Chapter 7
Doing What is Right: Behavioural Change in Service Delivery at the Higher End of Cultural Competence

A Psycho-socio-Cultural Model for Undergraduate and Postgraduate Health Care Professionals

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Abstract Developing cultural awareness is an important knowledge required to shape practice at both undergraduate and postgraduate levels in any health system where sustained health disadvantage exists between the first peoples, other minorities and the larger population. A further shift in thinking is required to achieve cultural appropriateness, then competence and then proficiency that requires knowledge, skills and experience based on positive behavioural change. Taking this approach, cultural competency is demonstrated when a measurable impact in service delivery and practice is realised, not just from a provider perspective but more importantly from a recipient and their community perspective. When identified communities use different understandings that impact on their health status, health practitioners who aspire to advanced practice should be capable of making a difference that is relevant and acknowledged by each community. This chapter uses a simple framework of define: measure: value: choose in order to address some of the differences in thinking and reasoning that can be used to better understand the roles played in improving the health status of individuals, families and communities. This should encourage a reconsideration of the significance of the bio-medical model and a greater engagement with the more complex psycho-socio-cultural model.

I am a non-Maori man who was brought up in New Zealand by strong women. I have a deep connection to both New Zealand where I was born and Australia where I now live.

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Conversation and Relationship Building with Elders

How do you know when you first start on a journey? Do you only start when you know the precise destination or are you able to accept the discomfort that the destination will be shaped by the manner in which you acquire and develop your knowledge as you take each step? Do you start with a question that you cannot answer, based on what you know and where you are? Do you start with what you would like to know, or like to know better? Do you start with what you know about yourself, or do you want to know more about others? Rather than stop and remain in a quandary, you should proceed and use your questions to guide the choices that you need to make with each and subsequent steps.

I have been asking these questions of myself, what I know, how I act and interact with others, probably ever since I was aware that I could think. When it comes to my current involvement in the education of health professionals, I have questioned what might I have done better and how could I share that to improve the learning of others. I have questioned the teaching of simple concepts, not because they shouldn't be taught or learnt, but the pace and sequencing of the progression from simple to complex. When our deliberate actions should align with an understanding of strategic direction, a basic understanding of performance, then we cannot separate individual actions from the accumulation of actions to a collective. To reverse the direction of deliberation, at what point do we start with a complex issue and begin to pull it apart to understand its components, and to accept the concept of a "holon" (Koestler's 1967 definition as cited by Checkland (1999), p. A54), a neologism, "where something was simultaneously a whole and a part". For example, the concept of health, as a definition, and health as in health care system, another concept, where the phrase misleads what actually is the focus of the system. Our health care system has a bio-medical focus on illness, disease, trauma and injury rather than a social determinants (Wilkinson & Marmot, 2003) model's consideration of the multiple influences impacting wellness, or the gradients of health. If the health care system is intended to improve health status in regard to wellness, then a shift is required in regard to how health care services lead to wellness. Our current health care model is based on acute medical care and that might not be optimal for the evidence-based health care burdens we should be well aware of. So, if we need to change how our health care services are delivered, and that links to how they are currently structured, do we wait for someone else to redesign the system? Should we start by building on what we do well, or should we consider where we do not achieve the levels of performance that we aspire to and begin to change those?

On all measures there is a disadvantage, relative to the larger community, in regard to first peoples in countries that have been colonised in the past 200–300 years. While there may be some biological markers or reasons for parts of this disparity, there are also psychological, social, cultural and political factors that influence the inequalities that can be observed. The enduring cultural disadvantages that exist provide areas of practice that I believe any student or practitioner in health care should aspire to do something about. However, it is not possible to develop a true

understanding or appreciation of Aboriginal culture just by reading about it. It is much more important, valuable, and likely to lead to real change in practice when you can engage with Aboriginal Elders and community directly. But, having raised your level of consciousness to one of willingness, what can you take to an Elder to give as part of any exchange? How much are you willing to give before you might begin to better understand yourself, to then begin to better understand something of Aboriginal culture?

A first step should be taken with someone who is familiar to you and hopefully, if you are convincing enough with your initial request, you will be invited to take several more in company. I was fortunate to be introduced to a number of Elders on my journey, and the numbers increase as I progress. I don't always know who is an Elder on first, or even subsequent meetings, but in time enough will be shared, when you are ready, to begin to learn more about Aboriginal culture.

This process, in itself, is a gift from the Ancestors. In Aboriginal culture, there is a long tradition of story-telling, starting with something simple that can be readily remembered, and then built on with increasing numbers of perspectives or dimensions, as you are able to grasp the complexity of more advanced concepts. In western culture arguably a reverse development occurs in explaining complexity, such as what (von Bertalanffy, 1968) first called general systems theory. von Bertalanffy's explanation of general systems theory was technical and for the advanced learner. Others then unpacked systems concepts into various forms more suitable for teaching and learning applications such as (Checkland, 1999) soft systems methodology, and arguably Schön's reflective practitioner (1995). The significance of the timelines, of traditional learning in Aboriginal culture compared with the relatively recent explanations in western academic literature, should not be discounted. There is a vast amount of wisdom in traditional knowledge.

Trying to understand the complexity of health care systems that exist, requires an appreciation of the process by which they evolved rather than were designed. Hospitals, the mainstay of most health care systems, were intended to address early eras in health care, initially quarantine and isolation for infectious and communicable diseases aided by the development of public health procedures. In the period between the World Wars in the twentieth century, the industrialisation of medical care was enabled, with the development of surgical techniques and procedures, aided by the development of antibiotics and other pharmaceuticals. After World War II, as we then entered the era of the New Public Health, hospitals were less suited to address the earlier intervention required to reduce preventable admissions linked to lifestyle and behavioural risks. Our health care systems are no longer sustainable in their current forms. Returning to the story, adopting the approach of Aboriginal knowledge sharing, we should start by asking the "simple" question what should the health care system aim to achieve? We could then ask what needs to change to restore the imbalances that exist? More questions and insight into our personal, as well as collective, contributions to community wellbeing will be required. Starting with "improved clarity" about what health care is intended to achieve is about **defining** the purpose that justifies what we should do.

Knowledge and Scholarship Around the Topic

Any student studying as a health professional contemplates their profession as an opportunity to make a difference in a way that is meaningful to them. There is something about the intended nature of the clinical interaction that is both compelling and rewarding. However, there are a number of assumptions that underpin being able to make a difference.

The first is the acquisition of new knowledge, skills and experiences that develop the individual to the point where they can begin to interact as a health professional, initially under supervision but once some competence has been demonstrated, more independently. There is a strong chance that learning has moved from simple interactions into some degree of complexity. But the question remains what is the level of complexity when pre-service education concludes and the shift to post-employment professional development begins?

What might not be questioned to any substantial degree are personal values, attitudes and beliefs that have shaped the individual prior to the decision to strive for, and be enrolled as a student, and how that also shapes what is learned, how it is learned and how it is applied. The experiences that you had when you were hungry, cold, hurt or unwell provide a context for what you identify with. They are a basis for what you expect regarding the difference that you can make. They also make a difference in regard to who you identify as a role model in developing your understanding about what happens when you are unwell, when you might suffer an injury or trauma, through play, sport or other interactions. Depending on where you were born, and what interactions you had during schooling with people who were different to you, you might have a narrower appreciation of the social determinants of health. The social determinants of health are of greater importance if inequities in health status are to be recognised and addressed.

Developing a professional identity should be based not only on acquiring the knowledge, skills and experience that supports the development within a profession, but should also be accompanied with the development of reflective practice engaging with what performance means within that profession. Making explicit the assumptions that underpin personal values, attitudes and beliefs require interaction and guidance from advanced practitioners, either those that are involved with teaching at pre- or post-service, undergraduate or postgraduate level, or, expert practitioners willing to mentor the aspiring practitioner. Dewey (1933, 1938) was critical of the manner in which curriculum stifled what was taught as opposed to what should have been learnt. (Schön, 1995) then developed and applied that work to professional practice. He spoke of reflection-on-action, reflection-in-action and professional artistry as being the levels of reflective practice that are common in professions. Schön argued that there was a tension between theory and practice that reflection could address. Practitioner reflection was based on looking back, reflection-on-action, and trying to better understand the interactions that occurred and to consider what changes might have been required to achieve better outcomes. Reflection-in-action was a higher level of reflective practice, with quicker reactions to make adjustments in a situation,

to ensure that any real time deviations from intended performance were adjusted so that the intended results were achieved. Professional artistry was demonstrated when an expert practitioner could consistently engage with complex issues of performance and consistently achieve better outcomes than other practitioners.

Ritchie (2010) argued that reflection-on-experience could occur when health professionals were challenged to shift a dominant perspective, their clinical profession, to consider a different values framework associated with management. A managerial perspective typically considers the resources used when clinical choices were made, to shape choices based on overall performance at levels above the individual. It is a more complex construct, and tensions arise from clashes in and between the ethics framework adopted: Deontological versus consequentialist or utilitarian ethics frameworks. An incomplete engagement with a deontological framework creates conflict between elements. The code of conduct espoused by the dominant health professions focus on "do no harm" (non-maleficence) or "do only good" (beneficence), but seem to place lesser value on equal concepts such as autonomy (the right of the individual to make choices affecting them) and justice (where individuals are treated equally based on clinical need alone, without bias or discrimination). I argue that reflection-on-experience arising from interactions with individuals from backgrounds other than the student of, or practitioner of, a health profession is an important part of the development required to address any unconscious or implicit personal bias. That reflection could lead to changes in personal behaviour that enable an improvement in the access and experience of health services by Aboriginal peoples. The evidence that supports our practice, the activities or tasks we engage in, the resources consumed, and the results (outcomes not outputs) achieved become what should be measured. These can then be assigned a **value** accordingly. We should only get to **choose** when we can distinguish their potential impact and value.

Reflections as Scholar, Teacher, Researcher and Professional

My own journey as someone who was interested in making a difference, in finding out what was required to become a better practitioner, involved work, study, reflection and research, in several countries. My initial interest was trying to understand what knowledge, skills and experience were required to become not only a manager, but a good manager. At the time I was beginning this quest, several countries were grappling with how to get better performance out of their health care systems. Those countries were New Zealand, Australia and Great Britain. I worked for differing periods in these three countries, in that order, comparing and contrasting how they delivered health services. Later, when I became an academic, that interest extended to Canada as well. The consequences of the legislative reforms that occurred, involving the grouping of autonomous hospitals into a geographic networked model, shifted the emphasis in management from the business administrators to the clinician-managers that emerged. In Australia the major clinician-manager winners were nurses, and that reflected their proportionate numbers. Degeling, Maxwell, Kennedy, and Coyle

(2003) were arguably the first researchers to evidence clear differences in thinking between clinicians and clinician-managers and this prompted a shift in my own thinking, scholarship and research. I had studied health administration at postgraduate level in New Zealand and Australia, within different curriculum and cultural contexts. It also meant I began to reflect on how, as an academic teaching management to clinicians, I might change not only what I taught, but how I taught and supported learners in that transition. The differences between roles were real but how could the transition be supported and facilitated?

While I was grappling with how to become a better academic practitioner, I recognised the need to shift from teaching traditionally, as I was taught, and that meant generally looking back upon theory and developing intellectual arguments. I changed my focus and emphasis towards shaping the future, and encouraging my students to develop as advanced practitioners. Drawing on the deliberations of the (Institute of Medicine, 2001) there was a need to prepare students for the new health systems that were required. That meant recognising the impact of an increasing burden of chronic and continuing conditions. There is a need to shift from a bio-medical model dominated by medicine to one that is multidisciplinary and team focused on out of hospital models of health care. Integral, in my view, to that shift was to consider who had benefitted least from the biomedical and institutional focus of care, and who might benefit more from different models of care.

That shift in focus enabled me to think carefully about my own upbringing and interactions with Māori, and the challenges I had in understanding Aboriginal and Torres Strait Islander peoples in Australia when I first arrived in 1983. The complexity of the gaps in morbidity and mortality experiences of first peoples aligned with my shifting views on how best to develop the advanced practitioners required to lead. Advanced practitioners were required to lead the transition from a traditional approach to an understanding of the New Public Health approaches required to prevent chronic and continuing conditions. This is where Bisognano (2013) argued that the focus should be flipped, with clinicians being challenged to shift from asking "What is the matter **with you**?" to "What matters ***to you***?" If we are to ask what matters to seekers of health care, then not only we should better understand what they think and believe influences their health status, but also what choices they can reasonably make to maintain or improve their health.

The opportunity to share my own experiences from participating in my employer's Indigenous Cultural Competence Program, and a number of Cultural Immersion Camps that involved travelling out to Menindee and spending time in the company of Aunty Beryl Philp- Carmichael and other Elders, linked to the learning resources and activities I provided.

Sharing reflections on my own experiences, and the exhortation to develop Advanced Practitioners who recognised the need and justification to change the way that they engaged with Aboriginal and Torres Strait Islander peoples in particular, meant that students also began to share more of their own stories. Different types of training in cultural awareness are increasingly required by employers who interact with Aboriginal and Torres Strait Islander peoples. But often that training is single event and evaluated based on knowledge shifts immediately at the conclusion of

training. A serious weakness seems to be the lack of any consideration of changes in behaviour that might be perceived from a recipient perspective. Often the training, despite the quality of its content, is delivered without recognising the significance of relationship building with local community, particularly the Elders who are the knowledge holders and the only individuals authorised to speak on behalf of their community. Increasing local input into delivering training and evaluating its impact is very much a process of building capacity and capability from the ground up. The Prime Minister, in a foreword to the *Closing the gap report 2019* (Department of the Prime Minister and Cabinet, 2019), asserted that a top-down approach to improve outcomes for Aboriginal and Torres Strait Islander Australians had not worked, and changes to policy and delivery of services needed stronger accountability through co-designed action plans. Challenging students to consider what differences they might make, what changes in their behaviours they might consider given that academically they are better prepared than most, has resulted in ripples of small but perceptible changes in the services they provide.

Methods of Teaching/Sharing/Providing Evidence/Student Voices

Students who enter the postgraduate programme have a typical sequence of three progressive subjects that I teach which introduces them to different ways of defining, measuring, valuing and choosing between alternatives to the therapeutic interventions that they have influence over. The introductory subject is conceptual, getting them to think about health in different contexts, and from different perspectives. The second subject, evidence-based practice, reinforces the desirability of shifting to New Public Health approaches to reduce exposure to risk behaviours that increase the probability of developing chronic and continuing conditions. The third subject introduces a clinical governance framework to address complex factors affecting the quality of clinical service delivery. Student understanding is evaluated by the extent that they can appropriately identify and engage with a performance issue relevant to the theory introduced in the subject. In recent years, an increasing number of students have used this assessment to write business cases that have led to authentic workplace change.

Given that these students are studying management, the business case reinforces their learning. But, influencing interactions at the individual patient level can, and does, precede the opportunity to develop a collective response.

I recently asked a group of students working under my guidance on a project concerning an Aboriginal community's experience of access to, and the manner they receive health services, to consider when their own thinking changed. With permission I will share an entry into a reflective portfolio by SRP, a postgraduate student.

"I have often been reflecting how my appreciation for [Aboriginal and Torres Strait Islander] health issues and general understanding of peoples has changed over the

course of both this subject and my entire [Masters] degree. As mentioned previously I have tried to pin point when this [mind] shift first started, in a hope of using this information to inform others and potentially shift their minds"!

Thinking back on my studies there is one particular assessment which has stood out in my mind. I was required to complete a project on an Aboriginal and Torres Strait Islander health topic, working in paediatrics it was fairly straight forward to select the issue of Ear Health and Hearing Loss as a topic I was interested in. The cycle below outlines at a very basic level what I began to see during this subject and how this started the changes within myself. If a child can be so greatly [impacted] by a health condition (through no fault of their own) and the cycle would then continue with their own children. Not to say that all Aboriginal and Torres Strait Islander children have issues with their ear health, however it is well established that the incidence in the Aboriginal and Torres Strait Islander is significantly higher than non-indigenous populations.

In hindsight, this is very much associated with the social determinants of health, which I have known about for a long time, but it took something more relatable to a personal area of interest to actually visualise the cycle social determinants can have on health. Reflecting on this and my previous learning I found that I had probably focused significantly on the impact of social determinants on adult health, and not considered the whole picture/life cycle. The fact that social determinants were effecting Aboriginal and Torres Strait Islander child health was no fault of the child, and this really "hit home" for me.

On further reflection, as I write this entry, I think I have been unconsciously laying blame on people for their poor health, due to determinants which may have been outside their control. Acknowledging the cycle of poverty and the impact it has on health for both Aboriginal and Torres Strait Islander and non-indigneous people has greatly shaped my view of individuals and how their health outcomes may be impaired. Reflecting further, I think my view has been shaped by my upbringing in a white, upper-class family. I have always had access to healthy food, shelter, high-quality education and any other every day necessity and then some. Being able to consider how life would be different for another person is an eye-opening exercise. If my understanding and for want of a better word, prejudice, can be changed, then I have no doubt others can be too. Is changing the mind set really as basic as the cycle below? To be honest, looking at the cycle now I feel somewhat stupid for not acknowledging this earlier in not only my studies, but life in general. I guess sometimes it takes something that you can clearly relate to and reflect upon, to bring about the "light bulb" moments!" (Fig. 7.1).

To conclude, I now have a dilemma about how much cultural knowledge is required before a health professional can change their thinking and interactions with all their patients. While a significant number of my students have participated in my employer's Indigenous Cultural Competence Program, more of my students now seem to grasp the challenge earlier, because their thinking about what was important to them when they commenced their study was based on their desire to do more good than harm. By suggesting that they strengthen what they do the least well, not

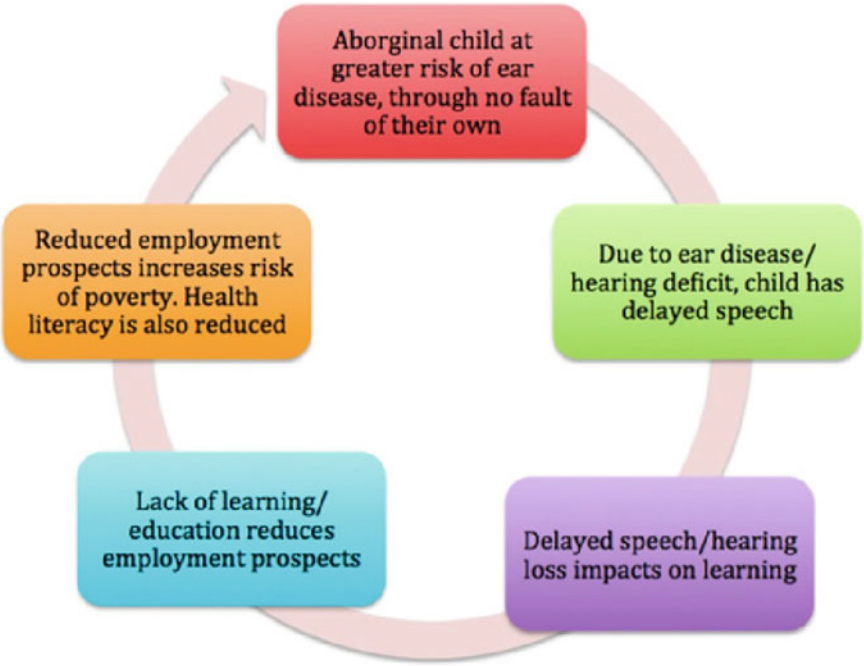

Fig. 7.1 Diagram by SRP © (2019)

necessarily personally but collectively, then perhaps we can make more progress in Closing the Gap.

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