

# Hospitals, nationality, and culture: Social workers, experiences and reflections

Doris Testa Victoria University Australia

## ABSTRACT

**INTRODUCTION:** Social work accrediting bodies mandate that workers analyse ways in which cultural values and structural forces shape client experiences and opportunities and that workers deconstruct mechanisms of exclusion and asymmetrical power relationships. This article reports the findings of a small-scale qualitative study of frontline hospital social workers' experiences and understanding of their mandate for culturally sensitive practice.

**METHODS:** The study involved one-hour, semi-structured interviews with 10 frontline hospital social workers. The interviews sought to understand how frontline workers and their organisations understood culturally sensitive practice. Drawing on their own social cultural biographies, workers described organisational policy and practices that supported (or not) culturally sensitive practice. Narrative analysis was used to extract themes.

**FINDINGS:** Data indicate that frontline hospital social workers demonstrated their professional mandate for culturally sensitive practice. Workers were firm in their view that working with the culturally other requires humility as well as a preparedness to value and engage the multiple cultural meanings that evolve in the patient-worker encounter.

**CONCLUSION:** The findings highlight that mandating cultural sensitivity does not necessarily result in such practice. Cultural sensitivity requires an understanding of how cultural and social location may be implicated in sustaining the dominant cultural narrative and signals the need for workers, systems and organisations to facilitate appropriate learning experiences to explore culturally sensitive practice.

**KEYWORDS:** culture; diversity; humility; hospitals; postmodernism; postpositivism

Of Australia's population, 46% were born overseas or have a parent who was born overseas. Of these, nearly 60% speak a language other than English. Twenty percent of people from backgrounds other than English have experienced race-based exclusion or have reported discrimination because of skin colour, ethnic origin or religion (Australian Human Rights Commission, 2014). Grounded in its commitment to justice, culturally sensitive practice reflects the mandate of international and national social work bodies (International Federation of Social Workers

(IFSW), 2014) to "recognise and respect ethnic, cultural and race based values, characteristics, traditions and behaviours and integrate these characteristics successfully into practice" (Australian Association of Social Workers (AASW), 2010, p. 43). Drawing on the experiences of 10 frontline hospital social workers of culturally diverse backgrounds, this article reports on how they understand and practise the international and national social work mandates to work inclusively with clients from cultures different to their own. It also includes their insights and understanding

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WORK 29(2), 96–107.

**CORRESPONDENCE TO:**  
Doris Testa  
Doris.Testa@vu.edu.au

about recognising and respecting the “culturally other.”

Notwithstanding the AASW’s mandate to provide culturally responsive services, international and national literature note the discourse debates surrounding what it means to work with diverse populations. Different discourse lenses will shape what is understood as: culture; what constitutes effective social work practice; practitioner role; methodology; goals; and social work models (Williams, 2006).

Prior to reporting the research, the author, cognisant of the theoretical paradigms that can be used to situate the report, drew on two of William’s (2006) paradigm conceptualisations: postpositivism (broadly aligned with essentialism) and postmodernism, broadly aligned with constructivism. The researcher determined that postpositivism and postmodernism best serve to describe the opposing frameworks used to understand culture. These two frameworks are used to demonstrate theoretically opposite ways of how social work roles and methods for cultural practice, cultural competency and cultural humility could be understood and used as entry points to social work practice.

## Two theoretical perspectives

### Postpositivism

In the postpositivism discourse, culture is stable and understood as part of an identity common to all members of a group. Founded in shared experiences, culture is maintained in continuous form (Nadan, 2014; Williams, 2006). Difference is seen in the context of systemic discrimination and the practitioner’s cultural discriminatory blind-spots remain uncharted and unchallenged.

Reflecting the postpositivism discourse and its emphasis on “fixed” indicators, researchers (Grant, Parry, & Guerin, 2013) argue that the term *cultural competency* provides specific indicators to monitor

appropriate cultural interventions. Providing the specificity required of the postpositivism paradigm, indicators privilege measurable knowledge, skills and values that demonstrate cultural competency (Institute for Culture Ethnicity and Policy (ICEPA), 2003; Nadan, 2014).

Practice focus is on technical proficiency (Cross, Bazron, Dennis, & Isaacs, 1989) and applied as a “one-size-fits-all” across nationalities without sensitivity to ethnicity or individual and multiple cultural identities that the culturally other brings with her/him (Williams, 2006). The emphasis is on the practitioner’s cultural knowledge, awareness, and skills and on *being* culturally competent. Reduced to formulaic interventions and checklists mapped along a continuum of competence, cultural knowledge, awareness and skills are key performance indicators of how successfully the practitioner (or the organisation) works across lines of cultural difference (Fisher-Borne, Cain, & Martin, 2015). Occupying a position of power, the worker’s values, attitudes and beliefs are not exposed or critiqued against the power and privilege afforded to those belonging to the dominant culture.

Garran and Werkmeister Rozas (2013) emphasise that a formulaic definition of cultural competency disregards the influences of power and privilege. Others criticise the cultural competence paradigm as being tokenistic, for assuming that the worker is from the dominant culture, for lacking a power analysis and for treating culture as a neutral phenomenon (Furlong & Wight, 2011; Garran & Werkmeister Rozas, 2013). Hosken (2013) argues that cultural competency training has the potential to reinforce stereotypes and that it is erroneous to conceive that a type of ethno-cultural matching can achieve cultural competence.

### Postmodernism

*Cultural humility*, a term coined by Tervalon and Murray-Garcia (1998), is situated within a postmodernist discourse. Culture

is understood as unfixed, drawing on contextuality and personal narratives. Juxtaposed against the postpositivist lens of cultural competency, a practitioner committed to cultural humility suspends her/his assumptions, expertise and knowledge about the culturally other and enters into a power sharing and exchange with the client. This means being open to the other and befriending the difference while working consciously to deconstruct the mechanisms of exclusion (Nadan, 2014).

Assuming an attitude of “not knowing,” she/he is an explorer and facilitator who helps the culturally other delve into her/his multiple identities, relationships and systems (e.g., patient, wife, mother, person of colour), while simultaneously reflecting on her/his own narratives, role and social positioning. As Williams (2006) and Nadan (2014) write, these exchanges and explorations become the emancipatory co-creation of multiple meanings and new relationships. The worker is not the expert. The practitioner is always *becoming* rather than *being* culturally competent.

Central to this discourse is the worker’s critique of the individual and structural power differentials between her/himself and her/his client. She/he advocates for self-reflection on ways in which cultural values and structural forces shape client experiences and opportunities. The practitioner’s encounter with the individual who has multiple identities and narratives, challenges the practitioner’s ethnocentrism, prejudices and assumptions, committing the worker to deconstruct her/his attitude towards cultural difference and moving her/him towards more inclusive practice.

Critics of the term cultural humility point to a fundamentally erroneous assumption that being culturally humble automatically translates into respect for diversity (Danso, 2016; Hook, Davis, Owen, Worthington Jr, & Utsey, 2013). Notwithstanding this, cultural humility is consistent with the mandate of professional codes (AASW, 2010; IFSW, 2014). It requires in workers “an examination of one’s

own attitude and values, and the acquisition of the values, knowledge, skills and attributes that allow one to work appropriately in cross-cultural situations” (AASW, 2013, p. 16).

### Cultural humility and the health care setting

In health care and other settings that social workers occupy, cultural humility challenges the worker to recognise that the cultural context of practice is not abstract. It also demands awareness that structural inequalities impact on health care interventions and that culture is not static but always negotiated within relationships of micro, meso and macro power (Grant et al., 2013) and within the many constructions of identity.

Researchers have found that people of culturally diverse backgrounds experience a difference in how health workers and health systems interact with them (Brach & Fraserirector, 2000; Horevitz, Lawson, & Chow, 2013). For example, Australian researchers Khawaja, McCarthy, Braddock, and Dunne (2013) found that language barriers, financial constraints, lack of knowledge of services, social stigmas and lack of appropriate culturally competent health service providers led to poor utilisation of mental health services among people of some culturally diverse backgrounds. Similarly, ICEPA (2009), conducting an audit of culturally diverse populations and cultural responsiveness in Victoria, Australia health settings, determined that, when health services failed to understand the socio-cultural differences between health care organisations, their workers, and their patients, communication and trust between them suffered. This breakdown led to a perceived or actual diminishing in the quality of care experienced by these patients.

Social workers working to empower and advocate for clients from culturally diverse backgrounds need to understand and incorporate into their practice the social and cultural influences on patients’ health beliefs and behaviour, including understanding their

own socio-cultural location and experiences. This involves a commitment to practice located within the cultural humility discourse.

### **Social workers and socio-cultural location**

Researchers have documented the need for social workers to develop cultural humility. A critical aspect of self-awareness includes the social worker's exploration and understanding of her/his own cultural social location and an examination of how one's own beliefs, biases and differences can either enhance or impede effective work with clients who are ethnically/racially different from themselves (AASW, 2010; IFSW, 2014; Morley, Macfarlane, & Ablett, 2014).

For social workers who belong to culturally diverse groups, their everyday practice might be located in a culture that might not be coherent to the culture they carry. Researchers (Wong et al., 2003; Yan, 2005, 2008) have noted the tensions that may confront social workers who belong to cultural backgrounds different from the dominant culture and who are situated in an organisational culture different from their own. These tensions include the worker's culture being at odds with the dominant culture and the client's culture; the burdensome expectations placed on workers who share a similar cultural background; the boundary confusion that may occur between the worker and clients of the same cultural background and navigating the multiple power relations that exist within and between cultures. Yan (2005) has mapped the range of responses to these tensions. He notes that workers can detach their cultural identity from their professional identity, separate their personal lives from their professional lives, switch between their cultural and professional selves when dealing with clients of similar cultural backgrounds, and selectively assume the organisation's culture.

Research from Melbourne regarding social workers of diverse cultural backgrounds is scarce and limited to postpositivist explorations of culturally competent

practice guidelines, benchmarks, and standards. Chalmers, Allon, White, Savage, and Choucair's (2002) research canvasses the barriers that workers face when working with people of culturally diverse backgrounds and list workers as solely responsible for culturally sensitive practice, ad hoc approaches and a lack of embedded, supportive hospital structures. ICEPA's (2003) review into culturally sensitive practice reporting requirements, minimum standards and benchmarks found a lack of a consistent definition or a framework for culturally sensitive practice. The review also found an absence of strategies to make culturally sensitive practice integral to the operation of the agency and a lack of appropriate measurement indicators of progress.

A number of reports (VicHealth, 2005; VicHealth, 2007) found the need for hospitals and hospital workers to understand that there is a strong relationship between exposure to cultural tensions and poor mental health and that people of cultural minority backgrounds experience more incidents of discrimination and intolerance than people of non-English-speaking backgrounds. Additionally, Victorian resource plans and guides (ICEPA, 2003; Metropolitan Health and Aged Care Services Division, 2006) outline how hospitals and workers can facilitate access to culturally responsive health practices.

None of the literature reviewed focussed specifically on frontline hospital social workers and their practice within culturally diverse hospital settings. The contribution of this research is its focus on, and the experiences and perspectives of, frontline social workers who routinely work with the complexities of diverse groups and communities and the organisations that serve them.

### **Methodology and method**

The overall qualitative approach used in this research falls within the constructivist epistemology and postmodernist theoretical perspectives. The research falls within the critical social research tradition because of

its political intention to make life better for a disadvantaged group (Henn, Weinstein, & Foard, 2009). The Chief Investigator (CI) belonged to a non-dominant cultural group. This demanded an ongoing reflexivity (Dwyer & Buckle, 2009) that brought a realisation that sometimes the worker and the researcher shared similar social work practice experiences, opinions, and perspectives, and at other times, they did not. The challenge was to probe information that may have seemed too familiar so that assumptions and familiarity did not impose themselves on the participant experiences.

Using a narrative research design, a semi-structured interview approach was chosen as the data-gathering method. In line with a postmodernist paradigm, this approach privileged the workers' voices and views on the topic and provided the participants with time and opportunity to explore their experiences and perceptions about working with diversity (Liamputtong & Ezzy 2005).

The researchers involved in this project identified as of a first-generation Maltese and Australian cultural background. The CI and Associate Investigator (AI) position themselves within a postmodernist paradigm. They understand that culture and cultural identities are individually constructed and located within personal and social narratives and ideologies (Fisher-Borne et al., 2015; Williams, 2006). The researchers understand that culture and cultural identities cannot be generalised across groups of individuals since cultural meanings and location change in response to different experiences.

Underscoring the researchers' belief that research is a relational process and that research data cannot be removed from the macro and micro social, economic and political contexts within which the data is analysed, the researchers' were aware that the CI's cultural background positioned her as both insider and outsider—listening to the participants' experiences and recalling her own experiences (Barcinski, 2007). Thus, within the cultural humility paradigm, the CI conducted the

semi-structured interviews assuming the "attitude of not knowing" and made available her own her own cultural narrative during the semi-structured interviews.

Making available her own cultural history and biography during the interview, the CI endeavoured to engage with the client in co-creating a "power with" relationship, bringing her closer to the participants and enable her, through shared narratives, to ethically represent the cultural other.

The research proposal, including details of informed consent procedures, risk minimisation strategies and interview protocols were approved by the Victoria University Human Research Ethics Committee (HREC No. 000023196). The participants' right to discontinue the interview without penalty or prejudice was stipulated at the beginning of the semi-structured interview. To alleviate any potential risks and discomfort that might have arisen when recalling and sharing personal or professional experiences of cultural bias or discrimination, participants were given the name and contact details of a counsellor.

This small, qualitative research project aimed to explore how cultural diversity impacts on social work practice in Western Health (WH), a large health care organisation in Melbourne's west. The research explored frontline social workers' (hereafter, "workers") experiences within a culturally diverse workplace and from the workers' own perspectives. The questions guiding this research were:

1. How do frontline workers understand culturally sensitive practice?
2. How do frontline social workers at WH experience the organisation's policies and practices in regard to culturally sensitive practice?

The research entailed two steps. Firstly, prior to the interviews, the CI conducted an information session that invited potential participants to hear about the research, explore current discourses and debates

concerning working with diversity, the range of terminology used to describe paradigms, the models of practice approaches used when working with cultural diversity and an invitation to participate in the project.

The second stage entailed the semi-structured interviews that were held at a participant-nominated location that offered privacy and confidentiality to the participant.

Of the 50 social workers employed at WH, eight females and two males responded to an invitation to participate in an information session about the research. All respondents agreed to participate in the research.

The CI conducted one-hour semi-structured interviews. These interviews canvassed understandings and experiences of culturally sensitive practice, perceptions of WH's responsiveness to cultural diversity at policy and practice level and the contribution (or otherwise) of a personal cultural lens to social work practice. In line with the postmodernist paradigm, participants, although provided with prompt questions, were encouraged to share experiences as they chose (Ritchie, Lewis, McNaughton Nicholls, & Ormston 2014). Strengthening the validity of the research, the interviews, digitally recorded and transcribed in full, were returned to the participants for checking (Dodd & Epstein, 2012). On receiving the transcripts all material was de-identified and assigned a pseudonym.

Transcripts were then analysed thematically using the NVivo™ computer program (QSR International). This involved becoming familiar with the transcripts through careful reading and rereading, coding and recoding units of data, establishing preliminary themes and settling on subthemes (Spencer, Ritchie, Ormston, O'Connell, & Barnard, 2014).

To ensure that the thematic analysis was robust, credible and trustworthy (Ryan & Bernard, 2003), auditing and checking of codes and recoding was carried out by the CI and AI. This shared and ongoing analysis confirmed or disconfirmed the analysis and generated

an emerging understanding of how workers experienced and understood their practice with people from culturally diverse backgrounds.

### **Participant characteristics**

Participants worked in a range of hospital wards and the years of employment with WH ranged from one to nine years. All workers identified themselves as having cultural backgrounds other than European. Four participants had migrated to Australia within the previous 15 years and six identified as first-generation Australian. One participant nominated an ethnicity to describe his socio-cultural background. In the findings below fictional names are used to protect the identity of individual participants.

### **Agency characteristics**

WH is located in Australia, in Melbourne's western suburbs, and is responsible for managing three acute public hospitals. The catchment area contains a high number of refugee and asylum seekers and the highest rates of births in Australia, as well as a much higher proportion of older residents than Australia's national average. Many within WH's catchment community experience entrenched disadvantage, higher-than-average unemployment, lower-than-average labour force participation and a large proportion of the population live below the poverty line. WH cares for a population of 700,000 people, who speak more than 100 different languages and dialects and employs over 6,200 staff plus volunteers (Western Health, 2015).

WH's strategic plan is committed to values that reflect social justice principles and names compassion, accountability, respect and excellence as underpinning its values and seeks to work collaboratively with its community to improve the community's health and wellbeing status. Additionally, it acknowledges that it requires a workforce that is competent and trained to work with its diverse community and aims to recruit and retain staff that reflect the diversity of its community (Western Health, 2015).

## Findings

### How do frontline practitioners understand culturally sensitive practice?

The data addressing this question are reported under one theme: *Culture and Knowledge* and three subthemes: *socio-cultural location, understanding culturally sensitive practice* and *being mindful*.

Social workers were aware that working with people from diverse cultural backgrounds required them to reflect on their own cultural location and to recognise the values, beliefs biases and differences in their interactions with patients of a different cultural background to their own. Various described, workers consistently illustrated efforts to demonstrate and integrate AASW values of respect and inclusivity and evidence practice within the cultural humility paradigm.

### Culture and knowledge

#### *Socio-cultural location*

Suggesting that culture is a stable form of traits, behaviours and expectations common to members of a group, all but one participant, Abiola, conflated the concept of nationality and ethnicity. Abiola explored the nature of culture by drawing attention to the influence of the multiple identities that shape personal narratives:

We have education in culture, we have politics in culture and we have services in culture. Africa then narrows down to Nigeria, and even when you come to Nigeria—it is a very multi-ethnic country. I am from one of the big three tribes, the Ibo tribe.

The workers in this research reflected on the different “knowledges” that they needed when working in culturally diverse settings. The first knowledge that workers considered necessary was self-knowledge, that is, knowledge of their own cultural

values and beliefs. Workers acknowledged that, as people from diverse backgrounds themselves, they had cultural insights that either did or did not resonate with their patients’ cultural worldviews.

Workers described experiences of being drawn into conversations about their cultural backgrounds. Some workers perceived their client’s cultural curiosity, although well meaning, as based on assumptions. For example, Esayas described an encounter where it was assumed that skin colour signals being born outside Australia, which although true for him, may not be for others of “brown skin”:

People are genuinely asking about my brown skin and green eyes, where I come from.

Other workers felt uncomfortable when having similar conversations. Their wish was to be “the same” as those from the dominant culture, thus they avoided “cultural” conversations. As Jaswinder, stated:

I found growing up (in Australia) I was made to feel different and I didn’t want to feel different, so now I don’t talk about culture.

#### *Understanding of culturally sensitive practice*

All workers understood that their practice approaches needed to be responsive to the patients’ circumstances, health literacies, and cultural backgrounds.

Asked to describe what they understood as cultural competence, all frontline workers were firm in their view that this required the worker “to know and to adapt” to all cultures. Their view was that claiming cultural competency was problematic and “overwhelming” (Navea). Workers were firm in the view that they could not realistically position themselves as cultural experts, since one could “never know every culture” (Emily). As Kiana noted:

Competence suggests if you're competent at something then you know it. I certainly don't know every culture and I don't know anyone but my own well.

Workers unfamiliar with the term, cultural humility, a term not "heard of until the [information] meeting" (Jaswinder) conducted by the CI, spoke of cultural humility as a "so much more appropriate" (Zhenli) practice approach. Some highlighted the new insight that occurred when introduced to the cultural humility paradigm as "the missing link in my understanding" (Kiana).

Workers named this shift as reframing how they position themselves within the worker–client relationship and noted that the term more accurately captured the respect and humility that they, as workers, wanted to communicate in their practice. Two reflections capture these views:

The term humility felt so much more respectful. (Kiana)  
I can't understand all these cultures—I just need to be humble. (Navea)

### *Being mindful*

Workers spoke of the new insights gained when working with cultures different to their own. These experiences provided opportunities for workers to reframe their "thoughts, beliefs and practice" (Navea) about culture and working with cultural diversity.

Workers named that reflective engagement on their own and their client's culture was pivotal to how they conducted practice. They considered reflective engagement as a conduit to recognising any personal bias that would influence their practice interventions.

Notwithstanding this worker reflexivity, some statements indicated a tendency for workers to homogenise cultural needs without checking that the client and worker have similar understandings and intervention goals. For example, Jaswinder

imposed on her client the value she places on family connection without checking whether her client shares such values:

Immediate family is definitely important. I think the idea of you never being alone is important in a hospital setting.

Similarly, Agnieska assumed, based on her mother's situation, that her client would need an interpreter:

If my mother was still alive and needing that type of support, I know she would prefer someone to speak Polish, so I find an interpreter.

Abiola, too, adopted a "one size fits all" approach while advocating for his client. Abiola homogenised his view of Russian culture:

Keeping in mind the culture that is confronting you in that point in time I there has been space to say "no actually, this is the way e.g., Russians think about this".

Workers described the personal dissonance they felt when their cultural values differed from some clients' values and beliefs. This dissonance was particularly stark when workers described their personal cultural notions of caring and having to accept caring arrangements different to their cultural/familial arrangements. As Maria stated:

Family caring is quite embedded in me, in family values and family culture so what I struggle with is when patients don't have that in such an intensive environment or critical time. (Maria)

The workers also had practice-based views on how to draw on their clients' cultural strengths and advocate for these strengths to be incorporated in case management. Workers maintained that acknowledging and incorporating cultural worldviews, beliefs and practices positioned them "beside" rather than "apart from" their culturally diverse population.

### How do frontline social workers at WH experience the organisation's policies and practices in regard to culturally sensitive practice?

The data addressing this question are reported under one theme: *Culture and practice* and two subthemes: *being mindful and culture, workers and organisation*.

#### Culture and practice

##### *Culture as "working beside"*

Expanding on what workers believed to be culturally sensitive, workers spoke of working *beside* patients. Reflective of the postmodern understanding described earlier, workers referenced the challenges that might arise when confronted with cultural narratives different to their own.

For example, all workers stressed that being mindful of the intergenerational expectations, combined with the family cultural expectations, necessitated that they manage the cultural disruption and distress that illness and its aftermath caused within the familial system:

In their generation you care for your parents until the end. You can see that it's challenging for them as a family group and the guilt involved for families. (Abiola)

This positioned workers as empathic partners, "You have to manage that distress with them, not for them" (Abiola). Other situations positioned workers as advocates, "she was screaming at the medical staff telling her to be quiet. I had to say 'hang on a minute; let her express grief her way'" (Emily).

All workers highlighted the importance of interventions that were respectful of religious beliefs. However, workers acknowledged the challenges associated with balancing personal/cultural beliefs and interventions "in a respectful way" (Maria), supporting the right to reject Western medical interventions, and working within WH's Western medical structures:

She had strong cultural beliefs around karma; I remember I had to advocate for her—she didn't want to be pressured into any western approach. (Kiana)

Preparedness to explore and confront issues of cultural clashes, might indicate that workers were positively inclined to confront the more challenging "working beside" interventions that involved, for example, end-of-life decisions.

##### *Culture, workers, and organisation*

Workers acknowledged that WH had policies (Western Health, 2015) to engage with different cultural groups but saw service gaps that directly impacted on the ability to do so as indicating that WH had "some way to go" (Esayas) if policy was to translate into practice. One worker was aware of WH's employment of a cultural advisor: "We have a lady who's part of the cultural engagement. She is involved in getting people of different cultural backgrounds on hospital committees" (Una).

Three workers indicated that more work was needed to action culturally sensitive policies. In Jaswinder's words: "I don't know how [policies] translate and trickle down to actually what happens on a ground level—our knowledge and our practice needs to grow." Some workers recognised that culturally sensitive practice is reliant on the employee preparedness to participate in professional development and on the availability of capital resources to expend on professional development. Maria's comment illustrates this reliance and also illustrates the tendency for worker to assume a one-size-fits-all approach when working with the culturally other:

Training is dependent on people. Even if you had all these cultural policies in place, there's no one really making sure that workers do the training; there's not enough money to be putting into training people in a certain way or to ensure everyone trained the same way.

All workers referred to effective and accurate communication with non-English-speaking patients as central to inclusive and rights based practice. They were of the view that WH was “not progressing with the different cultural groups that are coming through” (Una) and that attempting to engage interpreters or negotiate access to telephone interpreters, was problematic.

As indicated by Maria, “the bane of my life is trying to find a phone to get an interpreter.” Esayas added that access to translated social work information was an area in which WH needed to evidence culturally sensitive practice, commenting: “We don’t have a social work pamphlet in different languages so usually people don’t even know our services.”

A number of workers spoke about the challenges of interprofessional practice and the impact of positional and professional power on culturally sensitive practice. For example, Jaswinder was of the view that doctors, with positional and professional power, had the final say in whether or not cultural/ethnic factors were considered in medical interventions: “Some doctors are quite powerful in terms of they’re making all the decisions”.

## Discussion

The workers’ adjustment of practice interventions was indicative of their understanding and acknowledgment that personal values and beliefs have their genesis in formative socio-cultural histories (Harrison & Turner, 2011; Hosken, 2013). Workers articulated values that resonate with both the AASW’s commitment to social justice and human rights and its mandate to demonstrate culturally sensitive interventions (AASW, 2010). Affirming both the importance and social justice imperative of providing culturally appropriate resources so that health care services are accessible (Jovanovic, 2011; Knowles & Peng, 2005), workers were also aware that they held socio-cultural and socio-political positions that impacted on practice interventions. Cognisant of balancing cultural competency with cultural

humility, the descriptions of how practice was adjusted to respond to, and incorporate, their patients’ cultural beliefs practices and values, suggest the transformative and transferable learning described in the literature as going beyond abstract, static concepts and towards patient-worker negotiated interventions (Grant et al., 2013) and their wish to practise cultural humility.

Notwithstanding evidence that most workers conflated their understanding of culture, workers narrated their evolving cultural knowledge, their changing attitudes and their emerging practice when working within a diverse cultural setting. Their sensitivity to how their own sociocultural location, cultural values and beliefs either did or did not resonate with client world views and the impact of this on their practice reflects the fluid, dynamic process of *becoming* culturally competent (Dudas, 2012) and is consistent with the cultural humility paradigm (Hosken, 2013).

Cognisant of the importance of cultural concordance (National Health Workforce Taskforce, 2009), WH’s employment strategy aims to develop and promote a culturally diverse workforce. WH commits to “continue to deliver and enhance culturally appropriate health care” (Western Health, 2015, p. 17) through the provision of professional development opportunities, focussing these opportunities on integration and learning, i.e., competency, rather than on humility. Nevertheless, this responsibility, as noted by Harrison and Turner (2011) and Anderson, Scrimshaw, Fullilove, Fielding, and Normand (2003), and echoed in the workers’ responses, also needs a reciprocal worker commitment to attend the professional development opportunities.

WH’s difficulty in providing resources for use with its dynamic and emerging patient demographic is indicative of the challenges that confront health services attempting to build a capacity to work with a culturally diverse demographic (National Health Workforce Taskforce, 2009).

The findings of this research reveal that hospital social workers, while aware of the need for culturally sensitive practice may need to be more responsive to the discursive elements of the unfixed and constantly evolving nature of culture (Williams, 2006) and avoid practices that uncritically conflate culture. While the training emphasis remains on a technical, postpositivist approach to culture, WH will have difficulty designing appropriate policies that respond to the culturally other.

Similarly, on a day-to-day level, hospital policy and practices must appraise how the allocation of resources signposts cultural inclusivity thus avoiding the monocultural tendency to provide services that “[look] the same for everybody” (Abiola). These must ensure that workers are continually building on and exploring their own and their clients’ multiple cultural identities, while also balancing the need for cultural sources of information with practices seeking unique narratives and establishing the client as the expert.

### Conclusion

The author acknowledges that the generalisability and transferability of these findings are somewhat limited in terms of the geographic location, the smallness of the cohort engaged in the study and the contextual restriction to one field of practice, i.e., the hospital setting. Hence, there will be certain limitations in relation to making generalisations or transferring learning to other fields. However, despite these limitations, the research provides preliminary understandings of how hospital social workers understand the relationship between culture and culturally sensitive practice. The findings might have relevance to those interested in exploring the intersectionality of the nature of culture and methods of practice. They also have relevance to those workers and systems who wish to make decisions responsive to cultural diversity.

Expanding the research in scope and reach to include the perspectives of patients and their families and to investigate further how WH and its frontline workers can enhance culturally sensitive practice would add to the body of empirical research that pursues the fundamental principles of justice and inclusivity.

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### ACKNOWLEDGEMENTS:

The author acknowledges the funding received from Melbourne’s Victoria University Researcher Development Grant Scheme initiative that partly funded the data-collection stage of this project and Lutfiye Ali’s and Ande Szendroe’s assistance with the project’s recruitment and data-collection stages.

### COMPETING INTERESTS:

The author declares no competing interests in the publication of this article.

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