can be read to mean. Whilst I speak from my authority, I was conscious of the need to ensure that in this research none of my interpretations or authority was superimposed into the transcripts. Throughout the paramedic subgroup narrative I have removed the non-relevant vocabulary, such as double narratives, ums, ahs etc., ensuring a smoother flow of the narrative without the loss of any meaning, interpretation, or content.

Paramedic Education / Training

All participants were asked about education or training that had been delivered, either during their initial qualification or as part of in-service continuing education programs that related specifically to cultural or religious awareness. Included in the responses were multiple themes pertaining to their education as well as perceptions of the need for cultural or religious preparedness within their work as paramedics.

The next section provides an overview of the need for paramedics to have a developed cultural lens when working with their patients, their personal narrative of experiences, and educational input relating to cultural and religious preparedness.

Shannon, a paramedic of three years advised that she believes that paramedics need to be aware of her patients' cultural needs to assist in times of communication difficulties:

'We ought to be aware of cultural needs, that sometimes there may be some communication difficulties, but the interpreter service was always available to assist.' (S L13)

Similarly, Brian, a paramedic of five years standing indicated that high acuity cases such as a cardiac arrest where communication with family members can be critical, the patient's cultural differences for him can be challenging:

'The ones that really stand out would be the quite strenuous cases, where it might be a cardiac arrest where there is no option of communicating in English.' (B L27)

Not unlike his colleagues Brian and Shannon, Scott, a paramedic of 17 years also indicated that communication seems to be the key for him in understanding his patient's cultural values:

'I have undertaken language studies to help me better accompany patient groups that I had been working in, purely to be able to break down some of those cultural language barriers.' (S L165)

Scott's response was not atypical. When asked about cultural preparedness or awareness, many of the paramedics responded that the cultural and religious issues they were facing within their work were mainly confined to language or communication barriers. The specific needs of their patients, as they relate to individual culture or religion, did not appear to be a consideration when discussing cultural or religious issues pertaining to the care of their patients.

For some paramedics involved in this study, an understanding of meeting patient's cultural needs was bound by the ability to communicate in that patient's native language. The need for communication outweighed a desire to have a greater understanding of the centuries of cultural or religious richness that shaped the very person they were treating. Themes suggested that a paramedic's understanding of cultural and religious awareness related to being able to obtain a clear and concise medical history of their patient's in the English language. Such an understanding does not take into consideration that the cultural and religious requirements for each patient are strongly aligned with feelings, emotions, and, sometimes, centuries of entrenched rituals which go much deeper than language and communication.

Throughout Ambulance Victoria, the educational background of paramedics is still split. Although all paramedics undergo continual professional development within the organisation, paramedics' undergraduate education will differ. Paramedics will have either undertaken a post-employment in-service qualification at Associate Diploma level, similar to

the apprenticeship model, or will have completed their qualification pre-employment by undertaking a Bachelor Degree at university. When asked about their content within their respective undergraduate programs, the responses were consistent irrespective of the two modes.

Sarah, a paramedic who qualified two years ago commented that she was offered no educational input that related to cultural or religious preparedness either as an undergraduate student or in-service education:

‘There is certainly not the education on this area offered, certainly not in my initial education, and not in any of the PDP (in service) training held in my time as a paramedic.’ (S L71)

Nathan, a paramedic with three years experience, echoed Sarah’s comments by revealing that he also could not recall anything in his education that related to cultural or religious issues of patient care:

‘Looking back now it would have been obvious if I have, if I had have received some training, there was nothing at all.’ (N L41)

Whilst Marcus a paramedic graduate of nine years experience commented that he could not:

‘recollect any, any lectures that would have included any of these issues.’ (M L11)

Further, Stephen, a paramedic graduate of eight years, included in his comments that he could recall subject content relating to sociology, there was nothing he was exposed to either at university or in-service that related to cultural or religious care:

‘Not that I can recall, there is nothing I recall, no training at all. At university there was some subjects that related to sociology and that sort of thing, but nothing related to cultural diversity. Actually, when I think about it, there has been nothing offered by the university or the service that deals with any sort of cultural issues pertaining to our care of the patient.’ (S L12).

Additional responses included George, a paramedic of 12 years, who stated:

‘In my initial training, I can’t recall anything that was directed specifically to the needs of those people.’ (G L15)

Further Martin, a paramedic of four years remarked also that he could not recollect any subject matter within his education that assisted him in developing cultural or religious sensitivities:

‘I actually can’t recall anything at all; it was such a long time ago. I have had nothing related to cultural diversity training in my whole time as a paramedic. It is talked about sometimes,

over the years, I recall it is mentioned as something that is needed, but nothing ever happens.’ (M L11)

Responses appeared to indicate that the common theme was that paramedics in Victoria received limited or no education, either during their initial education, or via continuing in-service education programs, that prepared them for dealing with patients from differing religious or cultural backgrounds to themselves. This lack of educational input relating to cultural or religious preparedness may have led to paramedics within Ambulance Victoria being ill prepared to deliver effective patient care where cultural or religious issues for the patient are a central need. Paramedics learn their craft from either of the modes of educational program outlined above, however, with a lack of content relating to cultural or religious needs of patient care, paramedics in Victoria have not been able to effectively develop a socio / cultural lens.

Overall, responses from the paramedic participants indicate that paramedics recalled a complete lack of curriculum content in cultural or religious preparedness at all levels of paramedic education. As a corollary it can be typified that paramedics receiving either minimal or no education relating to cultural or religious preparedness may have led to a lack of knowledge of paramedics in Victoria relating to cultural or religious issues pertaining to their patients’ needs. Further, this may have led to a generalised view by paramedics of nationalities and cultures, more often derived from personal experiences and childhood exposure. In addition, it may have also led to homogeneous attitudes being formed by

paramedics to fulfil the gap relating to culture and religion caused by the lack of curriculum content.

When discussing their education about culture and religion, the paramedic participants were very quick to respond. It almost appeared like any delay in a response would indicate a lack of knowledge. Paramedics, by the nature of the work they undertake, are quick thinkers and decision makers; this also forms a strong part of their education. Delays in clinical decision-making can have considerable consequences for patient outcomes, so it is not surprising that participants in this subgroup responded in such a rapid fashion. Another potential explanation for this is that their responses may have been connected to a deeper sense of knowing that there are inherent issues within the system relating to cultural or religious care of their patients that they have either witnessed or experienced over the years of their employment.

Continuing with the discussion around their educational input that incorporated cultural or religious preparedness, Jason, a paramedic of four years revealed that he could not recall anything that related to this in his education:

‘Throughout this entire time we probably had about an hour or so on different cultures; it was a long time ago, I recall nothing specific.’ (J L13)

Tina, a paramedic of 11 years experience, stated that she received some minimal education relating to cultural preparedness by recalling:

'Maybe a total of maximum of five hours over the three years, there would have been no more. Even then, it was very general, it was all about communicating with non-English speaking people. Other than that, nothing at all. As for in-service, nothing has ever come up.' (T L15)

Scott, also commented that, during his undergraduate years, he received some very minimal input relating to cultural diversity; however, he recalls it to be more about communication styles rather than developing an understanding of cultural requirements:

'We did about a two hour session where one of the paramedics came in and gave us an overview, a little bit about cultural diversity, and dealing with some of those complexities, but very simple, but more about communication styles, than really about a background or understanding, Other than that, nothing. We have had nothing in-service.' (S L10)

Not unlike his colleagues' comments, Paul, who graduated 16 years ago recalled that even after direct questioning on cultural matters, his responses to these questions were general:

'I don't believe I have had any, I recall reference to a general conversation at university with lecturers about enlightening you on cultural awareness, but that only stemmed from my own questioning. I don't recall any syllabus that was directly towards it.' (P L14)

Natalie, with some five years experience since graduating included in her narrative that whilst there was some health sociology included in her formal education which included patient awareness and sensitivities, nothing was specific to aid her in her cultural or religious awareness:

‘At undergraduate level the only thing we did was health sociology which touched on having an awareness of sensitivities but nothing specific to cultural sensitivities, no, nothing specific.’ (N L11)

Whilst Michael, a graduate of 12 years commented that during his course various cultural groups were mentioned, however, the information delivered was not directly related to cultural awareness:

‘Just being aware that various cultures have sensitivities, whether they are religious sensitivities, or social sensitivities. My recollection is that it was more about the theory, the sociology of culture, not cultural awareness as it relates to patient care.’ (M L15)

Similarly, Dennis, a paramedic of four years, recalled that during his education he encountered one lecture on cross-cultural communication, which may relate to why some of the paramedic participants in their earlier dialogue viewed cultural and religious preparedness in this way:

'We had a little, we probably had 1 lecture when I originally trained in cross cultural communication, but nothing since that was about it, nothing at all. As far as post grad education in-service goes, I have not received any training on cultural or religious issues at all.' (D L12)

Georgia, a paramedic of 14 years responded to the question by stating that she also could recall only a minimal amount of time in her education devoted to cultural or religious issues of a general nature:

'In terms of my training, I can recall about four contact hours, if it was even that, over the three years that was related to cultural diversity. Even then it was just a discussion that it exists, that there are people out there of differing cultures, and who will respond differently to the expectations of pre-hospital personnel. Different cultures can respond differently to our presence, that they may respond differently to certain events such as the death of a loved one, different cultures exhibit different things, but in terms of the educational aspect, the four contact hours were just spent on that diversity exists.' (G L14)

Kate, a paramedic of four years experience, when asked about her education exposure relating to cultural preparedness, noted also that she received vague references to cultural issues in her undergraduate course and not anything since her employment:

'It was very, very vague more like you know, there are different cultures out there, deal with it, that was pretty much how it was covered really. In AV (Ambulance Victoria) we have had nothing, nothing at all.' (K L13)

Further comments supporting themes relating to education arose from the narrative of Shannon who commented:

‘Nothing out of university, but subject wise at university there was one that had a small amount covered. It did not delve into it in any detail, but it is something that you just have to deal with on road.’ (S L14)

Similarly, Cheryl a paramedic of 13 years indicated that that she also received minimal education relating to cultural and religious issues of patient care with her adding that she has been forced to gain this knowledge by on road exposure:

‘We did some initial training at AOTC (Ambulance Officers Training Centre) with about two hours of slightly varying cultures and most of my education came anecdotally since I was at Thomastown, so going into a branch where there is a huge cultural diversity you just learnt on the road basically.’ (C L9)

A paramedic of six years, Simon’s narrative supports Cheryl’s comments above. He recalls that his knowledge on cultural and religious issues also comes from on road encounters and not from his educational background

'I haven't undertaken any post grad courses, just my initial training, and the in-service updates. But up to date very minimal. It has been left up to us to learn, you know, exposure, from being on road.' (S L12)

Themes that emerge from the paramedic responses relating to either undergraduate or in-service continuing education appeared to be indicative of a complete lack of exposure paramedics have to prepare them for dealing with the diversity of patients that they will encounter. Of the responses obtained from the paramedic group, all twenty (n=20) (100%) indicated that they have had either no education or minimal education. There was no differentiation between recent graduates and those who had graduated more than five years ago. Similarly there was no variation relating to cultural or religious education and training that existed between paramedics who underwent their training within the post-employment model and those at university level. Five (n=5) (25%) paramedics indicated that they had received minimal education relating to cultural or religious requirements of patient care. When this was discussed, all participants reflected on either the lack of content actually relating to cultural or religious requirements, or the minimal time, often just a few hours, devoted to it. For those paramedics who did recall the two or three hours delivered over their three-year program, recollection of specific content was vague. We see this in both Paul's and Kate's responses when they assert that whilst there was some content delivered that related to culture and religion, it was more in a general conversational context than relating to specific cultural or religious requirements. It is unclear as to whether or not this is a reflection of content being general or irrelevant, or

indeed, if students are so focused in the clinical realms of their education that they have not deemed this exposure as being relevant, and hence not recalled it.

Prior to undertaking these interviews with paramedics, I had envisaged that the questions relating to their educational experiences as they connect to culture and religion would be relatively straightforward and result in clear and concise themes. However, the more the interviews progressed, I realised that this in fact would not be the case. Whilst education was a common theme, there were many layers that were unveiled, most of which required a deeper level of interpretation and analysis.

The most common theme of a lack of education was evident from the paramedic group. Responses were clear and succinct when paramedics were asked about curriculum content within their educational programs, with twenty (n=20) (100%) indicating that it was either nonexistent or, at the very best, inadequate or minimal.

Where paramedic participants felt that they had some exposure to cultural issues in a formal educational setting, this was exclusively confined to their undergraduate experiences. Georgia was the only paramedic participant who could recall content relating to cultural issues. In her narrative however, she adds that this amounted to only about four hours. All twenty (n=20) (100%) of the participants within the paramedic group were explicit that they had not received any input from their employer that related to cultural or religious preparedness.

Within these themes, further subthemes became evident that seem to indicate that whereas some of the participants recalled the few hours of formal education delivered at undergraduate level, the content lacked substance or relevance. In many instances, the educational content delivered at undergraduate level had a communication focus, that is, communicating with patients of linguistic diversity as opposed to cultural requirements. This would seem to support the paramedic group notion that language and communication is the key to understanding cultural and religious requirements of their patient care as discussed earlier. Alternatively, any specific input relating to the cultural or religious needs of the pre-hospital patient was confined to the student paramedics being advised that the community they are to serve was culturally diverse in nature, and that this should be recognised. We see this in the following extracts below. There was no further insight offered, nor tools developed, to assist in this process.

During the interview process I noted some non-verbal cues in the participant responses. Interestingly, most of the participants, when asked about their exposure to cultural or religious preparedness as it related to their work as a paramedic, looked somewhat confounded, and there were periods of significant pause before responses were forthcoming. This was in direct contrast to the rapid responses encountered earlier when paramedics were discussing their educational experiences and content. When inquiring of a paramedic about their education or knowledge base as it relates to treating a patient suffering an acute illness or injury, paramedics will not only not hesitate in responding, but more often than not will offer all the clinical variances, potential outcomes, and

complications that may be encountered. It was clear that asking a paramedic about an aspect of their patient care that they lacked a knowledge base in caused them to be rather reflective. There was a clear element of surprise that was apparent here as the paramedic participants were being asked about areas of their practice that did not relate directly to the physiological model. This was in direct contrast to what was seen earlier in the eagerness of the responses from paramedics when discussing their education; a known fact.

For some of the participants, further subthemes arose as to their lack of education having a direct relationship to the lack of preparedness they had as graduating paramedics in dealing with aspects of patient care, particularly when working in geographical regions with a high density of the local community being of diverse cultures. The pre-hospital service industry in very recent times has a strong focus on work readiness of university graduates, however much of this focus pertains to having a knowledge base and skills set to deliver patient care at a physiological level, (Edwards, 2011: Williams, Onsmann, & Brown, 2011). Not wanting to detract from the importance of this, equally, paramedics should be armed with sufficient knowledge and skill sets to meet the overall needs of their patients. The lack of curriculum content and the apparent lack of any in-service education reported by paramedics in addressing this issue has left graduate paramedics filling this gap with anecdotal information, and the need to gain such instruction via on-road experience.

The paramedic subgroup believed that having the ability to respond to the cultural or religious needs of their patients would be beneficial to patient outcomes. Their responses are noted below:

‘Having more cultural or spiritual training would benefit this process. Synergistically, it would enable you to be better equipped to manage people from varying backgrounds. Something we do not do now.’ (Brian L161).

‘We know very little about specific cultures, there certainly would be a place for leaning packages, and you know just to cover pertinent points about certain cultures or religions that need to be remembered when given these patients or people.’ (Nathan L100)

‘It would add to patient care, it would improve patient care I believe, every time I have conducted a job where I have not understood their culture or religion it has hampered the flow of the job.’ (Natalie L105)

‘I don’t think, I don’t think AV are able to meet these people’s demands or needs, I don’t think AV train their paramedics well enough to do that, in fact not at all. This at times seems to have a direct impact on patient care.’ (Kate L91)

‘Externally now that we are having university training, I think that it will be covered better, I don’t feel that coming the way I did through AOTC they prepared us in anyway shape or form. This has significant impact on patient outcomes.’ (Michael L93)

Further themes emanating from the paramedic participants relating to education on cultural and religious issues included the belief that having cultural and religious sensitivity is required for them to undertake their work effectively as paramedic practitioners. Eighteen (n=18) (90%) of the responses from the paramedic group were inclusive of themes relating to this lack of educational input actually impeding the quality of patient care delivered. On reflection, ten (n=10) (50%) of the paramedic participants had not made any noteworthy connection between the level of patient care and patient cultural needs. Again, the physiological focus is at the forefront of a paramedic's mindset. Throughout the interviews eighteen (n=18; 90%) paramedics seemed astonished that it is not an area they had given a great deal of consideration to, yet still acknowledged that at times it did have an impact on patient outcomes as they relate to the level of patient care they offered.

Sarah included in her response feelings of anger at not knowing how to deal with cultural or religious issues relevant to her patients:

'This is an increasing problem for us, going into homes, into situations that we are not familiar with, that are different from the normal, different from what we expect, I get angry sometimes that we are not prepared for this, that we have not been taught to do this.' (S

L46)

Dennis in his response believes that his lack of knowledge of cultural or religious issues results in frustration:

'It is not that we are not adequately prepared for treating patients from different cultural backgrounds, we are not prepared at all. It is frustrating, very frustrating. Looking back now, we should have had way more training in this area.' (D L48)

Michael admitted in his response that:

'I know that I do not have the knowledge to deal with the issues and this perhaps prevents me from responding the way perhaps I should,' (M L65)

When discussing this aspect of his education George revealed that:

'There was no information to prepare us as paramedics, at the time this was being delivered I thought it odd, that they would teach us that it exists, it was obviously important enough to mention, but not important enough to actually offer anything in they way of insight, let alone arm us with the tools to prepare us as healthcare practitioners. We develop ourselves by experience in these areas which is not a good thing' (G L24)

Marcus was eager to add in his dialogue that a senior colleague had undertaken to avail the branch team of some information pertaining to Middle Eastern culture.

'Nothing from this area what so ever, no nothing, no education at all, the only really structured educational process, where the team manager in a in a branch located in a very middle eastern clientele purchased or acquired a book on understanding Islamic needs and issues from the health perspective, and he made the branch members aware of the book he

purchased and put it in the branch library. It is still located on the bookshelf unwrapped.'

(M L18)

This is a single instance reported of a senior paramedic taking some initiative in attempting to offer education to his colleagues in the subject matter relating to cultural awareness. It would appear that the team manager mentioned in Marcus's response had identified a gap of knowledge relevant to the paramedic team. In response to the organisation's responsibilities for providing professional development, the attempt was made to fill this gap. Issues relating to the ongoing education of paramedics will be discussed later in this chapter. It would seem that despite the acknowledgement from the paramedic participants of the importance of the ability for them to meet their patients' overall needs inclusive of those pertaining to culture and religion, there may be some limitations. Whilst the maxim 'you can lead a horse to water but can't make it drink' may seem relevant here, there are other factors that may very well be in play. The very distinct ethos that exists inside Ambulance Victoria relating to education and skills development cannot be underestimated. The paramedic workforce in Victoria is made up of predominately DAPS graduates who have been paid a full time wage to undergo their undergraduate education. This has promoted an ethos within the organisation of 'do nothing unless there is a financial reward'.

When discussing professional responsibilities for individual professional development and continuing education, Marcus commented that he would only undertake additional education if it were to be provided by the ambulance service:

'It is the services responsibility, we undergo constant professional development days (PDP days) with the topics presented as dictated by the service. If we were to undergo training outside of this process we would not be paid for it.' (M L89)

Not unlike Marcus's comments, Tina also believes that the service should pay for anything she undertakes for her professional development:

'The delivery of our continuing education is determined by the service. We get paid to attend these events, often at double time. You will be hard pressed to find any paramedic who would undergo training related to their job without being paid by the service to do so. (T L102)

Included in his narrative, Stephen notes that he also believes the ethos of paramedics' unwillingness to undertake professional development opportunities is embedded within the reward:

'Some years ago paramedics received financial reward for our continuing education. Not only did we get paid to attend, there was a pay rise for the skills attained. This is not the case now. If the service wants us to gain knowledge in a certain area they should pay us to get it. The more advance we are at what we do, the more we should be financially recognised for it'. (S L 72)

Sarah's perspective on this issue is that she also believes paramedics should be paid to enhance their cultural or religious preparedness:

'If it was something that was pushed for and encouraged by AV, then I would probably do it. If they believe it is something we should know they should include it in our PDP days, and pay is for it.' (S L152)

Paramedics get financial reward for almost everything related to their work setting.

Uniforms, inclusive of shoes, socks are paid for; as are all meals whilst on shift. If paramedic crews receive a call out during a meal, there is a financial payment made. Paramedics are paid to attend all in-service training events, often at overtime rates.

Themes of responsibility for continuing education and professional development opportunities continued. When discussing continuing education, or in-service training programs relating to cultural and religious needs, Shannon commented further that:

'What it boils down to ultimately is the service, their responsibility. I mean, like all areas, if there is a need it should be dealt with by them (the service), it is their responsibility to pay us to learn these sorts of things.' (S L114)

Cheryl, in her response, believes that if education was required to ensure paramedics are more culturally prepared, then the service holds a responsibility to ensure this occurs:

'If paramedics need to be aware of cultural issues, or cultural beliefs, and the ambulance service fails I mean surely, it is their responsibility for not giving that information out

knowing that we are going to these people all the time, so the service should be more aware.’ (C L52)

Michael’s response included his view that if the service does not include cultural diversity education in their continuing education programs then this indicates to him there is not the need:

‘If any further education was needed, if there was a need to do this, then I would have presumed the service would have something in place. We have in-service programs for our development all the time, none of them relate to cultural stuff, so there is not the need.’ (M L53)

These themes continue with Scott adding that he believes it is the service’s responsibility to incorporate education on cultural issues within their professional development program:

‘Perhaps we need some education or training, in this area, it is certainly lacking, I mean we deal with these sorts of people all the time, it is surprising that the service has not addressed this issue, if they did, then I would probably do it, I mean that’s what they pay us for.’ (S L63)

When discussing issues pertaining to in-service education and cultural or religious preparedness, Stephen also believes it is a service responsibility, but in addition raises the issue of competing priorities for best patient care. He concludes that perhaps the

development of cultural or religious preparedness for paramedics is not seen by the service as being related to best possible care of the patient's needs:

'There are competing priorities I guess, our focus is offering the best possible care the patient needs, therefore cultural understandings are not a priority. Is it not the services responsibility to offer this if it is needed?' (S L65)

Further evidence that supports the emerging theme of service responsibility to provide its paramedics with cultural diversity training is in the response from George, who like Stephen, also raises the issue of resources:

'No, nothing, nothing formal in service, I mean, no not really it is almost impossible, there are too many restrictive issues, time, money, lack of support from the organisation. They should make it a priority but they don't'. (G L82)

Like his colleagues' responses, when discussing this issue, Dennis commented on the resources available, and highlights how the gaps he has identified in his knowledge have arisen from his on-road exposure:

'It never occurred to me during my training that it (cultural preparedness) was even relevant to our work. It was not until I was actually on the road that I began to become aware that there were gaps in my knowledge in this area. The service has never addressed this at all. It

comes down to priorities I guess. We have our in-service PDP days, I am sure that if it was an issue for us to know, it would be dealt with there but it never is'. (D L76)

Ambulance Victoria supports, convenes, and governs all aspects of a paramedic's career and professional development, internal to the agency. This seems to foster an organisational ethos that holds an underpinning belief that if the organisation does not provide education in a specific field, then it is either not required, or is of a low priority. Themes emanating from the paramedic group of participants indicated that some paramedics whilst acknowledging a need to be able to respond to cultural needs appropriately, believed that it was ultimately the service's responsibility to deliver this content.

Themes continue to indicate that there is a strong perception of paramedics that it is up to the agency to provide any input relating to cultural or religious preparedness. This seems to detract from a more professional approach, which encompasses responsibility for self-education and professional development. The ambulance industry nation wide is lobbying intensely to be recognised as a professional health industry service provider in line with their medical, nursing, and other allied health professional counterparts. Yet it is at this very grassroots level that shows the ethos and attitudes that exist within the Victorian service are insular and lack the foresight that their counterparts have achieved in addressing this need and acknowledging the benefits that a holistic approach to patient care brings. These themes seem to indicate there is a general unwillingness for paramedics to take responsibility or ownership of their own professional development.

Throughout the discussions, some paramedic participants (n=4) 20% commented on how, on occasions, exposure to different cultural groups had added to their knowledge or increased their awareness of cultural issues. Themes relating to the attainment of skills to deal with cultural and religious issues seem to indicate that some participants believed that they had picked up some cultural cues after frequent exposure enabling them to develop skill sets and an increased awareness of patient group needs, which aided them in dealing with patients of similar cultural or religious backgrounds in the future.

In his narrative, Martin commented that his personal travels had also impacted on his ability to be culturally sensitive. Paramedics' cultural legacies also impact on their insight into cultural norms, rituals and mores. The themes that have arisen from their narratives appear to support the notion that some paramedic participants have developed cultural clues that relate to learning from experience and exposure.

In his response Marcus indicates that he believes he has gained his knowledge from on road exposure to patients of differing cultures which aids him with future encounters:

'Absolutely, I mean, the more cases you experience the more you take on board in your gamut of skills and experience. This then helps in similar situations encountered in the future'. (M L156)

George, in his dialogue, suggested that in his experience, on road has also made him more aware of cultural clues:

'I think that most paramedics pick up cultural cues by exposure, yes, by observation. My learning is usually about experience'. (G L75)

During his interview Brian recalled that the knowledge he has gained from his on-road experiences in his view could not be obtained from a book. I found Brian's comment on this issue interesting given Marcus's comment earlier about the book purchased by the team manager on Muslim culture remaining on the bookshelf still wrapped:

'You build up a knowledge base that couldn't read about, once again it's a tacit experience, you've got to experience it, you can't read about it'. (B L158)

Similarly Martin recalls life experiences that have aided him in the area of developing cultural cues.

'I've travelled extensively in my time to a lot of different countries, particularly Muslim countries, so I sort of think I have developed a sort of awareness through my travels, but certainly not through the ambulance service or any education.' (M L34)

The role of tacit learning by experience, however, should be viewed with some caution. Whilst the benefits of clinical exposure cannot be underestimated, this usually occurs to permit clinical science students to consolidate theory and practice (Landers, 2000). In their research, Ingelgard, Roth and Shani (2004,) explored the nature and issues associated with fostering the dynamic learning capability within organisations. The results indicate that

dynamic or tacit learning capability is embedded and influenced by company culture, existing skills and competence, organisational structure, and incentives for learning. They also argued that enabling tacit knowledge creation is a fragile process that has to be managed with care, and is far more complex than the literature suggests.

Paramedic education, like all other health-related education programs, very much relies on a two-tiered collaborative approach. Within the university setting student paramedics receive underpinning theory and clinical knowledge within their undergraduate course. Practical skills development is also delivered, although the extent of the exposure to practical laboratories can vary from one university program to the next. Even so, the underlying principles remain the same. University programs also rely heavily on simulation activities to provide a safe environment for students to develop practical skills as well as the more patient focused skills of communication, empathy, etc. Whilst simulation activities try to recreate reality as closely as possible, like all simulation there are limitations, and whilst students tend to learn much from these measures, there is a real need for students to gain the 'real life' experiences in the industry they have chosen as a career path. It is for this reason that all paramedic students in Victoria undertake clinical placements within Ambulance Victoria. Again, the amount of hours exposed per student varies from program to program ranging from 360 to 560 hours over the three-year period; however, the learning benefits from this industry exposure cannot be underestimated. It is not surprising then that paramedics often refer to the value of 'learning on the job', and the importance that road exposure brings, even long after graduation. Paramedics, mostly, have a thirst for

knowledge, derived from a strong desire to be able to meet the needs of their patients in a crisis setting. Mostly, these needs, however, are confined to the physiological, and exclude the biopsychosocial.

The paramedic participants were asked to comment on the learning opportunities that existed from on-road exposure as they related to the cultural or religious needs of their patients. All participants had previously confirmed that they had experienced a high frequency of exposure to treating patients where cultural or religious issues were present. Presumably therefore opportunities for self-education relating to cultural issues after recognition of need should be evident. As the apparent lack of formal educational opportunities relating to the cultural and religious aspects of patient care within the organisation have been identified, it would appear that job exposure would be the only in-service educational tool attainable for paramedics.

Cultural and Religious Learning from Exposure

The paramedic group were further asked whether or not the frequency of exposure to a patient group where they felt a lack of knowledge or skills set to adequately respond had encouraged them to undertake any further education or reading in this area. Responses were varied with only a small number of participants (n=4) 20%, highlighting the importance of self-motivation and commitment to developing their skill sets essential to delivering adequate care to their patients. The skills sets attained from this motivation however once again appear to be confined to those of communication.

In his comments Jason noted that:

‘Probably the main thing that I have done extra I suppose is more in regards to communication, because I work in also Coburg, a lot of Italian speakers, so I actually learnt Italian, which has helped a lot.’ (J L72)

Similarly George’s response in this area focused in language. He commented:

‘I did an Italian course to try and improve my communication. I’ve always had an interest in cultures different to mine, informal stuff.’ (G L82)

Kate added to her narrative that, not only did exposure to differing cultural backgrounds assist with her knowledge in this area, but her gender was also of value. She commented that:

‘Absolutely, it has helped me learn a little bit of Italian for a start which is always good, and just the undemanding of being a female paramedic I am in a better position for people from a Muslim background. It’s made me certainly much more aware of leaving male partners in the back with Muslim females and just other little things, that you just don’t think about it until you are actually dealing with the situation.’ (K L66)

Martin, however, believed that previous work experience had assisted him in developing some cultural awareness skills not achievable in his current paramedic role:

‘I haven’t really read anything on any nationality or cultural aspects, I wouldn’t mind to if I had any spare time to learn to speak another language, it would be good. I had previous job I certainly had a lot more cultural interaction, I was working for interpreters and I certainly had to learn a lot about people and their culture when I was in that position.’ (M L64)

Interestingly, the themes from the component of this group that responded with an affirmative were exclusively related to communication, the assumption being that if you can speak the native language of the patient then you hold an understanding of their cultural and religious requirements inclusive of any specific health care needs. This, again, supports the perceptions some paramedics have that cultural and religious preparedness is limited to verbal communication, as discussed previously. Similarly generalisations were evident about gender, which is, if you are female, then you have a greater understanding of the female Muslim patient and the thousands of years of culture and tradition that has shaped her to be the woman she presents today.

Paramedic Experiences in Dealing with Patients of Cultural and Religious Backgrounds Different from Themselves.

Throughout the daily routine of the paramedic shift, it is typical that they would be attending patients who are of a different cultural or religious background to themselves. Melbourne is a multicultural metropolis, with communities from different cultural and religious backgrounds extending well into rural locations throughout Victoria. So much so, that recent moves have been made for the states slogan “Victoria – the multicultural capital” to be emblazoned onto the registration number plates of all motor vehicles

registered in Victoria. With paramedics in this state well equipped to deal with their patients' physiological needs, I believe it is important to consider the experiences of paramedics in dealing with patients of differing cultural or religious backgrounds in the light of the apparent lack of educational input into cultural and religious preparedness. Not unlike the themes that developed around education, themes arising from paramedics were again multi-layered incorporating subjects such as homogeneous attitudes, lack of knowledge recognition, anxiety, frustration and misinterpretation of the cultural norms of their patients.

Another sub-theme that arose as a result of the question pertaining to education was the impact it had on them as individual practitioners. Some respondents indicated intense emotional responses including anger and frustration when facing certain patient cohorts they felt ill equipped to deal with. These responses seemed to be mainly limited to the patient's sociological (biopsychosocial) needs as opposed to the physiological. This again indicates that paramedics, whilst well equipped to deal with a patient's physical requirements, are at somewhat of a loss to meet the more holistic requirements, inclusive of cultural and religious needs.

When asked about their experiences in dealing with patients of differing cultural or religious backgrounds from their own perspective, all paramedic participants (100%) (n=20) acknowledged that their lack of cultural or religious preparedness had resulted in an

increase in their stress levels and / or a decrease in the level of service afforded their patients.

In her responses, Cheryl commented that all of her patients get treated the same. This perception of equity does not take into consideration the many differing needs of her individual patients and as a result has the potential to result in inequity of care:

‘I mean they are all the same, patients I mean, they are all the same. It does not matter what background they have, it is important that all people get treated the same.’ (C L18)

Not unlike Cheryl’s comments, Marcus also commented on his need to offer the same level of care to all his patients, irrespective of individual need:

‘If a patient is sick and required transport, then that is what they get, it is not important what background they come from.’ (M 24)

Whilst Tina in her narrative acknowledged that:

‘I don’t tend to treat patients according to culture.’ (T L45)

During his interview, Brian was more specific, relating his experiences and focus on the physiological aspects to patient care and his ability to choose to ignore cultural requirements of his patients:

'I think I have a good ability to tune out, to tune out of the whole cultural thing and focus on the job at hand.' (B L114)

Similarly George echoed Brian's comments relating his physiological focus:

'Where cultural issues are at play, I like, almost everyone else, tend to step back a little bit, and focus, on what we know.' (G L66)

These themes tend to indicate the homogeneous attitudes some paramedics have towards their patients. What is not clear is whether this relates to the apparent lack of preparedness that paramedics seem to have when it comes to cultural or religious issues, or the physiological approach that the profession seems to adopt. Further strong themes arose from the paramedic group acknowledging their lack of knowledge of cultural issues pertaining to patient care. This would seem at odds for the paramedic practitioners who view themselves highly in relation to being able to meet the needs of their patients in the pre-hospital setting. When discussing these areas, most participants were obviously uncomfortable talking about aspects of patient care that they were not able to offer at the same level as they are able to achieve in areas relating to the physiological. One of the major themes emanating from this area related to the homogeneous attitudes of paramedics towards the multicultural community they serve, or the inability to recognize the importance of a person's cultural or religious background. This physiological approach to patient care, almost completely exclusive of any components of the biopsychosocial aspects of patient needs, became quite evident. The holistic approaches to patient care

now housed in many medical disciplines seem to be absent within the paramedic field in some instances.

As many of the paramedic participants in this study have mentioned, it is a service requirement that all operational paramedics attend the in-service professional development program (PDP). This program is arranged by the service and the content delivered to paramedics is determined by the service. The PDP is delivered twice a year, with the content delivered over a single day. Each paramedic is rostered to attend these events resulting in each paramedic undergoing two days of PDP per annum. Any changes to the organisation's clinical guidelines, policies, etc., are delivered to paramedics at this forum.

Over the past three years the content delivered to paramedics during their PDP's has been:

- Working with Mobile Intensive Care Ambulance (MICA)
- Intra Venous review
- Declaration of death
- Multiple casualty incidents – Transport and Triage Officers
- Clinical reviews
- Stroke
- New drugs – Fentanyl calculations
- Clinical Practice Guideline changes
- Peer support update
- Safe lifting (Back to Basics)
- Drug errors and results
- Paediatric resuscitation

This list while extensive, has a strong clinical practice focus with a heavy concentration of the physiological aspects of patient care. None of the above topics listed above appear to have any focus on the paramedic / patient relationship.

When discussing exposure to patients of differing cultural or religious backgrounds and the impact, if any, this had on them as practitioners, the paramedic participants became quite vocal. The discussion seemed to evoke a stronger emotional response from the group as they began to verbalise and admit an area of their knowledge base is lacking, resulting in a direct impact on the level of care they offered.

Shannon, like all her colleagues involved in this study when discussing her views about dealing with the cultural aspects of patient care and her own knowledge base noted that:

'I think it's because you don't understand the rules, or you don't have a really good knowledge of them at all, these people that are different to us. You worry that you will do something inappropriate when you didn't really mean to do it, and you will upset them I mean, how would you know anyway?' (S L37)

Jason, on the other hand, appeared to have a little more insight into his own management of patients from differing cultural backgrounds, having reflected on the issues facing him:

'There have been moments where I wished that I had a bit more of an insight into what they needed and what was appropriate with managing the patient in light of their cultural background. Reflecting back now I know nothing in this area.' (J I51)

Continuing on with this theme, Scott ,like the rest of his counterparts, also related his own lack of awareness of cultural issues and the potential effects this has on patient care:

'I don't know if I offending anyone culturally or spiritually by having a foreign object in their arm, like in a vein, I guess if I knew more then there wouldn't be a need for that kind of tentativeness. Other things that could be done, but in the thick of it all it trips you up, you just don't know how to get around this.' (S L149)

George also believes that in general paramedics lack the knowledge to deal with cultural or religious issues, and adds that even exposure to patients from differing cultural or religious backgrounds fails to improve knowledge for paramedics in this area. He acknowledged not only the lack of awareness paramedics have in cultural or religious preparedness, but also how this relates to patient care:

'The difficulty is not having the knowledge. Most paramedics have no knowledge of cultural needs, so there is a complete lack of insight, lack of ability to deliver. Even paramedics who have worked for years in communities such as the Jewish community fail to gain this knowledge.' (G L74)

In his comments, Nathan also expressed concern that his lack of cultural preparedness highlights his inability to address such issues when they arise, thus having an impact on the care of his patients:

'It made me far more aware of the fact that there are gaps in our understanding, in our knowledge. At the time when you are given your patients you don't have time to learn from them you can't ask them too many questions, there is not time. I don't have an awareness of their specific needs, just a highlight of our inability to address them. This does concern me greatly.' (N L50)

Throughout the interviews, all paramedics (100%) (n=20) believed that they lacked the knowledge to deal with their patients cultural or religious needs.

Not surprisingly, given the apparent lack of educational input paramedics receive that relates to cultural or religious preparedness, themes seemed to indicate that there is a distinct lack of knowledge base paramedics in this study have in dealing with patients of cultural or religious backgrounds different from themselves. Not only has this resulted in the sometimes homogeneous attitudes reflected above, but also seems to encompass a wider range of responses and attitudes. Clear themes arose as to paramedic participants openly acknowledging their lack of insight into such aspects of patient care. Further entwined within these themes were the deeper aspects that related to the consequences for both parties, the paramedic as a practitioner and the community members they serve.

Acknowledging a gap in the area of your knowledge base as it relates to your own capacity to undertake your role may be one thing, but then unpacking this as to the consequences this leads to may bring a further dimension. Interestingly, on reflection, the paramedic participants were able to communicate not only their lack of knowledge and skill sets in relation to cultural preparedness, but also reflect on specific instances where this had been highlighted in their practice.

When asked about instances in their dealings with patients of differing cultural or religious backgrounds, the paramedic subgroup were able to readily recall many occurrences, and offered reflection on implications this may have had for them as practitioners. It was during this component of the interviews that I was caused to reflect on the apparent cultural and religious ill-preparedness paramedics have, and the impact this has on their well being, self efficacy, perceptions of professionalism, and quality of patient care.

Attending patients requiring medical intervention is routine for a paramedic in Victoria. However, patients who require their medical treatment to be considerate of their cultural or religious requirements poses some obvious concerns for the attending paramedic. Further themes evolved outlining these challenges and also incorporated another layer of themes relating to credibility within the paramedic subgroup. That is if the paramedic as a practitioner was challenged in an area where they lacked the inability to meet the needs of their patients, then this had some potential to impact on their professional credibility with that patient. Such a loss of credibility holds the potential to have negative impacts on the

relationship that exists between the paramedic and their patient at a time when a trusting positive relationship is paramount for patient outcomes. The paramedic – patient relationship is so important that some paramedics are fearful of communicating with their patients in aspects of their needs that they are not familiar with for fear of being perceived to be, and being, ignorant and lacking in the required knowledge, as seen by the themes above. Themes of paramedic professionalism being compromised from these challenges also appear to form part of the subthemes emanating from the paramedic participants when discussing their experiences.

Marcus reported that his dealings with patients from different cultural backgrounds sometimes made him feel uncomfortable, particularly around issues of grieving:

‘The differing ways that families grieve. Some different cultural backgrounds are challenging, I don’t know how to handle it all, it is uncomfortable.’ (M L38)

Jason, in his comments, noted the challenges this brought to him and his lack of preparedness to deal with such challenges:

‘I am quite pragmatic, when it comes to being a paramedic, I suppose, it is because it is not my family. I try to be professional about it, but it is dealing with those people when they are in that situation that it can be challenging. I am not prepared for these challenges, it can often be a shock. I think that probably the first time I was in that type of situation it was a shock, because it is so diverse from what the background I come from.’ (J L50)

Georgia also reflected that in her dealings with patients of differing cultural or religious backgrounds proved to be challenging:

‘Earlier on in my career I would have been confronted by this and taken it personally, it was about me, later I would have understood it was more about the fact, the culture of that individual, whilst it is challenging, confronting, in the end it is not about us, not our responsibility.’ (G L67)

Natalie noted, in her comments, that her lack of knowledge in dealing with cultural issues caused her to feel embarrassed and resulted in a loss of credibility with the patient:

‘I did feel quite embarrassed, I had no idea what to do, how to respond, it was a difficult situation for me to be in. The problem was it became difficult, my credibility had been compromised, I think it may have been hampered in the moment. It was all downhill from there.’ (N L93)

Similarly, Martin’s experience appeared to echo Natalie’s comments relating to credibility:

‘There are times you don’t want to ask, you don’t want to appear stupid, ignorant. I asked family members tactfully, however it displays a lack of knowledge to the family, a knowledge we should have, credibility is at stake sometimes, I mean you always hope that this is what you are leading to, you hope to don’t put your foot in your mouth when you are dealing with these situations, It is not good enough to hope.’ (M L46)

Dennis also reflected on his own feelings of inadequacy in dealing with cultural or religious issues, particularly around cases incorporating high emotions:

‘Sometimes I reflect back at some of these jobs and I feel inadequate, perhaps even knowing that there is something that I could have offered the patient more than I did, especially if there has been a death involved.’ (D L53)

Some of the stronger subthemes emanating from what appears to be the lack of knowledge paramedics have in dealing with cultural and religious issues related directly to patient care. Nineteen (n=19) (95%) of the paramedics interviewed acknowledged that their lack of knowledge had at least some implications for patient care and confirmed that in many instances this transitioned into a lower level of care afforded.

Stephen admitted in his interview that:

‘It is at these times when dealing with these patients that you can lose all perspective in your care of the patient.’ (S L49)

Kate revealed that her lack of understanding on cultural issues had a definite impact on the level of patient care she offered:

'I do think we have a responsibility to know or at least understand or be aware that there may be things that we don't know that we are doing. This definitely has an impact on our level of care.' (K L56)

In his comments, Paul related that his inability to communicate effectively or identify what cultural sensitivities he ought to be aware of resulted in him interacting with patients of different cultural backgrounds in an ineffective manner with increased anxiety levels:

'There was quite a lot of palpable anxiety between the two, it was very difficult to be able to communicate and assess her, and not really knowing their particular background, what sort of sensitivities that I need to be aware of, it was difficult to comfortably and naturally interact with them as you would with most patients.' (P L45)

George believes that his lack of knowledge of cultural or religious sensitivities also impacts on the level of patient care. The metaphor below highlights how he feels, like a lost tool out of the tool bag:

'As a paramedic it makes you feel that there is one tool out of your tool bag that is being stripped from you. It makes you feel like you should have the ability to be more dynamic, more creative with your assessments as we are with other patients, and we are not.' (G L46)

Brian puts it much more succinctly believing that the lack of cultural preparedness actually 'trips him up' in his dealing with his patients:

'Other things that could be done, I am not sure what though. But in the thick of it all it trips you up, you just don't know how to get around this'. (B L45)

Nathan recalls a specific encounter where his lack of knowledge resulted in a definitive decline in the level of patient care, despite best intentions he held no ability to regain lost ground:

'I can recall some, interaction with Sikh, religion um, where I nearly did the wrong thing by shaving a man's arm for cannulation, I wasn't aware at the time that I wasn't allowed to remove a hair from his body, that caused a bit of an upset. After that there was no coming back, the trust was gone.' (N L28)

Kate further echoes the impact on patient care when she describes her experiences in dealing with patients of differing cultural backgrounds:

'Like all paramedics I make it up as you go along, because I don't think the ambulance service really adequately provides you with any information on how to deal with these types of things. This ultimately impacts on patient care, and not in a good way.' (K L57)

Dennis recalls that, in his experience, continued exposure highlights that individual situations require a trial and error approach, not normally seen in paramedic practice. This has direct implications for patient care:

‘Exposure to it just kind of highlights the fact that it is there, and each situation is different, and there is not one way that you can go into a situation like that, and have it work every time, it is kind of like a trial and error kind of thing. I know this is not good for patient care, but what else can we do?’ (D L57)

In recalling a specific incident, Cheryl volunteered that the level of care she offered in the situation described by her below was not of a standard she would normally have offered:

‘I would not normally have left the patient’s family alone until I realized or knew that they understood what was going on and going through the process of putting the patient back into bed and all those other nice things we would normally do all of them before we would even consider leaving the house or going outside to wait for anybody else. Whereas we just grabbed our gear and left these people, it was easier to do this than pretend we knew how to deal with their cultural stuff.’ (C L47)

With the lack of preparedness of some paramedics to meet their patients’ cultural or religious needs, consideration must then be given to the potential impact this has on patient care. Paramedics spoke at length about the patients they had attended where cultural or religious requirements had hampered their capacity to be effective practitioners. The

question arose however as to whether or not this transferred in any way to patient outcomes. The paramedic participants spoke not only of their own increased levels of anxiety, but also that of their patients, so much so at times that it impacted on the routine care they would normally offer. It appears that this lack of knowledge translates into paramedics becoming so overwhelmed by these confronting challenges that they lose perspective of their usual practice and this then stifles their usual responses. A direct result of this is that paramedics may resort to undertaking coping mechanisms that have a potential to result in actions they would not normally undertake. Similarly, paramedics' misinterpretation of some cultural norms appears to have resulted in some instances an increase in anxiety levels.

Sarah recalls an incident where she was not prepared for the outward display of grief resulting from a loss of a family member:

'What was unusual for us was the displays of grief, and wailing, and we were actually quite concerned about our own safety as the men started coming back we started worrying my god, will they blame us, how much danger are we in, are we going to get out of this alive.' (S L24)

Marcus also recounts a case where he was initially concerned for his safety due to the numbers of family members present:

I guess it is much because you are just not used to the culture, with large numbers like 10 or 20 all around you at one time, but surprisingly they were fine, they were absolutely

understanding, they were good, they were totally fine, they ended up being not too scary, at all.’ (M L28)

While recalling the exposure he has encountered in his dealings with cultural issues, Jason also expressed the concern for his own safety:

‘I guess, you know, even though you are right in what you are doing, you worry that they may react aggressively, that you are the one who is going to need the next ambulance.’ (J L67)

Themes of personal safety continued with Nathan’s recollection of a similar encounter to Jason where family members, often in large numbers, display high levels of emotion:

‘It is at these times your own emotions run high, apart from being scared. Apart from feeling that you will never see your family again.’ (N L47)

Tina also acknowledged her own increased levels of personal fear that related to her dealings with patients and family members:

‘I didn’t know how they would react, you just simply don’t know with these things can go; you never can tell what these people may do with the backgrounds they come from, my safety becomes my biggest focus.’ (T L33)

Kate in her response, also detailed feelings of fear and concern for personal safety:

'Once the arrest had been called, and my partner said to the family there is nothing more we could do. My feelings originally would normally have been quite compassionate of the family, and their situation, immediately they were told that, it was like turning on a switch, it was immediately, extremely full on and aggressive type behaviours and I initially felt very threatened and very much Oh my God they are going to kill us, I had to get out as quick as I could.' (K L39)

When discussing aspects of patient care as they relate to cultural or religious preparedness, all paramedics involved in this study indicated the lack of insight they held and the consequences this can at times have on patient care. As discussed earlier, paramedic experiences in dealing with these situations does not seem to indicate that such exposure assists them in developing this knowledge base. The strongest reactions from the paramedic participants were received when they were asked about their experiences as they related to their own feelings when confronted by such challenges. Themes indicating frustration, increased stress levels and anxiety were common threads voiced. Intertwined within these were also sub-themes relating to paramedic levels of fear for their own physical safety, inadequacy, and being professionally compromised.

When discussing a case where the patient's family was hyperemotional, Cheryl, in her narrative, stated that:

'I just felt that anything we had to say to the family at that time would interrupt the process they were going through and a bit of it was safety We really did not want to be involved in

any sort of an incident that the family would have regretted, taking anything out on us unnecessarily. It was much easier to just extricate ourselves.’ (C L54)

Similarly, Dennis included in his response that the relatives’ hyperemotional responses had caused him some concern for his personal safety and that he had made a timely exit:

‘Just because things were so aggressive and unnecessary, I had never seen this before, and just went from really calm, to not a good situation as soon as we announced the relative had passed away, to a really hyper escalated, overcharged, I thought it was much more important to be out of the way so left them to it.’ (D L76)

In her discussions, Cheryl advised that as a paramedic, she has nothing in the way of tools to respond to a patient’s cultural or religious needs, and as such she is on high alert for her safety:

‘It’s a struggle, you know, we have no tools, nothing at all to deal with these people, you are on high alert all the time to watch yourself, its self preservation.’ (C L40)

Simon, when he was recounting a story of attending a Middle Eastern family where a family member had suddenly passed away, spoke of what he believed was an overreaction to the present situation:

‘It was hard to concentrate on what we had to do, the whole time we were conscious of what was going on around us, the environment, all these people wailing and screaming, was it safe, this is what we are taught, our safety is a priority, neither of us felt safe. We were

glad to get out of there. They appeared so aggressive, over reaction to the situation at hand.’ (S L29)

Not unlike Simon’s story, George also told of his experience in dealing with a family of strong cultural background and his perceptions of the family’s responses being threatening to his safety:

‘We were concentrating on just getting out of there alive, and as quickly as possible, just wanted it over. We were scared, very scared. There was so much wailing and carrying on. It was insane.’ (G L43)

These highly charged and emotional events that arise from time to time in a paramedic’s work life are rarely a cause of concern for them. However it would appear that when these events are inclusive of cultural responses that the paramedic is unfamiliar with, there is, sometimes, the tendency for the paramedic to view this behaviour as threatening their safety. From the very early stages in a paramedic’s education, safety is taught as being the most important aspect of patient care. Safety aspects of the work undertaken as a paramedic are continually focused on in all areas throughout the degree programs. Students are so programmed and indoctrinated with safety considerations that it is viewed, without a doubt, as the primary consideration when working as a paramedic. When a paramedic considers his/her physical safety is at risk, their immediate reaction would be to withdraw him/herself from that situation. It is not surprising then that when discussing aspects of patient care that relates to them feeling threatened, paramedics also include the

fact that they withdrew from the scene irrespective of the patient requirements. What is surprising, however, were the levels of fear paramedics felt for their physical safety, purely as a result of response to an emotionally charged situation where family members appear to be experiencing a grieving response to the presenting situation in the light of cultural norms.

All paramedic participants were readily able to recall instances, some many, where their interaction with a patient of a cultural or religious background different to themselves had left them feeling inadequate, frustrated, inexperienced, and highly stressed. The emotions of fear appear to emanate from self-interpretations and cultural misunderstandings on their part. Ambulance Victoria has a world-renowned and widely-recognised professional and peer support program – the Victorian Ambulance Counselling Unit (VACU) - in place that supports paramedic practitioners in all areas of work related stress. VACU was established as a pilot program in 1986 after the Russell Street bombing. The Program began by providing 24-hour counselling services. The Unit expanded in the following year to provide a Critical Incident Stress Management Program, which included a Peer program component. The Mission Statement of VACU is to provide education, counselling and support based on best practice to Ambulance Service staff and their immediate families in coping with stress and trauma. It also promotes the well being of ambulance staff and to minimise the adverse effects of vocational stressors. VACU currently provides a range of services to Ambulance Victoria staff and their immediate families inclusive of 24-hour Counselling Line, staffed by six experienced psychologists with training in Critical Incident Stress Management. Up to six

face-to-face counselling sessions are provided per financial year by VACU Sessional

Psychologists are also available.

Critical Incidents prompting pro-active Peer Support notification include:

- Attending ambulance crash
- Attending serious injury / death Ambulance employee
- Attending death / serious injury / illness family member / personal friend
- Attending Patients with similarities to a family member / friend
- Serious event involving child (under 18)
- Serious medical event
- Serious trauma event
- Serious midwifery event
- Fatal accident – road trauma / drowning / machine / other
- Gross sights
- Pt died during treatment / rescue effort
- Multiple fatalities / casualties
- Murder
- Suicide
- Extreme or lengthy rescue effort
- Actual physical assault at scene
- On scene threats – chemical exposure / body fluid exposure / needle stick injury / infectious disease
- Suffered injury at this event
- Pre-existing injury exacerbated
- Clinical issues / errors at event
- Poor on scene management
- Distressed from dealing with the bereaved
- Involved in Ambulance crash
- Preparation for critical incident

This list has grown over the years as Ambulance Victoria discovers new reasons for staff to be contacted. For example, this can originate from the staff themselves, or via our Communication centre, picking up a crew's reaction, or from a manager that has been dealing with staff. (Ambulance Victoria, 2011)

Interestingly though, despite their own acknowledgments of increased anxiety and stress levels as a result of dealing with the culturally and religiously diverse community, none of the paramedic participants thought it fitting to seek such support. The paramedic participants acknowledged that stressors arising from their dealings with the culturally diverse community are not formally recognised within the industry.

These emotional responses relating to the paramedics fear of their own safety seem to be intrinsically linked to the themes of cultural misinterpretations of cultural norms with origins stemming from an apparent lack of knowledge in this area.

Information relating to the demographics of Ambulance Victoria's paramedic workforce rounds was obtained to gain a clearer picture of the religious and cultural backgrounds of the services' operational personnel. However, the paramedic workforce demographics of are only observed by the organisation by means of gender, employment status, and qualifications. As at 31 December 2011, Ambulance Victoria's demographic data of its paramedic operational personnel is outlined in table 3 below. (Ambulance Victoria 2011)

Table 3 Ambulance Victoria Demographics.

Status	Qualification	Total #	Female	Male	Female %	Male %
Casual	ACO	473	238	235	50.3	49.7
Casual	ALS	100	51	49	51.0	49.0
Casual	BLS	5	3	2	60.0	40.0
Permanent	Graduate	300	162	138	54.0	46.0
Permanent	ALS	1654	698	956	42.2	57.8
Permanent	BLS	70	3	67	4.3	95.7
Permanent	M.I.C.A	470	57	413	12.1	87.9
Permanent	T/ Manager	173	18	155	10.4	89.6

Source: Ambulance Victoria, 2011

It is interesting to note that Ambulance Victoria does not collect data on its operational workforce that gives indications of their paramedics' country of origin, cultural or religious identity. This, in itself, would appear to further support the themes arising in this study that indicate the organisation's focus being on the physiological aspects of patient care and seemingly to exclude the paramedic / patient relationship, which at times is inclusive of cultural and religious identity issues.

A documentation analysis of Ambulance Victoria was also undertaken to review the ambulance service's policies in relation to cultural preparedness, and the extent that they are mandated in continuing education programs, or influence the institutional culture. The document search of Ambulance Victoria's policies and procedures failed to locate any guides, procedures, or policies that incorporate any content relating to the cultural or religious preparedness of their paramedics.

Further to the emotional responses of fear outlined above, paramedics involved in this study also expressed increasing levels of frustration when dealing with the cultural issues of their patients and the potential for this to impede the level of care offered.

When asked about his dealings with patients of different cultural or religious backgrounds, Michael described his levels of frustration as being intense, relating this to his own perceptions of the level of care offered:

‘There is no doubt there is an intense frustration out on the road at times of recognized lack of understanding about what certain beliefs or the custom they may have. The feelings of intense frustration, not knowing what to expect, being trained to respond to all patients in the same manner, when in actual fact no two patients are ever the same, this is incredibly frustrating.’ (M L45)

Simon admitted that his frustrations related to his own lack of insight into the cultural needs of his patients citing that, for him, situations outside of the norm increase his frustration levels:

‘It’s frustrating and at times scary when the algorithm doesn’t fit the situation, and you begin to wonder what in the hell I should do next.’ (S L49)

Nathan also expressed frustration in his response when asked about his experiences:

‘My feelings? The first one was one of frustration, firstly because I couldn’t provide the level of care that I was expected to provide.’ (N L43)

The themes of frustration continued throughout the paramedic data. Dennis, in his response, stated that, as a paramedic, he was not only frustrated by his inability to recognise patients’ cultural needs, but also embarrassed:

‘Frustration because I was somewhat caught out of the fact that I was unaware of their religious practices, and embarrassment that I didn’t recognise his religious beliefs.’

(D L52)

Cheryl also stated that she felt embarrassed as well as frustrated, stating that it is not an isolated incident for her:

‘Frustration embarrassment, a desire to think I should try learn some more about various religious beliefs and cultures, I keep getting caught out on this, it is really frustrating.’ (C

L42)

Sarah acknowledged that it was her own levels of fear and frustration that led to her inability to follow her normal routine mode of patient care:

‘It was this fear, the emotional fear and frustration of what was going on that I have no doubt interfered with our normal routine, our way of going about our job, our routine approach, what we would normally do.’ (S L42)

Following on from the themes of anxiety and fears of self-safety outlined earlier in this chapter, the strongest themes relating to paramedics emotions in dealing with the cultural or religious needs of patient care are those pertaining to frustration and at times embarrassment as seen from the narrative above. These frustrations ,however, did not appear to be associated with the patient they were dealing with at the time. These feelings of frustration were more focused on themselves and their inability to deliver adequate patient care to meet their patients’ needs, and, again, are possibly linked to their apparent lack of education in this area. Further, paramedics are taught a range of approaches in dealing with their patients from assessment to treatment, stabilisation and transport. These approaches are always inclusive of the biophysical, and often rely on specific flow charts and algorithms to follow, that is, the patient presents in this manner then the action is specified. Should the patient’s condition change, then the action should be the specified route of the flow chart or algorithm. The framework that paramedics work within does not consider aspects such as the cultural or religious requirements of the patient, and, when faced with such situations, it is not surprising paramedics feel out of their depth as there is no flow chart to follow to guide them through this aspect of their practice.

When recalling instances of his dealings with patients of different cultural backgrounds to himself, Brian expressed some nervousness and anxiety when confronted with some cultural norms:

‘Middle Eastern culture to my knowledge the husband is quite protective of the wife, knowing that, um I guess there is an element of um, nervousness and anxiety around assessing them because um, because, I don’t know, you are thinking the whole time is the husband going to be looking over my shoulder the entire time, exactly what is expected of me?’ (B L132)

Family members exhibiting cultural norms pose some concern for George as he recounts just one of his experiences in dealing with members of a Vietnamese family:

‘Vietnamese families that are frequented around here you might have anywhere from up to ten or twelve people in the one room all watching, and depending on your confidence that can be interpreted as scrutiny.’ (G L123)

Martin, in his dealings with cultural issues, discussed a case where he found the responses of family members confrontational, admitting that is also impacted on the level of care he would normally offer:

‘The father was very sick and arrested and I was exposed to a lot of grieving, to a grieving process which I had never experienced before where they were pulling physically, the

women were pulling their hair out, and banging their heads against the wall which is apparently their cultural grieving process for people from Iraq and possibility other Middle Eastern countries, it was very threatening. We left the scene without undertaking the usual requirements we would normally do'. (M L22)

Stephen also found that his lack of knowledge of cultural or religious norms left him feeling threatened:

'It is not what we are accustomed to, it was scary. It really looked like black magic was being performed, they were rubbing stuff on him oil or something, we could not help but think that man was dead because if some ritual, some sacrifice, we could have been next.'

(S L35)

Michael finds that when confronted with cultural or religious issues that he is not familiar with his frustration levels increase and as a result it is easier to ignore such issues:

'I remember one time where I saw an arrangement of tattoos all over the palms of the hands and face of an elderly woman and I wasn't sure what that represented, or whether she was a special person within that culture, or whether she was an elder or spiritual leader, I didn't know what that represented, so it was concerning, frustrating, in the end it was easier to ignore it.' (M L41)

Sarah, however, on reflection after an incident involving a grieving family questioned the reality of the situation at hand and the perceived threat:

'Later on reflection I began to feel angry and upset, upset at the frustration felt at the time.

Perhaps we were not under threat.' (S L41)

Many such cultural misunderstandings seem to be related to themes of a lack of clear insight into specific cultural needs and cultural reactions or norms. Paramedics openly concede their need to receive further education in this specific area and their current responses to these situations seem to be borne out of ignorance. Such ignorance appears to manifest in an interpretation based on Australian norms and is not reflective of the real situation. Many paramedics communicated accounts of situations where they felt unsafe and reacted accordingly. However, on reflection, these same paramedics now believe that, at times, they just misunderstood the reality of the situation they were faced with. On reflection, they were able to acknowledge that the forces that were at play were more the cultural or religious components of the patients, or patient's family members, that were being ill-assessed or misinterpreted by the paramedics themselves. Similarly, paramedics that have a limited knowledge of cultural or religious requirements found that this only enhanced their anxiety; they knew enough to be aware there could be some contentious issues, yet they were not skilled enough in this area to identify how they could enhance their level of insight into cultural or religious awareness. Paramedics frequently stated that gaining insight as to why certain patients responded in specific ways would greatly reduce their anxiety levels and improve patient outcomes. Further to this, given that some cultural norms insist on relatives being present, as a display of care, concern and affection, it is interesting that the themes relating to these instances were portrayed in the negative by

the paramedic participants and became about themselves as opposed to the patient. Such themes were explicit about the paramedics viewing this as scrutiny of themselves, anxiety provoking, and, at times, threatening their physical safety.

Communication is a two way process. It is the mechanism that paramedics heavily rely on when undertaking their approach to assessment and patient care. Many paramedics struggle with gaining the required information from their patients when there is a language barrier and are forced to resort to using an interpreter. This is accepted practice given the many community members in Melbourne who are of non-English speaking backgrounds. An added layer of communication difficulties appears to arise when cultural norms dictate a communication hierarchy that paramedics are not familiar with.

Georgia acknowledges these difficulties in her responses when discussing cross-cultural communication and her own interpretation of how some cultural groups differ in their ability to communicate openly:

‘You certainly notice that there are some cultural groups that are less inclined to communicate with you, they lack a certain openness. Certain cultural groups certainly have differences in their general communications, in their interactions. Communicating with regular patients is easier, they respond, it’s much easier.’ (G L61)

In his dealings with a Muslim patient, Brian offers the example of how his own lack of knowledge of the cultural issues that were at play interfered with the communication process:

‘There was quite a lot of palpable anxiety between the two, it was very difficult to be able to communicate and assess her, and not really knowing their particular background, what sort of sensitivities that I need to be aware of, it was difficult to comfortably and naturally interact with them as you would with most patients.’ (B L46)

Scott, in his response, told of a situation that he encountered where he was ill prepared to deal with the communication hierarchy in this family:

‘It was frustrating, very frustrating, but there was not anything else we could do, I understand there is a communication hierarchy, but I don’t know what it entails. We got it as chest pain, short of breath, so there were some things we could do, but trying to get answers, it took until the son arrived. Until then we couldn’t do anything, gain any information at all. It was frustrating not knowing if there was something else we could have done.’ (S L98)

George, in his encounters, described an event where there was a clear cultural communication hierarchy evident; however, his own lack of knowledge in this area resulted in his inability to recognise it:

'We were talking to the young boy, but via the mother. The mother did not have the ability to speak to us, she had difficulty communicating as she did not speak a lot of English, and on top of that we had the layer of the husband who was in a different room. It was difficult, apparently we had to address him, and ask him, it was almost as like we should have known the hierarchy, like he was testing us, he was in the other room waiting for us to approach him and recognize him as the head of the family unit and obtain his permission to ask his family questions. This is not something I am accustomed to doing I don't understand the need.' (G 135)

Not unlike George's situation, Michael acknowledges that his inability to pick up on the cross cultural communication hierarchy proved challenging:

'We only picked up on this via visual cues, body language, every time we asked something, we were referred to the husband. We should have picked up on this straight away, but for some reason we persisted on pursuing and questioning, the mother and child. We would ask her a direct question, and she would literally just shrink back in her chair and looked into the other room at her husband. Had we been more in tune with this then we would have saved ourselves a great deal of grief.' (M L43)

Ironically, it would seem that open dialogue and communication would aid paramedics in obtaining results in areas where they are unfamiliar. Paramedics obtain much of their information relating to the care of their patients by varying communication types, and most are versed with extensive communication skills. Yet in dealing with patients of differing cultural and religious backgrounds, themes seem to indicate that paramedics in this study

view culture and religion as a barrier to communication. This does not however, seem to be evident in their communication with patients of similar cultural backgrounds to themselves. Data findings in this project indicate that some paramedics misinterpret cultural norms as being closed communication from their patients purely based on their own communication norms relating to their own Australian cultural backgrounds.

Not unlike cultural communication norms, some cultural or religious rituals seem to cause confusion to the paramedics involved in this study, resulting in misinterpretation and judgment on occasions.

Dennis described a situation where, when confronted by a cultural ritual he lacked the ability to understand the event resulting in a judgment of the family by him being made:

‘I have no idea what the family was thinking, they house was like an oven with, they had him on the bed lying down, making him much worse. They were rubbing this fowl smelling oil over his body.’ (D L35)

Not unlike Dennis’s situation, Marcus felt the challenge of integrating the cultural or religious rituals requirements of his patient and his own requirements for undertaking his paramedic role:

I am not sure of the family members were raving incoherently, or chanting, either way, they were in our way, having a huge impact on our ability to treat the patient. I mean, if they did not want us there, why did they call us?' (M L46)

Natalie also struggled with her understandings of cultural or religious rituals, which appeared to have resulted in her judgment of the family based on her own Australian norms:

'The scene was something out of a bad movie, even down to the heavy smoke filled room. Not sure why there was so much incense burning, but that could not have helped his breathing either.' (N L61)

Again, cultural or religious rituals presented concern for Sarah, and are not dissimilar to the previous narratives from the paramedic group. Sarah also struggled with gaining an understanding of her patient's needs and balancing this with her own paramedic duties. Again, as seen in earlier narratives, some paramedics view a display of cultural norms by their patients as impeding their practice, and, as such, question the need for the paramedics to attend:

'I recall this strange smell, to this day I have no idea what it was, but it was overpowering, strong, not a food smell, just strange. The people were aggressive, screaming, there was this one man, strange, weird, he looked like he was waiving

something around, like a stick in the air, it was all very tribal. We just wished they either had got out of our way or not had called us at all.' (S L24)

Jason also recounted an example where his lack of knowledge of cultural or religious rituals resulted in judgment of his patient and family:

'There was music playing, the whole scene looked like a ritual, witchcraft, it was way weird.' (J L28)

The exposure of paramedics to cultural or religious rituals appears to do nothing to enhance their understanding or knowledge in this area. The experiences of the paramedics in this study to patients of different cultural backgrounds indicate that rituals the patient, or patient's family, engage in, or the expectations they have of medical intervention, are viewed as unnecessary. This could be so due to the focus of paramedic education being so heavily weighted towards physical interventions. The paramedic subgroup also appears to believe that the behaviours of the family impede adequate delivery of the paramedic's interventions, with these interventions being embedded in Australian norms. The paramedic's perceptions in this area display strong themes of the animosity paramedics have towards patients in these particular situations. The paramedic's ignorance of cultural or religious rituals comes at a time when their patients are feeling most vulnerable and turning to their faith or culture for support, is evident in these themes.

Not unlike the cultural or religious rituals demonstrated by some community members outlined above, their emotional responses to specific circumstances also leave the paramedic subgroup perplexed at times.

Shannon, when describing the response of a patient to pain, expressed that, in her judgment, the patient's reaction was excessive and inappropriate at times:

'Their excessive crying or moaning about something that is not that serious, it's a bit over the top most of the time. I think at times they are quite flamboyant, their family unity might very much encourage you to express how you feel, regardless of whether it is appropriate, and most of the time it is not.' (S L101)

Georgia made similar judgments and generalised statements in her recount of an Italian family's response to pain by comparison to her own interpretation of Australian norms:

'Italian family where they're quite expressive about their pain and their emotions, way above anyone else. For example me breaking my leg I might be more reticent about, whingeing about it, as opposed to other cultures who relish in the pain, and allow everyone else to experience what their experiencing, totally unnecessary and seems more about attention seeking than what is real.' (G L108)

Themes of a lack of understanding of cultural responses continue with Sarah's narrative also including that she is surprised by European responses being as they are given they are 'westernised':

'The Europeans can be quite full on in that they are very westernised in most areas, but family wise when something goes wrong you have got to deal with them really firmly before the emotions get out of hand, particularly where pain is involved.' (S L42)

Paul admits that, for him, his own inability to understand some of the cultural norms relating to emotional responses leave him overwhelmed:

'Italian people in Northcote who have a very, I think culturally emotional response to pain and that sort of stuff, and to me I find that really overwhelming the way they carry on over such minor issues.' (P L35)

In his responses, George acknowledges that there are cultural differences in the way some cultural groups experience emotion such as pain; however he believes it to be excessive and too dramatic:

'There is a cultural difference in the way people experience pain, and the Italian and Jewish communities, particularly my impression has been that there is an expectation that they will sort of externalise the pain, and be far more emotional about it, far more vocal, both for themselves and for the relatives. There is far more drama associated with it than what is

needed. Whilst I've said Italian community and Jewish community, this also includes Mediterranean people in general, than say may be Anglo Saxon people.' (G L44)

Dennis also comments that some cultural groups present with exaggerated emotional responses that he believes are unnecessary. He offers the example of the Lebanese community:

'Lebanese, I don't really know how to explain them, but then again family orientated, when you go in they are quite stressed, it's stressful for them, and emergency for them, so when you go in you bring it down a notch and try to figure out where they're lying with their cultural experiences. It's always hard to assess them, their emotions are unnecessarily exaggerated.' (D L53)

Jason's expectations of his patients' emotional responses are that they should not be dissimilar to his own:

'I come from a background where there is not a great emotional outburst when someone dies. You go into these houses when someone has died, and there is wailing, I suppose you call it, yes, it is carry on, these people carry on, yes they carry on.' (J L41)

When discussing patient responses, strong themes became evident about paramedics views of how patients should respond to them in varying situations. This appeared to bring about a 'blame shift' in the paramedic responses from earlier responses about their lack of

education to now that of the patient. These expectations seem to be embedded in the norms one would normally expect to find within Anglo reactions. Considerations of cultural norms and how patients react according to their individual cultural norms seem to be either totally ignored or viewed as non-relevant to the paramedic. In many non-Australian cultures, cultural norms dictate how one responds to physical and emotional disquiet either as the patient or the patient's relative. Such responses are not only considered appropriate within the culture, but also expected. Emotional exhibition, within some cultural groups is considered respectful and a sign of compassionate understanding. Themes from the paramedic subgroup in this sphere display a strong disconnect between their understanding and misinterpretation of the patients responses, often being dismissed as unnecessary and attention seeking.

Cultural norms for some communities, particularly those of the African communities, influence communication and responses to authority. As discussed earlier in this chapter, paramedics in this study feel their uniform alone represents their authority and offers their patients the confidence in them that is deserved. However, little insight is held by the paramedic subgroup as to the fact that it is indeed their uniform that, in some instances, impedes this process. Many individual members of these community cultural groups have a genuine and well-founded fear of people in uniform. Many members of the African community have witnessed atrocities at the hands of people in uniform, and their reticence to be open in communication with paramedics can be viewed as just a reluctance to be compliant. Reluctance to communicate may stem from previous exposure to horrendous

situations, or merely fear of government affiliates holding the balance of power over benefit payments, asylum / immigration applications, etc. Irrespective of the basis of this, paramedics view this as a lack of trust the patient has in them as healthcare professionals and their capacity to address their needs.

Martin felt that his uniform should hold some authority, a command for respect. He discussed his dealings with Sudanese members of the community:

'I mean we are in uniform, this in itself should mean something, you don't need this added pressure, these feelings of fear that you are going to be attacked. This particular time involved a Sudanese family, these gangs they are in, when a family member is seriously hurt they are out of control. We just leave them to it.' (M L35)

Natalie discussed just one of the times that she has encountered problems with what she perceived was a lack of respect offered by a patient's family member to her and her partner:

'We went to a patient, it was his mother, she did not speak any English, he was about eighteen, he had to do all the communication for us, and he would not look us in the eye, we were both female in uniform. We were trying to figure out what was going on, and for some reason he just wouldn't look at us. We both felt uneasy about his behaviour, and lacked respect for us in this situation.' (N L153)

Georgia also believes that her uniform should command respect above and beyond normal cultural responses:

'Islamic people, um, in the, the men not feeling that women are appropriate people to make judgments or not appropriately competent. We are in uniform; this should mean something, our credibility at least. This infuriates me.' (G L29)

These themes continue with Michael, in his dialogue generalising that the African community are always in gangs and as such pose a safety threat; however, relies on his uniform to offer a degree of protection:

'Every time we go to a call to one of these patients (Africans), it is always in the back of your mind you know, is it going to be safe, are we going to get out of this unscathed. These people, they are always in gangs, it is the way they are, this can be very threatening, they are always angry, angry gangs of people, even the families are in, gangs. You would think that our uniform would be respected a great deal more.' (M L24)

Simon, like Michael generalises about the African community, and comments that the Maori community is aggressive with the intake of alcohol. He does, however, express some concern as to whether or not his uniform is of benefit or hinders the situation:

'The Maoris' can be quite aggressive in the nature that a lot of the time you go there are parties, loads of alcohol, lots of aggression, they are really an aggressive race, so loud. I wonder sometimes if it this aggression is a response to authority, us being in uniform and all.' (S L50)

Like her colleagues above, Sarah believes that it is her uniform that offers protection in a situation where community members' hostility will escalate if paramedics disagree with their patient's cultural beliefs:

'With the Africans and Sudanese, if you're going to go in there and disagree with their religious and cultural beliefs, even if you knew what they were, they will get nasty. I am glad we are in uniform, I am sure if we were not there would be more assaults on us.' (S L85)

Tina also made comments in her dialogue that she believed the uniform she wore commanded respect:

'It is concerning, we go about our routine, the job we are supposed to do, we are supposed to be regarded with respect, I mean we are in uniform.' (T L229)

Paramedics continue to display themes of cultural judgments, with such judgments seemingly derived from established Australian norms. Whilst many generalisations were represented in the paramedic transcripts, deep within these were themes of a clear lack of insight into cultural practices or religious requirements. Interestingly some of the themes within the transcripts not only generalised some specific cultural groups as being aggressive with alcohol consumption, but also indicated that this was an unacceptable practice. Yet, at no time, were there any parallels drawn of a similar nature to that of their Anglo counterparts. As seen in Michael's reflections, when discussing various cultural groups use

of paramedic services, he includes in his comments that he believes the African community members hold an unrealistic view of the use of paramedics:

'The day you have an Anglo as a patient is a bonus. The main patients I see in my work are, you know, the dark skin ones, not the Africans, the darker ones than that, the Sudanese. These are the ones who bring us the most concern. They call you at the drop of a hat for no real emergency, it is like we are at their beck and call. They are such an aggressive lot.' (M L19)

Within this, it is possible to interpret many of the comments made by paramedics involved in this study as being racist, in the sense that they carry many of the determinants of racism, as defined by Razack (1999) who maintains that racial discrimination occurs when a person is treated less favourably than someone else in a similar situation because of their race, colour, descent, or national or ethnic origin. He argues that humans construct racism, that it incorporates pre-judging someone based on a belief that one's own culture is better than others. He adds that it is also behaviour exhibited as exclusion, and can be determined via four components:

1. Categorising by race.
2. Stereotyping racial categories
3. Evaluating racial groups on the basis of assumed genetically determined characteristics.
4. Behaviour - these beliefs are used as the basis for discriminatory behaviour.

Two further definitions of racism are argued by Fleras and Elliot (1999) who state that racism consists of the power to put self-beliefs into practice in a way that denies or excludes those who belong to a perceived devalued category. They continue by presenting their components of racism by summarising an equation of racism as racism = prejudice + discrimination + power. Arguably, all the components of this equation are evident in some of the paramedic / patient relationships outlined by a number of the paramedic participants in this study.

Paramedic interpretations of their patients being loud, vocal, or demonstrative were often viewed as aggressive, when indeed there may have been no aggression exhibited. Similarly, many paramedics felt the need to take control of what they had assessed as an emotional response exhibited above what was considered normal by their own Australian standards, and contain the patient or patients' family. The role of their uniform was seen as a protective one which commands respect, with only one of the responses from the paramedic subgroup conceiving that, in some situations, it may be a hindrance. Yet there were no responses received that gave any indication that the paramedics themselves held insight as to why this may be the case.

Similarly, paramedics involved in this study believed that some cultural groups hold an unrealistic expectation of them as emergency health care providers, some viewing this as a cultural issue in itself. The paramedics appear to hold some expectations of cultural groups to conform to Australian norms as outlined previously. This also appears to be inclusive of

cultural groups conforming to the paramedics' parameters of what constitutes the use of their service.

Continuing on with this theme, and not unlike Michael's views, Martin also concludes that in his belief some cultural groups utilise the health services inappropriately due to a lack of understanding of what is available:

'In a lot of areas I have worked people that get sick irrespective of their illness will always think about going to hospital, and that's I believe a cultural issue in itself. Were they in their country they probably only had a hospital whereas in this community we have many services that they could access, it is a lack of understanding on their behalf. They have no understanding of what is available so instead we just get called.' (M L57)

In his comments on this issue, Nathan reported that members of the African community required some degree of education in the appropriate use of his services as a paramedic; however, when this was undertaken it was met with some resistance:

'With a lot of the Africans, it's like they've come from a third world country where they have got nothing, to now where they will call for anything, expect everything, and it is up to us to educate them, you don't need an emergency ambulance for this. When we do this, they become quite demanding, like it's their right to get an ambulance for something so minor.'

(N L144)

Themes of inappropriate use of paramedic services by some community members continued as Cheryl described her own experiences in dealing with members of the African community. In her dialogue she indicates that it is her belief that some community groups are 'spoilt' by the readily accessibility of paramedic services.

'I thought they (Africans) would hold a little bit more respect for Australia in that sense, but they will call for ridiculous things, you just think that they have come from something that is horrible, and they've probably got some horrible stories, and they don't ever get an ambulance or ever get seen at a hospital, and they come here and you try and educate them that this isn't an emergency and you could take yourself down to the hospital, they get quite huff and puff, and throw things around, it makes me think that we are kinda spoiling them a little bit. I mean, Australians know the system, when they call we know they need our help to get to hospital.' (C L147)

Themes originating from the paramedic group appear to relate to the dissimilarity that exists between the paramedic and patient cohorts on their respective views on the use of the ambulance service, or indeed what is considered to be an emergency. Paramedics have clear expectations of what they consider to be an emergency situation, and thereby warranting their services. Members of other communities however, are not so familiar with the medical systems as they exist in this country, or indeed bring the same expectations with them from their countries of origin. Australia has a healthcare system that is multifaceted, and multilayered, the complexities of which are often not conducive to those who are unfamiliar with the system. Indeed, this is the basis of the move seen in

recent times to cultural and religious-specific healthcare facilities. Community members struggle to navigate the healthcare system and utilise what is known and what they know will respond to their call of need. Many community members from all aspects of the population are also frequently restricted in mobility, either by physical, emotional, or financial mechanisms. For most of these community members, the first line of call for assistance will be the ambulance service. Yet paramedics perceive this need as an abuse of their service, with narratives such as 'demanding' and 'spoiling them', with comparisons of where they have lived and what they have been exposed to, and the belief that living in this country should now mean lived experiences here should pale into insignificance. Sub-themes also indicated that some community groups require educating in relation to the appropriate use of paramedic services. Whilst paramedics acknowledge their own lack of education in areas relating to cultural and religious preparedness, similarly, the paramedic subgroup believe that many cultural groups lack the education on effective and appropriate use of their services, and when attempting to do so is met with resistance and hostility.

In these multi-layered responses from the paramedic group, themes of trust became evident. Kate describes Sudanese families as being resistive and non-engaging thus hampering her level of care:

'Sudanese families I have been to I have noticed some resistance with their engaging. To not have their full trust can be disarming, I mean why bother?' (K L175)

Simon also concludes, in his narrative that there are issues of trust in the patient – paramedic relationship that have an impact on the delivery of his services:

‘These families (Middle Eastern) are very resistive, they are, on guard as soon as we enter into the house. It is a useless situation, the more we want information, the more resistive they are, their refusal to trust us. I don’t know then why they call for us in the first place.’

(S L177)

Within the paramedic subgroup, the themes of trust that were identified appear to cause concern for them. Whilst some cultural or religious practices may require the patient to be somewhat inhibited, respectful, and reticent, and is viewed by the patient as a respect for authority, paramedics demand the same authority, as seen in the themes already outlined. However, often it goes way beyond this. Paramedics in this study viewed their patient’s reticence as a lack of trust in their capacity as health professionals.

Entrenched in any health care professional is the requirement to deliver a component of education to the patients they care for, primarily confined to the injury or illness the patient presents with. This community health education service is also inclusive of health promotion and disease prevention, and is widespread amongst the paramedic profession. Stephen made the observation that from his perspective, part of a paramedic’s role is community education; however he believes that there are some cultural groups who are resistive of this:

‘Part of our job is to educate the patient, not the other way around. You have to realize that it is us that are in control of a situation, we have the knowledge, we have to contain and control. Many of these cultural groups refuse to accept this as a role we play.’ (S L58)

Marcus also expressed concern over some cultural group’s willingness to accept advice from him, and includes aspects of the balance of power this educative role has:

‘The Italian families are warm to your presence, the fact that they like you are there, they make you feel like you are important, they accept what advice you have to give. Whereas others, many other cultural groups are not all like that, if someone wants something specific, I am not going to expend energy arguing with them, trying to educate them when they think they know better’. (M L171)

Brian echoes both Stephen’s and Marcus’s views about some cultural groups appearing resistive to his education of them, and adds that, when this occurs, he shifts his focus to a physiological approach. This is also inclusive of an inequitable power relationship:

‘We have a job to do, we generally, do it well, I don’t really see there is a need to look at cultural issues; there should be an understanding of what we do as paramedics. The need is for them to see what we need to do, accept what it is we have to offer not for us to see what we should be doing for them. We are the clinical decision makers. I mean, you can try and do the balancing act, but even this is hard as we have no knowledge of this, so the focus has to be the physical care, I mean that is what we know, their physical needs.’ (B L34)

One of the strongest themes that came out of the paramedic subgroup, when discussing their exposure to patients of differing cultural backgrounds to themselves, relates to self-perceptions of superiority and importance as they relate to the patients they are attending. There appears to be no doubt that paramedics are well-equipped to deal with many facets of patient care including the provision of healthcare education for their patients. There does, however, appear to be such a strong emphasis held by paramedics on patient care relating to the physiological, with further subthemes indicating a lack of insight or unwillingness to recognise the value of a patient-centred approach. These themes relating to paramedic superiority seem to be related to their knowledge base of patient care, the fact that they are an integral part of the healthcare team, and the uniform they wear. These themes were so robust and seem to totally exclude any patient consideration. This authoritarian aspect became strongly evident from the paramedics involved in this study who seemed instinctively proud of their roles and an asset to the community, the focus of which however, was more related to the uniform they wore and the control they command than the skill sets they held.

All the paramedics in this study (n=20 100%) made comment during their interviews about the focus being on the physiological aspects of their patient care, with many reflecting on their education being focused on such aspects to the exclusion of sociological determinants of health care provision. There appears to be some tension that exists between the paramedics' strong physiological focus and their capacity to address the cultural needs of their patients. Some of the paramedics, like Nathan, believe that a patient's cultural

background presents a barrier to his care, and Nathan used the term 'fragmented' when commenting on the flow of the care, he offers when dealing with patients of this nature:

'There is a certain degree of synchronicity in jobs that you have, your clinical side, your clinical interaction, you also have your social interaction, the two usually synchronise and mesh together, and they just flow together like it should according to what we are taught. Where there is a cultural barrier, or religious barrier, they tend to clash, and the various aspects of the job become fragmented. It doesn't flow. Jobs with patients from western backgrounds flow better because there is the underlying understanding, an awareness, an assumption, I suppose, of what their expectations are, and their cultural backgrounds don't get in the way as much. I believe every time I have conducted a job where I have not understood their culture or religion it has hampered the flow of the job.' (N L105)

The themes of physiological focus were continuing, and often seemed to be used as a 'safeguard' for the paramedics involved in this study; the blame game continuing, as has been discussed previously in this chapter. The paramedics' lack of capacity to address the needs of all the patients they serve has already been identified by paramedics in this study as being the responsibility of their educators and their employer, and due to a lack of resources, even the patients themselves for not having an understanding of the paramedics' routine approach and respect for their uniforms. We now see a further shift in responsibility to the organisational system, the system that appears to 'dictate' the approach they have towards their patients. Scott, in his interview wrapped this theme up succinctly:

'The ambulance service is built on algorithms, everything we do is by the book, and you follow the physical process. There is nothing in the guidelines that suggests we should be treating other than what we can do. We are focused on the physical aspect, the physical needs of the patient, I am not sure why cultural needs, are needed to be considered. It is difficult to implement cultural needs into patient care, as interesting as it may be, our focus is clinical, we have a clinical approach to follow, this does not take into consideration anything else but the patients physical needs and perhaps some emotional support if needed.' (S L47)

Dennis, in his narrative, highlights that, for him, his lack of capacity to deal with the cultural or religious needs of his patients is almost permissible, as his colleagues are as ignorant of their requirements as he is. He appears to be indicating that if it is a level playing field for all paramedics in their knowledge base, then this is acceptable. He concludes that as there are no consequences for ignoring patients' cultural or emotional needs, then this is also acceptable. Again this physiological focus is so robust in the paramedics' narratives:

'If there is a cultural issue, your colleagues are as clueless as you are so it is OK, no one is the wiser. It is never considered important enough to worry about, I mean ignore the treatment of something, like a heart attack and there are dire consequences. Ignore a patient's cultural or emotional needs well there are no consequences.' (D L66)

Throughout the course of the interviews, some of the paramedic participants also touched further on the issue of the organisational culture, mainly relating to the demographics of

paramedics. In his discussions, Simon commented on the recruitment of paramedics being focused on Anglo Saxon community members:

‘I have noticed the ambulance service itself is comprised of a high majority, almost exclusively white Australian workforce. That’s interesting when we live in such a multi cultural community.’ (S L51)

Marcus also noted this focus, however, he included in his comments, that he believed the service, in recent times, had undertaken a shift in its recruitment to include cultural and religious groups that have previously been a minority. He does, however, state that there is a high attrition rate of these recruits:

‘I also feel that traditionally recruitment by the service has been aimed at Anglo Saxon WASP type presentations and now, probably because they have to, you are seeing a few more paramedics coming from what is not the middle class eastern suburbs type crowd, which I think is really positive and can only be a good thing, even though they don’t tend to last long.’ (M L95)

When looking at the responses and themes generating from the paramedic subgroup transcripts, it is important to consider the environment and organisational culture they work within. The paramedic workforce in Victoria is steeped in a historically military background dominated by the male gender. It is only in recent years that females have been accepted into the service as paramedics, and whilst the gender ratio is rapidly moving towards parity,

much of the founding culture is still prevalent today. The Anglo middle class paramedic heavily dominates the paramedic workforce within Ambulance Victoria today despite organisational attempts to recruit a more culturally diverse workforce. Student intakes in Victoria, whilst attempting to redress this issue, are struggling to recruit students from varying cultural or religious backgrounds, and where this does occur, this classification of student intake exhibits a high attrition rate from the educational programs.

Victoria University (VU) houses the largest paramedic educational program in Australia. The undergraduate program at VU supplies Ambulance Victoria with 72% of its graduate intake with 94% of VU graduates gaining employment with the service. These numbers have been consistent for the past four years.

As the program leader, part of my responsibility is to determine not only the data mentioned above, but also the demographic data of VU's paramedic programs. What are relevant to this study, I believe, are the following demographics related to the undergraduate paramedic program at VU. There is no reason to believe that this data will vary significantly to those of other Victorian universities offering paramedic degrees. Given that VU's paramedic program is based at St Albans campus, and the underpinning ethos of VU is bringing higher education to the disadvantaged west of Melbourne, you could expect to see a higher ratio of students from differing cultural and religious backgrounds attending VU compared to those of other Victorian programs. Table 4 shows the reportable student enrolments by gender in VU's 2010 / 2011 paramedic undergraduate program.

Table 4 Victoria University Paramedic Undergraduate Program Reportable Student enrolments by gender 2010 / 2011.

Gender	No of reportable course enrolments 2010	%	No of reportable course enrolments 2011	%
Male	382	53.3 %	383	51.7%
Female	335	46.7 %	373	49.3%
Total	717	100 %	756	100%

Source: Victoria University, 2011

Table 5 shows the reportable student demographics in VU's 2010 / 2011 undergraduate program.

Table 5 Victoria University Paramedic Undergraduate Program Reportable Student demographics 2010 / 2011.

Aust. Indigenous Identifier	No. Of reportable course enrolments 2010	%	No. Of reportable course enrolments 2011	%
Aboriginal	2	0.3%	1	0.2%
Origin other than Australia	2	0.3%	3	0.4%
Australian Origin	698	97.4%	733	96.8%
No information	2	0.3%	3	0.4%
Unknown	13	1.8%	16	2.2%
Total	717	100%	756	100%

Source: Victoria University, 2011

The data in table 5 is a clear indication that the gender mix of students at Victoria University is balanced at an almost equal mix and has been so for 2010 and 2011 being 53.3% (m) / 46.7% (f), and 51.7% (m) and 49.3% (f) respectively.

The data in table 5 offers insight into how using the Australian Ancestry identifier utilising student identified ancestry, is similar to the data I presented from the Australian Bureau of Statistics in the introduction of this thesis. This table offers evidence that in 2010 and 2011 97.4% and 96.8% of paramedic students at VU identified as Australian Origin.

Cultural or religious backgrounds are not a consideration of selection into the paramedic program at VU.

Conclusion

During the course of the paramedic interviews and subsequent data analysis, there were many themes that became evident, although some were significantly stronger than others.

When discussing cultural and religious issues relevant to the care of their patients, interestingly many of the paramedics involved in this study displayed some difficulty in grasping this concept. Confusing cultural and religious preparedness with communication, that is the capacity for paramedics to converse with their patients in the patient's native language, was a common theme.

The strongest of all the themes arising from the data collection from paramedics related to their education and training and the lack of curriculum content that they had received to adequately prepare them to deal with the cultural or religious needs of the patients they were attending. Given that the current paramedic workforce in Victoria is comprised of a

mix of university graduates and post-employment (in-service) models of education, there was no discernible difference between the two groups when curriculum content was discussed. Similarly, there was no difference in the responses received from paramedics who underwent their education in recent times or those who did so more than five years ago.

The paramedics in this study clearly identified that there was a lack of curriculum content in their education that related to the cultural or religious issues of patient care at either undergraduate or postgraduate levels. Some even appeared to be confused by the question and doubted the relevance. In instances where some of the paramedics in this study could recall minimal curriculum content at undergraduate level, there was a strong indication that this was both inadequate and lacked relevance by focusing primarily on communication styles. They also identified that it was limited to the use of interpreter services as opposed to actually defining the various cultural or religious needs of patient care.

The data from the paramedic subgroup identified there were several aspects to the education and training of paramedics in Victoria. Whilst the larger proportion of their formal education is delivered in their respective undergraduate programs, paramedics also receive ongoing formal education by attending ongoing professional development opportunities provided by their employer. Paramedics also learn by the more tacit opportunities that on-road exposure brings.

When discussing their continuing education as provided by Ambulance Victoria, the paramedics in this study all acknowledged that they had not received any input by their employer that assisted them in dealing with a culturally and religiously diverse community.

With respect to the opportunities on-road experience affords paramedics, most that were involved in this study suggested that this failed to give them any real understanding of the cultural or religious issues of patient care. In some instances such exposure only added to their confusion and increased their misinterpretation of what they were experiencing, often resulting in homogeneous attitudes towards their patients.

The data also suggests that most of the paramedics involved in this study believe that being more culturally and religiously prepared would enhance patient outcomes. However, all view this as an organisational responsibility. The ethos of the Ambulance Service appears to dictate that, if there were aspects of patient care that were important then Ambulance Victoria would deliver the information required. This appears to support the notion of some of the paramedics who questioned the relevance of a holistic approach to patient care. Similarly, whilst many of the paramedic participants acknowledged their lack of capacity to respond to the cultural or religious needs of their patients, all believed that the service should provide this or pay them for gaining such knowledge. The institutional ethos in this regard was so evident that it tended to cloud the paramedics perceptions of the ongoing self-education responsibilities that are seen in other professional healthcare disciplines.

During the interviews, the narratives of the paramedic participants revealed that a high percentage displayed a strong Australian focus that impeded their ability to look beyond the conventional and allow the integration of non-Australian norms. Many of the paramedics in this study continually referred of their need to focus on the physiological aspects of their patients, and cited procedures and algorithms to enhance the level of their patient care. This was to the exclusion of any biopsychosocial approach inclusive of cultural or religious needs, with many paramedics failing to see how this, at times, impeded the paramedic / patient relationship. This is not surprising given that the focus of Ambulance Victoria's continuing education programs and peer support critical incident notifications also excludes this relationship.

Throughout the interviews, paramedics consistently referred to the point that their uniforms should command respect, and failed to acknowledge that, in some instances, it is their uniform that impedes this very process.

The data collection from the paramedic participants also showed that the paramedic subgroup believed their inability to respond to patients' cultural or religious needs had significant impacts on them both professionally and personally. Responses from paramedics show that they experienced increased levels of stress and anxiety at times of dealing with patients who have specific religious or cultural needs. The data also suggests of significant increases in frustration and embarrassment experienced by the paramedics interviewed in

this study due to their lack of knowledge and capacity to address these needs of their patients.

This lack of knowledge and understanding of patients' religious and cultural needs has, in many instances, resulted in a misinterpretation of situations faced by paramedics. Some community group members displaying norms relevant to their specific cultural or religious identity have not been understood by the attending paramedics, resulting in the paramedics holding significant fears for their personal safety. According to the paramedics in this study, this has resulted in a decrease in professional credibility and lack of confidence that the patient has towards the paramedic further eroding the paramedic / patient relationship.

Throughout this data, there were the recurrent themes of responsibility and blame. The paramedics' narrative in this study consistently displayed a blame shift as the paramedics became more aware of a facet of their care they were ill equipped to deliver. This 'blame shift' commenced with the educational institutions' failure to provide them with the appropriate knowledge and skills sets due to a lack of curriculum content relating to cultural or religious preparedness. The focus of this responsibility, then became that of their employer, Ambulance Victoria, and its failure to supply them with the required knowledge. The culture of the organisation was also included in the responsibility realm, claiming that the responsibility of the paramedic is to only deal with a patient's physiological status. The final blame for paramedics in this study of not being culturally or religiously sensitive to

their patients' needs rested with the patients themselves, depicted by paramedics as failing to respect Australian norms and having unrealistic expectations of health services.

This chapter has detailed the paramedics' perspective, their voice, giving clear indications as to their views, both as healthcare professionals and from their individual personal perspectives. The next chapter analyses the patient data, giving their interpretations from their perspectives, and giving the opportunity for their voices to be heard.

Chapter 6

Data Findings

Community Participants Subgroup

My name is Tesfay, I am from Africa, Eritrea, and I cannot speak English very well. I now live in Melbourne Australia with my family, my mother Kidane, my husband Sayid, and our three children Saare, Hayat and Aziz. We have been here in this country for nearly 11 years now. I came to Australia with my mother and soon after my arrival I met my husband. (smile)

I have lived most of my life in Eritrea, and have no fond memories of my childhood there. Life was difficult for many reasons, but people only speak of the lack of food and water, people dying of hunger and thirst. What people do not speak of is the unspeakable; this is really why we are here, because of the unspeakable.

We lived in a small village and life was simple, I went to a small school but only for a few years, I still cannot read or write very well. My husband teaches me, and my children go to school here. They know much more than I do. (smile) My father worked in the fields when work was there which was not often. My mother worked hard at trying to feed us. There was much sickness around us all the time. My father's and mother's families also lived in the village.

In the years before I left Africa life had become very, very difficult. There were many soldiers who would visit the village often in the middle of the night. Many houses were burned and many people killed. I was 16 when my mother and I were forced to watch my father being beaten and cut to his death with a cutting blade. My uncles also were killed the same way with us being forced to watch and then tend to their needs after the soldiers left. Soon there were not many males left in our village.

The soldiers would still come, more and more frequently. The women were dragged by their hair and raped in front of everyone else to see. If we were not being raped, we were being forced to either watch or help to hold our friends or family still. You dare not resist too much, this would mean your death. (brief moment of emotion / teary)

I had three brothers. During these raids two were kicked by many soldiers at once, they were too small and sick to survive. My youngest brother Ali was only 4 years old, the soldiers took him, and we never saw him again.

In my country you could be tortured, beaten and raped almost every day of your life. Some of the people in the village, some of my relatives, moved out of the village trying to get to Israel. They would pay people smugglers to get them there to safety. We would hear that the people smugglers would hand over our friends and family members to more soldiers in the Sinai desert. They would have to pay more money before being permitted to pass. If there was no money they would also be raped and killed.

There was only my mother and myself left in our family. A friend of my father had arranged for us to flee the village and make our way to Australia via Malaysia and Indonesia. It took nearly eleven months. There were many scary moments during this journey with the smugglers, but nothing as scary as what we had already experienced. The whole time you feel like you are running away from something you had done, when what you were running to was safety. People here have no understanding of what desperation will make you do.

We settled in our new life, I have no complaints about our processing to be here, I am happy now.

My mother is sick much of the time, she cries all the time, often during the night. Her heart is broken and weak. We need to call the ambulance for her many times, but most times she needs it we don't, as she is always terrified. One time recently her heart was in pain, we called for the ambulance. The man and lady arrived and asked her lots of questions at once. My mother does not speak or understand English. She looked even more terrified. I tried to explain to them what was happening, but they would not listen. All my mother sees is the uniform and thinks of the soldiers. She was screaming. They wanted to give her a needle and went to hold her arm. She would not let them, this made them very angry. She has begged me never to call for them again. She says she would be happier to die. (via interpreter)

The transcribing of this personal narrative does not adequately relate the emotions of this very brave woman. Throughout her story telling she appeared to be removed of emotions and facial expressions were void, as if she was telling the story of another life. Only at one point, where she mentioned the systematic raping of women in her village, did her eyes become watery, with tears forming. She rapidly composed herself, physically manoeuvring her body back into an erect position. I could not help but wonder if her strength came from her life experiences, her cultural upbringing and her desire not to appear weak in front of this male stranger. Or indeed she was telling someone else's story, the story of her former self, the person she was no longer?

Introduction

This chapter presents the narratives of the lived experiences of the community groups in their dealings with Ambulance Victoria's paramedics. There were 20 community representatives from varying cultural and religious groups who were interviewed about their experiences with Ambulance Victoria's paramedics. These semi-structured interviews focused on cultural and religious needs of the community representatives during these experiences. The full demographic details of these community representatives, and the focus groups, are presented in the methodology section of this thesis. Similarly to the paramedic group, it is important to acknowledge that these community members' narratives embody their views, which are shaped by their cultural lenses. As Markus and Kitayama (2006) argue people in different cultures have strikingly different understandings of the 'self', of 'others', and of the 'interdependence of the two'. These construals can

influence, and in many cases determine, the very nature of the individual experience, including cognition, emotion, and motivation. All three attributes cannot be separated.

To protect the validity of this study, all community group members were asked the same series of questions. The questions were designed specifically to evoke responses that enabled me to gain some insight into their individual experiences. These six questions, along with the demographics of the community member groups and the constructs of the focus groups are noted in the methodology chapter of this thesis.

Obtaining access to the community groups was difficult. Many of the agencies contacted either did not respond, or did so with varying degrees of ambivalence. In some instances the cause of the ambivalence was not known, as there was no further contact despite repeated attempts from myself to consult with them. However, for those agencies that did respond, there was some concern expressed as to why the request for the interviews was occurring, conveying their concern that if the data collected from community members were expressive of the issues that the agencies had already identified in relation to Ambulance Victoria, then this may result in an adverse response from paramedics in the future.

This was surprising for me. My focus had always been the paramedics' experiences in dealing with cultural groups and the education they had or had not received in assisting in their cultural preparedness. Incorporated within this were the paramedics' responses to the

differing challenges in dealing with patients from such diverse cultural and religious backgrounds. I had assumed that by recording the narratives of the community group members of their experiences and dealings with Ambulance Victoria, this would add to the richness of the data collected. Community voices would offer a balanced perspective and perhaps, even validate some of the data afforded by the paramedic group. What I did not expect was that some of the community groups' official agencies had already identified varying issues relating to paramedics' inability to relate to their patients on levels that were inclusive of cultural or religious needs. This would suggest then that the experiences of some individual patients' has been of enough significance to report it to an agency that has been known, trusted, and seen as official by the patient. These resultant shift from the isolated individual experience to the wider community brings with it wider implications.

Although the agencies' responses were not a focus of this study, I thought it too important not to bring their perspective into this discussion. To ignore their concerns would only serve to offer a less balanced perspective. As the agencies themselves had previously identified an inability for paramedics to respond to varying religious and cultural needs of community members as being an issue, this would tend to suggest that the inability of paramedics to display cultural or religious sensitivities towards their patients extended far wider than just the 20 paramedics involved in this study.

Further, when asked if they had made any official approaches to Ambulance Victoria to make representation on either a specific incident or general concerns, only two of the seven

agencies responded in the affirmative. The seven agencies that had not approached

Ambulance Victoria responded with varying comments inclusive of:

- They are a very big organisation, we are just a very small community group
- We don't believe it would change anything anyway, they would not listen to us
- It is rare that David can take on Goliath and win
- Paramedics are a product of the service they work for, it is not going to change, they see us as all the same, foreigners.
- Like all government people, their systems are not people focused

I found these comments very pertinent, particularly given some of the themes that arose out of the paramedic group data relating to homogeneous attitudes, notions of authority and organisational ethos. The responses from the agencies seem to authenticate some of the paramedic data, and even sanction them. The themes identified from the paramedic data that were inclusive of authority, processes to be followed and homogenous attitudes seem to be evident in these comments from the agencies.

I found it interesting that these agencies also viewed their organisations as being powerless. The references to 'David and Goliath', and 'large organisations versus small organisations' seem to be reflective of their views that not only does the balance of power lie with Ambulance Victoria but it is a battle that needs to occur for the ambulance service to address their issues, as opposed to open dialogue and communication.

Of the two agencies' that had made contact with Ambulance Victoria, one had done so by communicating several occurrences where they believed that paramedics' lack of ability to either respect, or acknowledge, the cultural needs of their members, had resulted in adverse outcomes for the patient. The remaining agency indicated that a direct result of identifying a lack of ability of paramedics to meet the cultural and religious needs of their community members was the creation of a training program for the service. This program seeks to address identified gaps of knowledge in the organisation. Both agencies indicated that they had no response to their communication and program suggestion from Ambulance Victoria.

According to these two agencies, despite their efforts the outcome for them they believe is the same as the remaining seven. The apparent lack of response from Ambulance Victoria, as described by the agencies, has resulted in the agencies also acknowledging the fact that they do not believe the 'system' will change, and despite every effort, the ambulance organisation is too big to hear the voices of the minority. It was interesting to me that such terminology as 'minority' was used by the agencies, clearly indicating that they view themselves in this manner. I wondered at the time that, if they viewed their communities as 'minorities', did they also believe the verbs and adverbs that usually go with this label, such as 'marginalised' and 'powerless' were applicable to their communities.

Collecting the data from community groups was challenging as outlined in the methodology chapter of this thesis. What also presented a challenge for me was how to best present

these data to ensure not only the validity of the material was protected, but also that the richness of the individual voices of the participants was not lost or diminished in any way. I have purposely decided to present these data, and the themes arising, relating specifically to the six questions asked of each participant. I had thought of presenting this material according to cultural / religious groups; however, I believe that that this would only bring a religious or cultural specific sense to the data as opposed to a more combined and interconnected one, which this study aims to achieve. I therefore decided to present these data in a unified manner, giving a more general representation of the community representatives' views as opposed to a specific religious or cultural stance. The focus of this study is not on religious and cultural differences per se, but on the perceived responses of paramedics to these. Additionally, the overriding theme of this study is about diversity more than the specificity of individual community groups' needs.

Tell me about the reason for the ambulance call, and who made the call

The question on the initiation of the call for the ambulance yielded strong themes of self-identified emergencies. In all cases (n = 20; 100%), participants recognised the emergency nature of the need for medical intervention for either themselves or for a family member. In most cases (n=15; 75%), the persons needing assistance initiated all calls to the ambulance service via a second party; in all these situations it was a family member. In the remaining cases (n=5; 25%), the call to Ambulance Victoria was initiated by the person requiring assistance. There was no specific difference in these percentage breakdowns when relating them to the individual cultural and religious groups.

These data are reflective of the wider community throughout Victoria. Ambulance Victoria reports that, typically, the breakdown of calls requesting assistance is 77% arising from family members, public, or other medical and allied health workers, with 23% arising directly from the patient. (Ambulance Victoria communications, data 2011)

At the times that the calls were made, the person making the call held strong emotions such as fear and anxiety. However, in many instances (n=8; 40%), these emotions appear to be predominantly aroused by past exposure to, or information obtained from, other community members, and related to concerns regarding the ambulance service's ability to acknowledge their holistic needs, as opposed to anxieties relating to their own or their relative's actual medical emergency at that time. Not unlike the paramedic participants, emotions of fear and anxiety appear at the forefront of the responses:

'I was scared, very scared, I knew that my mother-in-law urgently needed help, she was barely conscious, I needed help very, very quickly. I was hesitant to call, I didn't know what to do, I was scared, she is a covered woman, last time they came they did not listen it us, they just kept removing her clothes, I didn't want that to happen again, it was very, very distressing for her.' (g1, p1)

Similarly, a participant from a different focus group expressed his own anxiety in calling for paramedic assistance for his father and his reluctance to do so given past experiences. Whilst not directly expressed in his narrative, this participant also alluded to his father's life experiences impacting on his response:

'I didn't want to call for the ambulance again, my father is a very proud man, our beliefs are very important to us, they are who we are; he is very religious man. They showed no respect for his fear; he has been through a great deal in his life. When I tried to explain to them why he was so upset, I was told by one of the young men that we lived in Australia now. It was very difficult for him, very distressing for him and me to have to go through that, it was worse for him to go through that than what was wrong with him. It is not the first time this has happened.' (g2, p3)

The comment above from the participant refers to the paramedic saying 'You live in Australia now'. This is reflective of some of the themes arising from the paramedic group where some paramedics' state their belief that all cultural groups should conform to Australian requirements. However, what was surprising for me was that the paramedic, as opposed to a theme emanating from the paramedic interviews and therefore isolated within the paramedic group transcripts, had directed this particular narrative at the patient and patient's family.

The theme of fear and anxiety arising from the community groups need to call for paramedic services, based on previous encounters, continues with this next narrative resulting from a specific religious ritual of a Muslim patient being ignored by the paramedic crew. In his narrative, the participant also explained that his father believed in 'the howling of the people of the Fire', where Muslims who break fasting will be strung up by their hamstrings, with their jawbones torn and presented to the prophet Allah:

'Last time I called for the ambulance to come to my father it was during Ramadan, they put a great deal of pressure on him to take some medication, he refused, he was fasting. They kept insisting, almost forcing it into him, they would not listen to him or I, we did not want them to intervene, there were alternatives that he would have accepted, they just did not want to know. Because of this I was very reluctant to call for them again but felt I had no choice he was very sick.' (g2, p4)

The failure of some cultural or religious rituals to be recognised by paramedic crews and the implications this has for patient care and patient outcomes should not be underestimated. Miran-Khan (2009) contends that ongoing recognition of beliefs tied to religious rituals need to be accommodated and respected within the healthcare setting. This is essential to patient wellbeing and assists in maintaining their identity and connectedness. She adds that without religious rituals there is no belonging for such patients in the absence of formal social transitions or rite of passage

Ver Beek (2010), in his study, supports the value of religious rituals in some patients who hold strong religious views. He claims that it is easy for some healthcare practitioners to fail to recognise the importance of religious rituals that embody a patient's sense of 'self' and 'wellness'. He maintains that, at times, the religious component of a patient's healthcare can sometimes outweigh the physiological requirements for some patients. As a result, adverse patient outcomes, inclusive of a deterioration of the patient's physiological condition and extended recovery rates, can at times be seen. Further, he argues that it is important to note that each person's experience is different: what might be a profound

requirement for one member of a family or religious group, may not be experienced in the same way by other members of the family or religious groups.

The theme of the community groups' reluctance to call for the interventions of the ambulance service, based on previous experience, is highlighted again in this next narrative. Here, this participant clearly makes the statement that within his own community there had been discussions held about the treatment of paramedics specifically based on religion:

'My wife needed urgent help, she was bleeding heavily, from, you know, down below. I have never needed to call an ambulance before, I was afraid at the time, afraid at what was happening to my wife, but more afraid of the stories I had heard from other people's experiences of the ambulance service and how they treat Muslims.' (g2, p5)

Of these four narratives there are some common overriding themes. Whilst the need for ambulance intervention had been clearly identified, there was still some reluctance, and anxiety to make the call for assistance, based on either past experiences or the experiences of others within the respective community group. Of the participants within the group of community representatives who expressed these concerns, all (100%) involved a person other than the patient making the call for assistance. What is not known is that given previous experiences, and the strong themes outlined above, whether the patient would have made the call if they were alone.

Tell me whether or not you felt that the paramedic crew recognised any of your religious or cultural needs or requirements.

From most of the focus groups, this question elicited a deafening silence. I recall the first time I delivered this question to a focus group and the silent response that I received. I immediately attempted to rephrase the question, to explain what it was that I was asking. I was interrupted by one of the focus group members, an elderly male who seemed to be a well respected elder in this group. He politely stated that:

‘We know what you mean by the question sir, the lack of response simply indicates that there is no answer to this.’ (g5, p5)

From this point on, I was prepared for the inevitable silence that would occur from one focus group to the next. I anticipated that only occasional responses would be forthcoming. As a researcher, I had always anticipated that the data collected formed the most powerful aspect of the research, that the narrative was the very basis of the findings. From this I have learned that perhaps, at times, the silence you obtain on specific questions can be just as powerful, if not more so. According to Schensul and LeCompte, (1999), conversation is the heart of the focus group, adding that qualitative techniques also highlight what is not said — silence — as clues to perspectives.

For some of the focus groups, however, there was the occasional response to this question, with themes arising that I did not expect. I had anticipated that perhaps I would be able to obtain some data that may have been inclusive of the fact that some of the paramedic crews had the capacity to recognise their patients' cultural or religious needs. This would have brought about some positive aspects to the study from the community group responses. However, in the cases where paramedics did recognise patients' religious or cultural differences, the community group participants saw this in a negative light.

One of the community group participants indicated in his narrative that the recognition of his cultural background by the paramedic crew resulted in negative comments being made by the paramedics attending their call. We see this in his reflection below:

'The paramedics obviously recognised we were of a different culture to themselves, as they made reference to it. The men made comments that all of us were aggressive people that aggression was in our nature. This was offensive, we are very gentle people, our willingness to be vocal is part of who we are.' (g6, p2)

This theme of negative affirmation appears to be representative of some of the paramedic themes outlined earlier, where paramedics had interpreted vocal outbursts, particularly at times of grieving, as aggression.

Themes of negative recognition continue with other community group participants' narratives. The next two extracts further support the theme that when paramedic crews do acknowledge their patients' cultural or religious backgrounds this has negative implications for being able to fully connect with the patient and his or her family:

'It was clear to them that we are Sikh, I mean how could you miss it? (He laughs and point to his turban). It was my father they were called to, he had some breathing problems. The paramedics were young, perhaps inexperienced, I do not know. When they were placing him on their bed trolley they told him they were going to remove his hat, as he would be more comfortable. When I tried to explain that we are of Sikh religion and the importance of the turban its symbolism of dignity, I was interrupted and told "yes we knew that as soon as we walked in, however we treat all people the same.'" (g3, p4)

'The recognition of our cultural heritage was verging on racism. I do not expect that paramedics hold any understanding of our cultural beliefs even related to health. What I objected to what the comments made by the paramedics 'Why do all you Asian's burn this stuff in your homes', can't you see it adds to your father's breathing problems.'" (g4, p2)

Both of these narratives show a lack of insight paramedics have in relation to the cultural requirements of their patients. Additionally, the reflections substantiate some of the paramedics' own beliefs relating to homogeneous attitudes.

Tell me about any of the features of the paramedic attendance that you liked in relation to their recognition of your religious or cultural needs.

When discussing what features of the ambulance attendance that were positive in relation to the recognition of their religious or cultural needs, none of the community group participants could identify a situation where this was the case. This question evoked confusion for some of the participants who were unable to differentiate this question with the previous one. The two questions were designed to elicit differing responses: the former inviting responses relating to the paramedic crews' ability to recognise cultural needs and requirements, the latter was intended to invite responses that were more specific about what patients liked about having religious or cultural needs recognised and met.

I recall wondering at that time whether or not these community group participants came to the focus groups with purely a cultural lens, responding to my questions from entirely a cultural perspective, and therefore clouding their responses in relation to other aspects of healthcare provision for them by paramedics. At that time of the focus groups with the African group of women, my own Australian values had the potential to 'contaminate' the interpretation I was making of their comments. It was not until I realised that it was my Australian expectations that were not being met that the comments from these women could be portrayed in their true meanings. Of course these participants brought with them specific cultural and religious lenses, this is the very being of who they are.

Only a small percentage (n=6; 30%), responded to this question, with the other group members in the various focus groups stating that they had nothing that was supportive of the service to add. Some of the community members appeared perplexed at the question.

Not unlike the paramedic group when asked about non-clinical issues relating to their practice, some community group members appeared not to be prepared for this question at all. I wondered at the time had they attended these focus groups as an opportunity to share stories of similar concerns or to take this opportunity to relay only their negative experiences and perceptions, despite redefining the question to ensure clarity. Many of the participants' appeared to struggle so much with this question that they stated they could not think of any appropriate responses. This was despite some of the participants' offering their input and giving cues to other group members as to the kinds of responses they could make.

The only themes from the community group members that were positive related only to how quick the ambulance service was in response to a call for assistance. How rapid the crew were in making a clinical assessment of the situation they were presented with was another positive comment that re-surfaced with many of the participants. This links strongly with the paramedic themes, outlined earlier, relating to their sole focus being aligned with a clinical focus, routine algorithm approaches, and their concentration on the physiological aspects of patient care. Interestingly, that this aspect of positivity is aligned with the expectations of Ambulance Victoria which centres around meeting the standards of government statutes. These requirements relate to response times (the time in minutes from the initial call for assistance and the arrival of the paramedic crew), and the time at scene (time in minutes the crew spends from the point of arrival to the point of loading the

patient and departing to hospital). This may appear to suggest that the paramedic crew's focus is to conform to organisational time constraints, irrespective of patient needs.

The following three participants' narratives are indicative of these themes, each highlighting the rapid response by the paramedic crews to the exclusion of any other positive aspects of the experience encountered:

'They came really quickly, they came like within 10 minutes, they got all their equipment in quickly, they got to her quickly, assessed her quickly.' (g1, p3)

'They arrived very, quick, I don't recall how long, but it was not a long time, they went straight to him, asking questions about what was wrong, they seemed to know it was an emergency.' (g4, p4)

'They asked me what was wrong with her, they quickly came to her, they quickly set up their stuff and tested what was wrong with her, everything, they asked me questions, that's about it.' (g5, p3)

When discussing aspects of the service that were of a positive nature, this participant acknowledged that she had used the service on many occasions for herself and other family members. Whilst the theme outlined in this narrative supports all others relating to rapid response times as being the only positive attribute of the service, there is also an underlying theme not specifically related to the question. At the time, however, I could not help but

think of the themes that arose from some of the paramedic participants in this study. In her narrative this participant included that the service 'always comes quick, you never have to wait very long, never'. I wondered about the paramedics' comments about their perceived 'misuse' of their services, what constitutes an emergency in the eyes of a paramedic versus that of some community members. I have seen firsthand countless times where paramedics have berated either patients or patient family members for calling for their services when there is a clear disconnect between the two as to what is believed to warrant an emergency ambulance attendance:

'It did not take long after I finally decided to call for them to get here, it never takes long, it is a quick service, they always come quick, you never have to wait very long, never.'
(g2, p3).

Similarly to the above narrative, this community participant's response, on the surface, again, reiterated all the others relating to rapid response times. However, there is a deeper underlying theme that is represented here relating to the fears and anxiety experienced by this community representative still being present after the paramedic crew's arrival:

'The only positive thing that I can say about the ambulance service, is that they arrive very quickly after you call them, even after they arrive, the fears are still present, you then have to worry about a whole new set of difficulties.' (g5, p6)

This narrative, as with all the above fails to emphasise any themes that have any correlation with treatment, professionalism, care, empathy, or respect; characteristics that paramedics are usually known for. It is common for patients and / or their family members to express feelings of relief on the arrival of the paramedic crew. Yet not only did none of the community group participants' make mention of this, the narrative above included that his fears and anxiety was not only maintained after the paramedic crew arrived, but their arrival brought with them a whole new set of difficulties. This narrative may also be reflective of earlier comments made by some of the community group representatives when discussing aspects of recognition by paramedic crews of their culture, (you then have to worry about a whole new set of difficulties).

Were there any aspects that related to your specific religious or cultural needs that you believe were not met.

This question clearly brought about the strongest themes and the most extensive narratives from the community group members. The strongest themes of the study clearly came out from the responses relating to what was not liked about the ambulance response; that is, identifying any religious or cultural needs that were met by paramedic crews. All respondents (n = 20; 100%), stated that the intervention of the ambulance crews failed to acknowledge the patient's needs relating to their religious or cultural beliefs. Further, all responses (n=20; 100%), identified a lack of respect. This was, by far, the most overriding and strongest theme to emerge from the data. Within these narratives, subthemes emerged inclusive of themes of high anxiety, embarrassment, and anger, and were consistent throughout the responses. We see this below:

In this first narrative, this community group participant calls on a piece of Australian paramedic history. Hatzolah, Australia's first and only religious specific ambulance service, was established in 1995. The establishment of this service was the Jewish communities' response to two identified needs at that time. The Melbourne Jewish Community had specific cultural, religious and emotional needs that could not be met by the then Metropolitan Ambulance Service (now Ambulance Victoria). The second identified need was that there were a large number of holocaust survivors who were reluctant to call an ambulance for fear of being taken away and never returning. As a key instigator of the setting up of this organisation nearly 17 years ago, it still surprises me that not only does the need for this agency still exist, but it is well supported and recognised by Ambulance Victoria:

‘There is a reason Hatzolah (cultural / religious (Jewish specific ambulance service) exists. Clearly if the regular ambulance service had the capacity to respect and recognise our faith and religion then there would not be the need for such a service.’
(g5, p1)

Further, support of the theme of Ambulance Victoria's inability to meet the cultural or religious needs of the communities they serve can be identified in the following narrative from a community group participant who is also an indigenous healthcare professional. In her dialogue, she states that not only has she seen paramedic's inability to respect indigenous cultural values and norms, she has, in fact, seen it on a recurring basis:

‘Western health professionals often experience difficulties in service delivery to Aboriginal people because of the disparity between Aboriginal and Western health belief systems. It is not surprising then that paramedics’ as part of this system also fail to respect our cultural values and needs. As an indigenous healthcare worker, advocate, and above all mother of three young children I have constantly been exposed to situations where paramedics have displayed a total disregard and lack of respect for our people’s ways. Examples are many, however the ones that seem to reoccur all the time and present issues are those relating to death and dying. Paramedics in particular have no ability to recognize our cultural beliefs and rituals, which are inclusive of all family members displays of grief, often in large numbers. Our traditional ways include wailing, crying, emotional outbursts all part of the grieving process. From some of the more traditional cultural groups, the stronger the emotions the more the bad spirits are scared away. The custom of self-mutilation, with the drawing of blood to demonstrate depth of grief, continues in some indigenous communities.’ (g6, p3)

In the latter part of her narrative above, this community group participant highlights some specific issues relating to the cultural norms of death and dying. She reports that, from her experiences, paramedics lack the capacity to have any understanding of the indigenous grieving process, and explains the components of this inclusive of strong emotional outbursts, and even self-mutilation. Once again, this correlates to some of the paramedic comments about their exposure to such cultural norms and their misinterpretation of this as placing them in physical danger.

The themes relating to the paramedic's inability to understand cultural grieving norms is continued by the narrative of this African community group participant, who outlines some of the more traditional approaches his community takes in these circumstances. Again, the paramedics lack of insight into this family's cultural norms has resulted in feelings of shock and lack of respect by this participant. He explains the grieving process and traditional approaches taken, inclusive of large gatherings of family members, the sense of community this brings, and the importance of voices being heard as part of grieving:

'My brother passed away at home. As he had been very sick, the whole community was there, he was very well respected. When he died everyone was upset, it was important for all of us to show our respect for him, to let his spirit know our love, respect. This is very, very important. We are a proud nation, our traditions are very strong. African voice is important, as is our music. These traditions are deeply rooted in our culture. The level of our voices decides meaning and purpose. Our songs often require us to call and receive from one another, like the wind calls from the trees and the earth answers. We have a very strong sense of community as brothers and sisters, this is what gives us our identity. Living closely together as large families is what we are used to, sharing all we have. When there is something to be done we all do it together. When someone is sick we are all there, if you are not then it is a sign of disrespect. The paramedics came and asked us to calm down, to stop carrying on so much, and if we did not they would have to call the police to help. I was shocked at this lack of respect for us and my brother.' (g3, p2)

The paramedics' lack of ability to understand and accept the strong cultural norms of this family resulted in them inappropriately assessing the situation. The outcome of this was the paramedic crew's misinterpretation of the circumstances they were faced with as being hostile and 'carrying on' to the point where they felt they required police assistance. The crew's lack of ability to comprehend and accept the situation at hand also caused them to devalue this community's cultural values.

Whilst the theme of lack of respect was constant throughout all of the responses from the community group participants, integrated subthemes relating to gender were also revealed, inclusive of those related to religious customs of being covered. In this following narrative a community group participant describes her experiences with members of Ambulance Victoria. She recalls that not only did the paramedics display a total disrespect for her mother's cultural needs to be covered; she adds a further theme that paramedic crews in some instances ignored her requests for compliance to cultural norms. This added a further dimension to the data. Whilst it has been established earlier in this study that paramedics receive little or no educational in-put in relation to cultural or religious preparedness, it would be possible to assume, however, that as healthcare professionals they do have the capacity therefore to respond to direct requests made by their patients or patient's family members that relate to cultural or religious requirements. The data here however is suggestive that this may not be the case. It is unclear as to how extensive this is throughout paramedic practice, or why this would be the case. This particular narrative however does conclude that it is due to the paramedics' inability to accept that a family member may

know more in some circumstances than the paramedic. If this is the case then the professional arrogance of paramedics may be a key factor in hampering any attempt for them listen to their patients requests, learn by experience and become more culturally or religiously sensitive. Paramedics, themselves, concluded in their narratives that constant exposure to patients of differing cultural or religious backgrounds played little or no part at all in developing their cultural or religious sensitivities:

‘She is a covered woman, they wanted to get through, there was no need, she had some breathing problems, that is all, nothing wrong with her head, we need to keep our scarves on, and I would say please keep, leave her covered, but they did not respect that. When they took her out on the bed, the trolley that they have, and left her uncovered, even her legs were bare, I had to repeatedly ask for her to be covered. I would say please cover her with a sheet or something. She would say please cover me, and I would say cover her, she is a covered woman, you know. She was very embarrassed about being uncovered in front of everyone. They ignored our requests completely, it was like they were letting us know that there was nothing we could tell them, they knew everything.’ (g1, p1)

Gender specific healthcare can easily be deployed in some healthcare facilities, however, this remains an issue for Ambulance Victoria. The logistics of ensuring a mixed gendered crew on every vehicle is impossible for the service’s rostering department to achieve. However, subthemes relating to gender emerged as issues for some of the community group participants. In the instance outlined above, gender specific healthcare was ignored.

Inclusive of this narrative is further evidence of the paramedic crew's lack of capacity to respond to a family member request. This participant further asserted that the paramedics' failure to respond to a simple request not only aggravated his father, but made the ordeal far worse. The experience of this particular community group participant was obviously quite profound and indeed traumatic. When delivering his narrative he was quite emotional; angry. His response showcases the long lasting impact present, and appeared to be unresolved:

'My father would have preferred to have been treated by a male, this is not a male dominant thing, it is not a disrespect to females, it is just part to his upbringing, part of our culture, part of him, it is hard for him to let that go, and why should he at his age? The ambulance people came in, one man and one woman, and the woman treated my father whilst the man stood there. My father was becoming upset, when this happens he can become difficult, I know this. I asked the male ambulance person could he please address my father, as I could see problems arising, he was getting distressed, angry. He simply said that he was driving on this shift, and that it was the lady's turn to attend to my father. It would have been so simple for them to swap roles, even just for my father. It showed a complete lack of respect for his needs, or my wishes. This did nothing but aggravate my father and me, it made his situation much worse than it was.' (g2, p2)

The subtheme of gender continues with another community group member's story. He recalls an incident concerning his father, and highlights some traditional values relating to men's business and women's business in the indigenous community. In his narrative he

acknowledges that difficulties in Ambulance Victoria's ability to provide gender specific healthcare, and is accepting that this is not always possible. He does, however, bring further evidence to the theme of paramedic crew's unwillingness to respond to family members' requests or advice. He concludes that the paramedic crew misinterpreted the gender specific issue, responding on the defensive believing her knowledge base was being questioned to that of being less than her male counterparts. Again, we see a further example of a negative response by a paramedic when confronted with a cultural or religious explanation from a community member. This would further support paramedics' failure to gain insight into cultural and religious norms from exposure:

'My father is an indigenous elder, and very traditional. We needed to call for an ambulance as his catheter was blocked and he was becoming very uncomfortable. For him there has always been men's business and women's business. It was very distressing and shameful for him to be treated by females. I know this has to be the case sometimes, but when he commented on this to the paramedics', they were obviously annoyed and told him that their knowledge was the same as any paramedics. He was not questioning their knowledge, just expressing his culture, which they totally disregarded.' (g6, p1)

This next story, from a community group member, supported all the themes that have been outlined above, inclusive of a lack of respect for cultural and religious values, and requests enabling the patient to conform to religious or cultural requirements. The narrative in this story is also inclusive of fear of not only the patient, but also the patient's husband; the

storyteller in this instance. He indicates in his narrative that the fear they both held was based on what they had heard from other community members about paramedics, as opposed to personal experiences. This would appear to support the earlier theme outlines in this section of this study that some community groups are well networked, and concerns held by some, particularly in relation to their cultural or religious requirements are communicated throughout their respective communities. Again, we not only see a failure of the crew's ability to respond to the cultural or religious requirements in this situation, but also continue to ignore the requests to do so by a family member:

'My wife was very, very frightened about strangers asking her questions about her condition. I tried very hard to assure her that it would be all right, they would care for her well. She was upset, I was frightened, for her, and for the things I had heard in the past from others needing ambulance help. When the ambulance arrived it was two men. When they walked into the house they were obviously very uncomfortable with our religion. They asked questions about her health, about her medical condition. They could see that she was upset, I tried to give them the answers, but they ignored me, wanting her to answer. There was a complete lack of respect for our values, our preferred way of handling this. Before she left, my wife asked if she could quickly wash, the ambulance men would not allow this, they said it wasn't necessary. I wanted to tell them it was necessary for her, but I was too upset and fearful of what they might say.'

(g6, p 1)

Interestingly this is the only narrative in all the responses from the community group participants that acknowledges that the paramedic crew appeared to be 'uncomfortable' once they realised the family's religious status. This particular theme had not been emphasised before by any other community member. Whilst earlier themes indicate that the realization that culture or religion was of significance brought negative responses from paramedics, this was the only observance of a crew feeling uncomfortable. Again this links closely with themes arising from the paramedic subgroup's narratives indicating that, indeed, some paramedics display fear, anxiety, and frustration when dealing with the challenges that the cultural or religious requirements of their patients bring.

Religious or spiritual requirements were also subthemes arising from the community group participants. Many of the comments made by these groups were about the importance that these religious rituals hold for individuals. Many of the community group members reflected on specific religious requirements and how paramedics had impeded these, despite family members' attempts at explanation. In this particular narrative, a relative tells of the importance of his father's prayers, and the request made to paramedics to allow him a few minutes to finish. The paramedic crew ignored the request resulting in the crew being perceived as aggressive by the family, causing unnecessary distress. Not only in this instance does the paramedic crew fail to respond to the family's requests, they actively prevent their patient from performing his religious requirements.

'My father was very afraid at the time the ambulance men came in, he was praying, constantly praying, as was my mother. The doctor had arranged for him to go to

hospital for an infection in the chest. When they arrived, I asked for them to possibly wait for a couple of minutes until his prayer had finished. Both the men ignored my request and interrupted him. He tried to keep praying, to finish his prayer, this was very important to him. The ambulance men still interrupted him, asking him questions, wanting him to hurry into the ambulance. To them it appeared that my father was ignoring him, but he just wanted to finish praying. The ambulance men became aggressive, all they had to do was wait a few minutes, everything would have been alright, instead everyone was upset, very, very upset.' (g2, p1)

Themes inclusive of the importance of faith, religion, and cultural values were evident throughout the community groups' narratives: many of the comments relating to issues inclusive of gender, prayer, cleanliness, and other religious or cultural requirements. Further subthemes arose of paramedics' inability to recognise, or respond to, specific religious rituals and traditions. This is not surprising given the already established lack of education or training paramedics have received in this area. Many of the narratives that included themes relating to specific religious rituals were also inclusive of a statement that the patient, and /or patients' family involved were 'very traditional'. This would seem to indicate that some of the community group participants were acknowledging that even within their own religious or cultural community there were varying layers of cultural or religious observances and compliance.

The following narrative supports these subthemes. Here, this community group participant recalls a series of incidents involving his father, an elderly man who is a

traditional Sikh. The story told here describes several paramedic crews' inability to acknowledge the specific religious rituals of his father. Again, we see an elderly man who is deeply religious and finds comfort in his faith, particularly at times of illness. The narrative is inclusive of his father's fear of dying without his specific religious symbols is overwhelming for him:

'We are a very traditional family, my father particularly. He was having some breathing problems from lung disease, he needs constant treatment. We have had many ambulances come, and almost always there is an issue with him. He is very spiritual, and also afraid when he is taken to hospital. His faith is very, very important to him. There have been times when the paramedics have just gone ahead to shave part of his arm and then they get angry when he pulls away. The removal of hair is forbidden, it is a sign of dedication to his spirituality. He always wears the Kirpan. It is purely a ceremonial sword a deeply religious symbol. It is not a weapon it has no sharp edges. Every time the paramedics take him to hospital they refuse to allow him to continue to wear the Kirpan. This is very distressing for him the fear of him dying without the Kirpan is overwhelming. One time the crew asked him to remove his Kara, (steel bracelet worn as a symbol to remind the wearer of restraint in their actions and remembrance of God at all times). There was no reason for this. He now refuses to allow me to call for an ambulance; I must take him to hospital myself.'(g5, p5)

A direct result of the paramedics' inability to recognise this patient's specific religious rituals is that the patient now refuses to utilise the services of Ambulance Victoria and insists on family members taking him to hospital. More evidence supporting this specific

theme arises later in this chapter when community group members disclose the comments they make to other community members relating to the services of Ambulance Victoria.

Ambulance Victoria expends considerable resources to educate the public on the use of its services. Many publicity campaigns advise patients to call for their services even if there is doubt that the situation is an emergency. As a paramedic, it is of great concern that there are members of the community who would prefer relatives to transport them to hospital at times of acute illness. The potential outcomes of this could be catastrophic.

Paramedics' inability to recognise or respond to specific religious rituals of their patients continues as subthemes, often resulting in negative outcomes for the patient or patient's family members. The community group member's narrative below raises another theme: that of misunderstandings due to patient care resulting in assumptions being made by paramedics that were untrue. In this particular instance, a lack of knowledge by the attending paramedics of specific religious or cultural rituals resulted in a negative experience for the patient's family. Further, this misunderstanding by the paramedics of their patient's religious requirements resulted in them questioning the family on elderly abuse. In this instance, the paramedics' responses indicated a lack of appreciation of cultural norms specific to this family.

'My mother had been ill for some time, she is a highly positioned elder in our community. In our former land she was a respected Shaman (problem solver by relying on the supernatural world of witchcraft). She had many marks on her body so that all

would know her position on our community. In the earlier time of her illness the paramedics would often comment about her marks, scars, referring her to be 'accident-prone'. At one time one even asked her if she had been mistreated. The abuse of an elder in our culture is abhorred. This showed a complete lack of respect for her and her position in our society. When she became much sicker, she turned even stronger to her beliefs of the magic, of being a Sharman. On two occasions different paramedics made comments relating to 'black magic' and 'sacrifice of people'. I was very thankful that my mother could not understand these comments at that time. One of the paramedics even seemed frightened of my mother (he laughs), frightened of a dying elderly lady.'

(g3, m3)

Not unlike the earlier narrative, once again the subtheme of elderly patients turning to their religion or culture during times of illness further supports the importance of respecting religious or cultural beliefs and not pre-judging patients based on their physical attributes.

This particular narrative I found pertinent given its specific correlation to some of the paramedic comments seen earlier in this thesis. I wondered how widespread the practice of 'magic' and 'witchcraft' was in some communities, and how many paramedics had been exposed to situations where this was evident. Some of the paramedics' narratives included references to black magic and sacrifice, with at least one paramedic including in his narrative that he was fearful for his own physical safety when confronted with this. The narrative above from the community group participant also notes with some mirth that one of the paramedics appeared fearful of his dying elderly mother. There is, of course, the possibility

that this study highlights paramedic fears that are echoed in the stories of community group participants. If not, however, this would seem to indicate that these subthemes of personal safety, fear, and anxiety from the paramedics are much wider than an isolated incident.

Although still inclusive of the overriding theme of lack of respect for cultural or religious requirements of patients by paramedics, the following narratives have revealed further subthemes relating to religious spirituality. Both of the two following stories told by community group participants reveal that there were strong religious forces at play for these patients at the time of paramedic intervention. Once again, the paramedics' inability to identify these forces as being important their patients' resulted in a negative experience for the patients. In the narrative below, the paramedics' approach indicates their focus for the physiological dimension as opposed to a patient's desire to have their faith and beliefs valued. This again draws parallels to comments made earlier by paramedics in their narratives about their 'systems approach', their focus being on the patient's physiological requirements.

In the second narrative, the paramedics' lack of understanding of their patients religious spiritual needs resulted in accusation by the paramedic crew towards their patient based on an their misjudged assessment of the situation they were faced with at that time.

'I was painting the window, and fell off the ladder. I damaged my leg a little and could not walk on it. The paramedics arrived, my daughter called for them. It did not hurt very much, but they insisted on giving me pain medication. When asked I told them

that I wasn't needing it, they said that they had to give it to me to transport me to the hospital. I told them that my pain was bearable and I would be OK without the pain medication. I did not want to impose. I am Chinese, throughout my life I had been taught self-restraint. I could not understand why they could not respect my wishes.'

(g2, p4)

'I was about to have my baby, my third baby, but it was coming very, very quick. My husband called for the ambulance and I had my baby with them, my little boy. I asked them to place him down after they wrapped him, but they insisted on giving him to me, I did not want to hold him. They gave him to my husband, he placed him on the bed. The paramedics accused us of not wanting to have our baby. This was not true. It is our way, our belief, we are Vietnamese. If we alert the spirits to our new baby they may take him from us. It is best that if we take no notice of the baby then so will the spirits. It was not neglect like they said.'

(g5, p2)

The final subtheme that arose from the community groups' narratives related to the paramedics' inability to understand, consider, and respect traditional customs relating to individual religious or cultural groups. Again, we see strong links with some of the themes that came from the paramedic narratives. This particular narrative draws attention to an Asian cultural norm relating to the lack of eye contact being a sign of respect. In this instance, this was misinterpreted by the paramedic crew as being the exact opposite, with them viewing this as a lack of respect for them as health care professionals, as was seen earlier in this study. Even when questioned by the community group member as to their comments, the paramedics response was viewed by this community group participant as

arrogant, not willing to listen to explanations or potentially learn from experience and exposure:

‘It was not a big thing I guess, but it meant more to my mother at the time. The ambulance was called for her, she had some bad stomach pains. She and all my family are very traditional in many ways, although compared to my relatives we are very western (he laughs). Not long after they arrived one of the paramedics made a comment to the other one that they were sick of the lack of respect Asians show them. I was stunned, really stunned. I challenged the comment, which surprised him, almost as if I had no rights to question him. He explained that ‘we Asians’ seem to have a problem showing respect to paramedics, that we refuse eye contact. I tried to explain that in some Asian cultures, the lack of eye contact is in fact exactly what he was asking for, a sign of respect. He appeared baffled by this concept, mumbled something I could not understand and left. Arrogance, that’s all it was, arrogance.’ (g3, p2)

Whilst the overriding theme of lack of respect by paramedics continues, subthemes emanating from this relating to traditional customs persist throughout the narratives. There is evidence here, as seen earlier, that the paramedics’ lack of capacity to recognise these customs has resulted in false accusations of impropriety. This particular narrative is also inclusive of the view that if the non-western community respects western approaches, then that same respect should be returned:

‘I was criticised for causing harm to my child. Holistic medicine is very important to my family. We do not disrespect western medicine and see its value. I do not think it is

much to ask for the same respect. Cupping is an important part of traditional Chinese medicine and its value is well recognised, but not so by the paramedics. They even criticised the oils I was burning that always help her.' (g3, p5)

This final narrative, taken from the community group participants, gives further support to the subtheme relating to paramedics' lack of capacity to recognise the religious or spiritual norms of their patients' or their patients' family members.

Here we see an emotionally charged situation following the suicide of a young man. The paramedics' misinterpretation of this situation was made based on their own Australian ethos. It is not unusual that paramedics' attend victims of suicide, and it usually evokes strong emotions from family members and paramedic crews alike, particularly when the loss of life involves a young person. In this narrative, the community group participant mentions two very distinct areas of concern to him relating directly to the paramedic lacking insight into their religious observances. In the first instance, the paramedic crew's inability to respond to a father's request based on a religious requirement not only resulted in added stress for family members, but the misinterpretation was viewed by family as an accusation that they had somehow contributed to their son's death. In the second instance, the paramedics' lack of knowledge of this particular family's religious and spiritual norms resulted in inappropriate questioning and, again, misinterpretation of the reality based on the paramedics' Australian values.

'It was a very difficult time. My son had many problems for quite a long time. The family was home preparing for a traditional feast. When I called for my son there was no answer. I went to his room and found him unconscious on the floor and could not wake him. I called for the ambulance, but deep inside I knew my son was not with us anymore. The paramedics arrived, and they could not do anything. We wanted to move his body so his feet faced the door, it is our spiritual tradition. They would not permit this, advising us that nothing should be touched until the police arrived. I found this very difficult and lacked respect for our needs. Did they think this was a crime scene? It was clear what had happened. My wife and I were shocked, and whilst we were waiting for the police to arrive one paramedic asked if my son's death was expected. I recall that I did not know how to answer this question, or what the question meant. He explained that neither of us seemed particularly upset at my son's suicide. How could I explain to him what suicide meant in our faith, that it the same as murder, that his soul is in limbo and in permanent pain. Indeed, should this have even needed explaining?' (g5, p5)

In this very emotional setting the community group participant concludes with a question 'should this have even needed explaining?' Here the narrative is clearly stating that in his view, paramedics should be aware of the cultural and religious needs of their patients, and that it should not be up to the patients, or the patient's family members to offer the explanations relating to these needs.

What would you have preferred the paramedic crew to do?

Open dialogue and communication were the strongest themes relating to suggestions from the community group participants to paramedics. In all the focus groups held, this was the overriding theme. In most of the focus groups this was the first statement made by a community group participant with other members of the relevant focus groups simply agreeing. Of the responses received, all participants in the community group believed that, in order to ensure that emotional, religious, or cultural needs were met by paramedics, they only needed to ask about those needs, or listen to suggestions offered by family members.

‘If they would just listen, listen to what we are telling them, this would help it would very much help.’ (g3, p2)

‘I understand it must be difficult for paramedics to know all the different cultures here, Melbourne is a very culturally diverse city. If they are unsure, all they have to do is ask.’ (g4, p4)

‘I have no doubt that at times it is confusing for them, but if they do not know, they should ask not accuse.’ (g1, p1)

The narratives, as brief as they are, clearly ask paramedics to engage in a dialogue with their patients’ or their patients’ family members if they have doubt as to what their patients’ religious or cultural needs are. One of the responses received takes this theme a little further by suggesting that it is one thing for paramedics to ask questions relating to cultural or religious requirements but that paramedics need to develop the capacity to respond to these suggestions.

‘Cultural awareness goes beyond listening, you have to have the capacity to respond to requests made, and they don’t. I would ask of them to develop this.’ (g2, p5)

The challenge here, of course, would be the ability of the paramedic crews to develop the capacity to respond accordingly, as suggested by this narrative. Earlier responses from community group members indicate that in many instances this may not be the case, and that the physiological focus that paramedics have actually impedes this process.

A further theme arising from this question identifies the training needs of paramedics as they relate to cultural or religious awareness. Although this study has previously identified the lack of education relating to the cultural preparedness that exists for paramedics, this as a theme identified from within the community group was surprising.

‘Perhaps some training would be of use to them, they need to undertake some education on how to treat our needs.’ (g2, p2)

‘The ambulance service has an obligation to accept who we are and respect our ways, but they do not. I am not sure if they (the service) provide education in this area but if they do it is not working. Paramedics should ask of they are unsure.’ (g6, p3)

Within this final narrative, the community group participant suggests a subtheme within training, citing what she believes is an obligation of the ambulance service to meet the religious and cultural needs of the community. This comment is in alignment with many

others within the subtext of the community group participants' narratives relating to the service and its representatives (paramedics) having an obligation to respond to their respective religious or cultural needs. Fakuda-Parr (2004) suggests that, worldwide, cultural groups are becoming more and more vocal about having their cultural and religious needs respected, acknowledged, valued, and responded to across all facets of all societies. This is clear in the data gathered in the current study and lends support to the call for more relevant and broadly based paramedic education.

Tell me what you would advise or comment on, to other members of your community about your experiences with the ambulance service.

Overall impressions of the ambulance service from the participants from the community group displayed strong themes of negativity when asked about what they would comment on to other members of their community. All participants within this group (n = 20; 100%), believed that whilst the family member's medical needs were adequately met, this was done to the exclusion of the patient's cultural or religious needs, again supporting the paramedics physiological focus identified earlier. Throughout this, a high majority of the community group participants (n = 15; 75%), gave indications that there would be a strong reluctance to recommend to family or friends that the ambulance service was a positive experience for them or their family member when requiring treatment. Of the community group participants involved in this study, a significant number (n=11; 55%), indicated that following their experiences with the services of Ambulance Victoria, they no longer request assistance and find alternative means to seek transport to tertiary facilities to obtain medical assistance.

The only themes relating to positive comments arose from how quick Ambulance Victoria was in responding to their request for assistance. The lack of ability of paramedics to deal with the cultural or religious needs of patient care, however, is still evident as a robust theme throughout the narratives. Within this though, there are further subthemes that relate paramedic interventions to those of their hospital counterparts in the provision of healthcare. Not only does this community participant's narrative identify paramedics' ignorance of cultural and religious beliefs, he relates this to hospital staff, who he describes as being more understanding of these issues and displaying a greater importance on them.

'It is a good service, in that they come quickly, they always come quickly. But I tell people of their ignorance of our beliefs, I am not sure if this ignorance is because they just do not know, or if it is that they do not want to know. At times I prefer not to call the ambulance service, if there are other ways of getting to help, then this is what I do. The hospital is far more aware of our beliefs, it seems important to them.' (g2, p3)

The themes of lack of respect continue, as does the subtheme of the comparison to other health care professionals' ability to provide cultural and religious awareness with their care. In this narrative, the community group participant presents the question as to why this is the case. Whilst I felt at the time this particular participant was asking this directly of me and requiring an answer, there was not one to be had. The perception of some of the community group members is, if other healthcare professionals are able to incorporate cultural or religious healthcare in their practices, why does it seem then that Ambulance Victoria cannot? I was tempted to respond with a potential list of reasons as to why this

could be the case, however, even the ones that I thought of at the time including resources, education, and training, seemed so superfluous, given that it would be seemingly easy to address these.

'I tell everyone that they have no respect, no respect at all for us. I don't know why that is, but they don't. Other medical facilities do, hospitals do, so why is it so different for the ambulance service?' (g1, p6)

A further subtheme that arose from this question was that of acceptance, this is the service that is offered to them. I wondered at the time if this had any correlation to some of the comments made by the community group agencies about 'David and Goliath' and that 'nothing will ever change'. This would place the end users of Ambulance Victoria, the community in a self-perceived situation viewing that the Ambulance Victoria held the balance of power. People in powerless situations coming to the conclusion that there is nothing those they can do, so accept that is the way it is. Georges (2002) argues that there is a hierarchy that exists within the provision of healthcare and, within this, patients become passive, believing any injustice with which a patient is confronted does so with a sense of powerlessness, accepting the status quo. This particular community group member acknowledges that for him, he prepares himself and other community members to lower their expectations, and receive a level of service that is inferior and not considerate of cultural or religious values.

'It is hard for them you know, to know everything, to understand all religions and beliefs, I accept that, I understand that. I would use service again if I needed to, but my expectations would be lower, I now know that it is an emergency medical service, just dealing with medical problems. This is what I tell everyone, if you need an ambulance you should call, just be prepared that they will not know or understand our beliefs.' (g4, p4)

The acceptance of this community group member is also inclusive of him coming to the understanding that paramedics from within Ambulance Victoria respond only to the physiological attributes of patient care.

Whilst the following three narratives are inclusive of themes relating to community group members unwillingness to utilise the services of Ambulance Victoria due to previous experiences, they also bring in strong emotions in their narratives: emotions of increased levels of anxiety, disappointment, shame of Ambulance Victoria are clearly evident. The first of these three narratives also indicates that it is her belief that Ambulance Victoria lacks the capacity to be a professional organisation.

'If I can possibly avoid it, I will never use the ambulance service again. There have been times perhaps I should have, but I have taken my father to hospital myself just to avoid what happened last time, my father is still very upset by that experience. I cannot recommend this service to anyone, the ambulance service needs to be ashamed; it is not a professional organisation at all.' (g5, p1)

'The only thing that I tell other Muslims is that if you need to call for an ambulance, you should do so as a last alternative, if you can avoid calling for them, then do so, this is sad, very sad, I know this, it is sad only because it would be so easy for things to be different, just for them to respect us, our beliefs.' (g1, p 5)

'I would be extremely reluctant to call them again, I know that my father would forbid it. There is nothing favourable that I could pass onto my friends or family about the ambulance service, I feel very strongly about this.' (g5, p5)

The fact that there is clear reluctance for within parts of the community to utilise the services of Ambulance Victoria purely based on the lack of ability of its paramedics to respond to the cultural or religious needs of their patients is a clear indication of the importance this holds for some community members. As indicated previously, this is of concern to me as a paramedic, and I speculate if this indeed would be an issue for Ambulance Victoria.

In its recent annual report (Ambulance Victoria Annual Report, 2010-2011), the service describes its charter as being a state-wide emergency medical response service, responding to more than 5.5 million people across an area of 227, 000 square kilometres. The report lists the aims of the service as being to improve the health of the community by providing high quality pre-hospital care and medical transport. Including in the charter is a list of five components:

- respond rapidly to requests for help in a medical emergency
- provide specialised medical skills to maintain life and reduce injuries in emergency situations and while transporting patients
- provide specialised transport facilities to move people requiring emergency medical treatment
- provide services for which specialised medical or transport skills are necessary
- foster public education in first aid.

The annual report also provides an overview of the 2010 – 2011 strategic initiatives as being:

- Improve the efficiency and capacity of response resources to meet expected growth in demand
- Support the introduction of the 10 hour rest break and address fatigue issues
- Consolidate rural emergency call taking and dispatch into a single ESTA operational centre
- Develop a state-wide non-emergency strategy
- Provide appropriate facilities for paramedics
- Ensure appropriate industrial agreement is in place

Throughout the service 2010 – 2011 charter, aims, or strategic initiatives, there is no reference to the service's desire to be more inclusive of the community's cultural or religious requirements, or become more active in community engagement. Indeed the charter, aims, and strategic initiatives of the organisation are seemingly exclusive to operational initiatives within the organisation, mentioning only the public in generic terms. Interestingly, towards the back of the report, there is a mention of the service becoming more actively involved with culturally and linguistically diverse communities. However, the

report made it clear that this was specifically related to the service providing general presentations to community groups about their role and what people should do when they need an ambulance. This single-sided approach to the sharing of knowledge must only add to the community groups' perception of Ambulance Victoria's organisational arrogance.

Conclusion

Acquiring the voices of the community group participants was an important component of this study. Not only did this allow an opportunity for the community group participants to be heard, the data collected enabled a more balanced view to be gained for this study.

The paramedic group participants' reflection on the times they have called for paramedic assistance was associated with feelings of fear and anxiety. Interestingly, these emotions were not associated with the emergency at hand. They were more to do with past experiences of paramedic attendance or what they had been told by other members of their community in respect to paramedics' lack of capacity to understand or respect their cultural or religious differences.

It was interesting to note that many of the community group representatives included in their narratives that, at times, paramedics did recognise their cultural or religious diversity. It was done so with homogeneous attitudes by the paramedics resulting in a negative impact on the paramedic / patient relationship.

When commenting on the positive aspects of paramedic attendance, the only statement made by the community group related to the rapid response of paramedics to the call for assistance and the prompt time for them to commence assessment and treatment. Not surprisingly, both these areas are key performance indicators for Ambulance Victoria.

The strongest narratives that evolved from the discussions with the community group representatives related to their perceptions of paramedics responses towards their cultural and religious differences. Community members believed that paramedics, in general, lack respect for their patients' cultural and religious values, and display an unwillingness to respond to such needs, even when requested to do so. Many of the community group participants also believed that paramedics misinterpret cultural and religious rituals resulting in adverse reactions from them towards their patients and theirpatients' families. This was seen by the community group participants as further damaging the paramedic / patient relationship.

For many of the community group members, previous experiences with Ambulance Victoria have resulted in their refusal to utilise the service in the future, preferring to seek other means to seek emergency medical assistance. This has the potential to have devastating outcomes for the patient. For those few members of the community group who continued to utilise the services of Ambulance Victoria, they claim they do so with decreased expectations and increased anxiety levels.

The overriding key to these issues, according to the majority of the community group participants, was open dialogue and communication, believing that if paramedics are unsure of their cultural or religious requirements, all they need do is ask. This concept will be explored in greater detail in the next chapter, conclusions and recommendations.

Chapter 7

Conclusion and Recommendations

Since commencing my career as a paramedic some, 27 years ago, I have always held a strong interest in aspects of patient care that go beyond purely the physical. From as far back as my initial paramedic training I was surprised at the total emphasis that pre-hospital care had on the patients' physical needs, where often the only reference to their biophycosocial needs was the common phrase that our instructors utilised constantly being "rest and reassure" your patient.

There have been considerable changes in pre-hospital patient management since I commenced my career. The paramedic in 2012 now has extended scopes of practice, access to a myriad of drugs, and advanced skills sets for invasive treatment modalities. These advances in patient care have arisen from some significant advancements in technology, drug therapies, and increased skills sets, which have occurred in medicine as a direct result of informed evidenced based research. Whilst critical to patient care, these advances however still relate to the patient's physiological needs and lack the capacity to be inclusive of a holistic approach towards patient care.

From my own experiences, I had become aware that, in some circumstances within the pre-hospital setting, patients' needs moved beyond just the biophysical. This was particularly

true when patients held strong religious or cultural beliefs. I had observed for many years that paramedics lacked the capacity to respond to such patient needs, and at the times this occurred the usual 'flow' of patient care failed to materialise, and the paramedic / patient relationship was, at best, hampered.

Although medicine and nursing have addressed holistic approaches to patient care, and developed strategies for culturally and religiously responsive patient approaches, no such strategies existed within the pre-hospital / paramedic discipline. To gain some further insight into this specific area, and to obtain some evidence of my hypothesis, the focus of my Masters research (Hartley, 2006), was on the professional interrelationship between members of the Muslim community in Melbourne and paramedics caring for them within the pre-hospital setting. This research discovered that paramedics were unable to respond to the religious and cultural needs of the Muslim community. The study also discovered that this lack of culturally and religiously responsive care resulted in the Muslim community's perception of decreased levels of patient care and diminished patient outcomes.

Whilst my Masters study (Hartley, 2006), focused on the Muslim community, I was eager to investigate the views of the wider population in Melbourne as well as the paramedics serving them. Victoria is a heavily populated state in Australia, and home to a large multicultural community, with representation from many cultural and religious groups not only increasing in numbers in recent times, but also in diversity. The focus of this study is on paramedic practice and the cultural and religious needs of pre-hospital patients in Victoria.

The study has significant original contribution to the discipline of paramedicine, as it uncovers features related to the care of the pre-hospital patient that, from my knowledge, has not been researched, documented or published before. This original contribution also offers significant input to cross cultural knowledge within paramedic sciences discipline, and has developed a new body of knowledge on cross-cultural issues in professional paramedic education and curriculum design. This will be detailed further in this chapter.

The more specific aims of this study was to investigate the overall set of philosophical beliefs of specific religious and cultural groups in Victoria, and the impact this has on pre-hospital care. This study was especially interested in whether improvements in pre-hospital care was possible, and if so, how this could be best achieved. Further aims of this study were to raise an awareness of cultural and religious issues within the pre-hospital setting, and to inform the development of cross-cultural and religious responsive curricular content in professional paramedic educational programs. The final aim was to broaden the understanding of paramedic practitioners to enable them to better respond to the religious and cultural needs of the diverse communities they serve.

The study recruited two separate groups of people for data collection, the patient group of community representatives and the paramedic group. To ensure a cross and diverse representation of cultures and religions were achieved, the study sought to recruit delegates from diverse communities, as outlined in chapter four of this thesis. Similarly, the study sought representation from the paramedic subgroup ensuring an equal mix of gender,

recent graduates, and longer-term graduates, as well as an even representation of the differing methods of undergraduate education.

The critical element of this research, given the overall aims was to ensure the correct research methodology, and underpinning tools, were selected to not only appropriately support the research but also enhance the research process. Given my strong social sciences background, I have always valued the narrative as a powerful medium, especially with research involving lived experiences. I am a qualitative researcher, and, as such, believe in this methodology as being the most appropriate given the very human nature of this study. I had specifically decided on a mixed methods approach that incorporated ethnography, thematic analysis, and narrative enquiry, with the underpinning supports of semi structured interviews focus groups and case studies as research tools.

The ethnographic methodology used in this study proved to be very effective as it allowed the true focus of the cultural and religious experiences of the community groups to be highlighted within the context of the community group members' social worlds. As Hammersley and Atkinson (2007) suggested, the ethnographic approaches used in this study were particularly useful given the contemporary health care setting of paramedicine, and the combined cultural and religious lived experiences, belief systems, and religious / cultural frameworks of this study's participants.

Of the methodologies, and underpinning support tools utilised in this study, narrative enquiry was of the most benefit. As the researcher undertaking this study, my focus was not purely on 'what happened', but more on what was the meaning of what happened, or people's perceptions of what happened. Narrative enquiry not only offered the flexibility of the individual narrative, but also ensured that the narrative was inclusive in these individual interpretations without losing the 'centrality' of the relevance to the research topic, as Schwandt (1997) stated would be the case. There is little doubt that the critical element of this study was the narrative of all participants, and narrative enquiry ensured the purity of the voices and stories were not lost, but 'in fact' were validated and transcribed with original intent.

The semi structured interviews also worked well. The pre-set framework of questions resulted in the ongoing relaxed flow of discussions and stimulated debate whilst at the same time ensuring that the focus of the conversations was retained. Participants in this study appeared to respond well to the semi-structured format, which allowed them to express individual opinions and ideas, without the perception that I, as the facilitator, held the power. This was true for both the focus groups and the one-on-one interviews.

The focus groups proved to me the most challenging of all the tools used in this study. Whilst they clearly allowed participants voices to be heard in a supportive and safe environment, they were exceptionally time consuming to arrange, and on, numerous occasions required rescheduling at the community groups requests. The focus groups had

complexities that I was not prepared for, primarily resulting from the diversity within diversity, meaning the varying requirements within a single community group. I had taken into consideration all that I had known and learnt over the years, such as gender specific groups, inter-cultural and inter-religious tensions. However, there were still some tensions that arose relating to hierarchy and respect within a specific cultural or religious group. These tensions related more specifically to the social order within a given community group which I was unfamiliar with. As such, in some instances community group members prior to engaging in the conversation referred to the elder of the community group. I realised that the tensions experiences were that of my own, as this process was a norm within the respective communities. Further challenges related to my own Australian values, and my conscious capacity to put these aside and maintain neutrality in my responses and guiding of the process.

The focus groups were facilitated by community agencies recognised by the community, who recruited volunteers according to the inclusion criteria outlined earlier in chapter 4 of this thesis. This worked exceptionally well, and I would readily use this strategy again. Community members hold their official community organisations in high regard, and housed within this is implicit trust. The calling for volunteers for individual community members by these organisations gave validity to the study, with the volunteers being eager to contribute with confidence and faith in the study.

This study also relied on the use of case studies and work examples to encapsulate and evidence the narrative. This tool was particularly useful and successfully complemented the narrative of both the community group and the paramedic participants. In many instances, the case studies and work examples permitted the capacity to unpack the narrative with context and enriched meaning.

The data analysis was without a doubt, the most labour intensive, yet the most productive. The data collected was rich, which gave me the focus and energy to spend the countless hours transcribing and analysing. I specifically chose to transcribe all the data myself. This gave me the opportunity to not only relive the interviews and focus groups, giving them purpose and meaning, but also to ensure that the context of the narrative was not lost.

The data was coded using axial coding, allowing the natural themes to evolve. From this, the axial coding method also allowed a greater level of abstraction of the data to be confirmed into more specific and common themes, ultimately resulting in a clear display of the interrelationships of the presenting themes. Whilst this method was exceptionally time consuming, it offered levels of understanding of the data that I believe would not have been achieved by software packages.

On reflection, there is little that I would alter in the undertaking of this study again. The chosen methodology, underpinning research tools, and strategies utilised in this study appeared to be effective and resulted in the desired outcomes, the retention of the richness

of the data, and the validity of the spoken word. The things that I have learned from the process would be perhaps to expect the unexpected when dealing with groups of participants from such diverse backgrounds, acknowledge that timelines are simply that, timelines that I have created for myself, and not necessarily reflect those of others on which the study relied so heavily.

The findings of this study discovered some significant gaps in the education of paramedics that relates to culturally and religiously responsive care. Despite the fact that their medical and nursing counterparts have recognised and valued this aspect of patient care for some time now, the paramedic discipline, to date, has not been responsive to these informed approaches. The study discovered that paramedics undergo virtually no education either in their undergraduate educational programs, or post graduate / in-service continuing education. The study also identified that there was no differentiation in relation to cultural and religious inclusive curriculum of those paramedics that received their undergraduate education within the higher education university sector and those who underwent the vocational education post-employment mode of education. This lack of education pertaining to cultural and religious responsive healthcare appears to have resulted in an identified lack of capacity for paramedics involved in this study to respond to the cultural and religious needs of their patients.

The study has also identified that the curriculum content for paramedics has a strong biophysical emphasis, resulting in the paramedics involved in this study having a physiological focus at the forefront of their mind when dealing with their patients. The

biopsychosocial elements of patient care do not appear to form part of the paramedics' skills sets.

The overall theme relating to cultural and religious preparedness that this study established from the paramedic participants was the impact this had on them professionally and personally when dealing with aspects of patient care that they were unable to respond to. This was particularly evident for those paramedics working in geographical locations with a high density of the local community being of diverse cultures.

The study discovered further themes that emanated from the paramedics involved in this study that indicate that cultural and religious sensitivity is required for them to undertake their work effectively as paramedic practitioners. However, their lack of capacity to do so resulted in intense emotional responses inclusive of anger, frustration, lack of professional credibility, inexperienced, inadequate, and increased stress levels. They also noted a decrease in the level of care afforded to their patients. Many of the paramedic participants involved in this study clearly recalled instances where their lack of ability to understand cultural or religious norms and rituals had also left them feeling unnecessarily fearful for their own physical safety.

Not only were these strong emotions that were encountered by the paramedics involved in this study uncovered, in many instances cultural and religious misunderstandings resulting in homogenous attitudes by paramedics were identified. Further, paramedics involved in the

paramedic subgroup demonstrated generalised and frequently judgmental views of patients from differing cultural and religious backgrounds to them. This was particularly evident when paramedics had a lack of knowledge relating to cultural or religious norms.

Ongoing themes emanating from this study revealed that the ethos of the paramedic industry itself hampered the development of the discipline's capacity to move towards a holistic approach to patient care. Paramedics themselves indicated a general unwillingness for them to take responsibility or ownership of their own professional development.

The community group participants of this study echoed the lack of capacity of paramedics to respond to the religious and cultural needs of their patients. The only positive aspect of patient care that the community group representatives related in this study was that of the rapid response times of paramedics. The study clearly highlights the disconnect between paramedics and the cultural and religious needs of their patients. This study evidences many instances where patients have been left feeling confused, disrespected, grief-stricken, and even violated by paramedic responses.

The common element that this study discovered from the community group expectations of paramedic intervention was not complex at all. Whilst some of the issues facing the community groups' religious and cultural requirements related to gender specific care, the community group participants were quick to add that they recognise the constraints of the ambulance service. As such, they are aware that this is not always logistically possible.

However, the study uncovered that the most pressing issues of the community group's participants related to open dialogue and communication. The common theme emanating from this group of participants was the expectation that, if paramedics are unsure as to what to do, simply ask and then respond to the requests of the patient or patient's family rather than choosing to ignore them.

The most concerning discovery of this research was the frequency in which the community group members stated that, due to past experiences of the ambulance services lack of capacity to respond in a culturally responsive manner, they now choose alternative means of transport to hospital for themselves or family members. Of similar concern are the overall impressions of the ambulance service held by the community group members involved in this study. The study clearly evidences the general consensus by the community group participants that the ambulance service lacks professionalism and is aligned at the lower end of the health care providers as far as trust, faith, and credibility are concerned. This is in contrast to the established high-end respect the remainder of the community has of the paramedic profession.

The study acknowledges its limitations, given the numbers of the participants involved. Even though the themes developed saturation within these confined numbers, there is still more than can be achieved in identifying some of the specific cultural and religious requirements groups have when attended to by paramedics. Overall, I believe this study was successful in achieving its objectives. The data collected now offers evidence that can be utilised to form a

framework of a culturally competent paramedic. This research can now inform curriculum design and encourage primary healthcare organisations to put in place continuing educational programs that have the potential to result in culturally and religiously responsive approaches. Culturally and religiously responsive curriculum design will aid in raising the awareness of paramedics of the holistic needs of their patients, and hold the very real potential to provide greater levels of care and improved patient outcomes.

As a result of this study, the future benefits of paramedics being able to better meet the needs of their patients will have considerable flow on effects. The paramedic / patient relationship will be improved where cultural and religious forces are at play. Paramedics will be armed with the tools for culturally and religiously responsive healthcare, which will reduce stress levels, anxiety, feelings of inadequacy, frustration, and anger previously associated when not being able to meet the overall needs of their patients.

Patients and their family members, as a result of having contact with culturally and religiously responsive paramedics, will have increased levels of confidence in the care offered them. Added to this will be the feelings of respect, understanding, and faith in the ambulance service as a healthcare provider.

The study recommends that promoting cultural and religious competence within Ambulance Victoria needs to be part of an overall ongoing quality management and quality assurance process that is supported by senior management. The study has shown that the successful

incorporation of culturally and religiously responsive approaches within an organisation occurs when the overriding governing bodies deem it a requirement, and mandate a set of guidelines to be included. These guidelines not only need to be explicit, but also assessable by means of external audits.

As indicated previously, the academic setting has the potential to make significant advances in the development of culturally and religiously responsive pre-hospital care, especially though the entry level programs where the enrolment numbers are the greatest. The nursing discipline has developed a long history of incorporating culturally and religiously congruent care into their higher education curriculum on a national level mandated by course accreditation and registration requirements. Medicine in more recent times has also adopted a similar approach, and has embedded content related to cultural and religious congruent care within all medicine undergraduate programs at a national level. They have followed the earlier processes founded by nursing governance processes ensuring this occurs via the course accreditation process. This, of course resulted in national standardised curriculum content related specifically to culturally and religiously responsive care.

In terms of paramedic education, it is suggested, from the findings of this research, that paramedics have gained minimal, if any, exposure that relates to cultural or religious preparedness within their education. This apparent lack of input into their education processes is not confined to their undergraduate programs, and extends through to their continuing education professional development programs delivered by their employing

organisation, Ambulance Victoria. The reported lack of curriculum content by paramedics has very much supported the profession in its physiological approach to patient care, and has not supported the paramedic in developing a more holistic method of patient treatment as has been achieved in other medical / nursing education programs. The transition from the vocational mode of education of paramedics into the higher education degree programs appears to have failed to address this issue, as there was no delineation in responses outlining the educational experiences of the participants.

This study has identified that paramedics have received either no or limited education preparing them for responding to the cultural needs of the community they serve. This is but one piece to add to the jigsaw about the most effective education of paramedics within a community characterised by diversity.

Whilst the data are highly suggestive of paramedic students not being exposed to a culturally and religiously inclusive curriculum, what the data are unable to confirm is whether this was not delivered, or simply not learned. Paramedic programs attract students who have a desire for a practical “hands on” profession. Students and qualified paramedics often refer to the social sciences as “soft subjects”. The mere use of this terminology can imply that paramedic students hold a lack of importance in these important areas of their studies. Further exploration is required for the future to determine paramedic curricula inclusion throughout Victoria and nationally to determine what is being delivered. On an

international level, a culturally and religiously inclusive curriculum is incorporated within only two higher education paramedic programs as detailed in chapter 2 of this thesis.

The inclusion of a holistic approach to patient care incorporating the cultural and religious needs of the pre-hospital patient is an important component of paramedic culturally responsive care. As such, this study recommends that the inclusion of culturally and religiously responsive curriculum is essential in the higher education paramedic programs given the diversity of the Victorian population. Culturally and religiously inclusive curriculum needs to be introduced early in the undergraduate program, integrated with purpose, and incorporated in a manner that shows clear relevance to other facets of paramedic care to ensure that there are the desired educational, professional and patient outcomes.

With thoughtful preparation and a systematic approach, including rigorous self assessment, academic staff involved in the delivery of paramedic programs, most of whom are paramedics themselves, can teach culturally and religiously inclusive education programs while developing their own competence in the process. However, paramedic academics must embrace the responsibility to assist their students in developing these critical skills for competent clinical practice, thereby assuring a more rounded paramedic graduate. The development of a culturally and religiously responsive curriculum can only be achieved through committed paramedic academics that value a holistic approach to patient care inclusive of the diversity of cultural values and beliefs. Whilst each paramedic academic

holds the capacity to make a positive difference, the greatest impact will be achieved through group processes and collaborative support for the overall goal.

Higher education programs, inclusive of paramedicine, are committed to the life-long learning strategies of their graduates. Culturally and religiously responsive paramedic curricula needs to embrace this concept to ensure graduates continue to develop as culturally and religiously responsive health care practitioners, and assist younger graduates to develop these sets of skills.

Recent graduates as well as community group organisations, should be given the opportunity to provide input into the content of curriculum that responds to culturally and religiously responsive care in the pre-hospital setting. This consultative process can guide paramedic academics in refining holistic care curriculum content and relate this to clinical experiences; ensuring graduates acquire the necessary skills for their workplace.

This educational process should continue throughout the employment of the paramedic within the realms of the existing in-service continuing education programs offered by any ambulance service, including Ambulance Victoria. This would, however, require a shift in the current curricula priorities of these programs, which predominantly focus on the physiological aspects of pre-hospital care. The introduction of culturally and religiously responsive content may also impact on paramedic service delivery and shift rosters, which would require a reappraisal of paramedic resource allocations across the state enabling

paramedics to be removed from their duties whilst undertaking culturally and religiously responsive education programs.

Ambulance services, universities, and educational facilities providing paramedic education need to take heed of their nursing and medicine counterparts by placing more emphasis on culturally and religiously responsive issues in curricula. Cross teaching with other health disciplines can only broaden the current paramedic curriculum from the existing physiological model to one which includes the biopsychosocial. The inclusion of content relating to cultural and religious issues in health-care should not be confined to only the degree course, but should be incorporated across all pre-hospital programs, including certificate courses, that relate to all aspects of pre-hospital practice, including emergency and non-emergency patient transport. This will assist in the development of a culturally and religiously responsive ethos within all facets of the pre-hospital industry.

Education within the diverse community groups could also greatly enhance the relationship between them and the ambulance service. A two-way consultative process needs to be established to allow open dialogue to occur amongst the paramedic practitioners and the diverse community they serve to ensure that best possible practice is offered and that expectations can be met if at all possible. This would also ensure that community members could better prepare themselves to accept paramedic services with enhanced understanding.

Such community education will also empower members of the community to relate to and guide attending paramedic crews to ensure a satisfactory outcome. The ambulance service's community education programs need to be proactive in their approach to the differing community needs by actively engaging the community it serves.

Stronger links between the ambulance service and the community need to be forged, as this will ensure that expectations on both sides can be measured and understood, including any limitations. Community consultation needs to have a higher profile within the ambulance service, with forums being held to open lines of communication as a two-way process, with attained information flow occurring from such forums back to the paramedics at the 'coalface'.

If any, or all, of these recommendations were to be applied, the result would be an attitudinal shift on both sides. This would culminate in a shift of behaviours, attitudes, mindsets and culture, predominantly by paramedics as the service providers. Such a shift would be a slow process, possibly taking years, with paramedics having an increase in professional and personal satisfaction, and the community members having their religious and cultural needs met, which will ultimately achieve better health outcomes for all.

The Culturally and Religiously Responsive Paramedic (CRRP) – a model.

The findings of this study permitted the formulation of a model of the culturally and religiously responsive paramedic (CRRP), the diagrammatic representation of which is on the

final page of this chapter. The CRRP can only be achieved if all the key players in the area of pre-hospital healthcare are engaged and committed. This would necessarily include the universities offering paramedic higher education programs, community groups representing patient diversity, the ambulance service, and the paramedics themselves.

As recommended earlier in this chapter, university programs offering higher education paramedic programs need to consider the delivery of a curriculum that is culturally and religiously inclusive and relevant to the pre-hospital setting. The higher education entry-level undergraduate programs are the best placed to have the most impact. This finding and recommendation is aligned to the findings of Jeffreys (2006) and Marshall (2010).

In order for this to be effective, this study recommends that universities give consideration to external and internal governance processes as supported by the findings of Berger (1998). As an external measure, the governing body responsible for the accreditation of paramedic education programs needs to consider mandating the inclusion of cultural and religiously responsive care into curricula, clearly detailing minimum requirements as supported by the findings of the AAMC (2005). As an internal measure, universities should be required to undergo the defined self-evaluation processes to ensure academics are able to achieve the desired outcomes of a culturally and religiously inclusive curriculum. This self-evaluation process needs to be inclusive of the curriculum content being delivered, the effectiveness of the content, as reported by the findings of the AAMC (2005) TACCT, and the

capacity of each individual academic to deliver it. These findings are not dissimilar to those recommended by Smedley (2003), Morse (1999), and Jeffreys (2006).

This study recommends that any planned approach of culturally and religiously responsive curricula content must be inclusive of the four approaches for effective integration of culturally competent health care as described within the review of the literature in this thesis, and supported by the findings of Leininger (1995), and should include an open consultative process with peak community bodies representing the diverse cultural and religious groups. Similarly universities should engage with Ambulance Victoria on developing a collaborative approach to producing culturally responsive paramedics. This would ensure that content of any education programs delivered by either institution are reflective of need and consistent in content.

Universities are also encouraged to collaborate with community groups to devise an inclusive curriculum. This would ensure that specific needs of individual community groups are addressed. There would be considerable benefit in the formation of a curriculum review / development committee which includes community group members and oversees curriculum content development. Such a curriculum should be inclusive of many of the issues raised by community members involved in this study, and could be regularly reviewed according to such issues. Areas that need to be considered in the delivery of such an inclusive curriculum are:

- Cultural and religious diversity, the demographics of the Australian community
- The impacts of culture and religion on healthcare and health practices
- Human rights, obligations, ethical issues in responding to patients needs
- That we all live in a multicultural society, but few of us live in a multicultural community
- The specifics of diverse communities:
 - The role of family members
 - Modesty and clothing
 - Specific rituals – religious and cultural
 - Death, dying and grieving requirements of society
- Patient outcomes from a holistic approach to patient care.

The study also recommends that, in order to achieve a CRRP, the ambulance service needs to be governed to do so by the peak industry body as an external governance process. This recommendation is supported by the findings of Munoz & Luckmann (2005). In the instance of Victoria, the state's health authority would control this via the ambulance directorate. The ambulance service should enter into a consultative two-way process with the varying community groups it serves. This would not only ensure that correct knowledge is achieved and relayed back to paramedics, but also act as a consultative forum monitoring the effectiveness of this process, and guide future requirements.

The ambulance service needs to give urgent consideration to offering ongoing in-service continuing education programs for its paramedics that relates to culturally and religiously responsive care. This would not only ensure paramedics' greater understanding of the cultural and religious issues facing them, but aid in changing the ethos of the organisation from its present physiological focus to one which is inclusive of biopsychosocial care. It is also recommended the ambulance service review the organisational structure, values and strategic vision of the institution to embrace culturally and religiously inclusive and responsive care. These recommendations are supported by the same evolutionary changes that have been documented in the discipline of medicine by the AAMC (2005).

Community groups will also benefit from the two-way consultative process with the ambulance service. Not only will they have a voice in the development of the CRRP, but such a forum will avail of opportunities for a greater understanding of the functions, limitations, and logistical constraints of the ambulance service as an organisation. This information can then be readily relayed back to the community via their normal communication processes.

Community groups and paramedic practitioners need to take advantage of the learning opportunities that come from exposure. Not unlike the two-way consultative process described above for the ambulance service and community groups, similar opportunities arise between them and paramedics at the very coalface of pre-hospital care. These learning opportunities are limitless and have the capacity to educate and inform both parties, and

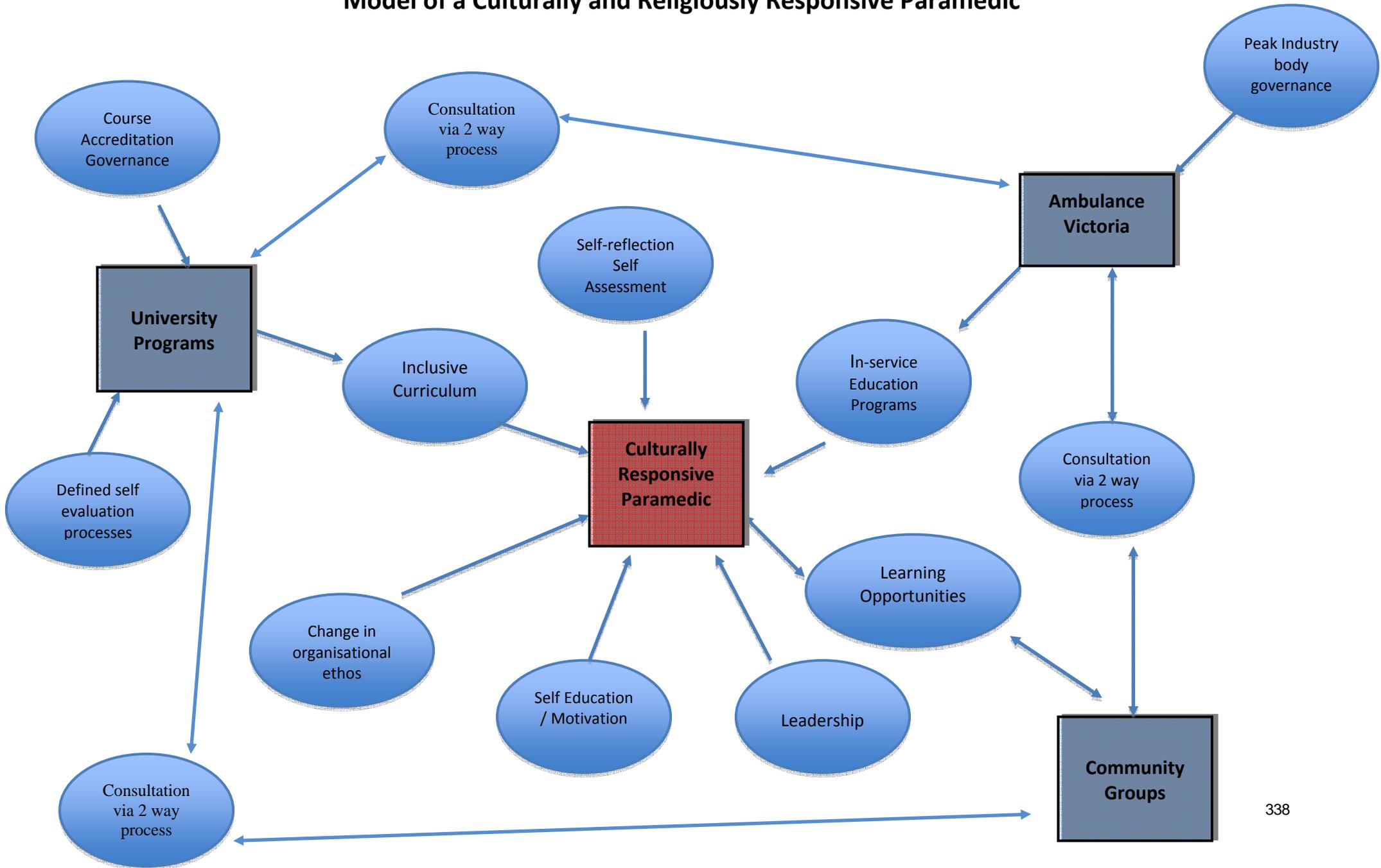
are well documented by Jeffreys (2006), Tabi & Mukherjee (2003), Baldwin (1999) and Leininger & McFarland (2002).

Paramedics, themselves, need to take ownership and responsibility for their ongoing professional development. Life long learning opportunities face paramedics each day of their career. Such learning opportunities related to the enhancement of culturally and religiously responsive care should be heeded. Self-education and motivation need to be components of paramedics' ongoing professional development if the CRRP is to be achieved. Not unlike paramedic academics, paramedic practitioners themselves should undergo continual self-reflection and self-assessment within a standardised context and framework, as outlined in the review of literature in this thesis. This tool will enable paramedics to not only establish themselves on the journey to becoming a CRRP, but also enable them to monitor their progress aligned to their motivation.

Finally, the CCRP needs to also incorporate issues relating to culturally and religiously responsive care into the leadership context as underpinned by the institutional approach that embodies graduate paramedic supervision. As described and supported by the findings of Smart & Smart (2002), new graduates rely heavily on clinical instructors for guidance in all aspects of the work undertaken by a paramedic. Setting examples by leadership will aid in the development of the CRRP and support the underpinning knowledge and skill sets in this area provided by the universities. This recommendation of this study is confirmed by the research findings of Tabi & Mukherjee (2003).

Providing all the elements above are incorporated, the model of a CRRP allows for a change in organisation ethos emanating this time from the paramedic workforce. There is still much to be achieved before the CRRP emerges and makes a real difference within the pre-hospital setting. From my own context as a researcher holding a passion for this very issue, I am keen to further explore all realms related to culturally and religiously responsive care in the pre-hospital setting. To aid in this process, my next project will include a study of paramedic students at varying universities nationally, and internationally, mapping their cultural and religious preparedness from the commencement of their educational program (what they brought with them), during their educational program (what they learnt from the process), and twelve months after post graduation (what they gained / consolidated from exposure).

Model of a Culturally and Religiously Responsive Paramedic



Addendum 1

Case Studies

Case Study 1

We were called to an imminent delivery; the lady was completely covered including her face. Basically, the only parts of her that I could see were her hands. Whether or not the patient and her husband were anxious about the impending birth, or whether they were anxious about the prospect of her being indecently exposed with the nature of delivering a baby, I am not sure. There was quite a lot of palpable anxiety between the two of them, it was very difficult to be able to communicate and assess her, and not really knowing their particular background or what sort of sensitivities that I needed to be aware of, it was difficult to comfortably and naturally interact with them, as you would with most patients. On reflection, it is only now that I realise my own anxiety levels were high, I was not prepared to be able to deal with the situation confronting me. The patient and her husband were looking towards me for support, but I was totally paralysed by the whole cultural thing. I had no rapport with these people, it was totally hampered by my lack of capacity to respond to my own perceptions of what they may, or may not have required. As it turned out we didn't deliver the baby, but it was certainly a moment where I wished that I had a bit more of an insight into what they needed and what was appropriate with managing the patient in light of their cultural background. I would like to be able to do this job all over again, do it differently; I did not like leaving it the way I did; I like to think of myself as more

professional than that. But then again, even now, nearly twelve months later, I am still unaware of how I should have responded in that situation.

Case Study 2

We were called to an Asian family; he was an elderly male with multiple health issues. He was very short of breath with an acute exacerbation of his COPD^{*}. I have no idea what the family was thinking; the house was like an oven when we walked in. They had him on the bed lying down which was obviously making him much worse. They were rubbing this fowl smelling oil over his body, which was doing absolutely nothing for him. The only thing it did do was make us more cautious about how we treated him, who knows what it was. I am not sure whether the family members were raving incoherently, or chanting; either way, they were in our way, having a huge impact on our ability to treat the patient. I mean, if they did not want us there, why did they call us? The scene was something out of a bad movie, even down to the heavy smoke filled room. Not sure why there was so much incense burning, but that could not have helped him either. It does not take much to work out that smoke and breathing difficulties are not a good combination. Sometimes however I do reflect back at some of these jobs and I feel inadequate, perhaps even knowing that there is something that I could have offered the patient more than I did, especially if there has been a death involved. At the time I don't think about it much, I am too focused on what we need to get done, treat the issue as best we can and transport. But sometimes I

^{*} Chronic Obstructive Pulmonary Disease.

look back and wonder if there is something more that we could be offering these groups; you know, the ones that are out of the norm, even though they are becoming the norm.

Case Study 3

We were called to a family of Islamic background; there was a language barrier there so it was difficult to ascertain what the situation was, or who the patient was. The patient ended up being a young boy who was about 13, and, as we normally do with minors, our communication was via the boy's mother. However, she seemed very reluctant to be engaged in why we were there or her son's care. I recall that I wondered at that time if she was indeed the patient's mother, and if so, why she was so disinterested. The boy's father was in another room so it was difficult to address him. It was almost as like he was testing us, he was in the other room waiting for us to approach him and recognise him as the head of the family unit and obtain his permission to ask his family questions. We only picked up on this via visual cues, body language, every time we asked something we were referred to the husband by the patient's mother. I did think that perhaps the parents were not together, or at the very least involved in some domestic dispute prior to our arrival. We should have picked up on this straight away, but for some reason we persisted on pursuing and questioning the mother and child. We would ask her a direct question, and she would literally just shrink back in her chair and looked into the other room at her husband. As soon as we engaged the husband, and asked his permission to question their son, it was good, the communication channels opened and it became much smoother. It infuriated me that we had to go through this charade. Why could he have not just approached us, it

would have been a whole lot easier. We were called into his home, it is not as if we were uninvited guests.

Case Study 4

We attended this patient; he was from Jordan a young male patient of around 45 years who had arrested. Even before we got there we both knew this was going to be one of those jobs that you want to get in and out as quickly as possible. In my experience, you do not want to be around Africans when there has been a serious injury or death. Things can get out of hand really quickly; they are so unpredictable at the best of times. On arrival he was clearly dead, there was nothing that we could have done. There was a huge outpouring of very upfront grief that happened straight after that, so there were lots of people running around yelling, screaming, punching themselves, punching holes in walls, bashing themselves in the face. It was so very different from any outpouring of grief that we usually see from any person from an Anglo Saxon background. Once the arrest^{*} had been called, and my partner had advised the family there was nothing more we could do, my feelings in these circumstances would normally have been quite compassionate towards the family and their situation. However, immediately this family were given the information, it was like turning on a switch, it was extremely full on with very explicit aggressive type behaviours and, as usually occurs with these people, we found ourselves in a very threatening situation. I recall thinking 'Oh my God they are going to kill us.' My coping mechanism for this was to just leave, to give them some space, and myself as well. Normally, I would never have left

* Death

the patient's family alone until I realised or knew that they understood what was going on. I would normally go through the process of putting the patient back into bed and all those other nice things we would do for them before we would even consider leaving the house or going outside to wait for anybody else. Whereas in these sorts instances, we just grab our gear and leave. I just feel it best to leave, it's for our own safety, we really did not want to be involved in any sort of an incident that the family would have regretted, like taking anything out on us unnecessarily. I have begun ensuring the police respond to these instances when we receive the call, and hopefully they arrive before we do.

Case Study 5

We were called to this Iraqi family where the eldest member, the father was very sick and arrested. There was an intense amount of grieving which I had never experienced before. The women were physically pulling their hair out and banging their heads against the wall. This is apparently their cultural grieving process. It was a surreal situation, I felt totally out of my depth. It was intensely frustrating. I recognise my own lack of understanding about what certain cultural beliefs are or the custom these people may have. I mean you always hope that you are not going to offend anyone, you hope you don't put your foot in your mouth when you when you are dealing with these situations. It is not good enough to hope though, we should know more about these types of patients, how to deal with them, what their needs are.

Case Study 6

We were called to the home of a Sikh patient who had chest pain, and requiring morphine intravenously. I held his arm to prepare for the cannulation* and went to shave the area, as is normal practice. I wasn't aware at the time that I wasn't allowed to remove a hair from his body. It was something as simple as that. The patient reacted strongly, almost abusing me, advising me that no hair was to be removed from his body. Even as he was telling me this, I was thinking why? What difference does it make? From that moment on, I knew that I had lost any form of rapport with this man, and the rest of the job was tense, not relaxed at all. He had no trust in me, in the care I was providing, and I was perplexed by such a strong response to the care I was trained to give. This resulted in strong feelings of frustration on my behalf because I couldn't provide the level of care that I was expected to provide. I also felt embarrassed because I was somewhat caught out by the fact that I was unaware of their religious practices. Looking back now, it would have been obvious if I had have received some training in this area, as I said, it was such a simple thing.

Case Study 7

We were called to an arrest; it was weird, too weird, and scary. There was a male patient, an African man, in full arrest; the house was full of people, and it looked like a house of black magic or something. I recall this strange smell, to this day I have no idea what it was, but it was overpowering and strong. It wasn't horrible like rubbish, nor was it pleasant like incense, but I do recall it being overpowering and something like I had not smelt before.

* Cannulation refers to intravenous access via needle, usually placed in the patients arm.

The people were aggressive, screaming. There was this one man, he looked like he was waiving something around, like a stick in the air, it was all very tribal, very ritual. There was African music playing really loudly, the whole scene looked like a ritual, witchcraft, it was way weird. It was hard to concentrate on what we had to do, the whole time we were conscious of what was going on around us, you know, the environment, was it safe, this is what we are taught, our safety is a priority, neither of us felt safe. We were glad to get out of there. We are not accustomed to situations like this. It really looked like black magic was being performed, we could not help but think that man was dead because of some ritual, some sacrifice, and that we could have been next. The whole time I recall feeling overwhelming fear, and was glad to be able to get out of the place. Much later, on reflection I began to feel angry and upset I was upset at the frustration and fear I felt at the time. In hindsight, perhaps we were not under threat, but it was this fear, the emotional fear of what was going on that I have no doubt interfered with our normal routine, our way of going about our job, our normal routine approach. We were concentrating on just getting out of there alive, and as quickly as possible, we just wanted the whole thing over so we could get back to the safety of the truck*. This is an increasing problem for us going into homes, these situations that we are not familiar with, that are different from the normal, different from what we expect. It is happening more and more, as the representation of different cultures increases in the community. I get angry sometimes that we are not prepared for this. It is not that we are not adequately prepared for treating patients from different cultural backgrounds; we are not prepared at all.

* Paramedics commonly refer to the ambulance as the truck.

Case Study 8

We did a job where we were called to a household where the male was in cardiac arrest; I think it was just before a wedding in a Muslim home. All the men were out celebrating, the arrest didn't go well, and he ended up passing away despite all our resuscitation efforts.

What was unusual for us were the displays of grief, and wailing, and we were actually quite concerned about our own safety. As the men started coming back, we started worrying 'my God, will they blame us, how much danger are we in, are we going to get out of this alive?' I guess my responses were so because I am just not used to the whole cultural thing. With large numbers of people like 10 or 20, there is always the risk of the whole crowd mentality thing, I mean if someone was to start something and the others followed, what chance would we have had? But surprisingly, they were fine, they absolutely understood, they were good, they were totally fine, and they ended up being not too scary, at all. I didn't know how they would react, you just simply don't know with these things how they can go, you never can tell what these people may do with the backgrounds they come from. I think it's because we don't understand the rules, or have a really good knowledge of these people that are different to us. You worry that you will do something inappropriate when you didn't really mean to do it, and you will upset them. I guess even though you are right, you worry that they may react aggressively.

The whole job left me with feelings of intense frustration, not knowing what to expect, being trained to respond to all patients in the same manner, when in actual fact no two patients are ever the same. The ambulance service is built on algorithms, everything we do

is by the book, follow the process. It is frustrating and, at times, scary when the algorithm doesn't fit the situation, and you begin to wonder what in the hell I should do next, and it is at these times that you can lose all perspective in your care of the patient.

Case Study 9

We went to a scene where there was a kid, he had just turned seventeen, and he had been assaulted. He went out looking for his sister and when we had got to the scene he was no longer around, but we saw a massive pool of blood in the gutter. The bystanders had told us that the kid had hit his head in the gutter, and that a gang of African kids had repeatedly stomped him on. Reports indicated that he had been unconscious for a little while, but he had regained consciousness and had gone home, which was just around the corner. We went to the house where the kid was, it was a party; they had thrown a seventeenth birthday. Even though he was only seventeen he had been drinking all day, and this was about ten o'clock at night, so you can well imagine the pickled state he was in. When we walked into the house he was covered in blood, the scene was quite intense, not only had he been drinking, but the whole family had been drinking; there were probably about 30 to 40 Maori people there. My partner that night has quite an intense personality and she was being quite direct. Because he had been assaulted, was Maori, had alcohol on board, was seventeen, was looking for his sister, he was being unreasonably aggressive, as were his dad and uncles. The atmosphere was emotionally charged. He himself was also a new father at seventeen. My partner just handled it wrong. It got real fiery. She didn't understand the importance of him going to hospital, and the fact that he potentially had a head injury,

which could explain him being difficult and irrational. She didn't explain anything to either the patient or family members, she just said to him, come on, we got to go, get up, you're being ridiculous, stop being silly, get up, don't come over here, don't do that, you can't take your child. Her responses seemed to inflame an already volatile situation. He wanted to take his child with him to the car, he wanted to say goodbye to his partner. She wouldn't let him do any of that. There was this one uncle who took offence to her attitude, which was not surprising, as I would have also. This kid could have been, potentially, quite unwell; he started vomiting. We're thinking does he have a head injury as he had obvious injuries to his face. If I was a sister, mother, father in this situation, and if I had two young (because we both look young), paramedics pretty much tell me to step back and stay out of it, I would react the same. I mean we are two young girls in a family taking control and giving no consideration to the family needs, and Maoris' are quite close, they're close and they're protective. This, combined with alcohol, Maoris always become unreasonably aggressive. I'd actually had left the scene to go and get the stretcher, and when I come back in it had blown up, to the point where I hit the duress button^{*}. It was all so unnecessary. My partner did not read any of the signals, the hyper-charged family, the need for family support, or the recognition of family relationships, particularly with Maoris.

* The panic button that alerts the communications centre that a paramedic crew is in danger. Police are called to the scene as a high priority.



Addendum 2

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled: "An Investigation for Paramedic Practice of Cultural and Religious Needs of the Pre-Hospital Patient in the Australian Community."

This project is being conducted by a student researcher Peter Hartley as part of a PhD study at Victoria University under the supervision of Dr. Maureen Ryan and Dr. Marcelle Cacciattolo from Faculty of Arts Education and Human Development

Project explanation

Cultural and religious practices can have considerable impact on health care, and with the increase in the cultural diversity of the population in Australia, it is important to know the religious and cultural needs of community members so that they can receive better health care. We are especially interested in how and where we can improve the services provided by paramedics to the diverse community of Melbourne.

Throughout the latter part of the twentieth century, health care provision was primarily based on western needs; with the assumption that everyone had the same needs and that those needs were biological. In more recent times, health care has shifted in emphasis so that the whole of the patient receives care. This has seen better outcomes for the patient and the caregiver.

This project relies on input from members representing various cultural and religious groups in the Melbourne community. With this input, the philosophical and practical cultural approaches can be identified and included into health care practice and health care training. With knowledge of the key aspects of culture, emergency paramedic care could be more sensitive to the cultural needs of the community it serves. The results should be better health outcomes for those community members needing emergency paramedic care.

What will I be asked to do?

For members of the community who wish to participate, a discussion will take place at a date, time and venue that are convenient to all. It will be a small discussion group of up to three (3) people. Groups will be separated as male or female and no mixed gender groups will occur. Alternatively, 1 on1 interviews can also be arranged. Participants will be asked about their experiences with using the services of the Metropolitan Ambulance Service. The group would set the topics for discussion under guidance from the researcher (Peter Hartley). It would be up to the participants to raise the topics considered important. The discussion will last approximately 30 - 90 minutes, dependant upon numbers of participants.

Your participation would be completely voluntary and you may withdraw from the project at any stage without penalty.

All information will be confidential. All participants must agree not to discuss what others have said within the group. In the unlikely event that anyone feels uncomfortable because of the discussions, the VU Psychology Clinic or support services provided by Ambulance Victoria will be available to assist.

What will I gain from participating?

You will be involved in a project that will make a major contribution to your community. The research has the potential to contribute to the cross-cultural knowledge within the discipline of paramedic science. Additionally, by ascertaining the key religious and cultural needs of the Australian community, this knowledge will culminate in cultural competence for paramedics and other pre-hospital health care workers.

Finally, this study should enhance the level of effectiveness of paramedic work in pre-hospital practice when dealing with patients. This has the potential to lead to an improvement in the overall care and potential recovery of the patient. Further, this study should result in decreased levels of stress for paramedics working in an environment where patient needs go beyond just the physiological, and begin to incorporate the biopsychosocial.

There will be no payments made to participants. Small reimbursement payment may be made to cover travel expenses in extreme circumstances.

How will the information I give be used?

All information collected will be strictly confidential.

Discussion may be tape-recorded. The tape-recording would be by permission of participants and is so that the researcher (Peter Hartley) does not have to take copious notes and can concentrate on the topics being discussed. Discussions will be typed and no names will be attached to the text. Instead, each person will be assigned a number to ensure that confidentiality is protected. No-one else will have access to the text and the audio tapes will be destroyed at the end of the project.

The findings from the study may be published. No names will be included in the material submitted for publication and all comments leading to the potential identification of specific individuals will be removed.

What are the potential risks of participating in this project?

There are no risks associated with this project.

How will this project be conducted?

This study will rely on semi-structured interviews to stimulate discussion and generate material for analysis, as the data is reliant on feelings and beliefs. The key needs of the Australian community will be formally identified using interviews in focus groups and case studies. In addition to identifying the individual needs of each of the specific cultural and religious groups, the focus groups will be asked to incorporate recommendations highlighting the potential benefits on health care outcomes for patients should their specific needs be considered in a holistic approach by pre-hospital health care workers.

The specific areas of interest that this study will identify and clarify for each of the religious groups will include:

Spiritual / Pastoral Care
Psychiatric Illness / Counselling
Medical Consultation
Life after Death / Fate
Religious Observations
Gender / Sexuality
Childbirth
Death and Dying
Transfusions / Blood Products / Organ Transplants – Donations
Elderly
Suicide
Drug Administration

Who is conducting the study?

Dr. Maureen Ryan (Faculty of Arts, Education and Human Development) 9919 4719
Dr. Marcelle Cacciattolo (Faculty of Arts, Education and Human Development) 9919 7575
Mr. Peter Hartley - PhD student (Faculty of Arts, Education and Human Development) 9919 2944

Any queries about your participation in this project may be directed to the Principal Researcher listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.



Addendum 3

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into An Investigation for Paramedic Practice of Cultural and Religious Needs of the Pre-Hospital Patient in the Australian Community.

This project relies on input from members representing various cultural and religious groups in the Melbourne community. With this input, the philosophical and practical cultural approaches can be identified and included into health care practice and health care training. With knowledge of the key aspects of culture, emergency paramedic care could be more sensitive to the cultural needs of the community it serves. The results should be better health outcomes for those community members needing emergency paramedic care.

You will be involved in a small discussion group of up to three (3) people. You will be asked about your experiences with using the services of the Ambulance Victoria. The group will set the topics for discussion under guidance from the researcher (Peter Hartley). It would be up to the participants to raise the topics considered important. The discussion will last approximately 30 - 90 minutes, dependant upon numbers of participants.

Your participation would be completely voluntary and you may withdraw from the project at any stage without penalty.

CERTIFICATION BY SUBJECT

I, "[Click here & type participant's name]"
of "[Click here & type participant's suburb]"

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study: "An Investigation for Paramedic Practice of Cultural and Religious Needs of the Pre-Hospital Patient in the Australian Community" being conducted at Victoria University by: Dr. Maureen Ryan and Dr. Marcelle Cacciattolo

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: Peter Hartley – PhD student – (Researcher)

and that I freely consent to participation involving the below mentioned procedures:

- Participation in small group discussion (focus group)

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.

Signed: _____

Date: / / 2009

Any queries about your participation in this project may be directed to the researcher Dr. Maureen Ryan 9919 4179 or
Dr. Marcelle Cacciattolo 9919 7575

If you have any queries or complaints about the way you have been treated, you may contact the Secretary,
Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001
phone (03) 9919 4781

*[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]*



Addendum 4

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled: "An Investigation for Paramedic Practice of Cultural and Religious Needs of the Pre-Hospital Patient in the Australian Community."

This project is being conducted by a student researcher Peter Hartley as part of a PhD study at Victoria University under the supervision of Dr. Maureen Ryan and Dr. Marcelle Cacciattolo from Faculty of Arts Education and Human Development

Project explanation

Cultural and religious practices can have considerable impact on health care, and with the increase in the cultural diversity of the population in Australia, it is important to know the religious and cultural needs of community members so that they can receive better health care. We are especially interested in how and where we can improve the services provided by paramedics to the diverse community of Melbourne.

Throughout the latter part of the twentieth century, health care provision was primarily based on western needs; with the assumption that everyone had the same needs and that those needs were biological. In more recent times, health care has shifted in emphasis so that the whole of the patient receives care. This has seen better outcomes for the patient and the caregiver.

This project relies on input from members representing various cultural and religious groups in the Melbourne community. With this input, the philosophical and practical cultural approaches can be identified and included into health care practice and health care training. With knowledge of the key aspects of culture, emergency paramedic care could be more sensitive to the cultural needs of the community it serves. The results should be better health outcomes for those community members needing emergency paramedic care.

What will I be asked to do?

For paramedics from the Metropolitan Ambulance Service who wish to participate, the discussion will take place at your branch location, whilst you are on shift, at a date and time that is convenient to all. It is understood that potential callout requirements may necessitate a return visit. Discussion will be one-to-one and semi-structured with the researcher (Peter Hartley), lasting approximately 1 hour. You will be asked about any paramedic experiences with members of the community from a non western cultural or religious background during the course of your work, and any cross-cultural education that you may have received during the course of your paramedic training.

Your participation would be completely voluntary and you may withdraw from the project at any stage without penalty.

All information will be confidential. All participants must agree not to discuss what others have said within the group. In the unlikely event that anyone feels uncomfortable because of the discussions, the VU Psychology Clinic or support services provided by Ambulance Victoria will be available to assist.

What will I gain from participating?

You will be involved in a project that will make a major contribution to your community. The research has the potential to contribute to the cross-cultural knowledge within the discipline of paramedic science. Additionally, by ascertaining the key religious and cultural needs of the Australian community, this knowledge will culminate in cultural competence for paramedics and other pre-hospital health care workers.

Finally, this study should enhance the level of effectiveness of paramedic work in pre-hospital practice when dealing with patients. This has the potential to lead to an improvement in the overall care and potential recovery of the patient. Further, this study should result in decreased levels of stress for paramedics working in an environment where patient needs go beyond just the physiological, and begin to incorporate the biopsychosocial.

There will be no payments made to participants. Small reimbursement payment may be made to cover travel expenses in extreme circumstances.

How will the information I give be used?

All information collected will be strictly confidential.

Discussion may be tape-recorded. The tape-recording would be by permission of participants and is so that the researcher (Peter Hartley) does not have to take copious notes and can concentrate on the topics being discussed. Discussions will be typed and no names will be attached to the text. Instead, each person will be assigned a number to ensure that confidentiality is protected. No-one else will have access to the text and the audio tapes will be destroyed at the end of the project.

The findings from the study may be published. No names will be included in the material submitted for publication and all comments leading to the potential identification of specific individuals will be removed.

What are the potential risks of participating in this project?

There are no risks associated with this project.

How will this project be conducted?

This study will rely on semi-structured interviews to stimulate discussion and generate material for analysis, as the data is reliant on feelings and beliefs.

The specific areas of interest that this study will identify and clarify for each of the religious groups will include:

Spiritual / Pastoral Care
Psychiatric Illness / Counselling
Medical Consultation

Life after Death / Fate
Religious Observations
Gender / Sexuality
Childbirth
Death and Dying
Transfusions / Blood Products / Organ Transplants – Donations
Elderly
Suicide
Drug Administration

Interviews will also collect any data relating to cultural diversity studies undertaken during your paramedic training.

Who is conducting the study?

Dr. Maureen Ryan (Faculty of Arts, Education and Human Development) 9919 4179
Dr. Marcelle Cacciattolo (Faculty of Arts, Education and Human Development) 9919 7575
Mr. Peter Hartley - PhD student (Faculty of Arts, Education and Human Development) 9919 2944

Any queries about your participation in this project may be directed to the Principal Researcher listed above. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001 phone (03) 9919 4781.



Addendum 5

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study into An Investigation for Paramedic Practice of Cultural and Religious Needs of the Pre-Hospital Patient in the Australian Community.

This project relies on input from members representing various cultural and religious groups in the Melbourne community, as well as paramedics operating within locations of high cultural and religious presence. With this input, the philosophical and practical cultural approaches can be identified and included into health care practice and health care training. With knowledge of the key aspects of culture, emergency paramedic care could be more sensitive to the cultural needs of the community it serves. The results should be better health outcomes for those community members needing emergency paramedic care.

For paramedics from Ambulance Victoria who wish to participate, the discussion will take place at your branch location, whilst you are on shift, at a date and time that is convenient to all. It is understood that potential callout requirements may necessitate a return visit. Discussion will be one-to-one and semi-structured with the researcher (Peter Hartley), lasting approximately 1 hour. You will be asked about any paramedic experiences with members of the community from a non western cultural or religious background during the course of your work, and any cross-cultural education that you may have received during the course of your paramedic training.

Your participation would be completely voluntary and you may withdraw from the project at any stage without penalty.

CERTIFICATION BY SUBJECT

I, "[Click here & type participant's name]"
of "[Click here & type participant's suburb]"

certify that I am at least 18 years old* and that I am voluntarily giving my consent to participate in the study: "An Investigation for Paramedic Practice of Cultural and Religious Needs of the Pre-Hospital Patient in the Australian Community" being conducted at Victoria University by: Dr. Maureen Ryan and Dr. Marcelle Cacciattolo

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: Peter Hartley – PhD student – (Researcher)

and that I freely consent to participation involving the below mentioned procedures:

- Interview

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.

Signed: _____

Date: / / 2009

Any queries about your participation in this project may be directed to the researcher Dr. Maureen Ryan 9919 4179 or
Dr. Marcelle Cacciattolo 9919 7575

If you have any queries or complaints about the way you have been treated, you may contact the Secretary,
Victoria University Human Research Ethics Committee, Victoria University, PO Box 14428, Melbourne, VIC, 8001
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*[*please note: Where the participant/s are aged under 18, separate parental consent is required; where the participant/s are unable to answer for themselves due to mental illness or disability, parental or guardian consent may be required.]*

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