



STATEMENT ON CULTURALLY-COMPETENT CARE AND CULTURAL SAFETY IN EMERGENCY MEDICINE

1. PURPOSE

This document is a statement of the Australasian College for Emergency Medicine (ACEM), and identifies the underlying principles and philosophies supporting emergency health care provision in the culturally and linguistically diverse populations of Australia and New Zealand.

2. BACKGROUND

The ACEM recognises that all Australians and New Zealanders “have the right to access health care that meets their needs. In our culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at every level of the health system—systemic, organisational, professional and individual.”¹

3. SCOPE

This statement provides a framework for the development and implementation of culturally competent practices in emergency medicine to improve the cultural safety of Australian and New Zealand emergency departments and health outcomes of all patients.

This statement is supported by the ACEM’s Statement on the Health of Aboriginal and Torres Strait Islander and Māori peoples of Australia and New Zealand (S52).

The ACEM acknowledges the Medical Council of New Zealand’s (MCNZ) Statement on Cultural Competence² and the specialist college accreditation standards in cultural competency set by both the MCNZ and Australian Medical Council.

This Statement is applicable to all emergency departments in Australia and New Zealand.

4. DEFINITIONS

4.1 Culture

Culture is a shared, learned system of beliefs, values and attitudes that shape and influence a person’s perception and behaviour. It describes the ways in which members of a group interact with each other, often operating at an unconscious level, which is the result of shared understanding and commonality of experiences.

A person’s culture may be influenced by ethnicity, religion, sexual orientation, gender, socio-economic factors, (dis)ability or age. A person’s beliefs and values may arise from many different aspects of their life, and patients and their families can belong to multiple cultures simultaneously.

Patients’ cultures affect the way they understand health and illness, how they access health care, and how they respond to healthcare interventions.

Each individual medical practitioner also has their own cultural heritage that informs the patient-practitioner relationship.

Furthermore, the emergency department itself has a culture in which there are clearly demarcated patient and staff rights and responsibilities and which may be unfamiliar or culturally foreign to many patients.

4.2 Cultural safety

In 1988, a first year Māori nursing student from Christchurch Polytechnic participating in a national hui (ceremonial gathering) concerned with the needs of Māori students, the *Hui Waimanawa*, posited that legal safety, ethical safety, safety in clinical practice and a safe knowledge base were addressed in nursing education, “but what about Cultural Safety?”³

Ramsden³, a Māori nurse who was commissioned to run the *Hui Waimanawa*, went on to define the key objectives of cultural safety education to be:

- To educate student nurses and midwives not to blame the victims of historical process for their current plights
- To educate student nurses and midwives to examine their own realities and the attitudes they bring to each new person they encounter in their practice
- To educate student nurses and midwives to be open minded and flexible in their attitudes toward people who are different from themselves, to whom they offer and deliver service
- To produce a workforce of well educated, self-aware registered nurses and midwives who are culturally safe to practice, as defined by the people they serve.

The fundamental premise that cultural safety actively addresses power imbalances and non-Indigenous privilege remains a cornerstone of the concept. However, cultural safety is now seen as being applicable for all health staff and for all patients, not just Māori, and as such aims to enhance the delivery of health services by identifying the power relationship between the medical practitioner and any patient, and empowering any patient to take full advantage of the health care service offered.⁴

Cultural safety can be defined as patient care in an environment “*that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together.*”⁵ It is primarily about the patient experience. Health care can only be perceived as culturally safe or otherwise by the patient who is participating in the service delivery.

4.3 Cultural competency

Cultural competency is a set of attitudes, skills and knowledge that allow an individual to interact effectively in cross-cultural situations. It requires a medical practitioner to continue to undertake a process of reflection on their own cultural identity and recognise the impact their culture has on their own medical practice.⁴ Cultural competence focuses on the capacity of doctors and other health staff to integrate culture into the clinical context and tailor care to meet patients’ social, cultural and linguistic needs.

5. ACEM POSITION

5.1 Statement of health status of culturally and linguistically diverse patients

The ACEM recognises that all patients have culture which will be a factor in their presentation to, and management in, emergency departments. Australia and New Zealand are countries of significant cultural diversity. However, there are culturally and linguistically diverse patient populations that are at greater risk of receiving culturally unsafe care and who have disproportionately higher burdens of disease.

These patient groups include Aboriginal, Torres Islander and Māori peoples as well as refugees, asylum seekers and migrants, many of whom do not speak English as a first language.

The ACEM recognises that there are hundreds of distinct cultural and linguistic groups of Aboriginal, Torres Strait Islander and Māori peoples in Australia and New Zealand. There are also commonalities of experiences stemming from the ongoing impact of colonisation. The health disparities for Aboriginal, Torres Strait Islander and Māori peoples are inseparably linked to the subsequent economic and social disadvantage, institutionalised discrimination and intergenerational trauma.

The ACEM acknowledges the ongoing health disparities for other culturally and linguistically diverse peoples including refugees, asylum seekers and newly-arrived migrants. Access to emergency care, as well as common health issues, vary widely in relation to the country of origin and particularly to: the context of pre-arrival health care; the degree of war, displacement, trauma and torture experienced; level of impoverishment and education; and immigration detention experiences.

5.2 Statement of cultural competency in relation to emergency medicine

The purpose of cultural competency and cultural safety in emergency departments is to improve the quality of health care services and outcomes for all patients.

The ACEM acknowledges that culturally competent practice, by aligning care to the patient's socio-cultural and linguistic context, can: improve communication between doctors and patients; increase patient understanding; decrease patient fear and anxiety; improve patient satisfaction; and enhance the ease and relevance of clinical assessment.

Subsequently culturally competent care can: reduce unnecessary investigation; increase accurate and timely diagnoses; and increase adherence to treatment and attendance rates at follow up appointments. It can also reduce: reluctance to seek medical care; and discharge against medical advice and take own leave rates. Overall, it leads to better clinical outcomes and improved patient wellbeing.⁶

5.3 Non-discrimination and right to culturally safe health care

Access to culturally safe care in emergency departments that is free of racism and other forms of discrimination is a right for all patients, regardless of ethnicity, gender, sexual orientation or other cultural identification.

The Australian Charter of Health Care Rights, endorsed by Australian Health Ministers in 2008 for use across the country, ensures patients have the *"right to be shown respect, dignity and consideration"*, and that *"the care provided shows respect to [the patient's] culture, beliefs, values and personal characteristics."*⁷

In New Zealand, the Code of Health and Disability Services Consumers' Rights 1996 guarantees to patients the right to services by a health professional *"that takes into account the needs, values and beliefs of different cultural, religious, social and ethnic groups."*⁸

6. RECOMMENDATIONS

6.1 Cultural competency

The ACEM is committed to ensuring all trainees and Fellows are continually improving their culturally competency.

This will be achieved by

- Directors of Emergency Medicine Training and assessors will be instructed to ensure cultural competency is a component of emergency medicine training programs and assessments as per the ACEM training curriculum
- Continuing Professional Development in cultural competency will be encouraged and ACEM educational materials provided
- Cultural competency will be assessed in Fellows by peer review and ongoing maintenance of Professional Standards

The ACEM also recognises the need for College staff to continually improve cultural competency in their interactions with members and ensure organisational activities occur in a culturally safe manner.

6.2 Cultural safety

The ACEM will advocate for all emergency departments in Australia and New Zealand to continue to develop culturally safe environments for all patients. Systemic change within emergency departments will be promoted so that:

- Service provision is adapted so that it reflects an understanding of the diversity between and within cultures, including addressing institutional discrimination
- All staff in the ED provide patient-centred care that includes:
 - Taking a cultural history with all patients and their families/carers
 - Incorporating diverse health beliefs and health priorities into ED care and management plans
 - All patients, their family and/or carer have access to support people according to their cultural needs
 - All patients are given the opportunity to speak to a cultural and/or religious representative of their choosing
 - All patients who do not speak English as a first language are provided access to a professional interpreter service and information in their primary language, including for Indigenous language speakers
- Effective relationships are established and fostered with local primary health care providers that care for Aboriginal, Torres Strait Islander, Māori and other culturally and linguistically diverse peoples
- Feedback mechanisms are in place for consumer engagement that represents the cultural diversity of the department's patient population (including being available in appropriate languages)
- The department fosters a work ethic of reflection regarding cultural safety and cultural competency and non-judgemental review of both individual clinician practice and the department's care systems

The ACEM will continue to develop and provide resources, frameworks, guidelines and standards in order to assist emergency departments to implement these improvements in cultural safety.

6.3 Barriers to Health Care Access

The ACEM acknowledges the many barriers which reduce access to the ED for culturally diverse patient populations and advocates that these are identified and addressed as far as possible within the confines of each local ED jurisdiction.

The ACEM will be a central point of advocacy for addressing barriers to health care access. Emergency departments will be encouraged to be local advocates for addressing barriers to health care access that are beyond the jurisdiction of the ED to directly mitigate.

7. REFERENCES

1. "Cultural Competence in Health: A guide for policy, partnerships and participation", Canberra: Commonwealth of Australia, 2005
2. Medical Council of New Zealand (MCNZ), 'Statement on Cultural Competence', MCNZ, August 2006.
3. Ramsden, IM "Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu", PhD Thesis, Victoria University of Wellington, 2002
4. Australian Indigenous Doctors Association and Royal Australasian College of Physicians (RACP), "An Introduction to Cultural Competency", RACP, 2004
5. Bin-Sallik, M, "Cultural safety: let's name it!" *Australian Journal of Indigenous Education*, 32 (2003): 21
6. Selection of references:

Johnstone, M, and Olga K. "An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context." *Journal of transcultural nursing* 18.3 (2007): 247-256.

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Garrett, P, et al. "What do non-English-speaking patients value in acute care? Cultural competency from the patient's perspective: a qualitative study." *Ethnicity & Health* 13.5 (2008): 479-496.
7. Australian Commission on Safety and Quality in Health Care (ACSQHC), 'Australian Charter of Health Care Rights', ACSQC, 2008
8. The code is set out in the Schedule to the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations, 1996. New Zealand

8. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

8.1 Responsibilities

Document authorisation: Council of Advocacy, Practice & Partnerships
 Document implementation: Public Health Committee
 Document maintenance: Policy and Research Department

8.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
v1	Mar-2010	Approved by Council
v2	Mar-2015	Reviewed to align with ACEM curriculum, Indigenous Health and Cultural Competency project framework and ACEM Quality Standards