



Culturally Responsive Palliative Care

Polish Community Cultural Profile

2014



Contents

Introduction	3
Background to the Project	3
Peer Education Resource	3
Discussing palliative care in the Polish Community.....	4
About the Polish community in Victoria and Australia	4
Polish Cultural Perspectives and Values	5
Community and Religion.....	6
Family.....	6
Attitudes to illness and pain management.....	6
Attitudes towards care.....	7
Attitudes towards mental health.....	8
Attitudes towards death and dying	8
Intergenerational Perspectives and the Migration Experience	9
A note about terminology	9

Introduction

Cultural perspectives and values from culturally and linguistically diverse communities in Victoria

Background to the Project

The Culturally Responsive Palliative Care Community Education Project formed part of Palliative Care Victoria's Cultural Responsiveness Strategy. The project was undertaken in partnership with the Ethnic Communities' Council of Victoria in 2013-2015 and with the Multicultural Centre for Women's Health (MCWH) in 2013-2014.

It involved community engagement and peer education to raise awareness of, and access to, palliative care services and focused on ten larger communities: Chinese, Maltese, Italian, Turkish and Vietnamese during 2013-15 and the Greek, Macedonian, Polish, Croatian and Arabic-speaking background communities in 2014-15.

In 2013-2015, 33 trained bilingual health educators delivered 150 community education sessions in eleven community languages to 4846 participants.

Further information about the Project, and links to the evidence base and summaries of the external evaluation of the Strategy are available [here](#).

Peer Education Resource

The bilingual peer educators delivered the information sessions using a Peer Education Resource that was tailored for each community in partnership with a Community Reference Group. In 2013-14, this process was coordinated by Maria Hatch and Dr Jasmin Chen from MCWH and in 2014-15 by Mike Kennedy from Palliative Care Victoria.

The first part of the Peer Education Resource contained background about the community and its cultural perspectives and values. These community summaries are set out below in this document and can also be accessed as individual PDF files.

A community reference group was established for each participating community and provided the project partners with invaluable advice and guidance in preparing the Peer Education Resource documents.

When referring to these documents, care needs to be taken to avoid cultural stereotyping and profiling. In undertaking this project, we learned multiple times that there is as much diversity *within* each ethnic community as there is between them, and that cultural perspectives and values are evolving and changing. However, this information may be useful in identifying some issues to be explored with clients or patients from culturally and linguistically diverse backgrounds to deliver culturally responsive person-centered care.

Discussing palliative care in the Polish Community

Talking about palliative care can be difficult for people from all cultures and communities. Although in the Polish community there is no specific taboo around talking about death, many Polish people may be reluctant to speak about their personal experiences with illness and dying. Palliative care can produce negative feelings because of its association with illness, death and dying. These negative feelings can trigger difficult memories. When delivering information to participants about palliative care, it is important to be respectful of their feelings and their right to privacy.

As a peer educator, it is important to remember that learning is an active process through which people create meaning and develop understanding. The ways that participants react to new information depend on their ideas, opinions, knowledge, personal experiences, understanding of the world and their own learning style. Particularly around topics such as death and dying, participants will bring with them a whole set of cultural and social beliefs that will impact their learning experience. Education sessions are a good opportunity to raise awareness about palliative care but also to explore commonly held beliefs about health and illness and to dispel myths about palliative care.

Discussing illness, death and dying can often trigger strong emotions and feelings in people, especially if a participant has been personally impacted by it. Participants should be informed that:

- They do not need to contribute to discussion if they feel uncomfortable and are not forced to participate if they don't want to.
- They may take a break or leave the room if they feel like they need to.
- If they would like to share a story or experience they went through, they do not have to identify it as happening to them but they can say it happened to 'someone they know.'

About the Polish community in Victoria and Australia

Polish migration to Australia dates back to the Australian gold rush in the 1850s, but the largest numbers of Polish migrants came to Australia after World War II. The first wave of Polish migrants included 65,000 displaced persons who immigrated between 1947 and 1952. Many were employed on the Snowy Mountains Hydro-Electric Scheme in NSW.

In the early 1980s, a second wave of migrants arrived from Poland. This wave was known as the Solidarity wave. The Polish government had declared martial law due to demands for political reform from an independent trade union movement called Solidarity. During this period, 15,000 new Polish migrants arrived. These migrants were different from the previous wave as they were mostly young, educated and married.¹

The improvement in living conditions in Poland and more stringent migration criteria in Australia have significantly reduced the levels of Polish migration to Australia.

In the 2011 Census, Victoria had the largest concentration of the Polish community, 16,387 people, with just over one third of the national total. 92.5 per cent of these people live in Melbourne. The Polish population in Australia peaked at the 1991 Census. Since then, the

¹ Stefan Markowski, "Polish Migration to Australia", *Humanities Research*, Vol. XV, No.1, 2009, http://press.anu.edu.au/hri/2009_01/mobile_devices/ch06s04.html accessed 30 June 2014.

improvement in living conditions in Poland and its eventual membership of the European Union in 2004 have significantly reduced the levels of Polish migration to Australia.

At the 2011 Census, 62 per cent of the Polish population in Victoria were aged 55 or older with 12 per cent in each of the 65-74, 75-84 and 85-94 age cohorts.

The Polish language is one of the top twenty languages spoken at home in Victoria. The main languages spoken at home by the Polish population in Australia are Polish (71 per cent), English (24 per cent) and German (1 per cent). 87.8 per cent of the Polish population in Victoria assessed themselves at the 2011 Census as speaking English “very well” or “well” while 11 per cent assessed themselves as speaking English “not well” or “not at all”.²

Polish people in Victoria have a very high level of Australian citizenship (91.3 per cent at the 2011 Census compared to 85 per cent for the total Australian population). The Polish population in Victoria are less geographically concentrated than many other culturally and linguistically diverse communities. Slightly more than half of the Polish population in Victoria live in the Glen Eira, Brimbank, Casey, Greater Dandenong, Monash, Kingston, Knox, Port Phillip, and Stonnington Local Government Areas with only Glen Eira (11.3 per cent) having more than 10 per cent of that population.³

Polish Cultural Perspectives and Values

Within any cultural group or community, individual views and values are shaped by many factors, including our age, gender, income, religion, sexuality, profession, education and political views, not to mention personal experiences. Individuals from the same culture do not all think alike or share the same value systems and opinions. Likewise, cultural values and attitudes can change over time and are never the same thing to everyone.

For the Polish community, shifting cultural values can become more apparent through the migration experience and there can be great differences between the views and values of two generations within the same family. For older generation migrants in particular, some traditional views and attitudes may have been preserved despite changing attitudes and practices in Poland. In this sense, despite close ties with Poland, Polish culture as it exists in Australia can not necessarily be generalised from contemporary Polish culture or with Polish communities living in other parts of the world.

Nevertheless, certain beliefs can have more influence or resonance with a cultural group and can be recognised as commonly shared or understood within a community. Individuals from that group do not need to personally agree with those values to recognise their cultural importance.

Here are a number of commonly held Polish cultural perspectives and values that may have bearing on their response to a discussion about palliative care. Please keep in mind that these perspectives will not apply to everyone in the Polish-speaking community and it is important not to make assumptions about people’s values and beliefs.

² Office of Multicultural Affairs and Citizenship (Victoria), “The Poland Born Community in Victoria: 2011 Census”, Fact Sheet Number A-21, 2013.

³ Office of Multicultural Affairs and Citizenship (Victoria), “Victorian Community Profiles: 2011 Census Poland-Born”, 2013.

Community and Religion

In the 2011 Census, the major religious affiliations amongst Polish people in Victoria were Catholic (68.4 per cent) and Judaism (10.2 per cent). 9.2 per cent stated “no religion”, which was lower than that of the total Victorian population (20.4 per cent).

For Polish Catholics, particularly those who are elderly, their daily life may be closely linked with the Catholic Church. Many Polish people may belong to a church, even if they are not regular attendees. In Melbourne there are Catholic parishes with Polish congregations and/or Polish priests in Bells Park, Keysborough, Richmond, St Albans and Sunshine.

Some Polish people believe in the special properties of prayer books, rosary beads and religious medals. Pictures of Pope John Paul II, the Virgin Mary and various saints can be found in many Polish homes and some people carry them in their wallets.⁴

Family

A successful family life is very important to Polish people. The father is generally the head of the family where often both parents work. The traditional family model is the nuclear family (father, mother and two children).

Traditional family values and loyalty are strong in most Polish households. The elderly play an active role in helping adult children in their daily routine with families. Although the extended family is also very important, many aged Polish people may not have extended families as many Polish migrants immediately after the Second World War immigrated to Australia with only their spouse, or alone. Younger Polish people who immigrated later are now bringing out their elderly parents who may have limited English.⁵

When caring for a person with a life-limiting illness, the role of the family is very important and there is often a moral obligation to provide as much care as possible. There is often an expectation that the person will stay and be cared for at home, regardless of their health status. There is a strong attachment to the home and a reluctance to go into residential care. The main carers are usually women and most often spouses. Culturally, it is the duty of the spouse to care for their husband or wife and they often feel shame about accepting services. This often results in increased stress and ill health in carers.⁶ As there is a tendency for families to be isolated from the community, carers themselves have little social interaction with other members of the community. It is important to emphasise that palliative care services can support the person with a life limiting illness *and* their carers at home.

Attitudes to illness and pain management

Research with the Victorian Polish community in the 2000s confirmed that most Polish elderly prefer to stay in their own homes for as long as possible, regardless of their health status and financial circumstances. Statistics show that older people from a Polish background often resist seeking help until crisis point is reached. This is a result of unwillingness to lose their

⁴ South Eastern Region Migrant Resource Centre, “Polish Cultural Profile – older people”, 2010.

⁵ Diversicare, “Polish Culture Profile”, 2006.

⁶ Australian Multicultural Community Services, “Polish Community IN Victoria – Attitude to medical care”, www.polishcommunity.org.au/index.php/about-polish-culture?id=28, accessed 30 June 2014.

independence and self-sufficiency as well as a notion of embarrassment connected to the necessity of seeking help from outsiders.

Traditionally, doctors and other health professionals are given great authority in various aspects of life and are well respected in the Polish community. Polish people are polite to authority figures and, not wanting to offend a doctor, may not ask for clarification on clinical issues. Polish people typically follow medical orders carefully and submit to various kinds of medical treatment including tests, operations and medication. On the other hand, alternative ways of treatment are also sought alongside mainstream medical advice, often without informing the medical practitioner. Herbal medicine and pharmaceuticals are sometimes privately imported from Poland.⁷

Due to the language barrier, Polish people usually seek out Polish-speaking medical practitioners but may change doctors if they believe they are not getting better fast enough. They may also discuss their health concerns with their community worker, if they have one. Ethnic organisations and ethnic workers are often the first point of contact for information and referral. The case workers in ethnic organisations can be a useful source of assistance and advice if their clients are referred to a palliative care service and can build on trust and existing relationships.

Polish people will access pain relieving medication and use it when needed. Patients and families will usually accept the use of opioids for symptom control if the rationale is clearly explained to them.⁸ Palliative care services should use a qualified interpreter for this conversation with the patient and family.

In the past, some family members may have preferred to keep the details of a diagnosis away from the person diagnosed with a life-limiting illness, reasoning that full disclosure will cause them to lose their will to live and give up on any possible treatment. However, attitudes to this issue are changing. Every family is different and if the patient wishes to know, the patient's wishes are paramount.

Palliative care was not provided in Poland until after 1990 so it is unlikely that elderly Polish people will be aware that such a service exists or what it entails.

Attitudes towards care

Family still remains the main support network for elderly members of the community but this is increasingly being supplemented by external services. Polish elderly are still reluctant to use mainstream services due to lack of knowledge of the service system and unfamiliarity with service providers. Many access services through ethno-specific organisations and may then be referred on with the involvement of the ethno-specific workers.

Due to past experiences, Polish elderly have a strong fear of authority and also fear invasion of privacy which may prevent them from accepting services. It is therefore important to know and understand each person's past experiences and try to maintain their independence as far as possible.

⁷ Australian Multicultural Community Services, "Polish Community IN Victoria – Attitude to medical care", www.polishcommunity.org.au/index.php/about-polish-culture?id=28, accessed 30 June 2014.

⁸ Andrew Taylor and Margaret Box, *Multicultural Palliative Care Guidelines*, Palliative Care Australia, 1999.

Once services are introduced, they are generally well-accepted but they need to be provided by bilingual workers. The gender of care workers may be an issue on occasions, with female workers sometimes considered inappropriate for a male client. Careful selection and matching of carers and workers with clients is essential.

The expectation that the family will care for its family members still prevails in the Polish community and it is seen as shameful to place your parents or family members into residential care. The perception is that decline is very rapid once the person is placed in the residential care facility. Some members of the community feel quite adamant about staying in their own homes. The overall perception is that people will die quickly in residential care due to loneliness, depression, isolation and lack of communication.⁹

Attitudes towards mental health

In the Polish community there is still some stigma attached to mental illness and this issue is not discussed openly in the community. Some Polish people may look for a physical cause of disease before considering a mental illness. There may be some discussion with people outside the immediate family about the fact that a family member is living with dementia, for example, with a church-based community who know the person and are familiar with their circumstances. If mental health issues do exist, home visits are preferred rather than clinic visits.¹⁰

For those who use or would use counselling, it is mostly for issues around depression and Post Traumatic Stress Disorder. Most people feel more comfortable talking to family members or ethnic community workers than to professional counsellors. If counselling is used, it would need to be face-to-face with a Polish-speaker. Telephone counselling services are difficult to access due to the complicated process of accessing interpreters in order to access the service. This type of service is also seen as too impersonal.¹¹

As there is a strong preference to deal with issues in private, there is some reluctance to use counselling services. Counselling, as a service, or even the term itself, does not tend to be recognised as most people consider psychologists and psychiatrists as the specialists who provide this type of service. It may be used for depression but it not common. If this type of service is to be used, it would have to be done in face-to-face contact with a person who speaks Polish or with an interpreter.

Attitudes towards death and dying¹²

Given the importance of the family and family connections, family members and friends will stay with the dying person so that he/she does not feel abandoned. For Polish Catholics, religious rituals include the administration of Holy Communion and the Last Rites.

Funeral customs are determined by the Church and the wishes of the family. After burial, mourners are invited for a wake or *stypa* where drinks and food are served in memory of the

⁹ Alzheimer's Australia Victoria, "Perceptions of dementia in ethnic communities", 2008.

¹⁰ Polish Community Council of Victoria, "Working with the Polish Community, n.d.

¹¹ Alzheimer's Australia Victoria, "Perceptions of dementia in ethnic communities", 2008.

¹² Diversicare, "Polish Culture Profile", 2006; Australian Multicultural Community Services, "Polish Community in Victoria – Burial and rituals associated with death", www.polishcommunity.org.au/index.php/about-polish-culture?id=26, accessed 30 June 2014.

person. Most Polish people have a stoic acceptance of death as part of the life process, and a strong sense of loyalty and respect for their loved ones.

Relatives also wear black clothing on the day of the burial. The spouse may choose to wear black clothes for up to a year (the year of mourning). Graves of loved ones are visited for years to come, particularly on All Saints Day – 1 November – when flowers and candles are placed on the graves.

Cremation or burial will be a personal choice based more on religious beliefs than cultural norms.

Intergenerational Perspectives and the Migration Experience

Intergenerational misunderstandings and conflicting expectations are common to all families and communities.¹³ Our history impacts greatly on the cultural context through which we see the world – both when we entered the world and where. Particularly for migrant communities, the differences in the experiences of one generation and another can be more pronounced, leading to more possibilities for conflict and misunderstanding.

For many first generation Polish people who have migrated to Australia, the experience of migration has given them a strong sense of independence and self-reliance in which they take great pride. It may also have been a source of stress, homesickness and isolation.

Particularly for many older members of the Polish community, accepting help from external services could be felt as an admission of weakness or giving up personal independence. Service providers have also reported that there can be fears about accepting services, particularly if service providers are entering the home. Fears around being mistreated, confined, moved out of home and the cost of services can all be deterrents to accepting external support.

In turn, the second and subsequent generations growing up in Australia can feel conflicting cultural pressures and heavy family responsibilities. The children of migrants must often navigate between the competing cultural values and languages of their family and Australian society. Typically, while the older generation will idealise traditional values and practices, the younger generation will be more adaptive to dominant Australian values and customs.

Not surprisingly, given the tendency of Polish migrants to assimilate more easily than many other migrant groups, the ability to speak Polish as a “second language” has declined in the second and subsequent generations.

A note about terminology

In the English language, words such as *grief*, *bereavement* and *illness* can have different meanings and connotations for different people. Similarly, people from ethnic backgrounds may have specific cultural values that they associate with these words. For example, some people might associate *illness* with karma or the supernatural, and discussions around possible treatment or

¹³ Parts of this section were developed from Ethnic Communities' Council of Victoria (2009), *Respect and Dignity: Seniors, family relationships and what can go wrong*, A Greek community education resource kit around elder abuse prevention, p. 2.

intervention need to take this into account in order for them to be meaningful.

Words such as *grief*, *bereavement* and *illness* are used in this resource with the understanding that there will be different cultural meanings associated with them. Education sessions are intended to be delivered in participants' first language, and therefore terms should be appropriately translated if applicable.

Educators should also be aware that in the health sector there are several terms used to describe terminal illness. Participants may have heard of some or all of the following:

Incurable illness/condition

Chronic and complex illness/condition

Eventually fatal illness/condition

Life-limiting illness/condition

Terminal illness/condition

It is equally possible that participants have never heard these terms before and educators should consider clear and culturally appropriate ways of communicating ideas around death and illness before their session.