PS62(G) Position statement on cultural competence and cultural safety 2023

Short title: Cultural competence and cultural safety

1. Purpose

The purpose of this statement is as follows:

1.1 To articulate ANZCA's ongoing commitment to the role and importance of cultural competence and cultural safety.

1.2 To promote cultural safety.

1.3 To serve as a resource to assist doctors to behave in a culturally safe manner.

2. Scope

This document is intended to apply to all doctors providing anaesthesia or pain medicine services.

This document considers the broadest aspects of culture, which can include participation in a number of cultural communities shaped by ethnicity, gender, religious or spiritual beliefs, age, employment and socio-economic status, sexual orientation and disability. Some may identify with more than one cultural group, and diversity also exists within individual cultures.

Cultural diversity has healthcare implications at a societal, organisational and individual patient and health practitioner level. This document aims to capture the overarching principles that should guide our approach to culturally competent and culturally safe healthcare delivery across all these domains.

3. Background

This document is supported by Standard 1 of ANZCA's *Standards for Anaesthesia*, which requires anaesthetists to care for patients in a professional, culturally sensitive and ethical manner.[i]

ANZCA's Purpose statement is "Our purpose is to serve our communities by leading high quality care in anaesthesia, perioperative and pain medicine, optimising health and reducing the burden of pain". The statement is inclusive of all cultures and encompasses service to the community in its widest sense.

Cultural competence requires the clinical environment to be considerate of the cultural needs of patients, their family and support networks, and our diverse healthcare workforce. Building on ideas around cultural competence, there has more recently been an increasing emphasis on the need for cultural safety within healthcare. Cultural safety requires doctors to bring self-reflection and insight into the inherent power differentials between provider and patients;[ii] it is defined with respect to the patient's experience of their care.

The culture of the health system and a clinician's own culture and belief systems impact a patient's experience of their healthcare. Doctors need to be aware of the potential impact of these interactions.[iii]

ANZCA recognises that health inequities exist between different cultures. Barriers to accessing timely, quality, individualised health care impact across all stages of life. Obvious disparities can be seen in statistics such as increased infant mortality and decreased life expectancy in First Nations peoples.[iv] The health care experience of patients from minority groups including those from the

LGBTQIA+ community and those with a migrant or refugee background, can also contribute to a reluctance to seek medical care, particularly where patients are discriminated against or judged.[v,vi]

Culturally competent doctors can build and support culturally safe clinical environments by reflecting upon and challenging those parts of clinical practice that may have contributed to these health inequities.

A culturally safe healthcare system is supported by ensuring a diverse healthcare workforce. The Australian Medical Council has identified that particular equity groups including people with disabilities and those from low socioeconomic backgrounds, may be under-represented within medical programs or fail to meet their full academic potential due to inequitable resource distribution or available opportunities.[vii]

4. Culture, cultural competence and cultural safety

4.1 In 1982, the United Nations Educational, Scientific and Cultural Organisation (UNESCO) produced this definition of ***culture***:

"Culture may now be said to be the whole complex of distinctive spiritual, material, intellectual and emotional features that characterise a society or social group. It includes not only the arts and letters, but also modes of life, the fundamental rights of the human being, values systems, traditions and beliefs."[viii]

Culture underpins our identities, thoughts, communications and values. ANZCA acknowledges the specific impacts on culture of colonisation and racism for Aboriginal and Torres Strait Islander peoples, Māori and Pacific Island peoples. These impacts have significant implications for the way that First Nations, Māori and Pacific Island peoples access and navigate the health system.

PS62(G) pertains to cultural safety across all domains, recognising that there are many elements of cultural safety and cultural competence relevant to individual cultural groups. There are also particular considerations for those people who identify as belonging to a number of cultural groups. ANZCA recognises that for specific groups, more individualised considerations will be required, and has produced a variety of relevant resources that complement this document.

4.2 The Medical Council of New Zealand defines ***cultural competence*** as:

"an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this."[ix]

Another frequently cited and early definition of cultural competence is as follows:

"Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations."[x]

4.3 ***Cultural safety*** builds on the concept of cultural competence, incorporating an active process of critical reflection on the part of the health practitioner. With respect to First Nation's peoples, AHPRA and the National Boards have described this process as requiring doctors to have the knowledge, skills, attitudes, practising behaviour and awareness of power differentials in order to deliver safe, accessible and responsive healthcare free of racism.[xi]

The Medical Council of New Zealand defines cultural safety as:

'The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. The

awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.'[xii]

Cultural safety is 'not defined by the practitioner but rather by the health consumer's experience - the individual's experience of care they have received, ability to access services and to raise concerns.'[xiii]

ANZCA supports the position of the Australian Medical Council, the Medical Board of Australia and the Medical Council of New Zealand that have all have articulated the expectation that doctors will practice medicine in a culturally safe manner.[xiv,xv,xvi]

5. Principles underpinning cultural competence and safety

5.1 Respect and understanding

5.1.1 Good medical practice requires an understanding of the roles of both privilege and disadvantage within our communities, and the impact these have on health outcomes.

5.1.2 Respect extends to acknowledging beliefs and values, and how these perspectives might impact on health. There will be times when these beliefs and values do not align with the medical model. It is the role of the healthcare system, including the doctor, to navigate a respectful and open approach to ensure that patients and their family are clearly informed of the likely diagnosis, available treatments and outcome expectations.

5.1.3 Doctors are encouraged to identify cultural biases and assumptions that are often reinforced by societal norms, and which impact on healthcare. Doctors should strive to approach clinical relationships with an open mind and avoid assumptions about the nature of relationships between patients and their support people, such as failing to recognise same sex partners.

5.1.4 Doctors are encouraged to seek out professional development opportunities that address the impact of cultural bias on health outcomes.

5.2 Culturally tailored communication

5.2.1 Patient safety relies on effective communication. Doctors should be sensitive to patients' needs and wishes and seek clarification from them if unsure as to how to best proceed. Communication can often be assisted by a third party, such as a professional interpreter, a health advocate, or a family or community member. It should be recognised that friends and relatives acting as interpreters may not be told private or personal information by the patient, and they may modify and interpret information they communicate to the doctor.

5.2.2 Patients may not disclose important information if they do not feel the method of communication chosen is right or their values and beliefs are not respected.

5.2.3 It should not be assumed that silence means the patient understands and consents.

5.2.4 Cultural safety aims to enhance the delivery of health services by identifying the power relationship between medical practitioners and patients. Through empowering patients and creating a mutually trusting therapeutic relationship, bidirectional communication of clinically relevant information will be enhanced, and patients will be given greater opportunity to take full advantage of the health care options available.[xvii]

5.2.5 Patients may prefer to be referred to or addressed in particular ways, and there may be expressions or familiarisations that patients find culturally unsafe. Doctors are

encouraged to seek an understanding of their patients' preferred mode of address, including for example, their pronouns.[xviii]

5.3 Patient-centred practice

5.3.1 Clinicians are encouraged to tailor care to their patient's specific communicated needs. It is important not to generalise or make assumptions about any person's needs or preferences based on their stated or assumed cultural group. For example, not all women may prefer a female doctor, and not all Māori patients may want whānau (family) present during consultations with a doctor.

5.3.2 Patient-centred practice identifies that a relationship founded on trust is, in turn, established through the demonstration of respect, compassion and clinical competence. These are the hallmarks that professionals should strive to establish in their dealings with patients. In that sense, cultural competence aligns with the universal expectations of patient care.

5.3.3 The cultural needs of any patient can only be defined by individual patients themselves, and their support network. Patient-centred practice encourages doctors to explore patient expectations of their clinical care, and to demonstrate the high level of health literacy necessary to ensure that patients can make informed health decisions.

5.3.4 There may be rare occasions when clinicians sense that tailoring clinical practice to meet cultural expectations could potentially compromise clinical safety. In this situation doctors should bring sensitivity, compassion, respect and expertise to such occasions to ensure that an agreed approach is reached. That is, clinical care should ensure that both cultural safety and clinical safety are achieved, without one taking priority over the other. Patient autonomy should be key to informing decisions where cultural and clinical imperatives collide. Effective communication in these scenarios may benefit from the involvement of relevant third parties.

5.3.5 Healthcare organisations can support culturally inclusive environments by recognising and dismantling institutional barriers that negatively affect health outcomes of culturally diverse communities. Doctors should be respectful and welcoming of marginalised groups, such as LGBTQIA+ people.

Examples of positive actions by institutions include developing specific health strategies and action plans (such as a Reconciliation Action Plan), using inclusive language and imagery on all official documentation and communications, supporting gender affirming care, and ensuring culturally diverse representation on advisory and consultative bodies within the organisation.[xix]

5.4 Partnership

5.4.1 Partnership can only develop on a basis of a good working relationship, an effective communication strategy and an understanding of patients' needs and wishes.

5.4.2 Partnership may take on different definitions within different cultural groups. In some communities it is more common to revere doctors and not challenge or disagree with authority figures. In these circumstances, doctors need to be sensitive to situations in which a person seems uncomfortable with advice but does not say so or fails to follow advice when they have expressed understanding of the information provided. Positive approaches might include politely asking patients to share their thoughts or asking them to explain the treatment plan in their own words. Shyness and fear can often be overcome by respect, empathy and the willingness to work with them.

5.4.3 Anaesthetists and specialist pain medicine physicians work as part of a team providing care to patients. The importance of cultural competence and cultural safety

extends to their working relationships with medical, nursing, midwifery and allied health, ancillary support colleagues and our culturally diverse communities.

5.4.4 Diversity in the healthcare workforce helps support and embed culturally safe clinical practices. Healthcare organisations should leverage their spheres of influence[xx] to support development, recruitment and retention of a culturally diverse workforce, which in turn, enhances the cultural safety of clinical environments.[xxi]

5.5 Issues specific to anaesthesia and pain medicine

5.5.1 Anaesthesia and sedation frequently involve patients being placed in vulnerable situations amongst strangers. For patients, this can increase feelings of vulnerability, and heighten common concerns that include dignity, preservation of modesty, and observance of any specific rituals or processes. These issues can be discussed with patients, their family and support people at the pre-anaesthesia consultation. Where possible, doctors should consider and facilitate the presence of support people to assist the patient around the time of their care.

5.5.2 Pain management can be particularly challenging in a cross-cultural environment.[xxii] Communication of pain can be affected by verbal and non-verbal indicators of pain, where:

- Expected or preconceived pain behaviours are misunderstood due to different cultures and underlying beliefs,
- Stoic and emotive responses to pain may have different meanings across cultures.

These challenges can also affect treatment. The therapeutic relationship may be impacted by patients' previous experiences both medical and non-medical. Emphasis on shared decision making is vital. It is recognised that this is a dynamic process and will evolve as a therapeutic relationship is established.

A more detailed discussion is found in the ANZCA publication Acute Pain Management: Scientific Evidence 5th Edition, Section 9.3.[xxiii]

5.5.3 There are specific clinical situations where cultural beliefs and traditions may have heightened importance. These situations include, but are not confined to, childbirth, death and dying, and the use of blood products, organs and body tissues in medical care. Doctors are encouraged to be vigilant to these sensitive domains, and openly communicate with patients and their families to ensure that they are able to provide culturally safe care in these situations. Consulting with experts and advocates such as community leaders may also provide useful guidance to help inform culturally safe care.

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[i] Australian and New Zealand College of Anaesthetists, *Standards for Anaesthesia* (2023) 4.
[ii] Martin Laverty, Dennis McDermott and Tom Calma, 'Embedding Cultural Safety in Australia's Main Health Care Standards' (2017) 207(1) *Medical Journal of Australia* 15.
[iii] Australian Medical Council, *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015* (2015) v.
[iv] Elana Curtis et al, 'Why Cultural Safety Rather than Cultural Competency Is Required to Achieve Health Equity: A Literature Review and Recommended Definition' (2019) 18 *International Journal for Equity in Health* 174.
[v] NSW Government, *NSW LGBTIQ+ Health Strategy 2022-2027* (2022).

[vi] Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, *Well Proud: A Guide to Gay, Lesbian, Bisexual, Transgender and Intersex Inclusive Practice for Health and Human Services* (2009).
[vii] Australian Medical Council, *Standards for Assessment and Accreditation of Primary Medical Programs* (2023).
[viii] United Nations Educational, Scientific And Cultural Organization (UNESCO), *Mexico City Declaration of Cultural Policies* (1982) 1.
[ix] Medical Council of New Zealand, *Statement on Cultural Competence* (August 2006).
[x] Curtis et al (n 4) 3; quoting Terry Cross et al, *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* (National Institute of Mental Health, Child and Adolescent Service System Program, 1989) 13.
[xi] AHPRA and National Boards, *Australian Health Practitioner Regulation Agency - National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* (2020) 9 <https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx>.
[xii] Medical Council of New Zealand, *Statement on Cultural Safety* (October 2019) 2 <https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/>; quoting Curtis et al (n 4) 14.
[xiii] Australian Health Ministers' Advisory Council's National, *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* (2016) 18 <https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/aboriginal+health/national+cultural+respect+framework+2016-2026>.
[xiv] Australian Medical Council (n 3) 6.
[xv] Medical Board AHPRA, *Good Medical Practice: A Code of Conduct for Doctors in Australia* (October 2020) 5 <https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>.
[xvi] Te Kaunihera o Ngā Kāreti Rata o Aotearoa Council of Medical Colleges New Zealand, *Cultural Safety Training Plan for Vocational Medicine in Aotearoa* (2023) 4.
[xvii] Royal Australasian College of Physicians, *An Introduction to Cultural Competency* (2004) 1 <https://www.racp.edu.au/docs/default-source/advocacy-library/an-introduction-to-cultural-competency.pdf>.
[xviii] Jami Jones et al, *Rainbow Tick Standards 3rd Ed* (La Trobe University, 2020).
[xix] Kyle Tan and Sai Ling, 'Cultural Safety for LGBTQIA+ People: A Narrative Review and Implications for Health Care in Malaysia' (2022) 3(3) *Sexes* 385, 390.
[xx] Australia and New Zealand College of Anaesthetists, 'ANZCA Reconciliation Action Plan' (2023) 3 <https://www.anzca.edu.au/safety-advocacy/indigenous-health/reconciliation-action-plan>.
[xxi] Ibid 5.
[xxii] Rahel Rogger et al, 'Cultural Framing and the Impact on Acute Pain and Pain Services' (2023) 27 *Current Pain and Headache Reports* 429.
[xxiii] Stephen Schug et al, *Acute Pain Management: Scientific Evidence* (Australian and New Zealand College of Anaesthetists, 5th ed, 2020).