

CULTURAL SENSITIVITY AMONG HEALTH PRACTITIONERS

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ABSTRACT

Studies on culture are important because we live in an increasingly diverse society. This study explores, from an interpreter's perspective the experiences of public health practitioners in working with a culturally diverse community. Twelve practitioners were recruited by convenience sampling. Through semi-structured interview, the meaning of cultural sensitivity is explored from the perspective of the practitioners.

For the participants cultural sensitivity means:

- a) knowing the historical background of the client;
- b) incorporating the clients current health practices with the heal education; and
- c) demonstrate behavior that is acceptable to the particular culture of the individual with whom one is interacting.

Findings suggest that the priority of the practitioners is in perform their roles to the best of their abilities. This role includes appearing to be culturally sensitivity as a means to achieve an end. This method of capturing the attention of the audience in order to ensure compliance to the health education is governed by the accountability to their governing bodies – professional colleges and associations. The thesis concludes with consideration of the implications of these findings for practice and research.

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CHAPTER 1 - BACKGROUND TO THE RESEARCH QUESTION

The focus of this study is on the cultural awareness of health professionals in the field of public health. This study explored the sensitivity and appreciation of the health professionals to cultural diversity for three reasons: 1) Canada is a rapidly growing multicultural society; increased immigration from non-European nations means that this society has evolved into a culturally plural one (Masi, 1995); 2) Public health involves working with an ethno-culturally¹ diverse community in particular, recent immigrants and refugees; 3) Aware of cultural diversity means being able to work more effectively and successfully in all areas of health care. In this context, sensitivity means cultural aware practice that requires an ability to postpone personal and professional priorities in order to be able to view service from the perspective of the client (Devore & Schlesinger, 1987). The definition notwithstanding, I chose to let health professionals define what cultural sensitivity meant to them. This study aimed at explaining what cultural sensitivity meant from the point of view of those professionals, and ways in which they believed they were culturally sensitive.

Background to Multicultural Awareness

This study is about cultural awareness in a multi-cultural society. Therefore, I believe it appropriate to provide the reader with a brief outline of three multiculturalism perspectives and a discussion of multiculturalism at the level of government policy. The intent herein is to provide the reader with some insight into the journey of multicultural policy creation to this point in time and also to set a context for my findings.

Multicultural Perspectives

Multiculturalism is a word that tends to elicit viewpoint ranging from support of cultural hegemony to cries of racism. There are a number of interpretations and definitions as to the meaning of multiculturalism or ethno-cultural diversity as it will be referred to in the study. It is useful therefore that a brief explanation be offered which serves to delineate the progression in thought, and perhaps, in action, of the ways in which advocates of multiculturalism approach the topic.

¹ The term ethno-cultural combines both eth and culture. Ethnicity: "Primary characteristics include common geographic origin, language and religion ... ethnicity also describes a sense of community transmitted over generations by families" (Mensah, 1994, p.35).

Culture: Refers to a shared way of life among a group of people, this includes: "language concepts, beliefs and values, symbols, structures, institutions and patterns of behavior" (Masi, Mensah & McLeod 1995, p.7). One's culture may differ from one's ethnicity or race. For more on culture see Geertz (1973).

Conservative/Corporate Multi-culturalists

According to McLaren, to conservative multi-culturalists or corporate multi-culturalists " ... ethnic groups are 'add on' to the dominant culture of the 'host' country (McLaren, 1994: p.49). It begs the question of how groups in power justify their position as non-ethnics, how they say "their traits and qualities are correct while the corresponding qualities are ethnic (McLaren, 1994, p.59). Conservative multiculturalism claims that everyone has an equal opportunity and can all reap the benefits which this society has to offer, but it fails to add that to do so one must become "deracinated, denuded and culturally stripped" (McLaren 1994: p.49).

Critical/Resistance Multiculturalists

Liberal and conservative multiculturalists claim that justice exists, it just needs to be rationed out equally; critical or resistance multiculturalists, however, see lack of equality as a systemic problem, therefore, changes are needed within the structure. Justice needs to be continually struggled for, it does not exist just because laws exist. The answer, they say, lies in recognizing and changing the dominance of the ideas and customs of mainstream culture (McLaren, 1994). According to critical multiculturalists, when diversity ceases to be an important issue one would hope that it is because awareness and sensitivity to cultural diversity has been absorbed and internalized by all (become natural); and not because it has acquired a negative connotation and ridicule, "treated as either marginal or too hot to handle" (Stiehm, 1994: p.151).

Left Liberal Multiculturalism

The left liberal multicultural view supports my position on cultural diversity. It recognizes that equality smothers cultural deference (McLaren, 1994). To treat equitably means that we ought to recognize and acknowledge cultural differences and to be sensitive to the variations that exist. However, the left liberal perspective locates meaning in experience, in that only the native can speak with authority about that culture (McLaren, 1994). The shortcoming of this perspective is that one has to show one's identity papers before one can speak authentically about an issue. Locating meaning in experience negates, by implication, academic expertise and acquired sensitivity of others to multicultural issues.

History of Multiculturalism in Canada

Policies on multiculturalism exist at the federal and provincial levels. Major corporations and institutions are in various stages of creating policies which speak to issues of culturally diverse employees and populations. In spite of this, and even though there has been an increase in interest and research in cultural diversity over the last two decades, the struggle for recognition continues. It is in this light that I deem it necessary to provide a brief account of the development of multicultural policy in Canada.

Canada's bi-lingual and bi-cultural policies were originally designed for the French and English only (Freisen, 1993; Kallen, 1988). Many groups felt left out. Consequently, initiated by the Ukrainians other ethnic groups collaborated and produced book four of the Report of the Royal Commission on Bilingualism and Biculturalism entitled: "The Cultural Contribution of the Other

Ethnic Groups" (Kallen, 1988: p.237). In this document are recommendations for multiculturalism and multilingualism. The government at the time, headed by Pierre Elliot Trudeau, rejected the idea of multilingual but suggested instead a multicultural policy with a bi-lingual framework (Freisen, 1993). The federal government's policy statement on multicultural sets out four objectives:

- 1) The Government of Canada will support all of Canada's cultures and will seek to assist, resources permitting, the development of those cultural groups which have demonstrated a desire and effort to continue to develop, a capacity to grow and contribute to Canada, as well as a clear need for assistance;
- 2) The Government will assist members of all cultural groups to overcome cultural barriers to full participation in Canadian society.
- 3) The government will promote interchange among all Canadian cultural groups in the interest of national unity; and
- 4) The Government will continue to assist immigrants to acquire at least one of Canada official languages in order to become full part in Canadian society (Freisen, 1993; Kallen, 1988).

Visible minorities claim that the policy does not place enough emphasis on combating racial discrimination. The problem with the multicultural policy lies in the fact that "...it says nothing and does nothing about pre-existing racial and ethnic inequality; the long term effects of structural racism; and the visual absence of representation among Canada's elites of visible minorities is nowhere addressed in the multicultural policy statement (Kallen, 1988: p.244).

Summary

Due to rapid and increasing immigration into Canada there is a need to examine cultural perspectives in health (Masi, Mensah & McLeod, 1995). We have seen that not only has the word multicultural changed to ethno-diversity in flight from an acquired negative connotation, but the meaning itself is wide and varied with much ambiguity. The last thirty years has seen a great deal of activity in terms of policy creation aimed at encouraging national unity and equality for all Canadian residents. It is evident, however, that great deal of work still needs to be done in terms of education, raising awareness against the systemic racism. Implicit in this study is the quest of whether efforts to raise conscious has had an impact at the level of public health practitioners in terms of awareness and sensitivity toward cultural diversity.

CHAPTER 2 - LITERATURE REVIEW

The relevance of this study lies in the fact that much research is needed in the area of ethno-cultural diversity (Masi, 1995). Studies on culture continue to be important because we live in an increasingly diverse society. According to statistics, no one ethnic group dominates, in terms of numbers (Masi, Mensah & McLeod, 1995). The purpose of this chapter is to present literature that explored the relationships and interactions between health care professionals and their clients. The literature will be discussed according to the following themes: a) culturally appropriate and culturally sensitive health care; b) ethnicity and culture; c) culturally sensitive professional development training for healthcare professionals; and d) Berger and Luckman's social construction of reality.

Definition of Culturally Appropriate and Culturally Sensitive Health Care

There are as many definitions of culture as there are cultural researchers. Tyler succeeded in capturing quite succinctly the essence of the meaning of culture as: "That complex whole which includes knowledge, belief, art, morals, laws, customs and any other capabilities and habits acquired by man as a member of society" (Tyler in Habayeb, 1995: p.224). One's ethnicity was defined not just by the country of origin but also the geographic location and shared history. Integral in the definition was the recognition that ethnicity is a continued tradition from the past. In direct contrast, cultural diversity can be described as a lack of homogeneity or sameness (Habayeb, 1995). There are countless definitions of health, what one culture considers abnormal, another culture may consider a way of life. It is virtually impossible for health professionals to have in-depth knowledge of all cultures. In light of that, it behooves health care professionals to take into account the ethno-cultural background of their clients. Awareness of their own ethno-cultural biases in their practice is important because: "Culturally aware practice requires an ability to suspend agency and professional priorities in order to be able to view services from the perspective of the client" (Devore & Schlesinger, 1987: p.137).

For the purpose of this study, culturally appropriate health is defined as providing services in the language of the person and being sensitive to the traditional culture, particularly in terms of health beliefs, patterns of communication between individuals, knowledge of living conditions and life circumstances. Culturally appropriate and culturally sensitive healthcare include cultural and racial sensitivity and awareness regardless of one's own culture (Mensah, 1995). "We will have achieved real good and sensitive care when we get to the point where so called mainstream services are all multicultural (Lechky, 1992: p.2221).

Recognizing Cultural Differences

As revealed in the literature members of various ethno-cultural communities expressed concern regarding health professionals' lack of understanding of ethno-cultural communities. Some communities expressed feelings of discrimination and racism, which they encountered in dealing with health professionals. Others expressed concern that they were treated as though they were all the same; which is an example of ethnic stereotyping. In contrast, health professionals maintained that they treated everyone fairly and justly by virtue of the fact that they treated all ethno-cultural communities the same. However, treating everyone the same is not equivalent to treating everyone

equitably. According to Masi (Masi, 1993), it is necessary to recognize difference in order to respond appropriately. Health professionals often expressed frustration with ethno-cultural communities, particularly in relation to non-compliance and a lack of interest in health related/health promotion endeavours. Implicit in this is the seeming lack of cultural knowledge on the part of health professionals.

Ethnocentricity

Knowledge of a culture is not always enough. There needs to be awareness of one's culture and awareness of one's biases (Elias & Macy, 1992). Even researchers who explored the area of cultural sensitivity inadvertently demonstrated their own bias in writing about their findings. For example, in Hay's (1994) conclusion of his study, he reminded the reader that his research is from the perspective of the Natives, and therefore, may not be reality. The word Native is used in the literature to refer to Canadian Aboriginal people. The point of interest is not so much in the findings of the study but rather in the implication of his words. One is left to wonder whether Hay really meant that the native viewpoint is not reality, because, as he stated reality is the Euro-Canadian perspective. Educators of multiculturalism ought to examine and confront their own feelings of ethnocentrism or intolerance before they attempt to raise the consciousness of others (Freisen, 1993).

A frequent theme stressed in the literature was the need for health professionals to know the meaning be the practices, actions, and behaviors of their clients in order to fully understand their client population. It was evident that health professionals may not understand the norms, actions, behaviors of their clients.

Communication

It is often not clear why individuals behave in certain ways. It is important, therefore, that healthcare professionals are knowledgeable regarding cultural norm, habits and behaviors of the client population in order to provide safe and efficient healthcare. One of the problems is that health professionals tended not to listen to their clients (Lechky, 1992). This in itself is unfortunate because cooperation in treatment is highest when communication between health practitioner and patient exists, when they share a common language, and there is respect for one another's goals in the therapeutic relationship (Anderson, 1987). To communicate more effectively, Grossman and Taylor (1995) suggested that it is necessary to pay attention to non-verbal clues and subtle nuances of expression for both the client and the healthcare provider.

Ethnicity and Culture

Health professionals were of the opinion that they treated everyone equally (Masi, 1995). While this may be so, it is necessary for health professionals to have insight into cultural variances that may exist. Ethnicity and culture are often used interchangeably, however, this does not necessarily mean that individuals who share the same ethnic background share the same culture. For example, the Caribbean consists of a group of islands, home to people of all races. Each island boasts its own unique culture. To limit Caribbeans to one people/one culture is a major infraction upon recognition on of cultural diversity.

Culturally Sensitive Professional Development/Training

The lack of sensitivity on the part of healthcare professionals an problem/concerns in communicating with clients has been previous discussed. A possible reason may be because multicultural education is limited. Stereotyping occurs due to a lack of knowledge. The frequency with which stereotyping surfaced among healthcare professionals is a cause for concern.

The following quote succinctly articulated a vision in cultural education for healthcare professionals.

"The goal of the ethno-sensitive or ethno-competent approach is to create or recreate programs and organizations that will be more responsive and responsible to the culture of minority groups. Training for cultural competence and the delivery of ethnic sensitive service requires understanding of one's own personal attributes and values, gaining knowledge about the culture of different groups and developing skills for cross-cultural work" (Gutierrez, 1992: p.326 quoted in Inglehart & Becerra, 1995: p.206).

Ethno-cultural education and training promotes an understanding of diverse lifestyles, beliefs and values, which healthcare professionals were encouraged to use to guide their practice.

Social Construction of Reality

In reviewing the literature it seems that the way in which health professionals interpret the actions/behaviors of others is a socially constructed process. Health professionals do not instinctively know and understand those who are not of their culture. What is known of other cultures is based on social relationships. According to Berger and Luckman (1967), humans construct their own reality and are constructed themselves by the reality that they participate in creating.

It seems that in order to play one's role it is necessary to have an awareness of society at large. Awareness of society is gathered through one's own socialization. To function competently and comfortably in a role, it is necessary to be intimately connected to the outside forces and influences on that role. This reality is validated, deconstructed and reconstructed through conversation and association with others. Relating my own study to the work of Berger and Luckman (1967), I examined the relationship and associations of the health practitioners in term of how their views on culture are formed.

Summary

The three most common themes that emerged in review of the literature were:

- a) ethnocentricity on the part of healthcare professionals;
- b) problems in communication; and
- c) a seeming lack of cultural knowledge possessed by healthcare professionals.

In review of the literature there seemed to be a dearth of research which examined perspectives of both healthcare professional and their clients in term of their experiences and impressions of each other. In light of that, the primary research question in this thesis asked: *How do public health practitioners experience working with individuals from a variant of cultures?*

The first objective was to show whether public health professionals saw themselves as adequately prepared to work with a culturally diverse community. For example, a) what did they identify as some of the main issues/problems they seemed to be facing in working with a varied ethno-cultural community? b) How did public health practitioners demonstrate cultural sensitivity? and c) By what criteria did public health practitioners determine whether or not they were cultural sensitive?

CHAPTER 3 - METHODOLOGY

In this chapter I will outline the research process of my thesis. Firstly, I will discuss the perspective from which I conducted the study and also my rationale for the chosen methodology. Following that, I will then describe the participants. A brief discussion on ethics and problems in qualitative research, as they relate to this study, will ensue. This will be followed by a detailed account of data collection and the analysis process I used. Limitations of the study will then be introduced and the chapter will conclude with a personal disclosure.

Rationale for Methodology

As previously stated, I chose qualitative methodology because it is in keeping with the interpretive perspective. Qualitative research was the most appropriate approach to this study because the aim was to describe the meaning of cultural sensitivity from the perspectives of those who were interviewed. A definition of reality, however, with its multiple influences, remains elusive to me. Due to its very nature, I can only define and know my own reality. I acknowledge however, that it is possible to record one's given reality. That reality occur in the moment when information is presented to me by one individual at one point in time.

This research focused primarily on the perceptions of the health practitioners. Since this is an interpretive research study it was appropriate to utilize qualitative methods, such as semi-structured interviewing, to explore the every life experiences of the participants.

Problems in Qualitative Research as it Relates to this Study

There are a number of inherent problems in qualitative research and therefore it was necessary for me to identify and address potential problems as they relate to this study.

- a) There was a risk of my view being colored by 'going native', that is, identify myself too closely with the health professional. In response to that, as a researcher I must be alert for signs of unintentional bias. For example, there must be self-awareness. I must also recognize my own philosophy and principles that guide my practice as a healthcare practitioner and as a person of a part ethno-cultural origin.
- b) My findings cannot be generalized beyond this study. Findings from this study pertain only to the individuals in the study and within the time frame and the environment of the study.

Participants

Process for Choosing Participants

The goal of this study was to understand how practitioners experienced working with a culturally diverse community. A total of twelve interviews were conducted. This number was deemed to be adequate by experts in the field for this type of study. It is also in keeping with grounded theory research. In grounded theory, sampling occurs until no new information emerges with regard to a particular category (Strauss & Corbin, 1990).

Non-probability Sampling

The participants in this study were chosen by utilizing non-probability convenience sampling. Probability sampling involves a process of randomly selecting participants. Random in this context means that every person in the study population had an equal chance of being included in the sample. Non-probability sampling means participants were selected in other than random ways. There are a number of inherent weaknesses in non-probability sampling, for example, investigator bias in choice of participants. For the purposes of the study however, it was quite appropriate as long as I remained mindful of the potential for bias. Non-Probability sampling is recommended when there are a very small number of participants such as this study. Convenience sampling involves selecting a number of participants who are conveniently available.

Ethics

Methods for Obtaining Consent

Participants were informed of the study and the interview process during an initial telephone contact when anonymity and confidentiality was assured. At the interview, prior to beginning the process, a consent form was given and explained to each participant. It was stressed to each participant that she may withdraw consent at any time during the study and confidentiality of name and any information received from the participant will be maintained (please see appendix A for information sheet and consent form).

Maintenance of Anonymity and Confidentiality

Anonymity was maintained by the use of codes in place of names. Interview transcripts and memos did not identify participants by name. In the write-up, the location of the research is listed as Southern Ontario so that participants cannot be identified. All consent forms and data, which may identify a participant, are locked up in a place to which access is limited to myself. In a final endeavour to ensure that anonymity was maintained, the practitioners were offered their interview transcripts to review.

Statement of Expected Benefits to Participants

I explained to each participant that they may or may not benefit directly from the study. Participants may use information gathered from the study to adjust, as they deemed necessary, their interactive processes with their clients. The community as a whole may benefit should results be utilized by professional colleges and associations as well as educational institutions, in terms of providing cultural awareness education and training.

Data Analysis

There are a number of qualitative research methods such as phenomenology, ethnography, life histories, and grounded theory. As previously mentioned, I utilized the constant comparative method, also known as grounded theory. The method chosen relies as much on the research question as it does on the researcher herself. Some researchers believe that data should not be analyzed but presented as is, with as little of the researcher's observation or opinions as possible.

In other words, allow the data to speak for itself. Others (such as myself) present their findings with their own interpretive comments. The challenge for me is to recognise that I am a part of the data, a part in the process of data collection. In recognizing and acknowledging my contribution to the interview process a somewhat detached view may indeed be possible.

Limitations of the Study

Limitations are an inherent part of any research project. Limitations of this study include but are certainly not confined to the following:

- a) The findings are applicable to only those participants in the study at the point in time when they were interviewed. Nevertheless, it is hope that the study will provide other health professionals with insights into their relationships with the multicultural community.
- b) Practitioners may have responded with very positive statements regarding their relationships with their clients for a number of reasons. For example giving responses they thought the interview wanted to hear, and/or the desire to appear to have an excellent relationship with the multicultural community.
- c) The venue for interviews varied. In retrospect, the workplace may not have be the most appropriate place to conduct interviews due to the risk of being overheard. There may have been an added caution in term of freedom of expression on the part of practitioners.
- d) Researcher's bias is acknowledged as inevitable in an research project. In spite of the effort made to reduce bias as much as possible, it inadvertently remains. In the entire process of this study, every effort has been made to limit researcher bias.

In spite of these potential limitations, I believe I have captured what culturally sensitive behavior mean to those who participated in this study.

Summary

This study was from the idealist/interpretive perspective which utilized a ground theory approach to data collection and analysis. Participants consisted of public health practitioners who were all chosen by non-probability, convenience sampling. The collection of data involved the utilization of semi-structured interview with probe questions. A qualitative approach to data analysis was taken.

CHAPTER 4 - HEALTH PRACTITIONERS' PERSPECTIV ON CULTURAL SENSITIVITY

In this chapter, I will summarize the health practitioners' accounts of their experiences in working with a cultural diverse community. This chapter will begin with an outline of where and how practitioners acquired their knowledge and expertise on cultural sensitivity and will then explore opportunities for professional development. The challenges and issues of working with cultural diverse groups as identified by the practitioners as well as a description of the ways in which they deal with these challenges will follow. During the interviews practitioners reflected on culture and articulated that in order to deal with cultural issues/challenges one must be culturally sensitive.

Acquiring Expertise

When as how they acquired the expertise in working with a culturally diverse population the responses identified three ways: experience and self-education. Many of the practitioners stated that when they first began working as health practitioners they had no idea how to be culturally sensitive. Experience seemed to be the number one mean for acquiring knowledge about various cultures and by interacting and asking questions. Often, by making many mistakes they came to understand what it meant to be culturally sensitive and insensitive. A great deal of time was spent reading and having discussions with their peers about various issues the occurred in the course of their day. Frequently, observation of clients would assist in the acquisition of knowledge. This occurred mostly by comparing how one person or group responded in a situation versus another.

The practitioners all went to colleges and universities in Canada and yet all stated that courses on cultural were few and far between. There may have been sociology and maybe an anthropology course in their university program that gave them a little knowledge of the meaning of culture which however, was only a textbook meaning. They felt that nothing could have prepared them for the real world of diverse cultures.

More than half of the interviewed practitioners were born outside of Canada and three were of a visible minority group. Those maintained that it was their own personal experiences which they believed gave them that added sensitivity. The remaining practitioners believed that their acquisition of knowledge was achieved by their extensive experience gained over the years. They said that a great deal of their information came from peers both in the workplace and out in the community.

In-services

It seemed that, in general, there was little to no professional development for staff in the private and public health clinics, regarding cultural diversity. What little there was, appeared to be poorly communicated to staff. Cultural expertise was mostly acquired by years of experience as a health practitioner. And for the ones lacking the experience self-education and discussion with peers augmented the acquisition of knowledge.

Working with a Culturally Diverse Community

The practitioners interviewed for this study expressed mixed experiences in working with a culturally diverse community. Many benefits were articulated which included descriptions such as fun, rewarding, job satisfaction and being fortunate enough to be able to gain better understanding of people in general. During the interviews it became apparent the practitioners displayed a great deal of enthusiasm when discussing challenges and issues of working with a culturally diverse clients. They were more articulate in describing situations and examples of the challenges they faced than in describing examples of benefits.

Public health practitioners defined challenges as situations, events, practices and habits which they did not understand or which they believed threaten or were in direct opposition to what they deemed to be right and true. For example, practitioners identified that they felt frustrated due to: a) the language barrier; b) male dominance/female subservience; and c) the strict customs of some Arabic or Muslim cultures, especially regarding rules placed on females.

Language Barrier

Granted all Canadian Residents should know English or French but this is not the case. Also there are many visitors from other countries. All practitioners agree that a lack of information brochures in the language of the client was another source of frustration to both the practitioner and the client. Some practitioners used sign language, others used pictorials but still felt the information they gave was inadequate. Several practitioners who utilized translators found them to be less than satisfactory.

Male Dominance / Female Subservience

Another challenge the health practitioners seemed to be facing was the male as authority figure in the household and the seeming lack of respect for his female partner. Although this is not much present in the western cultures – it is very prevalent in the large parts of the world.

The Meaning of Cultural Sensitivity

In light often aforementioned and other challenges faced by the practitioners, how then were they able to move beyond the obstacles they perceived in order to fulfil their role? How did they impart their knowledge to the clients or more importantly by what means did they persuade the clients to listen to them? According to the practitioners, to better serve their clients it was imperative that they conveyed their sensitivity to the cultural beliefs, norms and practices of their clients. To them this involved a number of steps. The practitioners maintained that in order to work effectively with the community they needed to understand their clients. Based on their training and expertise these practitioners indicated that the most important variable in providing health care in a culturally diverse milieu was the need to establish trust between the provider and the consumer.

What was meant by trust? To the practitioners this meant that the clients believed the practitioners would not violate them in their beliefs or practices, that they (the clients) would feel physically safe, that the practitioners would not threaten the authority of the male nor upset the social values

of their family or culture in any way. Although practitioners described several methods to accomplish this, the majority clearly stated that effort needed to be made to gain an understanding of both the political and historical context from which the clients' culture was derivative as well as, the clients' cultural affiliation.

Historical Background of the Client

Practitioners in this study were very eloquent in illustrating their appreciation for the historical background of the clients. Several of the practitioners claimed that the place of origin had a strong influence on the perspective of the individual. The perception was that this knowledge and awareness allowed them to be culturally sensitive in the delivery of health care.

Everyone came to Canada with firm beliefs and traditions some came from politically stable environment while others came here in flight for their lives. According to the practitioners it was in the appreciation of environmental differences that cultural sensitivity was built. Understanding the historical context of a client's perspective was vitally important for establishing trust. A recognition of the fact that history affects behaviour enabled the practitioners to present themselves in a way conducive to acceptance by the client. This in turn made it more probable that clients may be receptive to whatever message the practitioner was conveying. For these practitioners it was the development of trust that determined their success in being able to promote healthy living to their clients.

The Cultural Affiliation of the Client

How was trust established? The Practitioners learned very quickly that if they did not respond positively to the cultural affiliation of a group in terms of beliefs, norms and practices then just as quickly they would be shut out.

Male Dominance / Female Subservience

All the practitioners identified that the situation where the "man of the house... and the husband as boss" idea existed was not an ideal situation as far as they were concerned. Some practitioners felt the need to be careful lest their advice jeopardize the relationship between husband and wife.

The Degree of Harm - Bathing

According to the interviewed the client's cultural practice must always be utilized in the teaching. The practitioners maintained that if the practices of the clients were not shown to be valued then all the teaching in the world was not going to help - because they won't accept it.

Summary

The practitioners articulated a necessity for ongoing development of the relationship between client and health professional. Relationship building was done by being sensitive to the cultural norm, beliefs and practices of the clients. According to the practitioners, sensitivity was conveyed by blending their beliefs with those of the clients when imparting any knowledge to the clients. It

seemed, quite naturally, that all the practitioners believed that they demonstrated cultural sensitivity toward their clients.

Respect for Culture of the Client

To these health practitioners it was not enough to simply be aware of a client's political and historical background, nor was it enough to have knowledge of the client's cultural affiliation in terms of norms, beliefs and practices. According to the practitioners, being culturally sensitive meant demonstrating behaviour that was acceptable to the particular culture of the individual with whom one was interacting; it meant behaving in such a way so as not to offend or alienate oneself, being mindful that one was a guest in other people's homes and respecting the home owner and the home. These practitioners felt that if they behaved in a manner that showed respect for the culture of the client then there was a greater likelihood that trust would develop between them.

Infibulation

All the practitioners felt that they were constantly having to put their own biases aside. In discussing infibulation. Understanding and non-judgemental attitude should be demonstrated when discussing opposing views.

Summary

These health practitioners seemed to be aware that there were many different interpretations and worldviews. The practitioners articulated a desire in working with clients to educate them in a way that complimented rather than violated their beliefs. They expressed the importance of first knowing and understanding the historical context of the client. Based on this knowledge they stated it was then possible to adjust their approach accordingly. The practitioners seemed to be aware that utilization of the clients own beliefs, norms and practices elicited compliance to their agenda (agenda being whatever their job was, whether it was to educate, inform or advocate for).

All practitioners felt that behaving in a manner that conveyed respect for the cultural norms of the client meant that they gained the trust of the client and therefore a greater likelihood of being heard.

Determining When One is Culturally Sensitive

What criteria did the practitioners utilize in order to know when they were being culturally sensitive/insensitive? Many were aware of when they were being sensitive because their experience informed them when a behavior or a certain way of being was acceptable or not acceptable. From peers they gleaned more knowledge and information on the norms and practices of various cultures. Most of these peers were of the main stream culture themselves and gathered their information from experience. The Practitioners relied on their own knowledge which was obtained in various ways, for defining the meaning of cultural sensitivity. All practitioners stated that feedback from the clients told them when they were being sensitive or insensitive.

Summary

Practitioners expressed both empathy and frustration in dealing with a culturally diverse population. Empathy for the fact that their clients came from a traumatic background or from a less than satisfactory environment and continued to live in a less than satisfactory environment through no fault of their own. Practitioners admit to stereotyping and acknowledge that they often needed to examine their own biases. There were times when apprehension existed and the challenge was in doing their job without alienating the client.

Practitioners' Cultural Background

Most practitioners believed that it may initially be advantageous to be the same culture as the community they primarily served but in the long term it held no benefit. Rather than culture it was more a matter of personality which determined how relationship progressed. The practitioners highlighted a number of factors that may have determined the outcome of the practitioner-client relationship. For example the practitioners' level of education as well as the socio-economic status and even the geographical place of origin – all play part of this relationship.

CHAPTER 5 - DISCUSSION

In this chapter I will shift away from specifics as identified and discussed in chapter 4 and instead offer a commentary on the broader contextual issues of this study in relation to the literature. Specifically, I will address social relationships and the construction of cultural sensitivity. The key themes that emerged in the analysis of data in the following:

- a) In relation to their professional work, it seems that practitioners perceived themselves to be quite clear an authority on health related issues;
- b) It would appear that the practitioners interpreted cultural sensitivity to be a behaviour which was acceptable and in keeping with the norms and customs of the individual or group with whom they were interacting;
- c) Culture sensitivity did not include condoning norm values and customs of others i.e. there was little evidence of internalization of ethno-cultural values other than participants' own mainstream cultural values;
- d) Demonstration of cultural sensitivity seemed to be a means to an end for the participants.

Key Themes

The Health Practitioner as Authority

Public health practitioners are in position of power and authority. This manifests itself in a number of ways. They belong to the mainstream culture, that is, they possess mainstream cultural values by virtue of the fact that they hold post-secondary education, are professionals and are employed by a structure which belongs to, and is support by, main stream culture. The healthcare practitioners are given a mandate from the public health organizations which implies that health inform which belongs to the main stream culture must be impart to all other cultures in order for those cultures to be as knowledgeable and healthy as the mainstream culture. The dominant/mainstream culture utilizes science and evidence based practice as support in its stance for knowing the best or most appropriate methods for achieving health.

The concern with language interpretation caused a great deal of frustration to the practitioners. It seemed that they were not in control of the situation, at the moment. The perceived loss of control of the situation seemed to leave the practitioners feeling powerless in the process of interpretation. They had no idea what was being said and whether or not the information they gave was being conveyed to the client.

In one area in particular, the trust factor which, in disclosure, is deemed to be very important did not seem to exist in practice. For example, when a male acted as translator to a female, practitioners felt that their words were interpreted. The idea that the translator may modify the message in order to increase the understanding of his audience did not appear to have been acknowledged or even recognized by the practitioners. In some cultures for example, topics such as sex or discuss regarding the female body is inappropriate between males and females, unless they are married to each other. A male translator, therefore, would need to choose his words carefully in order to maintain propriety. The fact that some males would change the words/views of the practitioners because they don't consider those views to be right may also have existed.

It seems reasonable to deduce that the challenge with regard to the issue of language was more than with spoken word itself. It would appear that anxiety existed due to the fact that the practitioners were no longer in control (the authority figure) during translation, their position was secondary to the one conveying unknown information. The fact that they experienced difficulty in extending trust to the patient implied that the notion of trust which was deemed to be so important, seemed difficult to extend in the process of translation. Whether this meant that the practitioners' concern was due to the fact that the translators were perhaps not educated individuals and may therefore inadvertently convey misinform and therefore harm to the client or that control of the situation was temporarily in the hands of the interpreter, is unclear.

Culture, Gender, Class

It is important to keep in mind that those challenges which were identified by practitioners as "culturally generated" may just as easily have an origin in class or gender differences. For example, practitioners in this study belonged to different classes by virtue of their professional and occupational status, education and income. It seems that culture does not play a major part in creating "differences" between individuals when their social class is the same or similar. There is also data which suggests that gender bias may have played a part in the perspectives of the participants in this study in term of those issues they identified as "challenging".

Public health practitioners need to recognize that beyond the ethno-cultural backgrounds of their clients other factors exist which may contribute to the challenges they faced. For example, factors such as not belonging to a privileged class, of being an uneducated woman in a new country dependent on the male as bread winner, or be a female, sole support for her family, and so forth.

Cultural Sensitivity as a Demonstrated Behavior

Healthcare practitioners agreed that the most important factor in proving and receiving health care was the need to establish trust. In order for trust to be established the practitioner must:

- a) Have knowledge of the political and historical context of their clients;
- b) utilize and integrate various ethno-cultural practices into the teachings; and
- c) show respect for the cultural norms and traditions of various groups.

The practitioners perceived themselves honouring the norms and habits of the cultures they interact with, to the best of their abilities. They articulated what cultural sensitivity meant to them and demonstrated that they certainly walked their talk.

Internalization of Cultural Norms

The participating practitioners expressed frustration in relation to the issues and events they cited as challenges. When they were asked about challenges it seemed that each one stated issues and events which challenged their way of thinking and/or being and which they felt threatened their senses of authority and perhaps sense of professional identity. Most of what they declared to be challenging and in light of the fact that some practitioners also seem to lack appreciation for the

norms and practices of the cultures with whom they interacted, may be possible indicators that these practitioners could perhaps benefit from additional cultural education and knowledge.

Means to an End

Analysis of the data suggested that practitioners did indeed try their best to show that they were culturally sensitive because according to them, that was the way to capture the attention of the clients. There was some data that suggested that cultural sensitivity (articulated or demonstrated) may have been a means to an end. For the most part, public health practitioners conveyed a willingness to learn about their clients' culture and to be sensitive to their norms and practices. By their own admission, when they demonstrated knowledge and sensitivity to the cultural norm of their clients their ability to be successful in accomplishing their agenda increased. Being culturally sensitive toward their clients however, seemed to be secondary to success in fulfilling the purpose of their visits.

The statement that caring becomes at best an exercise in the imposition of an ethnocentric authoritative allocation of professional (i.e. middle class) values, where the client is defined as a passive recipient of what is professionally design as appropriate efficacious treatment. This was evident in the practitioner's use of words such as "ensure compliance" and "teach them what's right"... Implicit in the data is that the driving force may well be the agenda of the practitioners.

Lack of Professional Development Opportunities

Despite the plethora of information and research which exists relating to the need for public health professionals to be more knowledgeable about their culturally diverse clients, it would appear that there is no facilitation of a process by which this knowledge to be transferred.

It may well be that the way health professionals are educated needs to be revised so that multicultural health issues are considered and integrated into the curricula. It is well to note that healthcare professionals acquire information regarding cultural issues from colleagues whose own knowledge may be limited and may also not be accurate.

The way in which practitioners see the world is based on a combination of factors which include but are not limited to:

- a) Their socialization into the healthcare profession;
- b) Their expert knowledge of health;
- c) Their require role as an employee of an institution devoted to public health; and
- d) The power and authority which comes with that role.

It does not necessarily follow that the provision of more education on cultural groups would produce a more sensitive practitioner. I would suggest that a course, a workshop or program on self-awareness and self-reflection would be appropriate and of benefit in truly being culturally sensitive rather than in simply acquiring the tools to make one appear to be culturally sensitive.

Contributions of the Study

- a) This study adds to what seems to be little documentation on the experiences (in interaction with each other) of both health professionals and the multi-cultural community with whom they work.
- b) The study identifies the 'quality' of the relationships between health professionals and their clients (i.e. where strengths and weaknesses lie), as perceived and described by the interviewed.
- c) Health practitioners service a wide variety of cultures. They believe that success in their work depends on their knowledge of the various cultures with whom they interact.
- d) This study may be useful to other organizations and public health units, for identifying their own strengths and weaknesses, and addressing those at the level of policy.

CHAPTER 6 - CONCLUSION

The trend toward immigration is increasing. Due to the diverse nature of the immigrant population there is a need for research in ethno-cultural studies. In response to that need this research focused on exploring the experiences of public health practitioners who work with a culturally diverse population. A secondary objective examined whether practitioners believed themselves to be adequately prepared to work with an ethno-culturally diverse community.

Methodology

Due to the nature of the research question, which was interested in the lived experiences of the participants', qualitative methodology was employed. This methodology is in keeping with the interpreting worldview. Participants consisted of twelve public health practitioners who were recruited by non-probability convenience sampling. Data was collected by utilizing semi-structured interviews with guide questions.

Findings

When asked how they acquired their expertise for working with a culturally diverse population the responses identified three ways: on the job experience, reading and to a lesser degree in-services (educational sessions) offered by their workplace. Practitioners were aware that they were culturally sensitive in two ways: 1) when they demonstrated behavior which they knew to be acceptable to the particular culture of the individual with whom they were interacting and; 2) feedback from the clients indicated that they were sensitive or not sensitive.

According to health practitioners, working with a culturally diverse population was a challenge in itself. They stated that the most important variable in providing health care in a culturally diverse milieu was the need to establish trust between the provider and the client. That meant practitioners needed to:

- a) understand the political and historical context from which the clients' culture was derived;
- b) integrate the clients' ethno-cultural practices and beliefs into information which was given to them and;
- c) show respect for the client by demonstrating behavior that was acceptable to the particular culture of the individuals with whom they were interacting.

Further analysis revealed that practitioners:

- a) perceived themselves to be an authority on health related issues;
- b) interpreted cultural sensitivity to be a behavior which was acceptable with the norms and customs of the individual or group with whom they were interacting, it did not include condoning those norm and customs; and
- c) demonstration of cultural sensitivity seemed to be a means to an end for them.

The agenda of the practitioners was their priority and practitioners believed that their agenda was in response to the needs of the clients.

Clients contributed to the practitioners' notion that they were culturally sensitive by:

- a) overlooking occasions when practitioners made mistakes in terms of cultural practices;
- b) their reluctance to communicate with practitioners the fact that they disagreed with the health practices of the practitioners; and
- c) often falsely giving the practitioners the impression that they complied with instructions and education.

Next Steps

Practice

Implications for practice and research include public health organizations and governing bodies providing opportunities for personal and professional development of their members. Practitioners ought to be encouraged to take a proactive role in areas of professional concern and build partnerships with communities. For example, a team of healthcare practitioners and community members may want to identify needs and gaps in resources then develop and implement plans to address those gaps.

Research

Studies, which evaluate health care practitioners assessments and interventions that promote culturally sensitive health care are needed. Further exploration of the implications of the language barriers that exist is essential. Perhaps development and evaluation of a cultural assessment tool would be an asset.

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APPENDIX A - INFORMATION SHEET FOR HEALTH PRACTITIONERS

A STUDY ON CULTURAL DIVERSITY IN PUBLIC HEALTH: PERSPECTIVE OF HEALTH PROFESSIONALS

Canada is a rapidly growing country in terms of its ethno-cultural mix. In light of this, the Ontario Government set out guidelines to ensure that health services are distributed equitably to all groups. Incorporated within the guidelines is the suggestion to educate health professionals in cultural diversity. Public health departments and professional colleges, in turn, have responded to diversity by creating policies geared toward education of health professionals in ethno-cultural awareness.

This study will examine what policies are in place for the professional development of health professionals and the way in which those policies are implemented. The purpose of this study seeks to understand how public health professionals experience working with individuals from a variety of cultures.

What is my role as participant in this study?

My role will help to identify the educational needs of the health professionals regarding cultural diversity and ways in which those needs may be more fully addressed. I understand that there may be no direct benefit to me, however, findings from this study may benefit others in the future.

What do I have to do if agree to participate in this study?

If I agree to participate in this study the researcher will require approximately an hour to an hour and a half of my time. During this time we will have a discussion about issues such as my experiences in dealing with a diverse ethno-cultural community.

With my permission the interview will be tape-recorded. I will be able to review and make comments on the interview transcript if I wish.

My name and any information I give which can be traced directly to me will be kept confidential. My name will not be used in any discussion or in any publication of results. The final results of the research will be made available to me if I wish.

My participation in this study is entirely voluntary. If I chose not to participate in this study there will be no penalty. I HAVE THE RIGHT TO WITHDRAW FROM THIS STUDY AT ANY TIME.

Any information given up to the time of my withdrawal will be kept confidential, if I wish.

I have read and understood the above information.

I consent to participate in this study.

DATE:

SIGNATURE OF PARTICIPANT

SIGNATURE OF WITNESS

APPENDIX B - INTERVIEW GUIDE QUESTIONS FOR THE PRACTITIONERS

- 1) Can you describe what a typical day is like for you (in terms of work routine)?
- 2) How do you see your role in relation to the ethno-cultural community?
- 3) Which ethno-cultural group do you come in contact with during the course of your work?
- 4) Which ethno-cultural group do you have the most contact with on a daily and weekly basis?
- 5) Please tell me about your experience in general working with a culturally diverse community?
- 6) What are some of the challenges/issues that keep coming up in your dealings with a culturally diverse community?
- 7) Are there distinctive challenges with any group or groups in particular?
- 8) How do/did you deal with these issues? What do you do when an issue arises which is related to the ethno-cultural background of the client?
- 9) Please tell me about a particular experience that went exceptionally well.
- 10) Please tell me about a particular experience that did not go so well.
- 11) What (for you) are some of the benefits in working with a culturally diverse community?
- 12) What do the terms “culturally appropriate” and “culturally sensitive” mean to you?
- 13) Did the college or university you studied in offer any programs or classes on cultural awareness?
- 14) How did you acquire your expertise working with a culturally diverse community?
- 15) Does the professional college you belong to or the professional association you are member of offer any cultural awareness training? Are they optional or mandatory?
- 16) Does the clinic you work for offer in-services related to education and training in cultural awareness?
- 17) If it were your job to structure education/professional development on cultural awareness what would you do?
- 18) What advice (in terms of professional development) would you give to a professional who express a desire to work with an ethno-cultural community?
- 19) What do you think would make your job in dealing with a diverse ethno-cultural community easier?

Country of Birth: _____

Type of Profession / Practice: _____

Ethnic Origin: _____

Years in Canada: _____

Years in Practice: _____

Age: 20's 30's 40's 50's 60's

Education: _____
