



Interprofessional Learning Through Simulation Project

*He's not from here – Acute episode
with underlying chronic conditions
and cultural and social
considerations*

Facilitators' Guide

Acknowledgements

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The filmed scenario has been developed from the experiences of the Interprofessional Learning in Simulation Project Steering Group. All due care has been taken to make the scenarios as realistic as possible. The characters in the filmed scenarios are fictitious and any resemblance to persons living or dead is purely coincidental.



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How to use this resource

This resource (the Facilitators' Guide) provides the framework to support the development of communication and problem solving, together with problem based learning scenarios that encompass some challenging (but quite typical) patients that clinicians could expect to encounter as part of their practice. The goal of this interprofessional learning experience is to help prepare all health professionals – be they students or beginning clinicians – for working together.

This resource is intended to develop your understanding of the principles of interprofessional practice and raise your awareness of opportunities for implementing interprofessional practice in your own environment.

Throughout the resource are opportunities to consider how notions of interprofessional practice affect your current work practices and activities that enable you to reflect on these.

The goal of this interprofessional learning experience is to help prepare all health professionals – be they students or beginning clinicians – for working together.

Interprofessional learning through simulation

This resource utilises simulation as a means to facilitate a learning experience; one that recreates events that are closely linked to reality. Gaba¹ defined simulation as a technique, rather than a technology, to replace or amplify real life experiences with guided experiences, often immersive in nature, to evoke or replicate aspects of the real world, in a fully interactive pattern.

Simulation provides a safe learning environment for students to practice, where they are free to make mistakes, correct them and improve the processes of care.² Simulation is the bridge between classroom learning and the real life clinical experience, allowing students to put theory into practice.

Interprofessional learning through simulation provides learning opportunities to prepare future health care professionals for the collaborative models of health care being developed internationally³ and can encompass a range of environments and resources that harness technologies, including multimedia and online applications.⁴

Resource contents

There are four sections within this resource. Information presented in Section One and Section Two is largely focussed on interprofessional learning and Section Three contains an introductory section on racism and Islamophobia.

- Sections One and Two of this resource contain questions that require users to reflect on the content they have covered.
- Section Three requires users to watch the associated audiovisual resource 'He's not from here' and complete the questions that relate to interprofessional learning, cultural insensitivity and Islamophobia.
- Section Four provides a literature review about racism and, in particular, Islamophobia which can be used as reference material.

Learning objectives

The key interprofessional learning message of this resource is:

Self-awareness of cultural insensitivity, highlighting anti-Islamic attitudes (Islamophobia) and challenging cultural insensitivity with a co-worker

The learning objectives of this resource are based on **five competency domains** from the Australian audit of interprofessional education in health:

- Teamwork;
- Understanding roles and respecting other professions;
- Role clarification;
- Understanding of interprofessional education (IPE); and
- Reflection.⁵

Learning outcomes will be addressed through the consideration and discussion of material presented in Sections One and Two in relation to interprofessional practice generally, and Section Three which is focussed more specifically on cultural insensitivity and Islamophobia.

Learning outcomes

On completion of this resource, participants should be able to:

- Identify the key elements of interprofessional practice;
- Differentiate between interprofessional practice and current ways of working;
- Understand the importance of 'human factors' and appreciate how non-technical factors impact patient care;
- Develop an awareness of tools to enhance successful communication with patients/clients and carers;
- Describe strategies to develop a deeper understanding of other professions' roles and responsibilities;
- Identify what changes are required to promote interprofessional practice;
- Distinguish between the roles of the health professionals involved in this case study, including areas of possible overlap;

Section One: What is 'interprofessional'?

Why the need for interprofessional learning?

In today's health care setting, human service professions are facing problems so complex that no single discipline can possibly respond to them effectively.⁶ The World Health Organization (WHO) has stated 'It is no longer enough for health workers to be professional. In the current global climate, health workers also need to be interprofessional'.⁷

What does the term interprofessional mean?

Interprofessional learning (IPL) is defined as:

- Learning arising from interaction between members (or students) of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or education settings.⁸

Interprofessional education (IPE) is defined as:

- Occasions where two or more professions learn from, with and about each other to improve collaboration and the quality of care.⁸

Interprofessional practice (IPP) is defined as:

- Two or more professions working together as a team with a common purpose, commitment and mutual respect.⁸

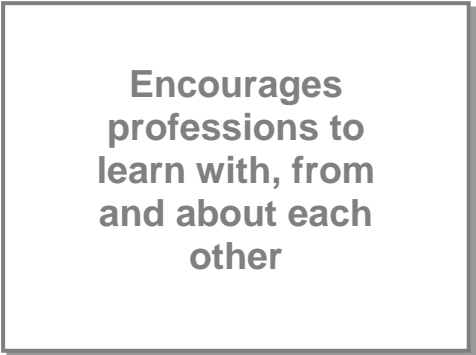
When interprofessional practice is working well it is thought to achieve the following six outcomes:⁹

1. Works to improve the quality of care:

No one profession, working in isolation, has the expertise to respond adequately and effectively to the complexity of many users' needs and to ensure that care is safe, seamless and holistic to the highest possible standard.

2. Focuses on the needs of service users and carers:

IPL puts the interests of service users and carers at the centre of learning and practice.



Encourages
professions to
learn with, from
and about each
other

3. Encourages professions to learn with, from and about each other:

IPL is more than common learning, valuable though that is to introduce shared concepts, skills, language and perspectives that establish common ground for interprofessional practice. It is also comparative, collaborative and interactive, a test-bed for interprofessional practice, taking into account respective roles and responsibilities, skills and knowledge, powers and duties, value systems and codes of conduct, opportunities and constraints. This cultivates mutual trust and respect, acknowledging differences, dispelling prejudice and rivalry and confronting misconceptions and stereotypes.

4. Respects the integrity and contribution of each profession:

IPL is grounded in mutual respect. Participants, whatever the differences in their status in the workplace, are equal learners. They celebrate and utilise the distinctive experience and expertise that participants bring from their respective professional fields.

5. Enhances practice within professions:

Each profession gains a deeper understanding of its own practice and how it can complement and reinforce that of others. This is endorsed where the IPL carries credit towards professional awards and counts towards career profession.

6. Increases professional satisfaction:

IPL cultivates collaborative practice where mutual support eases occupational stress, either by setting limits on the demands made on any one profession or by ensuring that support and guidance are provided by other professionals if and when added responsibilities are shouldered.

How is interprofessional practice different to how people currently work?

The Australasian Interprofessional Practice and Education Network (AIPPEN) have identified a number of terms currently that convey a similar but different intent and meaning to the term interprofessional.¹⁰

Interdisciplinary

- Interdisciplinary has been used by researchers and practitioners when they attempt to analyse, synthesise and harmonise the connections between disciplines, to generate a coordinated and coherent health delivery system.¹¹ 'Interdisciplinary' is said to lack the inherent depth of collaboration implied by the term 'interprofessional'.

Multidisciplinary

- Health professionals represent a range of health and social care professions that may work closely with one another, but may not necessarily interact, collaborate or communicate effectively.¹²

Multiprofessional

- Work occurs when a range of professional practitioners work in parallel. Each discipline has clear role definitions and specified tasks and there are hierarchical lines of authority and high levels of professional autonomy within the team.
- Multiprofessional, as a term, may not imply optimal levels of collaboration.
- Practitioners consult individually with service users and use their own goals and treatment plans to deliver services.¹³

Collaboration

- Is 'an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the ways patient/client care and broader community health services are provided'.¹⁴

Do we need to focus on interprofessional collaborative practice – don't professionals already work interprofessionally?

Interprofessional practice is a way of practicing that is based on collaboration. Nurses, doctors and other health professionals have for a long time worked closely together and have developed successful long-term partnerships. However, as has been stated:

We cannot assume that health professionals have either the skills or attributes required for interprofessional practice. They may need to learn how to collaborate. Developing interprofessional practice requires a commitment to engage in shared learning and dialogue. Dialogue has the potential to encourage collegial learning, change thinking, support new working relationships, and improve patient care.¹⁵

Although health professionals receive extensive professional development, most training emphasises specific disease processes, technology and treatment and has largely undervalued human factors. Human factors training is necessary to help individuals learn how to improve working relationships with colleagues and those from other disciplines.¹⁵

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and patient outcomes in health settings.¹⁶ The WHO has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals.⁷

ACTIVITY ONE

What would you expect to notice as indicators of interprofessional practice?

What range of factors might be different in an interprofessional practice environment?

ACTIVITY ONE: ANSWER AID

Anecdotes from clinicians with an increasing awareness of interprofessional thinking and behaviour in the clinical environment:

“I went to a placement and something clicked. It gelled and I suddenly got it...it’s more than an awareness of others – you realise you are not an island and it’s up to others as well. You can recognise opportunities for patients and refer them to other disciplines”.

“I used to get frustrated at them not seeing through my discipline lens but then I saw how difficult it was for me to learn about their discipline”.

“You begin to realise you are part of a bigger picture and because of that you need to be able to communicate with people in a way they understand... I was listening to nurses with all the jargon they use and it made me become more aware of the amount of jargon I use – I thought I was practising interprofessionally but didn’t realise I was using so much jargon”.

Section Two: Competency framework for interprofessional education

Although a range of competencies have been identified, there is no one overarching framework that provides a definitive set of interprofessional competencies. Initial findings from an Australian national audit of pre-registration interprofessional education in health identified five IPE domains to support the development of a national curriculum framework. The identified domains were:

- Teamwork;
- Understanding roles and respecting other professions;
- Role clarification;
- Understanding of IPE; and
- Reflection.⁵

Patients will increasingly demand physicians, nurses and other health professionals to communicate and work together effectively

Teamwork

The identified domain 'teamwork' included the elements: communication, leadership, attitudes, team relationships, and conflict resolution. We know that effective teamwork plays a key role in improving quality and safety in health care, and the need for increased collaboration and teamwork across the health professions is necessary in order to care for an aging population with multiple chronic illnesses.¹⁷ Patients will increasingly demand physicians, nurses and other health professionals communicate and work together effectively. Teams bring their collective knowledge and experience to provide a more robust foundation for decision-making than any single clinician can offer.¹⁷

Team functioning and collaboration is thought to be enhanced when individuals:

- Participate in team activities;
- Foster positive team relationships;
- Appreciate differing personalities within teams; and
- Demonstrate respect.¹⁷

Lack of focus on human factors

The elements that make up teamwork are regarded as 'human factors' and are the non-technical factors that impact on patient care. Human factors can be defined as the interaction of equipment and individuals and the variables that can affect the outcome.^{18,19} Bromiley and Reid quote Catchpole in their article²⁰, stating that more broadly the term clinical human factors can also encompass interactions with the environment that include an 'understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities, and the application of that knowledge in clinical settings'.

The contemporary focus of human factors in health care reportedly had its genesis in the work of James Reason in 1995 when he stated that, 'human rather than technical failures now represent the greatest threat to complex and potentially hazardous systems'.²¹ More recent research highlights that rather than poor technical skill, human factors such as suboptimal communication and organisational system and culture inadequacies were implicated in up to 87% of the errors, adverse events and near misses that occur.²²⁻²⁵

Historically, health care has regarded technical skills and competence as key to patient safety. Technical excellence in, for example, nursing and medicine is important because health care professionals need to know what they are doing to maintain high standards of care and quality outcomes for patients. However, other safety-critical industries (such as defence and aviation) have learnt that even the most technically qualified and expert individuals can encounter difficulties when under stress. Such non-technical abilities – sometimes referred to as 'soft skills' – need to be valued equally.²⁶ Humans, when under pressure, have a capacity to become overly focused or fixated on technical problems.²⁷ Focus on human factors to improve the way teams work is important because:

- Opportunities to optimise the way teams work is becoming progressively more difficult with an increasing number of part-time workers, increasing patient loads and decreased staffing;
- The attitudes and behaviours of those who make up 'teams' can be problematic at times and a lack of congruence in how teamwork itself is interpreted exacerbates underlying resentments, undermines professional esteem, and in some cases, creates outright conflict; and
- Working in teams at times can be fraught with difficulties and the 'ideal' of effective team-working, as defined in the prescriptive literature, is apparently rarely realised.²⁸

ACTIVITY TWO

Think about your team (past or present) and how your team functions...what are the issues that make it challenging to focus on improving team performance?

What strategies have you found to be effective in improving team performance?

What do you feel could be done to improve team performance?

Communication

Appropriate interprofessional communication:

- Maintains patient confidentiality;
- Provides and delivers feedback;
- Promotes the role of other disciplines to patient/carers;
- Communicates in a clear and concise manner;
- Validates the knowledge of other disciplines; and
- Explains discipline-specific terminology.

Interprofessional practice also places an increased focus on the needs of service users and carers. Although communication among and between professionals is critical, to ensure the interests of service users and carers remains at the centre of learning and practice, strategies to enhance communication practices with service users and carers are essential. Patient-centred care:

- Places the service users and carers at the centre of practice;
- Establishes patient-centred goals;
- Facilitates decision-making with patient/family; and
- Recognises and responds to the patient's changing needs.²⁹

The mnemonic LIPSERVICE will help ensure that you consider the many aspects of successful communication with patients and patients and will be utilised later in the resource.

-
- L** is for Language
- Does your patient speak English?
 - How well do they speak it?
 - Do you need to consider getting an interpreter to assist?
 - What is the person's education level and understanding – will you need to modify the language you use in order to help them understand what you are asking or telling them?
-
- I** is for Introduction
- Make sure you introduce yourself to the person, and give them your role – especially if what you do is something that is not commonly known. While most patients will understand the role of a 'doctor', they may not be familiar with what an 'occupational therapist' does. If in doubt, you should explain your role.
-
- P** is for Privacy, Dignity and Cultural issues
- Is this a person who is going to be embarrassed by being examined by someone of the opposite gender?
 - Should you ask before you address them by their first name (many more elderly patients are of a generation who value the respect that being called 'Mr' or 'Mrs' gives them).
 - Be aware of different cultural expectations that you may encounter.

S is for
Subjective
Questioning

- This is where you take the person's history.
- A thorough history will be invaluable in helping to make a diagnosis.
- Be aware of the power of 'leading questions' though.
- Ask open-ended rather than closed questions to obtain your answers.

E is for
Examination

- Some considerations here include talking the person through what it is that you are doing, especially if this is an invasive or unusual procedure for them.
- Knowing what is happening and why, as well as what to expect, can help alleviate the person's concern about what it is you are doing to them.

R is for Review

- Talk through what you have done as part of the examination – and what it added to your knowledge of their condition.
- For example, 'You were talking about how you get short of breath, and I could hear from listening to your chest that your lungs are quite congested.'

V is for Verdict

- The diagnosis.
- What their history and your examination have led you to think is causing their symptoms and signs.

I is for
Information

- What does the diagnosis mean for the person?
- Having a diagnosis of a lump in the breast can mean many things.
- The person needs to know about these.

C is to remind
you to Check
Understanding

- This is where you determine if what you have said has made sense to the person.
- People may only hear the diagnosis and then go into a state of shock – which means they don't process what you tell them next.

E is for End or
Exit

- What's going to happen next for the person?
- What about follow up?
- Referrals to other professionals?

Understanding roles and respecting other professions / role clarification

The need to address complex health and illness problems, in the context of complex care delivery systems and community factors, calls for recognising the limits of professional expertise and the need for cooperation, coordination and collaboration across the professions in order to promote health and treat illness. However, effective coordination and collaboration can occur only when each profession knows and uses the other's expertise and capabilities in a patient-centred way.³⁰

The World Health Organization report in 2005 argued that health care providers must work interdependently, demonstrating mutual respect, trust, support and appreciation of each discipline's unique contribution. Although it is changing, the traditional way in which health professional students are educated is uni-professional; and occurs within discipline- and profession-specific groups.³¹ Within uni-professional environments students develop a solid grounding in the specific knowledge of their own profession, although many, if not most, students leave educational environments with a cursory understanding of other disciplines' roles and responsibilities.

One educational approach which is thought to assist professionals to develop greater 'team awareness' is to understand other professional perspectives through 'shared learning'.²⁸ Shared learning has the potential to deepen understanding of how professional roles and responsibilities complement each other³⁰ and engender a greater appreciation of 'common' or overlapping competencies.³² An enhanced understanding of other professionals' roles and responsibilities possible through shared learning can alleviate some of the potential tensions that exist in relation to overlapping competencies between health practitioners.

Interprofessional practice is about developing professionals who are confident in their own core skills and expertise and who are also fully aware and confident in the skills and expertise of fellow health and care professionals.³³

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ACTIVITY THREE

Within your own discipline, how easy/difficult would it be to verbalise your concerns about a colleague's knowledge, skills or competencies?

Thinking outside your own discipline, how would you know what knowledge, skills and competencies other disciplines need/ should have? Pick a discipline you have contact with and explain what it is they do, as if you were explaining it to a patient.

Would it be more or less difficult to flag concerns about a colleague from another discipline, than a colleague from your own discipline and why?

ACTIVITY THREE (continued)

Over your career, how have you learnt about other professionals' roles?

Given that optimal interprofessional practice requires you to have a deeper understanding of other professions' roles and responsibilities, identify two professions you would like (or need) to know more about and list strategies you could implement to attain a greater in-depth understanding of that profession's roles and responsibilities.

ACTIVITY THREE: ANSWER AID

Each profession's roles and responsibilities vary within legal boundaries; actual roles and responsibilities change depending on the specific care situation. Professionals may find it challenging to communicate their own role and responsibilities to others. For example, Lamb et al.³⁴ discovered that staff nurses had no language to describe the key care coordination activities they performed in hospitals. Being able to explain what other professionals' roles and responsibilities are and how they complement one's own is more difficult when individual roles cannot be clearly articulated. Safe and effective care demands crisply defined roles and responsibilities.

Specific Roles/Responsibilities Competencies:

- RR1.** Communicate one's roles and responsibilities clearly to patients, families, and other professionals.
- RR2.** Recognise one's limitations in skills, knowledge, and abilities.
- RR3.** Engage diverse health care professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.
- RR4.** Explain the roles and responsibilities of other care providers and how the team works together to provide care.
- RR5.** Use the full scope of knowledge, skills, and abilities of available health professionals and health care workers to provide care that is safe, timely, efficient, effective, and equitable.

ACTIVITY THREE: ANSWER AID (continued)

RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.

RR7. Forge interdependent relationships with other professions to improve care and advance learning.

RR8. Engage in continuous professional and interprofessional development to enhance team performance.

RR9. Use unique and complementary abilities of all members of the team to optimise patient care.

(Interprofessional Education Collaborative, 2011)¹⁷

Reflection

The importance of personal reflection in interprofessional practice was highlighted in a national study designed to inform the further development of IPL in Australian health professional education and workforce development. The report identified the importance of reflection as interprofessional learning centred on:

...the relational aspects of practice or practising, with a learning and reflective focus on the team, as well as the individual, and is responsive to a body of knowledge and ethical orientation that engages with teams and team functioning as well as individuals and individual functioning.⁵

Processes that facilitate both individual and team reflection are critical to increase awareness and understanding of intra and inter personal relationships. One such tool to assist in the process of personal or team-based reflection to generate well-considered steps to problem-solving with team members, patients and clients, is the mnemonic ASPIRIN.

A Acknowledge the problem	Basically, is there something that needs to be addressed?
S Situational analysis	<p>What is the cause of the situation?</p> <p>How did it come about and who is involved?</p> <p>What is likely to happen if you don't act?</p> <p>What are the risks if you do act?</p>
P Provide some solutions.	<p>There is almost always more than one approach that could be used to try and solve this situation.</p> <p>Decide on which is the most suitable.</p>
I Implement	Your preferred solution.
R Review the outcome	<p>How did it help?</p> <p>Do you need to try something else?</p>
I Inform stakeholders	Let people know – communication is very important.
N Next steps	<p>Is this a temporary fix?</p> <p>Do you need to look at a different long term solution?</p> <p>Will the problem occur again and again unless steps are taken to resolve it in the longer term?</p>

ACTIVITY FOUR

Consider a problem (past or present) and utilise ASPIRIN to assist you to generate new ways of thinking about that situation.

Reflect on how you consider interprofessional practice has the potential to impact upon patient outcomes.

Reflect on what you have covered in this resource thus far and consider what changes you need to make to ensure your own practice is interprofessionally-focussed.

Racism and Islamophobia

Racism

- The inferior health status of minority groups in many Western countries is well-documented. The causes of these differentials in health care treatment are complex. Biological differences may have a small impact, but other explanations include:
 - Patients' mistrust of the health care system;
 - Socioeconomic variables;
 - Unconscious bias on the part of health care practitioners;
 - Communication impairment; and
 - Lack of cultural sensitivity and cultural competence on the part of health care practitioners.
- 'Racism is not just a question of group characteristics, stereotypes, or inter-group relations, but a question of ideology'.³⁵⁻³⁷
- Racist ideology attaches meaning to the *differences* in inheritable characteristics or a distinctive culture and influences the way one acts, thinks or feels.³⁷
- Two main types of racism are recognised: '*old racism*' and '*new racism*':
 - 'Old racism' refers to the belief that certain races are inferior and others (mainly white Caucasian) are naturally superior. 'Old racism' is referred to as 'blatant' or 'overt' and includes belief in racial hierarchy and racial separation; and
 - 'New racism' is described as 'covert'.
- At the core of the general population's understandings are the individual and collective attempts to 'make sense' of events. They may be adopted in response to questions of, for example, high unemployment and other perceived injustices.
- In these instances it is often easier to 'explain' a problem by blaming a group that is different and to find a solution to a problem by blaming victims, such as immigrants or asylum seekers.³⁸

- These attitudes both constitute and are reflected by the media, who are also used to construct and reinvent cultures and cultural identities.
- Anti-racism has been broadly defined as ‘forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism’ and as ‘ideologies and practices that affirm and seek to enable the equality of races and ethnic groups’.^{39,40}

Islamophobia

- Since the terrorist attacks in the USA on 11 September 2001 (9/11), the Bali bombing in 2002 and various other international incidents, ethnic minorities associated with Islam in most Western countries have experienced increased negative attention from the media, police and security forces, and from the general population.
- There has been an increase in all such countries in the extent of anti-Muslim or ‘Islamophobic’ hate crime, racial vilification and discrimination.⁴¹
- Fernandez⁴² identifies three basic themes in discourses relating to Islam scepticism:
 1. Threats to the position and rights of women;
 2. Threats to security; and
 3. Threats to the separation of Church and State.
- The 2004 ‘Isma–Listen’ report by the Human Rights and Equal Opportunity Commission (HREOC) revealed that the majority of Arab and Muslim Australian participants surveyed had experienced various forms of prejudice because of their race or religion.
- In the context of the health care environment racism can be present even unwittingly, for example, failure to call an interpreter, social assumptions, and thoughtlessness or poor cross-cultural understanding. Race relations have implications for both patient-provider interactions and the health of communities.⁴³
- The study by Rane⁴⁴ revealed that while Muslims value their Islamic identity, the majority of Muslim Australians share the same values as the wider Australian society.

A more complete literature review about racism and Islamophobia is available in Section Four.

Resource activities in relation to racism and cultural sensitivity follow in Section Three.

The scenario in Section Three highlights racism and Islamophobia and its implications for interprofessional collaborative practice.

Section Three: Scenario – He’s not from here...

Scenario

Mr Izadparast is a 55 year old man who migrated from Iran with his family two years ago. Mr Izadparast has been having stomach pain, diarrhoea and weight loss and his son has brought him to the ED. The examining physician has ordered a CT scan to aid in Mr Izadparast’s diagnosis. Mr Izadparast does not speak English, but his son is with him and accompanies him to the Radiology Department.

List of characters

- Mr Cyrus Izadparast (patient)
- Davood Izadparast (patient’s son)
- Radiographer
- Patient care assistant (PCA)
- Interpreter
- Radiology manager
- ED nurse
- Maxillofacial surgeon

What to do next

Section Three of the resource requires that you:

1. Watch each scene of the associated resource ‘He’s not from here...’:
 - Scene One – Radiology department
 - Scene Two – Improved practice
2. After you have watched a scene, complete the activity questions relevant to that footage.
3. If necessary, refer to the answer aid boxes after the activity questions for hints relating to interprofessional practice, racism and Islamophobia.

Scene One: Radiology Department

Please watch 'He's not from here...': Scene One



Notes:

ACTIVITY FIVE

What communication errors were emerging early in this scenario?

Put yourself in the son's position: what might be your first impression of the radiographer and why?

What role might perception have played in the scenario's outcomes (for all players)?

ACTIVITY FIVE (continued)

Identify if there is anything racist in the communication in Scene One.

What factors might prevent a team member from voicing their opinion?

What other factors, other than cultural insensitivity, do you think may be influencing the radiographer's interaction with the patient?

ACTIVITY FIVE (continued)

What is the process for arranging an interpreter in your place of work?

What barriers can be identified in this scene in respect to team work?

If you were the radiographer, how would you ensure you delivered patient-centred and culturally sensitive care in this situation?

ACTIVITY FIVE: ANSWER AID

What communication errors were emerging early in this scenario?

- The radiographer could have explained the hospital policy and procedure regarding checking the patient's name, date of birth, procedure, etc.
- The radiographer should have introduced herself to Mr Izadparast and his son as well as explaining her role in relation to his care.
- The radiographer spoke as if neither the patient nor son could understand any English – “I’ll be 10 years older at this rate” – which was condescending and rude.
- Non-verbal – the radiographer abruptly lunged at Mr Izadparast to check his date of birth before she informed him of what she was doing. She also rolled her eyes implying she was impatient and annoyed with him.

Put yourself in the son's position: what might be your first impression of the radiographer and why?

- Unfriendly.
- Doesn't know what she is doing because she keeps asking questions they have already answered (without explaining why).
- Disrespectful – use of culturally inappropriate body language and behaviour (e.g. pointing with her index finger, asking the female PCA to assist in changing Mr Izadparast into the gown).
- Feeling like he can't trust the radiographer to be caring or respectful of his unwell father given her abrupt and rude manner.

ACTIVITY FIVE: ANSWER AID (continued)

What role might perception have played in the scenario's outcomes (for all players)?

- Mr Izadparast –the hospital reminds him of prison and that only bad things will happen here;
- Son – his father is not being respected or cared for properly and it's causing him to become more upset and unwell;
- Radiographer – Muslims don't listen, are uncooperative and a threat; and
- PCA – the radiographer is always rude to people from Islamic backgrounds and she contributed to the situation escalating.

Identify if there is anything racist in the communication in Scene One?

'New racism' is described as 'covert' and includes intolerance towards specific cultural groups who are identified as key 'Others' to the (Australian) national imaginary. Intolerance to out-groups (see 'Section Four: Literature Review – Racism and Islamophobia' for more information on out-groups) is sustained through stereotypes, for example that Muslim Australians are terrorist sympathisers who fail to assimilate to Western culture.

Although the radiographer does not say anything overtly racist, victim blaming is a form of racist denial that allows the perpetrator to present the 'Other' in a negative light, while not damaging one's own self-presentation. ⁴⁵⁻⁴⁷

ACTIVITY FIVE: ANSWER AID (continued)

What factors might prevent a team member from voicing their opinion?

Mitchell et al⁴⁸ identified several factors that may constrain individuals from 'speaking up' against racism:

- Fitting in with social expectations: the possibility of jeopardising social relationships inhibits challenging of racist comments in the course of conversation;
- Fear of provoking aggression and conflict: individuals may not challenge racism for fear it may lead to 'bad feeling' or aggression;
- Assessing the relationship –family and friends: individuals may consider who they are talking to and the type of relationship they have with the people making the racist comments. The issue of social tension may be a consideration; and
- Form of racism – jokes: in addition to spoiling the fun, challenging jokes has the added complexity of it being easy for the joke-teller to deny racist intent.

What other factors, other than cultural insensitivity, do you think may be influencing the radiographer's interaction with the patient?

Situational Awareness (SA):

Level 1 SA – perception of information and cues from the environment. No interpretation or integration of data occurs at this stage. *"What are the current facts relevant to this case?"*

Level 2 SA – comprehension of the situation and the way the individual combines, interprets, stores and retains information. *"What is going on?"*

ACTIVITY FIVE: ANSWER AID (continued)

Level 3 SA – the ability to forecast future events and dynamics and is the highest level of understanding of the situation. *“What is most likely to happen if?”*

Level 4 SA – Resolution: awareness of the best available path to follow from several available paths to achieve the needed outcome in the situation. *“What exactly shall I do?”*⁴⁹

Scene Two: Improved practice

Please watch 'He's not from here...': Scene Two



Notes:

ACTIVITY SIX

The radiographer suggests referrals for Mr Izadparast to other health professionals (i.e. social worker, counsellor, physiotherapist, podiatrist).

Who would instigate a referral or contact with these health professionals?

Knowing what you do about Mr Izadparast, explain what you think each discipline referral will offer to his ongoing care.

List three reasons to defend the assertion: the radiographer is operating outside her scope of practice with regard to the referrals.

ACTIVITY SIX (continued)

List three reasons to defend the assertion: the radiographer is operating within her scope of practice with regard to the referrals.

In what ways were the principles of altruism, excellence, caring, ethics, respect, communication and accountability displayed in Scene Two, to achieve optimal health and wellness in individuals and communities?

Can you outline an example of effective communication in this scenario? Why do you consider it so?

ACTIVITY SIX (continued)

Harvard University's Project Implicit investigates thoughts or feelings that exist outside of conscious awareness or conscious control. This is called the Implicit Association Test (IAT). Visit the social cognition website to try out some of the tests, which assess implicit attitudes or stereotypes relevant to specific ethnic groups, and learn more about the research and yourself!

<https://implicit.harvard.edu/implicit//demo/selectatest.html>

ACTIVITY SIX: ANSWER AID

The radiographer suggests referrals for Mr Izadparast to other health professionals (i.e. social worker, psychiatrist, physiotherapist, podiatrist). Who would instigate a referral or contact with these health professionals?

It is usually the doctors or nurses who instigate referrals, as they are primarily responsible for coordinating patient care. However, it is appropriate for the radiographer to discuss the potential referrals with the ED nurse, as she has become aware of Mr Izadparast's needs.

Knowing what you do about Mr Izadparast, explain what you think each discipline referral will offer to his ongoing care?

Social worker – assess Mr Izadparast's social and emotional wellbeing. They may be able to identify any psycho-social issues and link into appropriate services in the community.

Physiotherapist – Mr Izadparast's muscles may be weak and the physiotherapist may assist with building up core strength and improving mobility.

Podiatrist – Provide an assessment and treatment in relation to the injuries his feet have sustained.

Psychiatrist – may help Mr Izadparast manage his anxiety while in hospital, as well as assess if there are issues from his past impacting on his current mental state.

ACTIVITY SIX: ANSWER AID (continued)

List three reasons to defend the assertion: the radiographer is operating outside her scope of practice with regard to the referrals.

- 1) Radiographers are not responsible for the coordination of patient care therefore it is not appropriate for her to make referrals.
- 2) The radiographer has not completed a comprehensive health assessment on Mr Izadparast and is therefore not in a position to be deciding to whom he should be referred.
- 3) The radiographer is not part of the team managing Mr Izadparast's care and is therefore unaware of any referrals that may have already been made.

List three reasons to defend the assertion: the radiographer is operating within her scope of practice with regard to the referrals.

- 1) It is the responsibility of all clinical staff if they identify a problem to refer to an appropriate health professional to discuss the issue and work with the team to organise for the referral to occur (or appropriately relay the information).
- 2) Interprofessional practice is about developing professionals who are confident in their own core skills and expertise, and who are also fully aware and confident in the skills and expertise of fellow health and care professionals.
- 3) Human service professionals are facing problems so complex that no single discipline can possibly respond to the patient's care needs effectively,⁶ therefore appropriate and timely referrals need to be made to ensure patient-centred care.

ACTIVITY SIX: ANSWER AID (continued)

In what ways were the principles of altruism, excellence, caring, ethics, respect, communication and accountability displayed in Scene Two, to achieve optimal health and wellness in individuals and communities?

Accountability: Active acceptance for the responsibility for the diverse roles, obligations, actions including self-regulations, and other behaviours that positively includes patient and client outcomes, the profession, and the health needs of society.⁵⁰

Caring and Altruism: Overt behaviour that reflects concern, empathy, and consideration for the needs and values of others and a level of responsibility for someone's wellbeing.⁵⁰

Communication: Imparting or interchange of thoughts, opinions or information by speech, writing or signs which are the means through which professional behaviour is enacted.⁵¹

Excellence: Behaviour that adheres to, exceeds, or adapts best practices to provide the highest quality care; including engagement in continuous professional development.⁵⁰

Respect: Behaviour that shows regard for another person with esteem, deference and dignity. It is a personal commitment to honour other peoples' choices and rights regarding themselves and includes a sensitivity and responsiveness to a person's culture, gender, age and disabilities.⁵¹

ACTIVITY SIX: ANSWER AID (continued)

Can you outline an example of effective communication in this scenario?

Why do you consider it so?

The radiographer is demonstrating greater awareness and sensitivity in the way she communicates. The radiographer invites Mr Izadparast's participation by asking "How about we have a look?", rather than simply insisting he get changed. Similarly, she explains about the procedure without the use of medical jargon and listens to the son to identify why Mr Izadparast is afraid. Through using different language, listening more carefully and maintaining eye contact, the radiographer is able to show empathy and validate Mr Izadparast's feelings:

- Verbal and non-verbal communication is appropriate;
- The patient is feeling less anxious and more engaged;
- The radiographer and team are working more effectively and respecting each other; and
- The outcome is patient-centred and as a result no incident report paperwork needs to be completed and time is saved.

ACTIVITY SEVEN

Watch Scenes One and Two again and complete LIPSERVICE (below) to determine how focused the individual characters were on the needs of service users and carers.

First letter	LIPSERVICE Questions	Your notes
L is for Language	<ul style="list-style-type: none"> Does your patient speak English? How well do they speak it? Do you need to consider getting an interpreter to assist? What is the person's education level and understanding? Will you need to modify the language you use in order to help them understand what you are asking or telling them? 	
I is for Introduction	<ul style="list-style-type: none"> Make sure you introduce yourself to the person, and give them your role – especially if what you do is something that is not commonly known. While most patients will understand the role of a 'doctor', they may not be familiar with what an 'occupational therapist' does. If in doubt, you should explain your role. 	
P is for Privacy, Dignity and Cultural issues	<ul style="list-style-type: none"> Is this a person who is going to be embarrassed by being examined by someone of the opposite gender? Should you ask before you address them by their first name (many more elderly patients are of a generation who value the respect that being called 'Mr' or 'Mrs' gives them). Be aware of different cultural expectations that you may encounter. 	
S is for Subjective Questioning	<ul style="list-style-type: none"> This is where you take the person's history. A thorough history will be invaluable in helping to make a diagnosis. Be aware of the power of 'leading questions' though. Ask open-ended rather than closed questions to obtain your answers. 	

E is for Examination	<ul style="list-style-type: none"> • Some considerations here include talking the person through what it is that you are doing, especially if this is an invasive or unusual procedure for them. • Knowing what is happening and why, as well as what to expect, can help alleviate the person's concern about what it is you are doing to them.
R is for Review	<ul style="list-style-type: none"> • Talk through what you have done as part of the examination – and what it added to your knowledge of their condition. • For example, 'You were talking about how you get short of breath, and I could hear from listening to your chest that your lungs are quite congested.'
V is for Verdict	<ul style="list-style-type: none"> • The diagnosis. • What their history and your examination have led you to think is causing their symptoms and signs.
I is for Information	<ul style="list-style-type: none"> • What does the diagnosis mean for the person? • Having a diagnosis of a lump in the breast can mean many things. • The person needs to know about these.
C is to remind you to Check Understanding	<ul style="list-style-type: none"> • This is where you determine if what you have said has made sense to the person. • People may only hear the diagnosis and then go into a state of shock – which means they don't process what you tell them next.
E is for End or Exit	<ul style="list-style-type: none"> • What's going to happen next for the person? • What about follow up? • Referrals to other professionals?

Section Four: Literature review – Racism and Islamophobia

The inferior health status of minority groups in many Western countries is well-documented. The reasons for this include poverty and related environmental factors, as well as lack of access to health care. A significant contribution may also be made by racial and ethnic disparities in quality of health care, specifically by differences in diagnostics and treatment of minority patients.⁵²

The causes of these differentials in health care treatment are complex. Biological differences may have a small impact, but other explanations include: patients' mistrust of the health care system; socioeconomic variables; unconscious bias on the part of health care practitioners; communication impairment; and lack of cultural sensitivity and cultural competence on the part of health care practitioners:

Of these, covert or unconscious bias, that is, the projection of stereotypes onto individual patients in ways that affect clinical decision-making, and lack of cultural competence may be the most directly remediable, if they are honestly recognised and if programs are designed to address them.⁵²

What is racism?

'Race' itself is a social construct, a category of classification in terms of inheritable characteristics (e.g. physical features, descent/blood etc.) and/or other social characteristics. What is important in this social categorization is that the distinct characteristics, attributes and qualities used to define a racial category are presumed to influence behaviour and attitudes such as in racial stereotypes.³⁷

'Racism is not just a question of group characteristics, stereotypes, or inter-group relations, but a question of ideology'.³⁵⁻³⁷ Racist ideology attaches meaning to the *differences* in inheritable characteristics or a distinctive culture and influences the way one acts, thinks or feels.³⁷

Stated differently, genetically inherited or culturally based differences are seen to contribute to a range of behaviours, some desirable, others undesirable. What is more, this ideology is also embodied and reflected in a range of social institutions, public policies and practices, all of which manifest as different forms of racism: individual, institutional or cultural.⁵³

The Australian Psychological Society notes that 'biological concepts of "race" have dubious validity, but that socially constructed notions of race are promoted and used in various ways to support current inequitable relationships among groups'.⁵⁴

Two main types of racism are recognised: '*old racism*' and '*new racism*'. 'Old racism' refers to the belief that certain races are inferior and others (mainly white Caucasian) are naturally superior. 'Old racism' is referred to as 'blatant' or 'overt' and includes belief in racial hierarchy and racial separation. 'New racism' is described as 'covert' and includes the following aspects:

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1. *Out-groups*: intolerance towards specific cultural groups who are identified as key Others to the (Australian) national imaginary. Intolerance to out-groups is sustained through stereotypes, for example that Indigenous Australians are welfare dependent, drunks and fail to assimilate to Western culture;
2. *Cultural diversity and nation*: The ideology of nation is important to understanding racism. Opinion polls in Australia have found that many respondents are in favour of cultural diversity, yet many have concerns regarding cultural maintenance amongst migrant groups. There appears to be unresolved tension in attitudes towards cultural diversity in Australia; and
3. *Issues of normalcy and privilege*: Some argue that there is a privilege of Whiteness, which is associated with a way of life and perspective where racism is unseen or is considered an exceptional aberration. There may be an element of denial attached to these issues.

The Australian Psychological Society believes that:

The expression of racism and prejudice has changed over recent decades from overt to more covert and subtle forms, but research reveals that they are still prevalent in Australia and other Western countries. Victim-blaming and scapegoating are common responses to attempts to make sense of social problems such as high unemployment levels. The media often reinforce negative stereotypes of minority groups.⁵⁴

Research conducted by Dunn et al.⁴⁵ revealed that racist attitudes in Australia are positively associated with age, non-tertiary education, those who do not speak a language other than

English, those born in Australia, and with males. Anti-Muslim sentiment is very strong, but there is also some intolerance towards Asian, Indigenous and Jewish Australians.

Essed^{39,55} defines racism as 'the definitive attribution of inferiority to a particular racial/ethnic group and the use of this principle to propagate and justify unequal treatment of this group'.

Berman and Paradies³⁹ define racism as:

That which maintains or exacerbates inequality of opportunity among ethnoracial groups. Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions/affect) or discrimination (racist behaviours and practices). Racism is one manifestation of the broader phenomenon of oppression which includes sexism, ageism and classism.

Racism can occur at three conceptual levels which co-occur in practice:⁵⁶

1. *Internalised racism*: occurs when an individual incorporates ideologies within their world view which serve to maintain or exacerbate the unequal distribution of opportunity across ethnoracial groups;
2. *Interpersonal racism*: occurs when interactions between people serve to maintain or exacerbate the unequal distribution of opportunity across ethnoracial groups; and
3. *Systemic/institutional racism*: occurs when the production and control of, and access to, material, informational and symbolic resources within society serve to maintain or exacerbate the unequal distribution of opportunity across ethnoracial groups.

There is a variety of other terms that arise in literature in relation to racism:

- *Ethnicity*: refers to cultural distinctness in values and norms deriving mostly from national origin, language, religion, or a combination of these;
- *Ethnocentrism*: refers to privileging of one's own cultural assumptions, values and perspectives at the expense of alternative perspectives when making value judgements or making sense out of situations or events;
- *Discrimination*: is a manifestation of prejudice that can be both individual and systemic, and overt or subtle. It finds expression in failures to act, tokenism, aversion, and exclusion;

- *Segregation*: can also be a manifestation of racism. It is present in residential, economic, social and psychological forms; and
- *Oppression*: is the systematic use of power or authority to treat others unjustly.

All of these processes are outcomes of the dominance of one particular group over others.^{54,57}

The language of racism

'The ways in which racism and prejudice work at various levels of society can be seen in our use of language, in everyday understandings of the sources of social problems, and in the media'.⁵⁴

Research in both Australia and New Zealand regarding attitudes to Indigenous peoples revealed that even in populations that are traditionally viewed as non-racist (e.g. university students) subtle racist language and attitudes exist. For example, objections to affirmative action, such as increased support for Aboriginal students at university, were viewed as 'unfair' and 'inequitable'. 'Such qualitative and language-based research supports the view that contemporary racist attitudes are subtle, flexible, ambivalent, and embedded in wider social values that, in effect, support and legitimise existing racial inequalities'.⁵⁴

Policies and initiatives to combat sexism, racism, and other forms of discrimination are characterised by some members of the community as attacks on the rights and freedoms of individuals to say, feel, and behave as they please. Such objections have typically been framed within the rhetoric of 'political correctness'. While genuine political correctness can be a strong force in encouraging more acceptable and reasonable behaviour, it is represented by opponents as undermining free speech in the service of minority group interests.⁵⁴

At the core of the general population's understandings are the individual and collective attempts to 'make sense' of events. They may be adopted in response to questions of, for example, high unemployment and other perceived injustices. In these instances it is often easier to 'explain' a problem by blaming a group that is different and to find a solution to a problem by blaming victims, such as immigrants or asylum seekers.³⁸ These attitudes both constitute and are reflected by the media, who are also used to construct and reinvent cultures and cultural identities.

Television, film and magazine images and lifestyles become the touchstone for what is reasonable, desirable, normative and 'good'...Prejudice and racism at the level of media images and coverage are subtle and far-reaching in part because they are an integral part of such constructed realities.⁵⁴

Denial of racism, in varied forms, is a key feature of modern racism. Van Dijk⁴⁶ identified four types of self-denial that allow the individual to talk about race whilst avoiding a charge of racism:

- Act denial ("I did not do/say that at all");
- Control denial ("I did not do/say that on purpose");
- Intention denial ("I did not mean that"); and
- Goal denial ("I did not do/say that, in order to...").

Denial of racism across these four types allows a speaker to present the 'Other' in a negative light, while not damaging one's own self-presentation. Negative comments about ethnic groups are unacceptable, hence speakers manage them by using particular types of language, such as hedging or minimising, and other strategies, such as justifications, excuses and blaming the victim.^{46,47} 'Presenting oneself as "even-handed" and "balanced" are important discursive tools to mitigate against accusations of racism, while simultaneously downplaying the extent of the racism'.^{47,58}

Nelson⁴⁷ identifies four discourses of denial – absence, temporal deflections, spatial deflections and deflections from the mainstream:

- Absence discourse – where one claims there is no racism;
- Temporal deflections – is a strategy of denial or minimisation where a passage of time separates a person or place from racism;
- Spatial deflections – where one claims an absence of racism in a particular locality or place; and
- Deflections from the mainstream – ambivalence where individuals are often willing to acknowledge 'pockets' of racist issues, but not structural or systemic racism.

The language of denial surrounding racism has important repercussions: those who are the victims of racism may fail to recognise the extent of their victimisation and those who deny its existence fail to recognise the need for anti-racism strategies.

Mitchell⁴⁸ identified several factors that may constrain individuals from 'speaking up' against racism:

- Fitting in with social expectations: the possibility of jeopardising social relationships inhibits the challenging of racist comments in the course of conversation;
- Fear of provoking aggression and conflict: individuals may not challenge racism for fear it may lead to 'bad feeling' or aggression;
- Assessing the relationship – family and friends: individuals may consider who they are talking to and the type of relationship they have with the people making the racist comments. The issue of social tension may be a consideration;
- Assessing the situation – making a difference: individuals may be inhibited from speaking out by their assessment of the likelihood of their comments making a difference, i.e. the beliefs of others present a brick wall; and
- Form of racism – jokes: in addition to spoiling the fun, challenging jokes has the added complexity of it being easy for the joke-teller to deny racist intent.

As a facilitator for speaking up against racism in everyday conversations, participants in one study⁴⁸ reported that they were 'confident in challenging non-factual statements where they felt well-informed and authoritative about the facts'. Mitchell⁴⁸ further asserts that 'responding to racism in everyday social interactions represents an important site for anti-racism'.

Anti-racism

Anti-racism has been broadly defined as 'forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism' and as 'ideologies and practices that affirm and seek to enable the equality of races and ethnic groups'.^{39,40}

Strategies to reduce racism and prejudice include the following:⁵⁴

- Changing stereotypes: it is often thought that contact between groups should be sufficient to break down stereotypes, however this is generally not the case. Even when presented with contradictory evidence, stereotypes generally persist. There are some conditions under which stereotypes have been found to change:
 1. Through repeated or widespread instances of encounters or examples that do not confirm the stereotype;^{59,60}

2. If disconfirming evidence is provided by a representative of a group who is, in every other way, regarded as a typical group member.⁶¹ Cooperative rather than competitive contact, which encourages viewing out-group members as individuals, and recognising diversity within groups, thus undermining stereotypic expectations and generalisations;⁶²
 3. At an individual level, people themselves can overcome their automatic stereotypic expectations,^{63,64} and
 4. Changing the classification system used to categorise self and others. Rather than identifying as a member of one in-group versus various out-groups, we can identify as an individual within one large group within which differences exist and can be suppressed.
- Cross-cultural awareness education: for example workplace programs and school programs;
 - Parenting in early childhood: research in developmental psychology suggests that parenting and educational practices can have a major impact on children's development, attitudes, and behaviours towards out-group members;
 - Working with youth: workshops, youth committees, involvement in campaigns and peer education are some of the ways in which young people can become involved in challenging racism;
 - Using the arts: the arts can provide opportunities for communicating both anti-racist sentiments and the experiences of minority groups to the wider community;
 - Media interventions: compared to health issues that have been associated with numerous media advertising campaigns over the last two decades, media advertising has been under-utilised in marketing regarding social issues such as racism; and
 - Government legislation: more than any other form of intervention, legislating against expressions of prejudice and discrimination is likely to invoke controversy and disapproval among some sectors of society. Australian laws are aimed at protecting individuals and also protecting those individuals who make complaints about racism. Commonwealth and State laws make it unlawful for a person to racially discriminate against another person and also make it unlawful to encourage, incite, permit or allow racist acts to occur.

At the simplest level, attempts to combat racism are ultimately designed to prevent or redress the disadvantage caused by such experiences and to ensure equal access to and ability to participate in social, cultural, economic and political life. However, efforts to tackle racism and to ameliorate disadvantage (whether caused in whole or in part by racism) are related yet distinct endeavours that warrant separate approaches in both policy and practice (see Table 1).³⁹

Policies and practices that seek to address disadvantage by focusing solely on targeted communities will do little to enhance relationships between communities and are unable to tackle the systemic racism that is at the root of ethnoracial disadvantage...

Disentangling notions of disadvantage, multiculturalism and anti-racism makes it possible to bring anti-racism praxis to the fore via policies and programs that focus on broader community attitudes and social systems.³⁹

Table 1. The differing responses to racism and disadvantage

Combating racism		
<i>Institutional</i>	<i>Individual</i>	<i>Addressing disadvantage</i>
Equal Opportunity legislation and mediation	Dispelling false beliefs	Access to affordable housing
Institutional Ombudsmen	Promoting empathy	Access to appropriate health care
Regulation of the media	Intercultural contact	Appropriate educational support
Anti-racism public media campaigns	Anti-racist educational curricula	Appropriate welfare support
Anti-racism auditing of organisations	Workplace anti-racism training	Employment support and training
Regular reviews into the nature, prevalence and solutions to racism in institutional settings		Translation services
Increased capacity to monitor and report racist attitudes and behaviour		Language classes
		The provision and dissemination of information on processes, policies and rights to ethnoracial minorities
		Programs focused on encouraging social participation by ethnoracial minorities (e.g. arts, sports)

Source: Berman and Paradies, 2010³⁹

Islamophobia

Since the terrorist attacks in the USA on 11 September 2001 (9/11), the Bali bombing in 2002 and various other international incidents:

Ethnic minorities associated with Islam in most Western countries have experienced increased negative attention from the media, police and security forces, and indeed from agitated citizenry. There has been a concomitant increase in all such countries in the extent of anti-Muslim or 'Islamophobic' hate crime, racial vilification and discrimination.⁴¹

Experiments conducted by Spruyt and Elchardus⁶⁵ in Belgium found that 'anti-Muslim feelings, sometimes equated with Islamophobia, are (much) more widespread than anti-foreigner feelings, sometimes described as xenophobia'.

Fernandez⁴² identifies three basic themes in discourses relating to Islam scepticism:

1. Threats to the position and rights of women;
2. Threats to security; and
3. Threats to the separation of church and state.

The 2004 'Isma-Listen' report by the Human Rights and Equal Opportunity Commission (HREOC) revealed that the majority of Arab and Muslim Australian participants surveyed had experienced various forms of prejudice because of their race or religion. These experiences ranged from offensive remarks to physical violence. Most experiences were described as isolated incidents involving strangers, although many participants had experienced prejudice in the workplace, educational facility, or from government services such as police.

Participants felt those most at risk were those easily identifiable by appearance, name or dress – particularly women wearing traditional Islamic dress. 'These experiences are having a profound impact on Arab and Muslim Australians. The biggest impacts are a substantial increase in fear, a growing sense of alienation from the wider community and an increasing distrust of authority'.⁶⁶

The absence of consistent legal protection from religious discrimination and vilification across Australia was cited by participants as a cause for concern and a reason for reluctance to formally complain. Conversely, a bilingual (English and Arabic) Anti-Racism Hotline in New South Wales logged over 400 calls between September and November 2001. The number of Hotline informal complaints, although only the 'tip of the iceberg', is an accurate reflection of the

real prevalence of racism, abuse or violence against Muslim Australians, which the HREOC survey suggests was 87% post 9/11. The relatively low number of formal complaints has been attributed to the perception by victims that nothing good will come of the reporting process. Of those respondents in the HREOC survey who did lodge a formal complaint, 70% were dissatisfied with the outcome. 'Arguably then, the State not only induces hate crime by modelling it...but also systematically neglects or declines to bring the perpetrators to justice when hate crimes are committed by individuals'.^{66,67}

Participants identified lack of knowledge and misinformation about their history, culture and faith as the major underlying cause for the rise in prejudice against them and that this lack of knowledge and misinformation has been exacerbated by terrorism and an international climate of political tension between the Arab and Muslim world and western nations, including Australia.⁶⁶

'In the HREOC survey of Arab and Muslim Australians, around 47% of respondents believed their communities had been vilified in the media' and 'participants also felt that biased and inaccurate reporting of issues relating to Arabs and Muslims is commonplace amongst some sections of the media and is extremely damaging'.^{66,68}

The 'Isma-Listen' Report's recommendations included two relating to public language and media. The first recommendation suggested that the relevant media industry groups 'consider undertaking information campaigns in relevant community languages and in a variety of formats to inform Arab and Muslim organisations and community members about their standards and complaint processes'. The second recommendation was 'that government agencies responsible for promoting multiculturalism consider facilitating consultation between media organisations and ethnic and religious community organisations, including Arab and Muslim groups, to improve mutual understanding'.⁶⁶

Poynting and Perry⁴¹ assert that 'hate-motivated vilification and violence can only flourish in an enabling environment'. Government legislation passed in several Western countries, including Australia, in the wake of 9/11 saw the surveillance and harassment of Muslim residents undertaken in the name of the 'war on terrorism'. In many instances this harassment, in the form of raids on people's homes, occurred with the media present. The ensuing publicity sought to ensure any 'terrorist sympathisers' remain firmly underground, but also legitimised hate crimes in the street. The badgering of Muslims by the state 'makes people feel comfortable with their

prejudices and grants those who hold pre-existing racist attitudes permission to express those attitudes and expect them to be taken seriously. It empowers individual prejudices and fuels popular fears'.⁶⁹

Research undertaken by Pedersen and Hartley⁷⁰ investigated the specific values of participants regarding their perceptions of Muslim Australians and Islam. The participants who revealed the highest level of prejudice were, predictably, those with lower educational levels, more right-wing views and a stronger identification with Australian identity. The high-prejudiced participants were concerned about gender inequality within the Muslim community, but less concerned about equality generally and also reported that Muslims 'were not conforming to Australian values'. The same participants 'scored higher in the reporting of negative media-related beliefs, were more likely to perceive higher support in the community for their views than was the case and were more negative towards Muslim men than Muslim women'.

Identifying the values that underpin Islamophobia is important when developing strategies to decrease prejudice. 'Australian values do not seem to be influenced by 'the abstract ideals of political discourse'; rather it is influenced by popular culture and 'real' people, places and communities'. This suggests that attempts to counter prejudiced attitudes should 'do so in a way that is more integral to Australians' day-to-day lives'. To do this, we need to know what values people hold dear.^{70,71}

The concern some have regarding Muslim Australians' 'failure to integrate' and 'conform to Australian values' is connected to the fear of 'home-grown terrorism'. However, research into the values of Australian state school students from Muslim backgrounds revealed that:

These students were learning English and history in schools and, through taking part in activities such as sports, they were integrating with other students. At the same time, they were also retaining many traditional cultural values and affiliations. Arguably, their biculturalism was allowing them both to sustain self-esteem and to stretch their culture gradually to adopt Australian values and behaviours.^{72,73}

The prejudice against Muslim Australians extends to other social indicators, such as the labour market, where 'even after 10 years of residence for migrant Muslims, the unemployment rate is almost double the Australian average'. The reluctance to employ Muslim Australians does not appear to be linked to English speaking proficiency, as non-English speakers from European backgrounds do not encounter the same difficulties. 'So where skin colour was once more

important historically, now cultural factors appear to take precedence, with religion providing the ultimate marker of preference'. This is supported by evidence that Asian and Middle Eastern people of Christian faith seem to manage dramatically better than Muslims. One reason for this discrepancy could be the Muslim identity, appearance and dress which is an unmistakable identifier and represents, to some, an imperviousness to change. 'Their extremely small numbers in both the overall population and the labour force render Muslims more susceptible and defenceless in the face of intolerance and prejudice, while international factors enhance this vulnerability'.⁷⁴⁻⁷⁶

The impact of racism on health is well-documented, if not fully understood:

In attempting to explain negative health outcomes experienced by racial and ethnic minorities, researchers have increasingly turned their attention to racial and ethnic discrimination. Racism is a potent psychosocial stressor that is characterized by both social ostracism and blocked economic opportunity...Racism has also led to inequitable access to social, educational, and material resources. These resources have both direct effects on health status (i.e. through access to healthy diets and health care) and indirect effects on health status, through their influence on stress, psychosocial resources, and positive and negative emotions.⁷⁷⁻⁸⁴

In a study of Arabic-speaking patients' acute hospital experiences in Australia, Garrett and Forero⁴³ found that:

Arabic-speaking patients at times articulated a sense of separateness or difference based on particular cultural beliefs, particularly related to female modesty, the wearing of the hijab (scarf), mixed gender wards, and examination of females by male providers. Others believed that Muslims or Arabic-speaking people were perceived negatively, and consequently may be treated inequitably.

In the context of the health care environment racism can be present even unwittingly: for example, failure to call an interpreter, social assumptions, and thoughtlessness or poor cross-cultural understanding. Race relations have implications for both patient-provider interactions and the health of communities.⁴³

Much of the discourse and associated prejudice surrounding Muslim Australians emphasises the perceived incongruity between Muslim culture and religion, and that of the wider community. However, the study by Rane⁴⁴ revealed that while Muslims value their Islamic identity, the

majority of Muslim Australians share the same values as the wider Australian society. 'The research showed that Muslims highly value Australia's key social and political institutions, including its democracy, judiciary, education and health-care systems'. The study also revealed that the respondents' trust in the Australian Government and the media is low. Furthermore, 'respondents to this study overwhelmingly oppose terrorism, view the targeting of civilians as incompatible with Islam's teachings and consider Islam to support gender equality'. These views are consistent with similar research reflecting the views of Muslims globally.⁸⁵

Conclusion

Research has demonstrated a 'generally poor public perception of Islam in Australia. This antipathy is reinforced by problematic media treatment and a hostile government disposition. The negativity has material impacts upon Muslim Australians'. The source of Australia's racism towards Muslims is not biologically based, but rather cultural and religious in origin. There is a widespread belief that Muslim Australians fail to integrate or assimilate into 'Australian' culture and that Islam represents fanaticism, violence and misogyny.⁸⁶

Islamophobia has given rise to an alarming increase in anti-Muslim and anti-Arab prejudice in Australia, particularly since 9/11. This prejudice has manifested in hate crimes, which frequently go unreported, diminished access to the labour market and suboptimal health care.

Participants in the 'Isma-Listen' project identified six key areas for improvement and further action:⁶⁶

1. Improving legal protections;
2. Promoting positive public awareness through education;
3. Addressing stereotypes and misinformation in public debate;
4. Ensuring community safety through law enforcement ;
5. Empowering communities; and
6. Fostering public support and solidarity with Arab and Muslim Australians.

The way forward for the acceptance of Muslim Australians into the wider community includes the addressing of stereotypes and misinformation, and 'the need for a shift in public discourse to more accurately reflect the commonality, rather than incongruity, between Muslim views, opinions and concerns and those of the wider society'. The study by Rane et al.⁴⁴ concluded that 'Muslims in Australia are engaging in a process of redefining the priorities of their faith in the context of contemporary Western society'. Similarly Dunn et al.⁸⁶ conclude that 'racialization constructs both the Other and the Self, and so expanding popular understandings of Australian-ness beyond Anglo-Celtic/Christianity is fundamentally important'.

As in other developed countries, the primary responsibility of Australian health care practitioners is to meet health consumer's needs, while respecting and supporting their values.⁸⁷

As the population of patients grows ever more diverse, cultural competence and freedom from bias are becoming increasingly urgent professional responsibilities. It is important to note that in the vast majority of cases these documented disparities in diagnosis and treatment do not reflect conscious racial bias or calculated cultural insensitivity. Reducing racially or culturally based inequity in medical care is a moral imperative. As is the case for most tasks of this nature, the first steps, at both the individual and societal level, are honest self-examination and acknowledgement of need.⁵²

Further information regarding Islamic culture and religion and Muslim beliefs and practices can be found at:

Saeed, A. (2004). Muslim Australians: Their beliefs, practices and institutions.

Commonwealth of Australia. Available at: <http://www.abdullahsaeed.org/book/muslim-australians-their-beliefs-practices-and-institutions>

Culture and religion information sheet: Islam. (2012). Government of Western Australia. Available at:

http://www.omi.wa.gov.au/resources/publications/cr_diversity/islam.pdf

Department of Health Western Australia, Substantive Equality Policy. Available at:

<http://www.health.wa.gov.au/CircularsNew/Attachments/415.pdf>

Department of Health Western Australia, Equal Opportunity and Diversity Policy.

Available at:

<http://www.health.wa.gov.au/circularsnew/attachments/331.pdf>

Acronyms

AIPPEN	Australasian Interprofessional Practice and Education Network
ASPIRIN	Acknowledge the problem; Situational analysis; Provide some solutions; Implement; Review the outcome; Inform stakeholders; Next steps
ED	Emergency Department
HREOC	Human Rights and Equal Opportunity Commission
IAT	Implicit association test
IPE	Interprofessional education
IPL	Interprofessional learning
IPP	Interprofessional practice
LIPSERVICE	Language; Introduction; Privacy dignity and cultural issues; Subjective questioning; Examination; Review; Verdict; Information; Check understanding; End or exit
PCA	Patient care assistant
WHO	World Health Organization

Glossary

Anti-racism	‘Forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism’ or ‘ideologies and practices that affirm and seek to enable the equality of races and ethnic groups’. ^{39,40}
Cultural insensitivity	A lack of awareness that cultural similarities and differences exist and have an effect on values, learning and behaviour.
Human factors	The interaction of equipment and individuals and the variables that can affect the outcome. ^{18,19}
Interprofessional education	Occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care. ⁸
Interprofessional learning	Learning arising from interaction between members (or students) of two professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings. ⁸
Interprofessional practice	Two or more professions working together as a team with a common purpose, commitment and mutual respect. ⁸
Islamophobia	Prejudice against, hatred towards, or irrational fear of Muslims.
Mnemonic	Any learning technique that aids information retention, e.g. acronyms and memorable phrases.
New racism	Covert racism in which constructions of ‘race’ continue to perpetuate economic, social, political, psychological, religious, ideological, and legal mechanisms of structured inequality. ⁴⁵
Old racism	Refers to the belief that certain races are inferior and others (mainly white Caucasian) are naturally superior. ‘Old racism’ is referred to as ‘blatant’ or ‘overt’ and includes belief in racial hierarchy and racial separation. ⁴⁵

Simulated learning

environment

A technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion.¹

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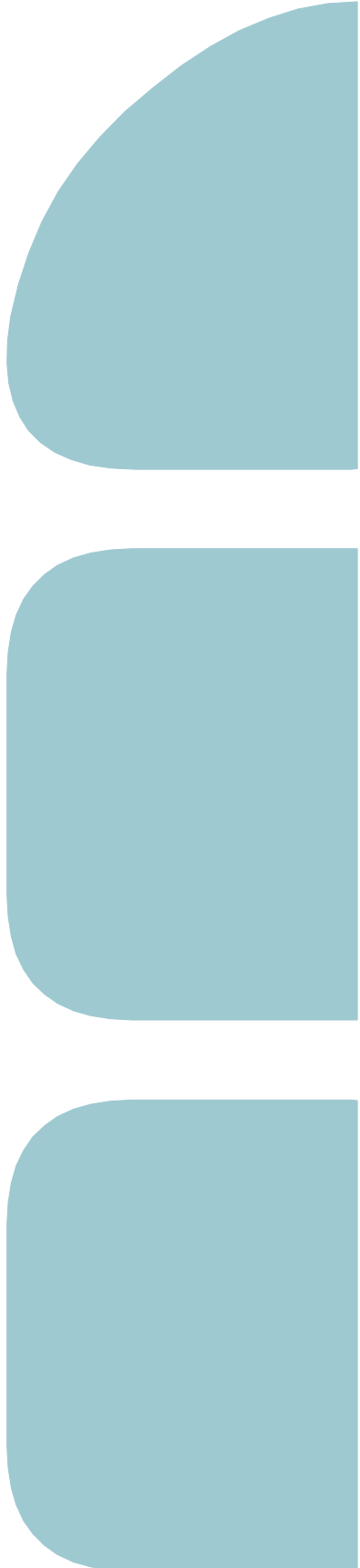
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