Intercultural Residential Care in New Zealand

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*Along with other Organization for Economic Cooperation and Development (OECD) countries, New Zealand's society is aging such that an increase in the number of older people requiring residential care is predicted. What cannot be foreseen is how culturally defined health beliefs affect the care given to older people in residential care. In this article, the authors describe and discuss the culturally based health beliefs of some Pacific Islands caregivers and predominately European (*Pakeha*) older people resident at one long-term care facility in Auckland, New Zealand. The delivery of care is influenced by culturally related beliefs about "being old." Racism is evident in residential care, and the authors discuss the reactions of caregivers, residents, and management. This research extends the discussion of caregiving and receiving into the cross-cultural setting, and the findings highlight a number of elements in cultural differences between carer and cared-for that might affect care practices at the residential facility studied.*

Keywords: *residential care homes; health care beliefs; older people; residents; caregivers; intercultural care; ethnicity; Pacific Islands; Pakeha*

Caregiving within residential care presents a complex mix of staff having too much work for too little pay (Flicker, 2002); vulnerable, frail, older care recipients; and a bureaucracy setting administrative hurdles that potentially affect care. Little is known about the workforce caring for the daily needs of residential care recipients, and what is known is based mainly on ethnographic studies conducted in the United States (Clough, 1981; Diamond, 1992; Foner, 1995a; Henderson, 1995). Examination of nursing homes has offered insight into residential care under the United States health care system, where physical and psychological abuse "we know, is distressingly common" (Foner, 1995a, p. 39). In the United Kingdom "old folks homes" have not fared much better than their United States counterparts. In part due to these homes' having been the United Kingdom's workhouses of past times, residential care facilities have been viewed negatively (Wilson, 2000). Whether in the United States or in the United Kingdom, the detrimental views associated with these homes have been reinforced through studies that show inadequate quality of care (Ballard et al., 2001). However, residential homes have been

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viewed in more constructive ways in other countries, including Denmark and the Netherlands, which since World War II have given these "institutions a halfway decent image" (Wilson, 2000, p. 149).

In residential care homes, the dynamics of race, ethnicity, and gender affect relations between aides, managerial staff, and residents (Foner, 1995a, p. 148) and feed into, rather then create, divisions between groups (p. 149). Low wages keep the nursing-aide workforce at the margins of subsistence income and underline workers' status as poor women (Diamond, 1992, p. 186).

In this context, the giving and receiving of care is complex, and the concepts of sensitivity, acting in the best interest of others, and reciprocity, described as being integral to caregiving, can be reexamined (Tarlow, 1996, p. 76). Opie, Fulcher, Hawke, and Allen (1992) examined caregiving to those with dementia and found caring relationships were lived and negotiated in terms of related spectra, from obligation to dissociation, and from commitment to repudiation (p. 108). Poor caring relationships could undermine the identity of the carer and be personally destructive, and were expressed as carer stress (p. 109).

Documentation about residential care in New Zealand has followed the same path as that of the United Kingdom and United States. In the late 1960s, residential care emerged in New Zealand (North Shore Old People's Welfare Council, 1969). Since that time, medically based literature has been written on the care and mis-care of the aged (Department of Health, 1988). This focus on the neglect of the elderly has resulted in organizations' being set up to look after the welfare of older people (Age Concern New Zealand Incorporated, 1992; Maclean, 2000). Concern about the increased number of older people in the future has also resulted in interest from the state. The Ministry of Health (2001) has released a strategy for older persons (Dyson, 2001; Glackin, 2001), which will be complete by the end of this decade. Along with the United Kingdom and the United States, New Zealand is following a global trend toward an ever-growing aging population (Organization for Economic Cooperation and Development [OECD], 1996). On an international level, this means that the quality in residential care will be of increasing interest to researchers, health funders, and consumers over the next decades. On a national level, researchers are showing increasing interest in issues surrounding older people. Financial support for this study was provided by the Pacific committee of the New Zealand Health Research Council of New Zealand (HRC).

INTERCULTURAL CARE

The expected increase in older people in New Zealand follows similar lines in the United States, both in terms of the general population (Tiamiyu & Bailey, 2001) and with elderly people from ethnic minority groups (McLaughlin & Braun, 1998), and there have been calls for health care workers to become more (inter) culturally competent (Lester, 1998; Wilson, 2000). Studies about health belief systems of ethnic minority groups (McLaughlin & Braun, 1998) and culturally specific health care practices from 27 different ethnic groups residing in the United States and Canada (Purnell & Paulanka, 1998) have reinforced the need for more work on ethnic and cultural competency issues.

The concept that "our own cultural conceptions of age and ageing are just that: our own" (Foner, 1984, p. 1) is reinforced in one comparative study (Fry, 2000) that

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focuses on the well being of older people from 7 communities in Africa, Ireland, the United States, and Hong Kong. The author argued that health beliefs within given cultural contexts are integral to health care practices. Another United States study examining 70 White and 100 Mexican young people's attitudes about older people reinforced this view when it found that the Mexicans' attitudes toward older people were more positive than those of their White counterparts, in part because there was more contact with older family members (Culbertson & Margaona, 1981).

Other research on the differences between health care practices of Blacks and Whites in the United States is mostly about caring for the elderly in their homes (Lee, Peek, & Coward, 1998). There is ample description of ethnic and cultural differences between groups of older people such as Franco-Americans (Woolfson, 1990), Lebanese Americans (Shenk, 1990), African Americans (Wallace, 1990), Latinos (Angel, 2000), and Russian émigrés (Brod & Heurtin-Roberts, 1992). Although most of this literature focuses on older people rather than on the caring workforce (Giordano, 1992; Taylor, 1998; Wilson, 2000), one Canadian research team did discuss the intercultural experiences of ethnic minority caregivers from the Philippines and the Caribbean working with predominately White care recipients (Neysmith & Aronson, 1997). Racist behavior by care recipients toward the caregivers was a common occurrence. An integral part of intercultural health care practices relies on the effectiveness of communication between caregivers and those they are caring for.

A substantial proportion of those caring for older people in residential care are of non-European descent, whereas the elders they care for are from all races and ethnicities but tend to be White. Although the reasons for this are not entirely clear, a mix of culturally related attitudes to aging, financial barriers, and the perception that ethnic minority elders are not safe in residential care culminate to mean that ethnic minority elders are underrepresented in residential care. The "United Nations" of paid caregivers is well described (Diamond, 1992, p. 187; Foner, 1984, p. 148). The low remuneration available, systematic capture of health care workers from other nations such as the Philippines (Diamond, 1992, p. 148) and ownership hierarchy creating social control contribute to the workforce makeup's being mainly from ethnic minority groups. The impact of cultural beliefs on patterns of caregiving in residential care has not been considered in depth in the literature. Themes identified in this field study show that concepts developed in the context of informal caregiving (Opie et al., 1992; Taylor, 1998) can be used to discuss the giving and receiving of formal care. This is in addition to the literature and will need to be further explored in future studies.

STUDY FOCUS

Our aim in this study was to gain greater understanding of caregiving in residential care and the way in which intercultural care was understood through Pacific Island(s)– and Pakeha-based[1] cultural filters within one residential care setting located in one New Zealand city. The focus of the study was to examine thematically and report the narratives of a group of older Pakeha residents, aged 65 years and over, and a group of Pacific Islands caregivers of various ages employed at a residential care facility in the greater Auckland area.

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METHOD

This was an exploratory field study and was conducted at one religion- and state-funded welfare-based long-term residential care home in Auckland, New Zealand. We chose the facility because of the high number of non-Pakeha caregiving employees, with the majority being of Pacific Islands descent, who had been involved in a larger study investigating fall prevention practices. Approximately 95% of the 30-plus full- and part-time caregivers employed at the residence were of Pacific Islands descent. The residence caters for up to 100 (mainly older) people at high-level dependency in both nursing-home and secure dementia care units. At the time the study was completed, the residence was operating at three-quarters full-bed capacity.

The Sample

We gathered data using nonparticipant observation to set the scene and understand the context in which residents and staff interacted. We selected a sample of residents, nursing assistants, and registered nursing staff for semistructured interviews. Senior staff at the residence extended the invitation to participate to 10 Pacific Islands caregivers on duty during the day over a 2-week period during September and October 2000. We chose two day shifts, 7 a.m. to 3 p.m. and 3 p.m. to 11 p.m., from Monday to Friday, for interviews because of the presence of a higher number of staff members and the likelihood of staff being able to relieve a colleague for ½ to 1 hour, so that an interview could take place. All caregivers agreed to participate. The same senior staff also asked 10 of the older residents to participate in the study. Eight of these residents agreed to take part. Along with the 10 caregivers, this resulted in 18 semistructured interviews.

All caregivers were of Pacific Islands descent. The majority of caregivers self-identified as Pacific Islands born, although some had been raised in New Zealand. Islands-born caregivers came originally from Samoa, Tonga, and other Pacific countries. Seven of the 10 caregivers were less than 45 years of age, whereas the other 3 were aged between 55 and 65 years. Seven of the 10 interviews with caregivers were conducted in English, and 3 were carried out in Samoan. Most caregivers were female.

The majority of resident participants were female and Pakeha. The residents were considered by management to be in good health and thus able to participate in the interview process. One resident was aged about 80 years and was bedridden due to a bone fracture, whereas another was using a wheelchair, also because of a fracture. Residents were aged from 70 to more than 90 years. All residents were wheelchair bound or required assistance to get around the facility. Only one resident, aged about 75 years, was mobile enough to use a walking frame under staff supervision.

The Interviews

We used personal interviews to explore issues related to caring, receiving care, culturally related attitudes toward older people, and experiences of living and working in the long-term care setting. Interviews were conducted by the two authors: a

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Pakeha woman aged in her late 30s and a Samoan man aged in his mid-20s. Both had qualitative research training and a social science background. Initial meetings were in the break room and in the corridors around the nursing stations. The interview process was purposefully informal to encourage communication between researchers and caregivers. Interviews lasted 15 to 40 minutes and were conducted either in a private room made available for the purpose or in the resident's room. Caregivers and residents were unwilling to be audiotaped and suspicious of active writing during observational periods. Staff and caregivers deemed note taking during interviews inappropriate, so we took notes immediately after the interviews and examined them for recurring themes and patterns (Adler & Adler, 1994).

The Caregivers

Caregiving participants were asked to comment on their working environment. Questions designed to open up conversations such as What is it like working here? What types of work are you expected to do? and Who works with you? were intended to encourage the caregivers to offer their perception about working at the residence. Attitudes toward older people within their own cultural groups were enquired about and explored, as were their experiences in caring for older people from differing cultural groups.

The Residents

Using a semistructured interview technique, the interviewer asked the residents how long they had been at the residence, the stories behind their admission to the facility, and how the facility catered to their particular care requirements. English was the first language of all but one resident, and all interviews were conducted in English. One interview was conducted between the resident and both researchers. The resident mistook the researchers for mother and son. Subsequent interviews were with one interviewer only, as researchers recognized the potential for confusion about the relationship between researchers.

Data Analysis

We identified themes by reading and rereading notes and through ongoing discussions between the researchers. Direct quotation of conversation was not possible, because audiotaping was deemed inappropriate by the management of the residence taking part in this exploratory study.

Ethical approval for the study was granted by the University of Auckland Human Subjects Ethics Committee. This field study was an extension of a randomized controlled trial investigating the effect of a falls prevention intervention in residential care and was prompted by anecdotal and focus group information about cross-cultural care arising from that larger study (Kerse, Butler, Robinson, & Todd, 2004). A strong sense of protection of the worker during participation in this current qualitative study meant that reassurances of confidentiality of information were given and reinforced by management in introducing the researchers into the setting. Residents were equally reassured of confidentiality of information given about any aspect of living in residential care. In considering the potential for conflict

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situations in the research setting, an ethical dilemma arose, as residents are inherently powerless, and abuse has been described. As it happened, we observed no potentially abusive situations. Management eagerly received feedback of anonymized information in report form (Kiata, Kerse, Abel, & Park, 2001).

A Methodological Consideration

Aware of the subjective nature of "our" readings of the narratives of the participants, who might or might not agree with our interpretations, the study allowed the researchers to subscribe to the notion that "we are free in being able to question and re-evaluate our inherited identities and values, and to challenge received interpretations of them" (Sawicki, 1991, p. 101). What follows is a response to that challenge.

RESULTS AND DISCUSSION

Intercultural Care

We discussed how care delivery and reception was mediated across cultures using practical situations experienced by carers when working with frail older people. Intercultural differences were premised on commonsense beliefs about old age and caring for the aged. Pacific Islands' cultural beliefs about older people are epitomized in respect, reverence, and the idea that older people are the most important within the family (Oliver, 1989).

The Caregivers' Perspective

A caregiver succinctly stated that culturally based differences were evident within the residence. This participant, a Tongan woman aged in her 40s, spoke about the variations between the Pacific and Pakeha models of care in the following way: Pacific people invest in caring for their children, and in return their children will care for them in their old age. Contrary to this philosophy, Pakeha people rely on monetary investments to ensure care for their older years. For elderly people, there comes a time when an independent lifestyle is no longer possible, and cashing in their investments becomes necessary. For Pakeha, this means having to pay for long-term care (usually) in a residential setting away from their homes, and strangers provide the care required. For Pacific Island elders, however, the earlier investment in their young people means that the children, now grown, will care for them as elders within a familial context. The main point of difference between these models, as expressed by Pacific Island caregivers, lies in the amount of mutual trust and respect between the elderly and the young within families. It is important to add that in the Pacific milieu, the concept of family includes extended family members who appear to have, in Pakeha terms, no familial ties at all. We have summarized these views in Figure 1.

All caregivers discussed the differences in care offered and received and their perceptions about Pakeha older people and their "own old people." Old age for Pacific Islands people means a form of submission and little active agency

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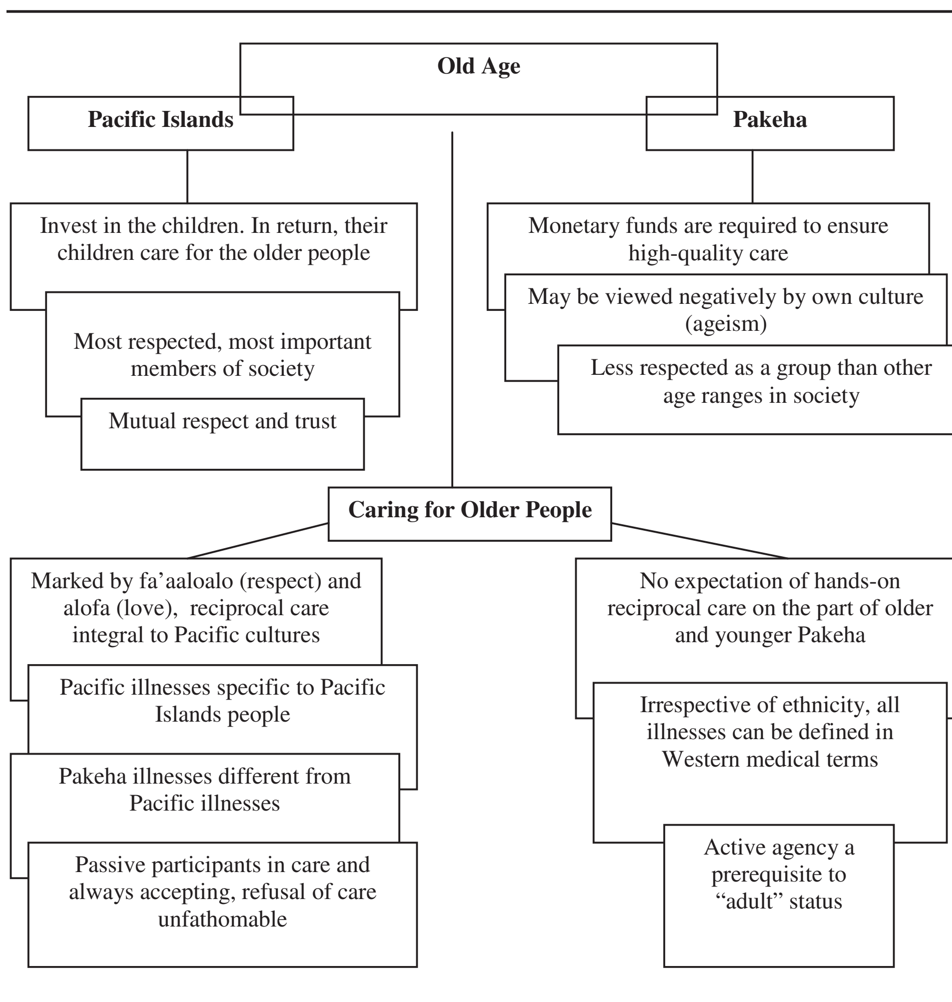

FIGURE 1: Intercultural Differences in Views Expressed by Pacific Caregivers and Pakeha Residents

regarding the type of care received (Carer S, a woman aged in her 40s). As explained to the interviewers, belief systems based in Western European ideology are seen as allowing Pakeha elderly a great deal of agency. In Pacific terms, active agency tends to be viewed negatively, because it is perceived as challenging not only the quality of care being provided but also the carer–cared for relationship. A prime example can be seen in Samoan etiquette, which determines that the relationship between the carer (usually a young person) and the elderly is marked by *fa'aaloalo* (respect) and *alofa* (love), and is mutually understood as such. Basic necessities such as food and physical care are given to the elderly at the carer's discretion. However, the older person and the caregiver understand that submitting to the role of "cared for" does not necessarily mean loss of empowerment for the aged. This is because, culturally, the respect accorded to the elderly is paramount.[2]

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The Residents' Perspective

Storytelling as narrative was resonant of Powers' (1995) research on the institutionalized elderly; Powers found that perceptions held by nursing home residents were told in narrative form, with the events of everyday life, including interactions with fellow residents and staff in the nursing home, featuring large.

In Figure 1, we have summarized the prevailing theme of how cultural distinctions about care for the elderly differed between Pacific and Pakeha peoples. Although not stated explicitly, all resident participants were of the opinion that aging occurs within particular social and cultural contexts. Active agency, as expressed by Pakeha residents, was seen as a prerequisite to adult status, and residents felt misunderstood at times. From the residents' perspective, illness was well understood, and behavior of confused older residents (distinct from those interviewed) was expected and understandable. In Figure 2, We have summarized and contrasted caregivers' and care recipients' views.

This is an extension of the discrepancy observed between some of the core values of United States–based society concerning independence and individualism and the realities of increasing frailty (Hornum, 1995, p. 164). The dependent state is valued in Pacific cultures and not seen as disempowering. Little wonder, then, that cultural concepts by societies not based on Western (European) constructs might find the Pakeha way a minefield of confusion.

In the context of the negotiation involved in giving and receiving care (Opie et al., 1992), differing expectations of care and of older people's behavior will create confusion and unsatisfying care relationships.

Illness and Understanding

Ethnocentric views about what constitutes a family can also be applied to differences in perceptions about older people and illness. Caregivers had great difficulty in making sense of residents' behavior, such as refusing food, care, and, sometimes, medication, because in the main, Pacific Islands elders are unlikely to refuse care. As this behavior was not part of their previous experiences while caring, they believed they were the result of Pakeha (only) illnesses. This meant that the Pacific caregivers were likely to attempt to reason with the residents about their awkward behavior. Here, problems could arise. Some Pacific Island caregivers had little or no experience negotiating with older people refusing care, even though this might have been due to illness and beyond either party's control.

This view could be affected by experience and training. Carer I expressed a view that Pacific older people were straightforward to care for, whereas Pakeha behaved in unexpected ways that included refusing care. Carer K, who was about 20 years of age, added that lack of understanding about Pakeha illnesses resulted in treating all residents (who are mainly Pakeha) in Pacific-defined terms, because "we did not know anything about diseases like Parkinson's and others" before working in residential care. The Pacific caregivers' beliefs were that some elderly people, irrespective of ethnicity, are simply *leaga le ulu* (crazy), although there was some evidence that acquiring knowledge about Western illnesses during training had enabled greater understanding to develop. As this caregiver stated, "Now I do not laugh at them anymore, I take them more seriously" (Carer K, 20s).

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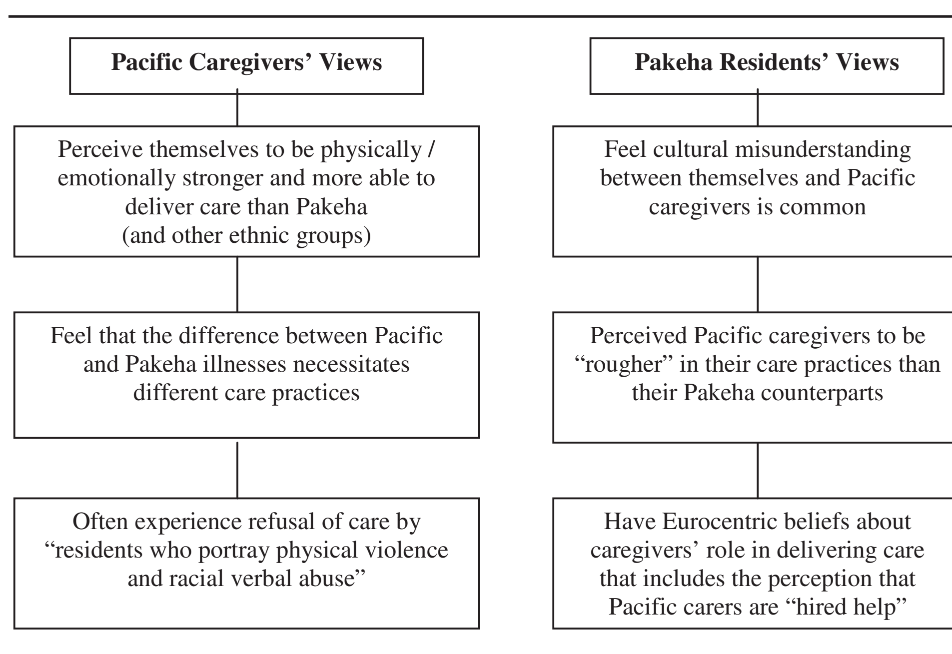

FIGURE 2: The Perceived Role of Carers Within Residential Care

There remains a need to understand more fully other cultures' health and illness beliefs and subscribe to cultural tolerance (Browne, 1997). To further our understanding, we used a model similar to that of Lowe and Struthers' (2001) framework of nursing in Native American culture. We found it useful to conceptualize the distinction between the Pakeha and Pacific Islands views of old age in the dualistic terms of a Pakeha/Pacific model.

Caregiving staff at long-term care facilities are likely to benefit from open dialogue about the needs of those for whom they provide care (Hornum, 1995). It is important to take into account the Pacific-based view that Pakeha illnesses affect Pakeha people. Pacific Islands caregivers expressed the belief that Pacific peoples have different understandings about illnesses from Pakeha, and these can be dealt with in culturally specific ways (Macpherson & Macpherson, 1990).[3]

These observations reinforce successful caring as a negotiated process that requires reciprocity for success (Tarlow, 1996, p. 80). Receiving care remains a major part of a reciprocal relationship between the carer and the cared for in most Pacific cultures, and if that care is not received willingly, caregiving can be disrupted.

Carer Role Suitability: A Question of Race(ism)

Caregivers believed that the type of work they were employed to do was a natural extension of previous experiences with looking after the emotional and physical needs of infirm family members. Carer P, a woman in her 60s, believed that the cultural obligation in most Pacific cultures of caring for elderly and/or infirm family members transfers well into the residential care situation, because it allows the care-

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givers to cope with the stress of demanding Pakeha residents. Carer P believes that traits such as strength distinguish Pacific people from Pakeha, who tend to leave the caring of "their" elders to others (such as Pacific Island carers) in institutionalized settings. A younger colleague, aged in her 20s, stated that Pacific Islands caregivers are "better than others [ethnicities] because they respect their elders" (Carer I).

In the majority of interviews with caregivers, the discussion at this point moved its focus to the way in which some residents did not want "particular" caregivers lifting them for toileting purposes (Carer T, 30s). This task is physically intimate and often demanding, especially for very frail residents. The carers stated that some residents resisted care in a variety of ways, including yelling and swearing that often included verbal racial abuse, and in a physical way, with scratching, kicking, and hitting. One story related by Carer L, who is about 25 years of age, reflected the reality of caring for some. In a recent incident, a resident had refused to be toileted by Carer L. Insistence on completing the task resulted in the caregiver's being physically and verbally racially assaulted by the resident. Calling out for assistance brought Carer M, another Pacific Islands woman also aged in her 20s, to Carer L's aid, and eventually the resident was placated and toileting completed. Reflection on the above incident resulted in both caregivers talking about how for some residents, racist behavior is commonplace.

The caregivers in our study stated that demeaning racial remarks were, more often than not, ignored, because "they weren't worth" bothering about (Carer I). Another way the Pacific Islands caregivers deflected racist remarks, such as being called a "nigger" (Carer M, 20s; Carer P, 60s) or a "black bastard/bitch" (Carer I, 20s; Carer T, 30s), was to laugh about what was said when sharing with coworkers the latest antics of residents. Carer T thought that the reason the residents often "behaved badly" in racial terms was because they were of a particular age group, in which racism was perceived as the norm. These residents had been around long before political correctness became fashionable and certainly before the passing of legislation that made overt racism illegal in New Zealand. The residents had lived through the colonial era, when New Zealand was only one of "mother" England's many colonies, and non-Europeans were thought to be inferior to Europeans.

The response of management was occasionally to make a special dispensation and roster a Pakeha caregiver for one resident who, Carer T, a man in his 30s, reports, consistently refused to be cared for by "colored people" because she felt uncomfortable about "them."

The Residents' Perspectives

Although it was unclear whether what we have termed a "colonial" frame of mind was pertinent to the residents' belief systems, a number did suggest that the care they received differed along ethnic lines. In Figure 2, we contrast caregivers' and residents' perceptions of the caregiving role.

For the residents, the care received was a major event in their lives and was discussed as part of the life stories shared with the researchers. Miss E, who was in her 90s, stated that "black, white or brindle" the caregivers had chosen to care for people in the residence. Miss E's rationale was that the caregivers must be kind and compassionate people irrespective of ethnicity or cultural differences. However, some residents discussed the way care was practiced in terms of ethnic difference.

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Also aged in her 90s, Mrs. H talked with the female Pakeha interviewer about the "European girls," who were all "very good" as caregivers, but the "darkies" come from other cultures, and they can be "quite bossy" because they "don't understand us you see?" There was talk about the Pacific Islands caregivers' not being as considerate in their care practices as their Pakeha counterparts. Aged in his 80s, Mr. C stated that there were differences in care practices between the "Island and white girls"; however, Mr. C would not expand on these differences. Mrs. B, who was aged about 80 years, stated that there was not a lot of difference in care although some of "them" (non-Pakeha caregivers, that is) tended to "be a bit rough."

Caregiving is an emotionally and physically wearing series of activities. It is easy to see how racist behavior on the part of the recipients of care interferes with the reciprocity necessary for successful caring (Tarlow, 1996, p. 78) and might move the experience of caregiving toward indifference and dislike (Opie et al., 1992, p. 108). These findings are not unique, with other researchers finding that "there is abuse from residents, ranging from angry comments to actual physical violence . . . There are insults, name-calling, swearing, and even threats of blackmail. [Caregiving] aides have to swallow racial abuse as well" (Foner, 1995b, p. 170). Although the racism they regularly experienced left them angry or sad, caregivers mostly ignored the comments, because they found that refuting racist behavior was time consuming and pointless, and racist attitudes were difficult to change (Neysmith & Aronson, 1997).

Racism is a reality in residential care, and this study adds to the description of how caregivers, residents, and management respond. Management might have allowed this discrimination to continue, because it provides comfort and support to the resident and shows respect for the uniqueness of a resident's viewpoint (Elliot, 1999). In a Canadian study, management occasionally rostered caregivers away from discriminatory patients (Neysmith & Aronson, 1997), and others provided explanation of this behavior in terms of residents' illness (Foner, 1995a).

Quality of Care

Caregivers in our study stated that the arduous demands of the caring role were well suited to Pacific peoples and women in particular, and they considered themselves to deliver excellent care. Caregivers talked about how Pacific Islands women were better equipped to deal with the emotional and physical demands of the type of work the caregiving role entailed than other ethnic groups, specifically Pakeha caregivers. It was suggested that Pacific people are often better suited for this type of work because they possess the qualities needed to care for the elderly infirm, such as physical and emotional strength.

Residents reported some situations that raised questions concerning the quality of care they received. Mrs. B demonstrated how this roughness occurred by splaying her fingers and explained that when used as a lifting technique, this hurt a great deal because of the pressure points applied by the fingers. Mrs. G and Mrs. F, both aged in their 80s, had the view that caregivers' inattention sometimes resulted in resident falls, although using their initiative, residents said, they had come up with various strategies to stop being physically hurt. As the majority of the workforce at the long-term care facility was non-Pakeha, it is highly likely that the residents' narratives involve carers from minority groups.

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Although not based on race, research supports the view that some caregivers cut corners to complete tasks within the allotted time frame (Bowers & Becker, 1992). The behavior of the care recipient will influence the caregiving relationship, and many things, including culturally related beliefs and expectations, would influence that behavior. Refusal of care could sometimes be symptomatic of senile dementia (Foner, 1995b), and violent behavior toward caregivers might be one of the ways in which residents can oppose care offered, perhaps because (personal) space is being invaded (Biggs, 1993; Brown-Haysom, 2000).

Placing implicit trust in the adequacy and competency of care practices from one's own cultural paradigm, whether Pakeha or Pacific Islands or any number of other cultures, must not be taken as a given. We must state, however, that all the caregivers participating in this study appeared to have genuinely cared for the elderly they looked after at the residence. The study was not intended to pass judgment on the care practiced at the residence. Rather, it was intended to indicate some of the areas in which culturally defined differences that can influence care practices could be elucidated and discussed. This requires an "equal starting point" that "may be justified by appealing, not to the worth or truth of different cultural beliefs and practices" but rather to the commonsense "assumption that both provider and patient [resident] are equally invested in their cultures" (Jecker, Carrese, & Pearlman, 1995, p. 7).

Limitations

Positioning the participants' narratives onto a framework that is, in a sense, "user friendly" without negating the residents' and caregivers' perceptions of their lived realities within the residential facility remains difficult. We do not claim to be offering a representative sample of residential care facilities in New Zealand or, indeed, within the Auckland area. What we do offer is a snapshot of one Auckland residential care facility.

CONCLUSION

This article was based on themes emerging from observations and 18 semi-structured interviews conducted with 10 Pacific Islands caregivers and 8 older residents at one residential care setting in Auckland, New Zealand. Within a local context, the methods used in this study go some way to elucidating more fully how residential care delivery is both carried out by carers and taken up by residents in long-term care facilities. Further studies could use this exploratory study as a starting point to explore cultural patterning of care delivery and reception in the residential care setting. Owing to the dearth of research of intercultural care practices in residential care settings, future studies could begin with a demographic study of the formal caregiving workforce.

We do not live in an ideal world, and there remains a constant tension between what should be happening and what is actually happening in the everyday world of caregiving and receiving in residential care. Beliefs and expectations about what "should" be happening differ between the cultural groups participating in this exploratory study. Racism is evident whether because of illness or colonial attitudes

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and is tolerated by caregivers in most situations. An active debate about approaches to management to protect workers might be advantageous. Although no clear-cut conclusions have been reached, opportunities for further exploration with a view to influencing conflicting situations will arise. Cultural competence entails involving the culture of the health care recipient in all aspects of clinical and nonclinical encounters, and one may hypothesize that increased understanding of culturally related views would benefit both care deliverer and recipient.

With increasing ethnic diversity among residential elderly and those employed within residential care, both internationally and within New Zealand, further understanding of health care beliefs and practices of both the caregivers and the care recipients who do not share common cultural paradigms is crucial to effective delivery of health care for the aged.

NOTES

1. New Zealand has two official languages, Maori and English. For the purposes of this article, the Maori term *Pakeha* will be used. Pakeha means non-Maori, European, Caucasian (Ryan, 1997).

2. In Samoan terms, respect for the elderly is epitomized at meal times. The elderly are always served first, and the best food is chosen for them. Only when the elders have started to eat can others (even very small children) begin their meals.

3. The attempt to define and categorize the caregivers into discrete groupings is extremely difficult due to cultural differences such as those found between Samoa and Tonga.

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