



# **BUILDING CULTURAL COMPETENCE: AN ABORIGINAL AND MULTICULTURAL PERSPECTIVE**

## **Invited Panel Discussion**

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<sup>1</sup> A companion kit entitled *Conversations on Caring – Volume 1* is available through the CHPCA Marketplace ([www.chpca.net](http://www.chpca.net)) for use in Canada in staff development, continuing professional development (CPD) and health sciences education.

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### **Suggested Process and Learning Objectives for Problem-based, Small Group Learning and Local Staff/Professional Development Learning Circles**

#### **INTRODUCTION AND SUGGESTED LEARNING OBJECTIVES**

##### **INTRODUCTION**

This transcript is a web-based version for use with a companion MP3 professional development podcast. This MP3 session is also part of a larger set of digital audio recordings forming a resource entitled *Conversations on Caring, Volume 1 (CoC)*. CoC is a learning resource which has been prepared from previous Pallium Project professional development events. These events are the *Monthly Continuing Professional Development (CPD) Audio-conference Program* series. The *Monthly CPD Audio-conference Program* series was supported in 2005 and 2006 through a contribution from Health Canada's, Primary Health Care Transition Fund (PHCTF) as part of Primary Health Care Renewal in Canada. The views expressed in these sessions do not necessarily reflect the official policies of Health Canada or the employing organizations of members of the Pallium Project's, Community of Practice. These materials have been prepared as "reminder resources" for participants of the original CPD sessions and as learning resources to help support improved access and enhanced quality for provision of Hospice Palliative Care in Canada.

The MP3 audio files and this PDF of the written transcript have been post-produced from the original event in order to provide essential information and enable use, generally within 1 hour time blocks. Each of the sessions has been based on topics which practicing Registered Nurses have identified as important to improving practice and service locally as part of a 2005-2006 audio-conference series entitled *Improving Care in Our Communities*. While program-developed and organized principally from a nursing process and case-management perspective, sessions reflect the inter-professional and trans-disciplinary perspectives of both the Guest Resources/Invited Panelists and the local participants, many whom reflect a diversity of perspectives of social workers, spiritual care providers, primary-care physicians, hospice/palliative program volunteers and others.

##### **SUGGESTED LEARNING OBJECTIVES FOR THIS SESSION**

By the end of the session the participant should be able to discuss all or part of the following:

- A working definition of cultural competence.
- The constitutional definition of Aboriginal people as it operates in Canada.
- Common sensitivities and jurisdictional concerns which may present in co-mingling policies and practices for Aboriginal people and Multicultural populations in planning and provision of hospice palliative care.
- The importance of historical and socio-cultural considerations when working clients from different cultural backgrounds.
- Key considerations in how culture might impact provision of palliative services.
- Some unique issues in working with Aboriginal clients and families.
- Some unique issues in working with immigrants, refugees and culturally-distinct groups.
- The paramount importance of not stereotyping based on cultural background in provision of quality care.
- The importance of self-awareness and well-constructed, open questioning and non-defensive listening in working with clients and families whose culture is other than one's own.

**BUILDING CULTURAL COMPETENCE: AN ABORIGINAL AND MULTICULTURAL PERSPECTIVE**  
**Invited Panel Discussion**

**P. Gaye Hanson, RN, BScN, MPA**  
**President, Hanson and Associates Consultants;**  
**President, Aboriginal Nurses Association of Canada**  
**Whitehorse, Yukon**

**Adrienne Wiebe, PhD**  
**Coordinator, Multicultural Services**  
**Capital Health, Royal Alexandra Hospital site**  
**Edmonton, Alberta**

**Moderator**  
**Jacque Peden, RN, MN**

**Original Air Date – October 27, 2005**

**JACQUIE PEDEN**

Gaye, can you tell me, what does it mean to be culturally competent?

**GAYE HANSON**

Thank you Jacque. First I want to talk about Aboriginal people being the indigenous or First Peoples of Canada and in this terminology, we are talking about First Nation, Metis and Inuit people of Canada. Multicultural communities are individuals and families outside of Canada, so as much as we are pulling these two communities together in this presentation, I think it is important to distinguish between the two groups as well as create bridges in certain areas of competence.

It is also important to distinguish between the two in terms of their historical and current experience and also their socio-cultural realities. When we are talking about cultural competence, in my mind, it is the step beyond cultural awareness - we can go through all kinds of experiences and educational programming to develop an awareness of other cultural groups and some of the diversities that they deal with without developing competence. Cultural competence is a collectivity of skills, abilities, capabilities, competencies that an individual puts together in order to build high quality relationships and care relationships with families from different cultural backgrounds.

This form of cultural competence is highly contextual. It may well be different in one community or one care setting compared to another and certainly responds to the diversity within a particular cultural group. Competency of this kind allows a practitioner to assess where an individual or family reside within the broader context of that particular cultural group and respond accordingly.

**JACQUIE PEDEN**

Adrienne, do you have anything to add to that definition?

**ADRIENNE WIEBE**

I think that Gaye has really covered that well. The only pieces, and of course there is a lot more to discuss related to this, but the only pieces I think we need to remember as well are that culture is not static. This isn't something that you pin down once and then you have it permanently figured out. It is constantly changing and that is part of the complexity that we deal with. Intergenerational change or change as people interact with other cultures or mainstream culture is constantly occurring.

The other piece that I think is really important for us to remember is that the grounding for culturally competent practice is self awareness; that is, an understanding your own cultural background and your values, where you are coming from and how that impacts how you relate to others.

**JACQUIE PEDEN**

Yes, that makes sense to me. Adrienne, can you tell me, what are the key areas where culture can impact how we actually provide palliative care?

**ADRIENNE WIEBE**

Well, for this question, Gaye and I were thinking that we would just note some of the really broad areas where culture has a big impact in our palliative practice. One of the biggest areas of course would be family, social structure and dynamics. So, how the family is organized is important and this applies both to Aboriginal and other culturally diverse groups. The roles and responsibilities in the family and, particularly, in palliative care around decision making – who makes decisions and how are they made; and about the disclosure of bad news – how is that done within this particular family structure.

A couple of the other areas where culture has a big impact would be the perceptions of health and illness and dying – so what are the cultural perspectives and the spiritual perspectives? We are talking about spiritual perspectives as well as values, like life value orientation – so how does this particular culture see time (past, present, future orientation; whether they see things as cyclical/linear, that sort of thing).

Another piece that comes into palliative care would be the perspectives of the “locus of control” – so whether a person feels like they have, from their cultural perspective, some control over what happens in their life or how much do they feel that things just happen and they can only respond to what happens around them.

The other big part, which I am sure that most of the people who work in palliative care are aware of, is communication styles and how we interact with each other. Things like personal space, conversational style and pacing and treatment of professionals – that sort of thing. Those are really broad areas. I haven't really given you any really interesting information about specific cultural groups, but these are the broad areas that we need to keep in mind when we are thinking about cultural competency in a cross-cultural context.

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### JACQUIE PEDEN

Yes, I think that what you have identified is some key areas specific to hospice palliative care where we need to consider that the person may be from another culture and that we might need to do something a bit different. Do you have anything to add to that Gaye?

### GAYE HANSON

Adrienne provided an excellent summary and it certainly gets to many of the points we have discussed and are valid in our work. Just to accentuate the idea mentioned about communication styles in relationship building – if we think about relationship building as a process that is iterative in nature, each time we come into contact with an individual or a family, we are hopefully deepening and broadening our relationship with them. Within the relationship development process, there are nexus points in the beginning and throughout – the key decision making points. It is also important to recognize that because you don't know all of the various things that are affecting that family, the relationship development process may be an inconsistent and ever-evolving dynamic.

You cannot assume that because a family sort of “has it all together” and seems to be well organized with well defined roles and responsibilities that one day there will not be an accumulation of stressors in that day that then cause them to move to another place. That commitment to relationship building requires that we always assess as we are re-entering the relationship to establish what is going on with the family. It is important that we not to get to the point where we are making an initial assessment and that that assessment stops evolving along with the care relationship. That would be the only other area that I would add to what Adrienne has already mapped out.

### JACQUIE PEDEN

So, Gaye, what are some unique issues for Aboriginal people?

### GAYE HANSON

I think some of the unique issues are the history of Aboriginal people in this country, and obviously that differs from place to place and Aboriginal group to Aboriginal group. In particular I am thinking about the effects of colonization, residential schools, the impacts of culture on language, on location, place of residence, that sort of thing.

We also need to develop the understanding that Aboriginal people live in all different kinds of settings (rural, remote as well as urban locations) and that often affects the way they see the world and how they relate to it.

There are always jurisdictional issues within the lives of Aboriginal people as it relates to health and related care. Often there are federal and provincial - territorial responsibilities as well emerging responsibilities with First Nation and Metis governments. The values and characteristics along many of the lines that Adrienne has mapped out, do differ across Aboriginal groups, within Aboriginal groups and between Aboriginal groups and others.

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### JACQUIE PEDEN

Adrienne, what are some unique issues for immigrants, refugees or other culturally distinct groups?

### ADRIENNE WIEBE

As Gaye pointed out, I think that history, context and historical experience are very important, particularly for immigrants, refugees and cultural groups. Just to distinguish between those: when we speak of immigrants, we are talking about people who have come to Canada usually by choice – they have chosen to come here and they have applied and usually they come based on their professional skills or their education – that sort of thing.

Refugees more often don't come by choice. They are usually fleeing a difficult situation, either war or natural disasters or whatever, and they are often sponsored by the Canadian government or by church groups or by non-profit groups. They [Refugees] come in quite a different situation – they don't have the language abilities that immigrants who come as independent immigrants are chose for, so they [refugees] have a lot more challenges to adapt to life in Canada. The thing that would be different for immigrants and refugees [as compared to Aboriginal people] is the experience of migration.

There are a whole bunch of things that happen to people through that experience such as the loss that occurs when they leave behind their homes, their cultures and friends and then come to a new country and go through a process of adaptation. Often at the end of life or when people are nearing the end of life, spirituality becomes more important as well as the culture of their childhood or where they came.

[Culture and spirituality] become very important in terms of how they make meaning of what is happening to them [at the end of life]. People often look back to their birth culture to make meaning of the process of dying. I just wanted to mention that what we are seeing here at the Royal Alex Hospital, and I am sure this is similar across the country, is that the people we have in palliative care are often the older immigrant groups that are now reaching their 70s and 80s. These are people who immigrated in the 1950s and 60s and 70s – Italians, Portuguese, Ukrainians; those groups are among those that are reaching the elderly stage [today].

Often the refugees and immigrants we see arriving in Canada today are younger, so I think the majority of people you would be seeing in palliative care would be from the older immigrant groups. The only other thing that is important is what I mentioned before about changing dynamics between generations. So for example, if you are dealing with the elderly Italian person, they might have particular ways of seeing things and understanding things and wanting to do things whereas maybe their children who are often the decision makers or care takers may see things differently. I think that is all at this point. Thanks.

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### JACQUIE PEDEN

Okay, thank you. Gaye, how do we implement culturally competent care into our practice for Aboriginal people?

### GAYE HANSON

One thing that we need to be thoughtful of is the wide range of diversity that needs to be understood and responded to in order to assure culturally competent care. On one hand, we may have a group of Aboriginal people that are change oriented and quite acculturated, aligned with mainstream society in many ways in terms of their values and lifestyles and on the other hand, subsistence oriented people, the more traditional people, that are more closely tied to their traditional lands that may have more traditional values.

We tend to get caught, sometimes, in thinking about the comparison between Aboriginal and mainstream society without somehow being able to see and being able to really be clear about the diversity which exists within the Aboriginal society. I think that is important. We need to take care to not assume that just because someone is older that they are necessarily more traditional. We are seeing within Aboriginal populations a return often to more traditional beliefs and values among some of the younger people and some of the older people have been involved with mainstream society for two or three generations and have become very much integrated into that way of thinking.

In the work that we have done in developing a curriculum around Aboriginal end of life and palliative care, we came to the understanding that the best approach is a relational approach. This means that the care team invests in developing respectful and responsive relationships with individuals, families and communities. The purpose of investing in the relationship is to hear their requirements, to hear their priorities and allow for those requirements and priorities to direct care as much as possible within the care setting. We always know that we don't have all of the capability to respond that we would like to have in any particular care setting. We do need to commit to being able to do the best that we can and to be as responsive as we are able to be in respecting the needs of the dying individual as well as the family that is involved in that whole process.

Investing in further understanding in the history, issues, challenges, values, communication styles, relationship features, including how a family may sometimes deal with conflict and particular impacts of what they see as trauma or what they see as a difficult situation and other aspects of Aboriginal life provides the context for good working relationships. I see the investment in ongoing development of awareness and building skills and competencies as being a life long practice and grounded, as Adrienne identified, in a very thorough self awareness.

It is very difficult for us to work across the cultural relationship, kind of "divide", without being clear with where we are coming from as individuals. To seek experience, to seek training, to seek advice and mentoring from individuals

that are knowledgeable about these populations is certainly my word of advice for individuals interested in furthering cultural competence.

### JACQUIE PEDEN

Would you suggest that, as a nurse who may be going in for the first time with an Aboriginal family that part of your assessment would then be to ask about their history, ask whether or not they have had experience with residential schools? Could you give me some practical ideas of how you would begin your assessment? How would you begin to gather the information you need so that you can be culturally competent?

### GAYE HANSON

First, I would suggest that it really depends on the nature of the family but I tend to believe that we need to develop some mutual trust and respect before we can move in with a whole battery of questions. I recognize that sometimes that is very difficult depending on the care context but particularly a very traditional family may not respond well if they are faced with ten or twenty questions that are very directive. It is much better to try and invite the family, to let them tell you as much as they are prepared to offer and in any one sitting to share their stories about their experience.

For example, ask them to tell you what is going on in their family now as it relates to the health care experience. Ask them to tell you about where their family comes from. Where do your relatives live? Try to get a sense of their current and historical experience, through more indirect questioning. Show them that you are seeking to understand their family context without using series of very direct questions. Again, if you are working with more of an acculturated group, they would be more comfortable with an assessment instrument sort of approach.

### JACQUIE PEDEN

Are there certain issues that we need to be aware of when we are working with Aboriginal people? Certain cultural beliefs or traditions that we should know about?

### GAYE HANSON

Well, certainly there are many different examples of some of the traditional beliefs and to recognize that a First Nations person may or may not hold traditional beliefs – for example, in one family you may well have a traditionalist who, for example, may believe in reincarnation, may believe in the role of the ancestors in welcoming or guiding the person into the spirit world. Within that belief system often a strong connection to traditional land base and extended family. There may be the use of cleansing ceremonies, such as sweat lodge or smudging or fasting – those kinds of things.

What is very important is to not make an assumption that because someone comes from an Aboriginal background that their spiritual or religious beliefs tend to run along traditional lines – that you may just as easily have someone in the same family who is a very devout Christian or is engaged in another

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world religion such Buddhism or the Baha'i Faith. It is important to seek to understand the individual beliefs as well as the diversity of beliefs within one family which can sometimes be a source of conflict, especially at a situation around end of life.

### JACQUIE PEDEN

As a health care provider, are there behaviors or things we should not do when working with a traditional family? Can you give us suggestions of ways that we don't offend people with traditional beliefs?

### GAYE HANSON

I think one of the things is to try and have as much time available as you can possibly have. If there is an opportunity to sit with the family, to have tea or to share food with the family, that that is a very traditional way of creating community and showing respect. Often a family with that background wants to know who you are as an individual, so they may ask you questions or provide you openings to share a little bit about who you are as a person. They are interested in knowing if you are a mother or a father or if you have children, how long you have been practicing nursing or medicine or another health profession, what some of your interests are.

Often the mainstream view of those things is that personal information somehow doesn't belong in a health care setting, but often a traditional family will trust you because of who you are and what you bring as a whole person, not just because you have a particular professional designation. As much as you can be, remain open to sharing yourself. If the setting allows for taking some time to have some tea and bread as the context for a real conversation and the sharing life stories - that can be a wonderful foundation.

### JACQUIE PEDEN

Thank you. Adrienne, how do you implement culturally competent care into practice when we are working with immigrants and refugees?

### ADRIENNE WIEBE

I think many of the things that Gaye talked about with the Aboriginal community are similar with immigrant and refugee populations. I think that one of the things we often suggest to people is when you are beginning the relationship, begin formally and carefully to gauge how these people would like to interact. Gently and calmly – and I know this is one of the things that the Pallium materials have really stressed and they did it really nicely in the video clips that I saw that Gaye and company prepared. The other thing is building on what Gaye was saying about building on the personal.

For many people from many cultures, but we don't want to stereotype it, the personal relationship comes first before a professional relationship. They don't want to see you just as a nurse or a physiotherapist or a physician, but rather, first you are a person to them. When you begin a conversation, it is best not to jump right into the technicalities of the diagnosis and the treatment, but rather start off with some

time to open. You know: how are you? how was your day? how is your family? – those kinds of things, exactly like Gaye said about Aboriginal communities. Also, if appropriate, sharing a bit about yourself so that you are two human beings interacting rather than a professional and a patient first off.

Another thing, and I completely agree with Gaye on this, as it applies to other cultural groups as well, is to only ask relevant questions about culture. It is sort of impossible to sit down with someone and say: "Well, tell me about your culture," and then go through a whole list of questions. Most of us can't do that. You can't do a five minute wrap up explanation of your own culture. These things are revealed through time and as they become appropriate.

When you are discussing something specific about care, then that is the time to ask, is there anything we should know that would help us provide this care for you, or as they [issues] come up, ask the questions. The other thing is to ask about preferences and how they would like to do the decision making. Who are the people in the family who should be involved in that? [in other words,] not making the assumption of individual autonomy which is sort of the way our mainstream system operates, but leaving it more open to the family to decide how they want to do that. As well as their preferences about disclosure of information (who in the family should be involved when information is being shared?).

The other thing I would add is about people's interpretation of their illness and trying to understand how they view this illness – for many people from different cultural backgrounds, and even for mainstream people from your basic middle-class Christian backgrounds, a lot of people see illness as a result of something not just from a medical model but that [the illness] may be the result of something that I did.

[In this way we are] trying to understand where people are coming from and how they see their illness as part of their life and then seeing if there are ways of integrating what they see as the appropriate response to that into their treatment. That is rather vague but I am hoping that you can understand the general gist of what I am saying in terms of how to approach people that have different perspectives on health and illness and dying.

### JACQUIE PEDEN

Can you give me examples of questions if you particularly wanted to talk about advance care planning, so you are wanting to talk to them about possibly planning a home death or their decision of how long they want to provide care at home if the person is at home and you want to specifically talk about that area of death and dying. What would be some examples of questions that you could think of that you could ask that would be acceptable?

### ADRIENNE WIEBE

For an example, we did a small study here at the Royal Alex Hospital that included three groups. We did interviews with – Italians, Chinese and Sikhs, and asked them about the death and dying process and asked them how they felt about that

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and about disclosure of poor prognosis. It was really interesting that the majority of the Italians did not want to disclose the complete bad news to the patient. They would rather have the main family learn about [the diagnosis] first and then they determine how they want to disclose that, if they want to disclose that, to the patient. This was related to their thinking that patients lose hope when they find out that there is a negative diagnosis.

In the Chinese community however we found that people were more often, (remembering always that we don't want to stereotype), that within the Chinese we found that many of them didn't want to discuss death and dying or negative prognosis in a really open way because when you talk about something out loud, it is more likely for that thing to happen. That has a real impact on whether you are going to create a personal directive. Why would you want to sit down and discuss all the negative possible things that could happen to you in the future, for example to be brain dead and on life support; why would you discuss that if that is more likely to make that happen.

In terms of disclosure and decision making in the family, if there is a way of asking the patient – because we don't want to make the assumption that the patient doesn't want to talk directly with the care provider about it – if there is a way to ask them, “Would you prefer me to discuss this more with your son” or whoever it is who seems to be the major decision maker in this family and then they say, “Yes, yes you can talk to them about it”, then take your cues from them about who to speak with in greater detail about the issues. That is an example.

### JACQUIE PEDEN

I found that really challenging. I was working with people in the home when the patient or the client wasn't told or didn't seem to be aware of what was happening. I think that is very challenging as a health care provider because it is different than our beliefs.

### ADRIENNE WIEBE

Especially the mainstream system which is set up in such a way that it is almost completely based on personal autonomy and decision making. It is almost a legal requirement that physicians are required to speak first with the patient about the diagnosis, so how do you deal with that as a care professional? It is a big challenge.

### JACQUIE PEDEN

Any suggestions?

### ADRIENNE WIEBE

I haven't got the complete answer for you unfortunately. As I was saying, I think the best way to cope with it is a negotiated response – asking the patient, who would you prefer, who would you like me to talk with or in [a round about] way getting at how much they want to know and how much they want you to discuss it with other family members. I think that that is probably common across the board, in most other cultures.

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I think that probably for most mainstream Canadians in a few generations back we were much more collectively based in our decision making and our identity and how we interacted in the world was much more based on family and community rather than the individualism that is sort of dominant today. I think in our care, involving the family is very important and making sure that they are involved in the way that they want to be.

### JACQUIE PEDEN

Okay. We do have a couple of questions from the participants' registration forms, so let's deal with those first and then I think we will open it up for questions from the audience. The first question was from Andrea Mowry from Kelowna and she actually wanted to know about resources – websites or books.

### GAYE HANSON

The Pallium Project has developed a course planning manual and courseware entitled, “Responsive Hospice Palliative Care with Aboriginal Clients in Rural and Remote Settings” and this is courseware that is if you were to deliver all of it, it would probably take six days or so. What we tend to do is pick bits and pieces from the resources depending on how much time we have available and that is supported by a series of PowerPoints and fourteen DVD segments as Adrienne had suggested.

This is licensed courseware and right now we are in the process of training trainers in this courseware across the country. We now have twenty-five trainers that were trained in Vancouver in September, so we do have some BC based trainers. It is not courseware that is generally available although we can offer it up for review and we certainly could make some arrangements to train trainers in this courseware if that was to be helpful. We could also make the list of resources that we used available to you.

We found that when we did the literature review on the basis of which some of the work was done, that about three years ago, there was very little in the literature around Aboriginal views related to hospice palliative care and particularly around the cultural competency and the degree of depth of understanding that we need around what that means in Aboriginal communities. Aboriginal Nurses Association of Canada is also a resource and has released a number of publications that are not considered academic literature but they are certainly in the grey area literature category. We could make a list of that available, Jacquie, for distribution.

### JACQUIE PEDEN

That would be great between Adrienne and you, if you could make up a list and forward it to the Pallium office and then have it sent out to the participants of this teleconference that would be great. The next question is actually for you Gaye, it is from Regina Bracher in Nanaimo. She wanted to know how you would support Aboriginal patients in a palliative care unit.

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### **GAYE HANSON**

So we are talking a hospice or a hospital based palliative care unit?

### **JACQUIE PEDEN**

Yes.

### **GAYE HANSON**

My response to that would be that one of the things that is very helpful is to try and make sure that you are organizational content, context and policy and procedures allows for visitation by the family. Sometimes when we are in an institutional setting, the numbers of visitors that want to come and the number that sometime want to be available around the bed at one given time can be a problem in an institutional environment, so that's just an example of some of the policy issues. An Aboriginal family may also want to have traditional ceremonies in a hospital setting and certainly the Royal Alex where Adrienne works has made special arrangements for the physical space that is ventilated in such a way that sweetgrass ceremonies and other ceremonies can occur.

To find out if the family does engage in traditional practice and whether or not any of that would be, in their view, integrated into end of life care. Often, we were talking about some of the "magic questions", the answers to which can direct care. I find that before we start asking questions, it is good to begin with a statement of intention that lets the individual know that you understand that they come from a cultural background that may have unique requirements and that it is your intention to do whatever you can to respond to those. That will often give the person permission to start bringing forward some of the special concerns. In some cases, concerns that they weren't sure would be welcomed in an institutional environment. To make that commitment is a great start.

It is also very important to be honest about what is realistically possible. Honesty is deeply valued in Aboriginal culture. It may be honest to say that there are some concerns and challenges we may have a problem accommodating. The limitations may include what is physically possible in the environment, what is required to stay within guidelines related to ethics as it is practiced in that environment or the policy considerations.

For example, if there is a very clear policy that the patient has to know absolutely everything to do with their diagnosis and illness, it may be difficult to try to work within that policy and still be respectful of the family's wishes. The family, at some level, needs to know that there is an issue to be navigated and be informed of the reality of the legal requirements along with what the staff can do to respond their culturally based requirements. Those are just some thoughts I could come up with Jacquie. Thank you.

### **JACQUIE PEDEN**

That was great. I like the suggestion to give them your intention of providing support for them. I like what you said. I think it is a good idea.

### **MELANIE, GRANDE PRAIRIE, ALBERTA**

Hi, this is a coworker of Belle's actually – Melanie. We were just wondering – you mentioned the video clips – how can we get a copy of that or is there a way?

### **GAYE HANSON**

Yes, there are two methods to access the courseware and one would be to organize a training of trainers by which we could train and license individuals to bring the courseware to your area. You could invite someone up to actually deliver a course or you could request the material for review. The reason we are licensing material and holding the material with a string attached is not because there is any cost involved but it is just to make sure that the quality of delivery is there when these materials are accessed and used.

One of the requirements for example is to use an Aboriginal co-facilitator in delivering the materials and also to use a local cultural resource person to bring local knowledge. It would be fine to connect with me directly and we could find a way of making this material available in Grand Prairie.

### **MELANIE, GRANDE PRAIRIE, ALBERTA**

Okay. Do we have your email or a way to get in direct contact with you?

### **GAYE HANSON**

Editorial note: Inquiries about Pallium Project educational materials can be directed to [education@pallium.ca](mailto:education@pallium.ca)

### **BELLE THOMAS, GRANDE PRAIRIE, ALBERTA**

Okay, thank you.

### **SANDY PULFER, KELOWNA, BRITISH COLUMBIA**

This is a colleague of Andrea's – Sandy Pulfer. How would you respond to the comment that people are much more alike across cultures than they are within their own cultures? I would like to hear the speakers comment on that. Thank you.

### **GAYE HANSON**

Ok, I can take the first run. I can hear Adrienne saying, "That's hard". Basically, what we understand is that physiologically, on the inside we are all the same, right? There are many similarities in our physiological makeup – our physical makeup – as human beings. On a spiritual level we are all human beings. We have a connection human to human and I remember having a spiritual experience with a visitation of my Cree grandmother and she sort of turned into this rainbow of every color in the universe and so I said, "Are you still Cree in the afterlife?" She looked at me and responded, "I am everything and I am nothing. It doesn't matter here." So, on a spiritual level we are human beings – we have that connection of humanity and that is why it is important to get beyond the differences to make that

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connection between human to human. I noticed traveling the world in my twenties that the admiration that you can express for the beauty of a child for example – a parent picks up on that even if you have no language in common. The fact that you gesture and let them know by body language that you think their child is beautiful.

What differs is then how you move into a relationship. I remember traveling in Thailand and as an old public health nurse I always wanted to reach out and touch a baby. In Thailand if you touch a child's head with your hand as a stranger that that is seen to be a major insult to family and injurious to the child at some level. So the way in which spoken language and what we say and how we say it and how our body language is interpreted across cultures is where I think the complexity occurs. As we intend to make connections, none of us intend to be racist, none of us intend to be disrespectful of someone but it sometimes happens because we just don't know any better.

I often find that in relationships that it helps to communicate a sort of disclaimer that says "I hope to and I intend to be able to communicate and connect with you human being to human being and let's try to deal with the difficulties of getting that communication link established by respectful and gentle communication and good feedback". In that way you give people permission to let you know when things aren't working well. I think it is the social context, communication styles and all of that that can be different or misunderstood that dynamic somehow gets in the way of us connecting in our sameness.

### ADRIENNE WIEBE

I think that Gaye got the real core of it. I think that's the balancing or juggling act that we are doing: we want to recognize difference and respect difference but at the same time understand the similarities and commonalities around the globe. We all have multiple identities. In some way you can identify and connect with other people based on any one of those.

For example, as a woman I can maybe connect with another woman from a culture that is completely different than mine just because I am a woman and many of our experiences are the same as women. Or growing up on a farm; maybe you grew up on a farm and somebody else comes from a farming background in another country – there have got to be connections there in your identity as rural farmers. The similarities are the things that can bring us together, but at the same time we need to recognize and respect and not deny differences across cultures.

Recently I was in a workshop where a woman from the Dominican Republic was saying how offended she was when someone said to her, "Oh you are such a good friend - I don't even see you as black." She felt very offended by that because it was such a denial of a core part of her identity being from the Dominican Republic. I guess that is the tricky thing we are trying to navigate in this – finding the places

[similarities] where we can connect with each other and then learning how to grow to understand and respect each other better around the differences. Thank you.

### JACQUIE PEDEN

I would like to share with you the take home messages from the speakers which are:

- The challenge for health care providers is to understand respect and facilitate our patients' culturally based perspectives and practices but at the same time,
- Not to stereotype them within categories that erase their unique individuality.
- The next one is like spirit or faith, people's cultural beliefs and practices often become more important to them as they make meaning of the dying process.
- Finally, appropriately demonstrating respect and caring are the foundation for establishing a culturally competent relationship with our patients. Knowledge of specific cultural beliefs and practices are secondary.

I'd like to thank Gaye and Adrienne for joining us today and sharing with us ways to become culturally competent and ways to implement cultural competence into our practice.