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Original Research

Cultural desire need not improve with cultural knowledge: A cross-sectional study of student nurses

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ABSTRACT

Cultural desire is considered to be a prerequisite for developing cultural competence. This study explored cultural desire among student nurses towards Aboriginal peoples and its association with participation in a one-semester unit on Aboriginal health through a cross-sectional survey. Our main outcome, cultural desire, was measured using two items level of agreement with Aboriginal health being an integral component of the nursing curriculum and an expressed interest in Aboriginal health. 220 (74.58%) student nurses completed the survey. Completing the Aboriginal Health and wellbeing unit did not influence students' opinions on inclusion of the unit as part of the nursing curriculum (odds ratio OR 0.73, 95% CI 0.43–1.29) or their overall cultural desire (mean difference = −0.69, 95% CI −1.29 to −0.08, p = 0.026). Students who completed the unit reported a higher understanding of Aboriginal health (OR = 2.35, 95% CI = 1.35–4.08) but lower interest levels in the subject (OR = 0.45, 95% CI: 0.24–0.84). Further research is necessary to explore how and when cultural desire might develop in nurses who are trained in cultural competence particularly in the contexts of post-colonial disparities and political conflict.

1. Introduction

Including cultural content in nursing curricula has become common in countries that have become multicultural or have a colonial history. The rationale for including culture in the curricula could be conflict resolution (Richardson and Carryer, 2005), reducing racism (Durey, 2010) or addressing oppression (Arieli et al., 2012). Needless to say, it is a highly debated topic (Nairn et al, 2004). When discussing the cultural aspects of health care, several terms have been used such as cultural awareness, cultural sensitivity, cultural safety and cultural competence. While Cultural competence is a term developed in the USA and is used in the context of providing care to multicultural clientele in the United States and Canada (Betancourt, 2002; Doane and Varcoe, 2005), cultural safety originated in New Zealand as a response to the poor health outcomes of the Maori when compared to their non-Indigenous counterparts (Papps and Ramsden, 1996). Australia has largely adopted cultural safety as a means to address the unique needs of Aboriginal people. However, there are some who disagree with this adaptation stating that the concept is poorly understood within mainstream health services and that a comprehensive multicultural approach is more useful (Johnstone and Kanitsaki, 2007).

The term cultural desire was coined by Josepha Campinha-Bacote (Campinha-Bacote, 1999) as part of her model of cultural competence (Campinha-Bacote, 2002). Whilst the constructs of this model include cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire, it is the desire to practice in a culturally competent manner that motivates a health care professional to seek the knowledge, skills and encounters of cultural competency. Cultural desire therefore underpins the entire process of cultural competence. However aware one is of the differences in one's culture from that of one's patient or whatever knowledge or skills related to cultural competence one might acquire, it might all be in vain if there is no desire to be culturally

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competent. Hence, we aimed to explore student nurses' cultural desire towards caring for Australia's Aboriginal peoples and its association with completing a one semester Aboriginal Health Unit.

2. Background

Indigenous peoples around the world endure poorer health and social circumstances than non-Indigenous people and the continuing disparity is largely thought to be due to neglect, denial and a lack of political commitment (Gracey and King, 2009). Aboriginal people in Australia are no different. In fact, Australian Aboriginal people who constitute 3% of the total Australian population (MacRae et al., 2013) suffer some of the worst health outcomes when compared to Indigenous peoples of other colonised countries such as Canada, New Zealand and the USA. For instance, when compared to indigenous peoples of these countries, mortality rates for Australian Aboriginal people are the highest and life expectancy is the lowest (Freemantle et al., 2007). During their most productive years of life (25–64 years), Australian Aboriginal people die at rates that are 2.2–11.6 times the mortality rate of their non-Aboriginal counterparts (MacRae et al., 2013). What is more alarming is that most of these deaths are preventable. Mortality rates for preventable causes of death for Aboriginal people are between 3 and 4 times that for non-Aboriginal Australians (MacRae et al., 2013).

Factors that contribute to the vast disparities in health outcomes between Australian Aboriginal and non-Aboriginal people are several and complex. These factors largely relate to the consequences of trauma and grief due to loss of land, family and culture, as well as the continuing exclusion from "full participation in the social, political and economic life" of modern Australia (Saggers and Gray, 2007). In addition, Aboriginal people do not access health services in proportion to their need and mostly access medical care only when they are in a crisis (Briscoe, 2000). Consequently, they are over represented in acute care wards and underrepresented in ambulatory health services. Poor utilisation of health services by Aboriginal people is mostly related to issues of appropriateness and acceptability (Scrimgeour and Scrimgeour, 2007). These include cultural, language and gender barriers, fear of hospitalisation and a lack of trust in mainstream services due to institutional racism (Isaacs et al., 2010). Many of these factors are directly or indirectly linked to the routine practices of health care providers such as nurses which are often influenced by popular fallacies and stereotypes of Aboriginal people that are predominantly negative (Goold and Usher, 2006). These prevalent stereotypes also contribute to both interpersonal and institutional racism that is endemic in Australia (Henry et al., 2004; Larson et al., 2007; Paradies, 2007).

One solution towards overcoming health disparities and challenging common stereotypes associated with Aboriginal people arose from a national review of nursing education undertaken two decades ago in Australia. This review recommended that Aboriginal people be included in nursing education as a group that needed special attention (Bennett, 1995). More recently, a high level Indigenous Nurse Education Working Group advocated for a national approach to the development of an Aboriginal health curriculum targeted at improving the capacity of all nurses to provide culturally safe care to Aboriginal people (Indigenous Nurse Education Working Group, 2002). Currently, the Registered Nurse Accreditation Standards of the Australian Nursing and Midwifery Council requires the, "Inclusion of a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples' history, health, wellness and culture." (Australian Nursing and Midwifery Accreditation Council, 2012). The inclusion of this subject at the university level is considered necessary since it is either excluded from or only superficially covered in school curricula. Hence students' knowledge and opinions on the subject are mostly influenced by the media and hearsay (Goold and Usher, 2006).

The impact of culture on nursing care was first explored by Madeleine Leininger in the USA and was referred to as Transcultural Nursing (Leininger, 1978). This concept required of nurses to try and understand the different needs of patients from a different culture. Since then, the concept has been analysed from different perspectives. For instance, Cultural awareness, cultural sensitivity and cultural safety are terms that relate to the levels of cultural competence where cultural awareness refers to being aware that there are people who have different world views than oneself and therefore have different needs and expectations. Cultural sensitivity refers to people's actions and institutional protocols that are tailored to the needs of those who identify with different cultures. Cultural safety is achieved when patients are satisfied that health care personnel and institutions have included their cultural needs in their treatment (Taylor and Guerin, 2010). Therefore while cultural awareness and cultural sensitivity are attributes of health care providers and health services, the client decides whether or not these are culturally safe.

In Australia, Aboriginal content has been recently included in nursing curricula as an approach to reduce the stark inequalities in health and circumstances between Australia's Aboriginal and non-Aboriginal people. Targeted, structured teaching units on Aboriginal health and wellbeing have shown to improve students' knowledge, skills and attitudes related to Aboriginal health in Australia (Paul et al., 2006; Pedersen and Barlow, 2008; Ranzijn et al., 2008). In the United States, similar units have had varied results. One study showed that the teaching of cultural competence was welcomed by students of all year levels (Brennan and Cotter, 2008) while another study showed that students found it difficult to understand the concept of cultural competence, had concerns about integrating cultural competence into clinical practice and research and highlighted missed opportunities in teaching (Sumpter and Carthon, 2011).

Inclusion of Aboriginal content in the curriculum can cause unease among students (Thackrah and Thompson, 2013). Those who have had no previous exposure or knowledge about Aboriginal history are shocked to hear of the stories of the post-colonial period such as that of the Stolen Generation (Human Rights and Equal Opportunities Commission, 1997). Such students are also distressed when they hear racist comments from others which have emerged from personal or familial experiences that were predominantly negative. On the other hand, most white Australian students who harbour strong negative attitudes towards Aboriginal people can become resentful when they hear that most of their health and social problems stem from the continuing disenfranchisement following colonisation. Despite continually reminding students that they were not responsible for what happened to Aboriginal people post-colonisation, students cannot help but feel a sense of guilt which affects each of them differently depending on their prior knowledge and experience. When discussing cultures of peoples that have no emotional or political significance to students, responses may be mostly of surprise, amusement or wonder but an interest in the subject is almost always present. However, the discussion is bound to become difficult when it relates to the culture of a group of people whose mention itself makes students feel uncomfortable. Nonetheless, it is argued that if properly considered and delivered, cultural knowledge and skills of students can be improved by adding structured cultural content into nursing curricula (Sargent et al., 2005).

However, racist and discriminatory propensities are not necessarily eliminated despite cross-cultural education (Allen, 2010; Allen et al., 2013). Whilst learning about the need to provide care