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One size fits all? The discursive framing of cultural difference in health professional accounts of providing cancer care to Aboriginal people

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One size fits all? The discursive framing of cultural difference in health professional accounts of providing cancer care to Aboriginal people

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Objectives. Cancer is the second biggest killer of Aboriginal Australians. For some cancers, the mortality rate is more than three times higher in Aboriginal people than for non-Aboriginal people. The Aboriginal Patterns of Cancer Care Study explored barriers to and facilitators of cancer diagnosis and treatment among Aboriginal and Torres Strait Islander people in New South Wales.

Design. Our team – which includes both Aboriginal and non-Aboriginal researchers – conducted in-depth interviews between 2009 and 2010 with Aboriginal people with cancer, their carers and health professionals who care for them. In this paper, we identify recurrent patterns of ‘discursive framing’ in the 16 interviews with health care professionals. We are particularly interested in how these frames assisted participants in constructing a professional position on what ‘cultural difference’ means for the design and delivery of cancer care services to Aboriginal people.

Results. Despite geographical, organisational, disciplinary and cultural diversity, these interview participants consistently drew upon six discursive frames, which we have interpreted as either eliding a discussion of difference (‘everyone is the same’) and ‘everyone is different’) or facilitating that discussion (‘different priorities,’ ‘different practices’ and ‘making difference safe’). An additional strategy appeared to actively resist either of these positions but then tended to ultimately prioritise the eliding frames.

Conclusions. While none of our participants were dismissive of the idea that cultural identity might matter to Aboriginal people, their reliance upon familiar narratives about what that means for cancer care services has the potential to both symbolically and practically exclude the voices of a group of people who may already feel disenfranchised from the mainstream health care system. Critically unpacking the ‘taken for granted’ assumptions behind how health care professionals make sense of cultural difference can enrich our understanding of and response to the care needs of indigenous people affected by cancer.

Keywords: Australia; indigenous; cancer care; cultural difference; discursive framing; delivery of health services

Introduction

Cancer is the second biggest killer of Aboriginal and Torres Strait Islander Australians (hereafter respectfully referred to as 'Aboriginal Australians') (Australian
Institute of Health and Welfare 2011b). Aboriginal Australians between 45 and 64 are significantly more likely to die from cancer than non-Aboriginal Australians (Australian Institute of Health and Welfare 2011a). Clinical and epidemiological attention to these issues began to be made visible in the 1990s and early 2000s (e.g., Condon et al. 2003; Veroni, Gracey, and Rouse 1994), gaining increasing prominence in the last few years (e.g., Garvey et al. 2011; Newman et al. 2008; Supramaniam, Grindley, and Pulver 2006). Research from New Zealand has also shown that survival from cancer is lower among the Māori people of that country (Hill et al. 2010). Similar patterns of reduced health outcomes among the indigenous populations of other countries with histories of colonisation have led to a global 'call for action' (e.g., Stephens et al. 2006). A central question that has focused the local research and policy response to cancer inequities is why Aboriginal Australians seem to be less likely than other Australians to receive a timely cancer diagnosis, and to access effective cancer treatment and care. One hypothesis is that Aboriginal Australians may be reluctant to engage with the tertiary or specialist health service settings in which cancer care is delivered because they feel excluded from that system (Kowal and Paradies 2010), particularly in contrast to the tailored primary care available from Aboriginal community controlled health services (ACCHSs; Armstrong 2006). But less is known about how the health workforce who care for Aboriginal Australians make sense of these issues. This paper aims to address this gap by taking a discourse approach to understanding how health professionals think and talk about the cancer care needs and experiences of Aboriginal Australians.

Cancer beliefs, health professionals and discourse

The first account of cancer from an Aboriginal perspective was published in 1993, which proposed that health care professionals often had a limited understanding of the needs of Aboriginal Australians with cancer, and of the barriers that could prevent them seeking care (Kirk 1993). For example, McMichael et al. (2000) have argued that Queensland Aboriginal women’s perceptions of breast cancer diagnosis and treatment are shaped by a more holistic concept of health than western systems of biomedicine are able to accommodate, emphasising spirituality and connections with land and prioritising social relationships over individual care needs. Prior (2009) has also described cultural differences in Aboriginal beliefs about cancer care, viewing the ‘white man’s hospital system’ as fearful and cancer treatment – surgery in particular – as futile or contravening of cultural values. In the last few years, a major contribution was made by Shahid and colleagues (2009) in describing the beliefs of Aboriginal Australians with experience of cancer in Western Australia, including an analysis of communication barriers in hospital settings such as a lack of trust felt by Aboriginal Australians due to traumatic personal and collective experiences relating to mainstream health care, and a lack of understanding among health care professionals about Aboriginal family structures, cultural practices and life circumstances (Shahid, Finn, and Thompson 2009).

Prior (2009) has argued that a more culture-focused approach to cancer care would decentre the authority of mainstream services and improve relationships between Aboriginal patients and their care providers. McGrath et al. (2006) have argued for a greater range of cross-cultural education initiatives to be funded in which health professionals would have the opportunity to improve their understanding
of Aboriginal Australians’ views of cancer while Aboriginal people learnt about biomedical explanations of cancer prevention and treatment. The Chief Executive Officer of the Cancer Council Australia described that this as ‘both ways’ communication, entitling an article published in Cancer Forum as: ‘Some of us know some things and some of us know others’ (Olver et al. 2005). These positions all acknowledge that research and service interventions in Aboriginal health must be collaborative and culturally appropriate, focusing on the strengths, expertise and self-governance of Aboriginal Australians as custodians of their own health and well-being (Smith 1999). But they also reproduce a particular set of assumptions about what cultural difference means in this context, including that Aboriginal concepts of health are always distinctly different, in both philosophical and practical ways, to the biomedical, post-colonial, advanced liberal ‘institution’ of the mainstream Australian health care system (Newman et al. 2007).

Another way to think about this is to conceptualise Aboriginal Australians with cancer and the health workforce who care for them as distinctive ‘discourse communities.’ Little, Jordens, and Sayers (2003, 73) describe these as ‘groups of people who share common ideologies, and common ways of speaking about things.’ From this perspective, cultural difference can be seen to be made up of a set of meanings and practices that reflect the ‘ideologies’ and ‘ways of speaking about things’ that characterise any particular social world. Even those people who participate in more than one discourse community – such as health care professionals who themselves identify as Aboriginal – will necessarily contribute to and be shaped by these particular forms of discursive engagement. However, what we know of cultural difference from the qualitative literature on Aboriginal cancer beliefs has tended to be, quite appropriately, drawn from an analysis of the beliefs of Aboriginal Australians themselves. Less attention has been paid to the health workforce who care for Aboriginal people with cancer, and their particular ‘ways of speaking’ about cultural difference and what it means for cancer care.

Social theory on ‘discourse’ – informed by the work of philosopher Michel Foucault – has been influential in qualitative research on health, illness and medicine. An example related to this topic comes from the Canadian nursing scholar Annette Browne, who has produced a broad and valuable set of research insights into the discursive treatment of First Nations health issues (e.g., Browne 2005; Browne and Varcoe 2006). Browne has argued that ‘Dominant cultural discourses – generated in the wider social world – can also shape the perspectives of healthcare providers, and the knowledge and assumptions they hold about the patients they encounter in the clinical setting.’ (2005, 68) Discourse, to this way of thinking, operates as a ‘constellation of related statements that reflect and reproduce particular points of view’ (Allan, Gordon, and Iverson 2006, 46). This suggests that observing the ways that health care professionals conceptualise particular issues can also be revealing of the role of broader cultural discourses in shaping ‘belief systems’ (Lupton 1992, 145). This can also assist us in making sense of the Aboriginal experience of mainstream health care services as ‘invariably embedded in the history of colonization and in current political discourses, including racializing discourses that shape policy and everyday interactions’ (Tang and Browne 2008, 114). Therefore, an analysis of the discursive ‘framing’ of a particular concept such as cultural difference creates an opportunity to reflect also on the way that particular points of view can become the dominant ‘ways of speaking’ in health service settings.
The first aim of this paper is, therefore, to describe the dominant discursive frames we observed in these interviews, which we hope will generate new insights into the ways in which cultural difference is conceptualised in relation to Aboriginal cancer care. A second aim, however, is to discuss the alternatives to uncritically reproducing ‘taken-for-granted’ positions on cultural difference.

Methods

The Aboriginal Patterns of Cancer Care (APOCC) study was a five-year multi-method project including both Aboriginal-identified and non-Aboriginal-identified researchers with a broad range of disciplinary, scholarly and community interests. Ethics approvals were provided by the Human Research Ethics Committees of the Aboriginal Health and Medical Research Council of NSW (AHMRC), The University of New South Wales and the Cancer Council New South Wales. The qualitative arm comprised in-depth interviews with Aboriginal Australians who had been diagnosed with cancer ($n = 22$) and their carers ($n = 16$). This paper focuses on our interviews with health care professionals ($n = 16$).

Participant recruitment and profile

Health professional participants were recruited through ACCHSs and the oncology departments of tertiary hospitals in urban, regional and rural areas of New South Wales. Recruitment included direct approaches (phone calls), snowballing and word of mouth referrals. Eligible participants had contributed to the provision of cancer care services, including oncologists, Aboriginal Hospital Liaison Officers, social workers, palliative care workers and nurses, and could report either regular/ongoing experience of providing care to Aboriginal patients or less/irregular contact. All participants were required to speak conversational English. The researcher attempted a minimum of three telephone calls to each potential participant, leaving voicemails where possible. All of the successful telephone contacts resulted in an agreement to take part, but two of those potential participants cancelled prior to their interview due to time-poverty. Participants were offered $30 reimbursement in recognition of their contribution of time and expertise. For those working in services which did not permit the acceptance of cash gifts, supermarket vouchers to the same value were provided. Participants were told the interview questions were open ended and focused on cancer causation and treatment, experiences of providing care to Aboriginal Australians affected by cancer and suggestions to improve cancer care services.

Sixteen in-depth interviews were conducted between 2009 and 2010, mostly in-person ($n = 14$) but also by phone ($n = 2$) for participants who preferred that option. Participants included more women ($n = 11$) than men, and half ($n = 8$) identified as Aboriginal (none as Torres Strait Islander). Most were working in urban settings ($n = 10$), with the remainder in rural or regional parts of New South Wales. Participants were employed in 12 different health care services, across a range of organisational settings including hospitals, area health services and Aboriginal Medical Services. They reported a diverse set of professional backgrounds including cancer medicine, nursing and education. These participants were also diverse in the amount of experience that had had in providing cancer and other care services to
Aboriginal clients: some had extensive (even daily) contact with Aboriginal men and women, while for others this was only occasional.

**Interview conduct and analysis**

Interviews were conducted by three interviewers, of which two identified as Aboriginal. [Note: All of the Aboriginal-identified health care professionals were offered the opportunity to be interviewed by Aboriginal-identified researchers, but none said they preferred that option.] The interviewers were all trained in qualitative in-depth interviewing as well as principles in establishing cultural safety. The interviewers were mentored by an Aboriginal Elder who also provided cultural advice and support to the rest of the team, and the one non-Aboriginal interviewer received additional training in Aboriginal cultural competency. Monthly team meetings provided opportunities to review progress and debrief about the sometimes quite emotional experience of conducting the interviews.

Most of the interviews lasted between one and three hours. They were recorded on digital audio recording devices and professionally transcribed. Transcripts were checked against the original recordings by the project cultural mentor/advisor who clarified Aboriginal language and terms, and provided notes on emerging themes. A second round of checking was conducted by another researcher to ensure accuracy and to de-identify the data. Pseudonyms were created for each participant, and discussed among the interviewing team to ensure that the names were culturally and demographically appropriate. An analysis workshop was then conducted, before which the authors each read the transcripts and identified potential themes. This process was informed by grounded theory, with key points in the data informing the development of codes, then discussed and refined into a coding framework (Strauss and Corbin 1998), and used to guide the coding process in NVivo 9 software.

For the current paper, a focused analysis of the health care professional transcripts was then conducted by the lead author and the notion of ‘discursive framing’ developed. Framing has been defined in the literature as an ‘acceptance of preferred ways of organising meaning’ (Rosenthal 2008, 65) and common to the research on discursive framing is an interest in how specific frames can ‘promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation’ (Entman 1993, 52). In pursuing this, the lead author drafted an analysis of the dominant frames in the health care professional interviews in relation to cultural difference, along with a discussion of their purpose and implications, following the principles of thematic analysis (Braun and Clarke 2006). This was revised and refined through team discussions and reviewed by the ethics committee of the Aboriginal Health and Medical Research Council of New South Wales prior to submission to this journal for peer review.

**Results**

The concept of ‘cultural difference’ featured throughout our interviews with health care professionals. While this may not be unexpected in a research project aimed at understanding the particular needs and experiences of Aboriginal Australians with cancer, cultural difference was not described in a straightforward or unproblematic way in these interviews. Rather, participants actively made use of a set of dominant
discursive frames in constructing a professional position on what cultural difference means for the design and delivery of Aboriginal cancer care.

**Everyone is the same**

The first frame promoted the idea that everyone has the same needs and experiences in relation to cancer care services. This was most often based upon a belief that there was no meaningful difference evident between the Aboriginal and non-Aboriginal experience of cancer itself. For some participants, this was stated as a self-evident ‘fact’ based on the physiological potential for cancer to affect, quite literally, any ‘body,’ no matter their cultural background. For example, as an Aboriginal health worker based in a regional Aboriginal Medical Service put it: ‘It doesn’t discriminate. Cancer doesn’t discriminate’ (William).

Other aspects of the cancer experience were also described as being ‘shared’ in an undifferentiated way among all of the people who access cancer care services. As a Non-Aboriginal Radiation Oncologist based in an urban hospital setting suggested in recounting a story about an Aboriginal patient: ‘I don’t think his experience was any different... It’s equally devastating to people of other cultures if you’ve been diagnosed with a terminal illness’ (Sabita). An Aboriginal Health Worker based in a regional area health service stated similarly that:

> Every person has a culture, it may not be Indigenous culture it might be another form of culture and... I think that they are different in different ways, but they are also the same [in] terms of your fears and things. (Alana)

Cancer is characterised here by a series of ‘truths’ which are believed to override or exceed the potential for any meaningful differences to exist between individuals or groups of people. Whether it is explained as a biological ‘truth’ regarding the potential for any person to develop cancer, or a cultural ‘truth’ about the global or cross-cultural meanings of cancer diagnosis, cancer is represented as having an ‘equally devastating’ impact on everyone. This flattens out the complexities of cultural difference in favour of a narrative of ‘equal treatment,’ subsuming any potential particularities in the experiences of different cultural groups. The following quote from a Non-Aboriginal Cancer Care Coordinator working in an urban area health service typifies this frame: ‘All our patients pretty much get treated the same... So it would be no different what goes on and how we refer and how we manage them’ (Teagan).

**Everyone is different**

The second frame constructed an alternative position which focused on a perceived multiplicity of differences. This was most apparent when participants endeavoured to articulate differences they had observed among the various Aboriginal Australians they had known to access cancer care services. For example, for an Aboriginal Liaison Officer working in an urban hospital, there were a range of differences evident between Aboriginal Australians who lived in the country and the city: ‘bringing people from the country is another different type of health’ (Bonnie).
The following examples describe perceived cultural differences among Aboriginal Australians according to their educational background and communication style:

I think everybody has a different experience...but to say Aboriginal and non-Aboriginal, no...Sometimes it’s education...You know, some people need to be spoon fed and some people need...it to be repeated, so everybody is different. (Teagan: Non-Aboriginal Cancer Care Coordinator in an urban area health service)

Aboriginal people will only tell you what they want to tell you. But some Aboriginal people will speak up and say. So we all have different things...Some of them will talk about it and just try to deal with, tackle the problem head on. Others just like to keep it with themselves or with the family. (Eric: Aboriginal Liaison Officer working in a regional hospital)

As this shows, a discursive frame that asserts that ‘everyone is different’ does not preclude engaging with the significance of cultural difference for individual people. Yet, it still resists attributing a shared set of differences to a particular population; in this case, Aboriginal Australians.

**Different priorities**

The third frame described cultural difference among Aboriginal Australians as pertaining to having different priorities in their lives which complicated their capacity and willingness to engage with cancer care services. This frame was particularly focused on recognising the socio-economic and structural circumstances of everyday life for many Aboriginal Australians. An obvious example can be found in participants’ descriptions of financial stress among Aboriginal Australians with cancer, as in this quote from an Aboriginal Health Worker working in regional area health service: ‘I think that our experiences are a little different because...we are in lower economical situations’ (Alana).

This frame also encompassed more than the relatively easy to ‘recognise’ issues of structural exclusion from cancer care services, such as a lack of finances, housing, employment, transport and so on, suggesting that Aboriginal Australians may have entirely different priorities to engaging with the mainstream health care system. One example is the disproportionate burden of disease experienced by Aboriginal Australians, which means cancer care can have a lower priority than other health issues. But the needs of Aboriginal Australians with cancer were also represented here as being shaped by the politics of social disadvantage and marginalisation. As an Aboriginal General Practitioner (GP) in an urban Aboriginal Medical Service put it:

Our people are worse off by just about any social index you can measure, whether its poverty, imprisonment, housing, so all of those issues don’t go away just because you’ve got cancer...[Some] are only just coping already with the care that they have to give [to] family members and then the diagnosis is another burden that they really were not prepared to cope with...and you have all the consequences of higher degrees of mortality and morbidity that our people face and if you are living with cancer in those conditions, it’s going to be a lot harder. So things like getting to appointments, getting yourself fed... because a lot of us don’t have decent employment condition[s]. And when you’re sick, that doesn’t change, it just gets worse. (Evelyn)
According to this frame, because Aboriginal Australians are ‘worse off by just about any social index you can measure,’ there is an incredible burden placed on families and communities in coping with the range of challenges they face in everyday life, and this is only exacerbated by a cancer diagnosis. Cancer treatment or care may be far less of a priority than simply making ends meet.

**Different practices**

The fourth frame conceptualised cultural difference as something which is enacted through different practices. This included cultural beliefs, with Aboriginal Australians described as holding specific and characteristic views about the origins, implications and treatment of cancer which were seen to differ from the ‘western’ medical model. As an Aboriginal GP working in an urban Aboriginal Medical Service put it regarding Aboriginal concepts of cancer therapies:

> We are always looking for non-drug ways to look after ourselves... That’s our culture is to connect with the land and with the ancestors and to look after our spirits in order to make our body stronger and part of that is bush medicines, use of herbs and...and healing sort of work, massage, physio, sitting down under a tree and listening. (Evelyn)

As an Aboriginal identified medical practitioner, this participant can speak in an inclusive way about the role that different practices can play in shaping the particular needs and experiences of Aboriginal Australians with cancer: ‘that’s our culture.’ However, the non-Aboriginal interview participants in our study also made use of this frame. This was particularly evident in the way that non-Aboriginal participants described what they saw as being Aboriginal cultural protocols and preferences relating to cancer care including a reported reluctance to speak about cancer, a fear of entering hospitals where loved ones have died, and a desire to return home rather than stay in hospital for the recommended course of treatment. One of the most common ways in which cultural difference was articulated in terms of different practices by our participants was by describing family as holding a particular significance for Aboriginal Australians.

**Making difference safe**

The fifth frame foregrounded both the potential and the responsibility for cancer care providers to make difference ‘safe’ for Aboriginal clients. This extends from the third and fourth frames, conceptualising cultural difference as important to Aboriginal Australians with cancer, but also describing what health care organisations could and should do to recognise and accommodate those differences. Examples included permitting smoking ceremonies to be performed outside hospitals, and employing more Aboriginal Australians in cancer care services: ‘Sometimes you just really need to see a black face...To make that heart to heart connection’ (Evelyn).

The following extract is from an interview with a non-Aboriginal Palliative Care Nurse who was working in an urban area health service, and who spoke at length about opportunities for making difference safe for Aboriginal Australians with cancer:
I think we need to do a bit of our own shift in the way that we think about things. Just because we actually come to people with training and the resources and a willingness to hear what's happening for them, where in this situation is not enough. But it's also not enough as well in other cultural groups as well, but you'd know that there is a difference when you come to someone's home and their first language is not English. Then of course you know that you need to think of them differently, but when you walk into a home of someone who was born and raised [in Australia] and was here before your ancestors even came and they speak English, I think there's an expectation that you're going to be able to build a rapport and understand one another... But in fact that's not correct, [and] I don't know that we really get that sometimes. (Heather)

The cancer care workforce is described here as typically recognising and appreciating the service implications of cultural differences among patients from non-English-speaking backgrounds, but as considerably less willing and able to do this with English-speaking people who identify as Aboriginal. There is an implication here that Aboriginal Australians should be somehow more able to fit into the 'default' models and styles of care delivery within the mainstream health system, while those from ‘other’ (i.e., overseas born) culturally and linguistically diverse backgrounds require a shift in thinking and acting to accommodate their particular needs.

**Resisting a stable position on difference**

Our participants rarely made use of only one discursive frame in their interviews, nor did they always articulate these frames in a consistent fashion. On the contrary, it was much more typical that different frames be drawn upon at different points in each interview as a means of constructing and validating complex narratives about Aboriginal needs for and experiences of cancer care services.

For example, a non-Aboriginal cancer clinician working in an urban hospital (Gareth) drew upon the following frames in the course of the one interview, constructing a complex position on difference:

*Everyone is the same:* Like many people when you initially give that sort of diagnosis, [there is a] shock and lack of processing and it takes several visits to really examine the reaction and help people through it. And it's no different in the Aboriginal setting.

*Everyone is different:* I've had the whole range of socio-economic and educational backgrounds with Aboriginal people, so I think it's highly discriminatory to think that there's a one size that fits all and that you can make any sort of statement of what Aboriginals think can cause cancer.

*Different practices:* We've been doing a lot of research in non English speaking background groups and it's clear that there are all sorts of really quite significant cultural issues that determine awareness and willingness to access screening.

*Different practices/Everyone is different:* I think generally in an Aboriginal setting, it's more [of] a family... It's the transmission of the diagnosis to a family rather than an individual and so it's usually done in a communal setting. But my experience is... [that] there simply again is not a one size fits all and there's no 'Aboriginal response'. I think that's a very simplistic view of culture that isn't borne out in reality and that individual reactions vary according to a whole gamut of background experiences that are interpreted through a particular prism of culture but are not somehow unique and just that Aboriginal experience.
The first three extracts provide evidence of how quite different frames can be drawn upon to construct a single professional position on cultural difference. What is interesting to note here is that although the approach to negotiating different frames appear at a surface level to resist taking up a stable position on cultural difference, this slipperiness actually achieved a very similar outcome to the eliding frames. Thus, the fourth example, which draws upon the quite dissimilar frames of ‘different practices’ (e.g. Aboriginal people have particular cancer care needs), and ‘everyone is different’ (e.g. you can’t generalise about any particular cultural group because every individual has different needs) were deployed here in such a way that further talk about how difference might be experienced by Aboriginal Australians is clearly being discouraged.

**Discussion**

Our primary aim in this paper has been to identify the dominant ways in which cultural difference was discursively framed in interviews with health care professionals who provide cancer care services to Aboriginal Australians. We observed that a series of frames were drawn upon in constructing a professional position on the role of cultural difference in shaping Aboriginal engagement with cancer care services. We will now discuss the relationships between and implications of these dominant frames, and consider alternative modes of facilitating talk about cultural difference in cancer care. However, it is important to note at this point that we have been quite deliberate in choosing to not analyse these interviews according to how these health care professionals identified culturally (Aboriginal or non-Aboriginal), professionally, geographically and so on. While we are not proposing these participants should be collapsed into an entirely undifferentiated category of ‘health care professional,’ we do propose they are bound together in their shared experience of contributing to the production of the Australian health care system at the time of data collection. Thus, in line with the interests of this paper, we view their interview ‘texts’ as providing insights into the particular ‘ways of speaking’ which are promoted and precluded in the discourse community of Australian cancer care.

Looking back at the frames we identified in this material, the first two had the effect of eliding talk about cultural difference, and appeared to also avoid the ‘problem’ of accommodating that difference in the design and delivery of cancer care services. This was most obvious in the first frame, as there was little room for a recognition of cultural difference if ‘everyone is the same.’ This seems to be supported by broader discourses which have become increasingly ‘taken-for-granted’ in the past few decades in contemporary health care service settings, particularly those of social inclusion and health equity. Yet, the attempt to very deliberately construct an ethics of care which treats everyone in the same way has the potential – as you can see in this analysis – to close down conversations about why some patients may want or need to be treated differently. And although it may make room for the possibility that cultural difference might matter to Aboriginal Australians, talk about what that means for cancer care was also elided by the second frame. Synthesising the difficult and diverse issues associated with health care experience into a set of shared characteristics and preferences is entirely undermined by proposing that, really, in the end, isn’t ‘everyone different’?
In contrast, three of the other frames appeared to facilitate talk about cultural difference. For example, the notion that there may be a range of competing problems and concerns in the everyday lives of Aboriginal Australians permits recognition that not only is cancer care not always the highest priority for everyone, but that there are a whole host of reasons why Aboriginal people may find themselves in that position. Acknowledging the potential for cultural difference, therefore, also requires a recognition of the role that a history of racist policies of dispossession and assimilation can play in shaping the contemporary engagement of Aboriginal Australians with mainstream health care services. Our participants presented themselves as quite committed – for the most part – to recognising particular ways of being in the world could influence the experiences and needs of different cultural groups with cancer care. But to borrow the phrasing of Nancy Fraser (1995), this limits the discussion to a ‘politics of recognition,’ without extending into the more significant implications of a ‘politics of redistribution.’

The frame we identified as ‘making difference safe’ did, however, go this extra step in implying that cancer care services could better accommodate the needs of Aboriginal Australians. Shaped by a discourse of ‘cultural safety,’ this frame assumes that it is essential that health care environments are viewed as ‘safe’ for people from minority cultural backgrounds (Lynam and Young 2000). What is important to note here is that whether cultural differences are represented in positive and productive ways, as markers of cultural strength and celebration, or as a problem of incompatibility between Aboriginal patients and health care organisations, the responsibility for recognising and responding to that incompatibility is still invested with the health care organisation, and not the health care consumer. This ensures that the burden of addressing health disparities is not placed on those with the least resources. It also suggests, however, that there are limits to taking a top down approach. If genuine change is to be achieved within the health care system, it will require a shift in the culture of health care services to acknowledge that Aboriginal Australians have a legitimate set of cultural needs and expectations which need to be recognised and accommodated. This requires not only a more systemic recognition of how racist thinking and practice ‘determines’ the health of indigenous peoples (Paradies, Harris, and Anderson 2008), but also an appreciation of how the action focus of an indigenous-led paradigm such as cultural safety can facilitate change for the benefit of all (Wepa 2004). As Downing, Kowal, and Paradies have put it, cultural safety moves beyond ‘trying to teach about “indigenous culture”,’ toward examining processes of power imbalance and identity (2011, 254), with the potential to bring forth a whole new way of thinking about cross-cultural relations in health service settings.

Our analysis affirms the importance of building critical reflection into the practice, policy and design of cancer care services, including paying deliberate attention to alternative and potentially useful ‘frames’ for understanding cultural difference. As Browne has argued, it is essential that health care professionals ‘question assumptions, challenge dominant discourses, and engage in critically reflexive practice’ (2005, 81). Many of our participants appeared to feel quite uncomfortable with constructing a position about what Aboriginal Australians might think or feel, and that is not in itself a problematic instinct. Certainly, it is comforting that none of the health care professionals we interviewed had any obvious desire to undermine the rights of Aboriginal Australians to determining and
defining their own health needs and experiences. However, it was all too easy for
many of our participants to draw upon well-trodden narratives about what difference
means or does not mean, without perhaps recognising that this could be both
symbolically and practically devastating for people who may already be feeling
disenfranchised from the mainstream health care system.

This was perhaps most evident in the final frame, which demonstrated that not
only can multiple frames work alongside each other, but also that the frames which
elide talk about difference could be used to destabilise talk about the salience of
cultural difference. Our analysis showed how one participant was able to make use of
frames which appeared to support the notion of cultural difference but then resisted
this conclusion by consistently withdrawing to a position of relative ‘neutrality.’ In
an era of anti-discrimination, there may be many reasons why a health care
professional might be nervous about misrepresenting the experiences of a particular
cultural group or population. But the slipperiness of this frame suggests that there
may also be a powerful impetus for non-Aboriginal health care professionals, in
particular, to resist becoming ‘tangled up’ in the politics of social inclusion by not
contributing at all to the articulation and recognition of cultural difference. It may
appear less complex and possibly also more ‘professional’ to rely upon a frame which
elides talk about cultural difference, particularly one which relies upon the least
controversial argument that ‘everyone is different.’ But if a particular culture of
health care work comes to dominant the field, individual health care professionals
may feel less supported in celebrating cultural difference, which could compound the
sense of exclusion that we know some Aboriginal Australians feel about engaging
with mainstream cancer care services.

The claim that the primary concern of cancer services should be cancer, not
culture, is a familiar one. Tang and Browne noted a similar discourse among
Canadian health care professionals who ‘tended to take for granted (or presume) that
“everyone is treated the same” irrespective of the patient’s background or social
positioning’ (110), and who therefore ‘tend to gloss over or deny [the] existence [of
racialization]’ (114). We can conclude that the eliding frames we observed here evoke
values held dear in advanced liberal, democratic societies, with citizens envisioned as
having equal access to the same service regardless of their social, cultural or
economic differences. The effect of these discourses, however, can be a flattening out
of difference, or at least, a reluctance to talk about it. As an alternative to this fear of
getting ‘tangled up,’ health care professionals could instead be encouraged to think
about both sameness and difference as equally essential to achieving patient equity in
cancer care settings. Culyer has differentiated between horizontal and vertical forms
of equity, with the former focused on treating the same those who are the same in a
relevant respect (such as having the same ‘need’), and the latter focused on ‘treating
differently those who are different in relevant respects (such as having different
‘need’)’ (1995, 727). So while cancer care services should indeed be focused on
providing equal care and treatment to anyone in need, this is not incompatible with
tailoring those services to the particular expectations and preferences associated with
and shaped by cultural difference. At the very least, recognising the value of both of
these roles will offer the best opportunity for facilitating open communication about
the issues arising from cultural differences within cancer care, both in terms of
designing the best possible care plan for each individual patient, but also creating
more culturally welcoming environments and practices in those service settings. Future research would be particularly welcomed on the challenges of opening up and sustaining conversations about cultural difference among non-Aboriginal health care professionals. The experiences of non-Aboriginal researchers in negotiating similar tensions in Aboriginal health contexts would also benefit from further exploration (Kowal 2012).

Conclusion

We approached this paper as a collaborative opportunity to develop new qualitative insights into the ways in which cultural difference was discursively framed by health professionals who care for Aboriginal Australians with cancer. By describing the use of dominant discursive frames in our interviews, we can see that despite considerable diversity in their health service settings, professional experiences and cultural backgrounds, these health care professionals consistently made use of and reproduced a quite limited set of ‘taken for granted’ frames. Some had the effect of discursively ‘eliding’ the possibility that patients who identify as Aboriginal may bring with them a set of cultural practices, beliefs and values that health services have a responsibility to understand and accommodate, while others ‘facilitated’ that talk. We hope that by critically unpacking some of the assumptions made by health care professionals about the role of cultural difference in cancer care, we can enrich our understanding and response to Aboriginal health priorities in Australia, and encourage a more systematic reflection on the use of dominant frames, and the alternatives that may strengthen the engagement between First Nations people and cancer care providers.

Key messages

(1) Little is known about what cultural difference means to the cancer care professionals who care for Aboriginal Australians.
(2) Health professionals can be over-reliant on discursive frames which either ‘elide’ or ‘facilitate’ talk about difference.
(3) In an era of anti-discrimination, health professionals may be fearful of misrepresenting the experiences of a cultural group.
(4) Actively facilitating talk about cultural difference has the potential to promote a more inclusive culture in cancer care.

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References


