Statement on Cultural Competence

1. Purpose

The purpose of this statement is as follows:

1.1 To identify ANZCA's commitment to the role and importance of cultural competence in effective clinical practice and patient care.

1.2 To identify and communicate the expected standards of cultural competence.

1.3 To serve as a resource to assist clinicians deliver culturally competent care to patients, and their family/support network.

2. Scope

This document is intended to apply to all trainees and Fellows of the Australian and New Zealand College of Anaesthetists (ANZCA), which includes the Faculty of Pain Medicine.

3. Background

ANZCA's mission statement is "to serve the community by fostering safety and quality patient care in anaesthesia, pain medicine, and perioperative medicine". The statement is inclusive of all cultures – service to the community in its widest sense.

It is apparent that health inequities exist between different cultures, and the role of cultural competence is about challenging how as clinicians we practice - and what is it about our practice that maintains health inequities.

A person's culture is complex and can include participation in a number of cultural communities shaped by gender, religious or spiritual beliefs, age, employment and socio-economic status, sexual orientation and disability. People may identify with more than one cultural group, and it is also acknowledged that diversity exists within individual cultural groups.

Cultural competence involves ensuring the clinical environment is inclusive of the cultural needs of the patient, and their family/support network. Cultural competence also involves doctors navigating the health system for patients to ensure they receive the best clinical care.

ANZCA recognises that the culture of the health system and a clinician's own culture and belief systems influence their interactions with patients, highlighting the need to be aware of the potential impact of this.

Cultural competence finds legitimacy in the positive experience of the patient and their support networks, and contributes to improved health outcomes.[1]

4. Culture and cultural competence

4.1 In 1982 the United Nations Educational, Scientific and Cultural Oganisation (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, value systems, traditions and beliefs."[2]

4.2 Flowing on from the concept of "cultural awareness" is the concept of "cultural competence". The Australian Medical Council, the Medical Board of Australia and the Medical Council of New Zealand have each expressed the expectation that medical specialists will demonstrate cultural competence in their practice of medicine.

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."

4.3 Culture defines our identities, thoughts, communications and values. In Australia and New Zealand the College acknowledges the specific impacts of colonisation and racism on the indigenous peoples, the Aboriginal and Torres Strait Islander cultures (in Australia) and New Zealand Māori (in New Zealand).

5. Principles and culturally competent practice

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 patients' 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 the patient 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, which impact on health care. Doctors should strive to ensure they come into a clinical relationship with an open mind.

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

5.2 Culturally appropriate communication

5.2.1 Safety and quality patient care relies on effective communication. The doctor needs to be sensitive to the patient's needs and wishes, and to seek clarification if unsure of how best to 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 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.

5.3 Patient-centred practice

5.3.1 Clinicians are encouraged to tailor care to the patient's specific communicated needs. It is important not to generalise or make assumptions about a person's needs or preferences based on a person's 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 Cultural safety aims to enhance the delivery of health services by identifying the power relationship between the medical practitioner and the patient, and through establishing a relationship founded on trust, empowering the patient to take full advantage of the health care service offered.[4] It is perceived that this will contribute to improved communication strategies which allow the sharing of clinically relevant information.

5.3.3 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 of-course the hallmarks professionals should strive to establish in their dealings with all patients. In that sense cultural competence aligns with the universal expectations of patient care.

5.3.4 The cultural needs of the patient can only be defined by individual patients themselves, and the patient's support network. Patient-centred practice encourages the doctor to explore the patient's expectations of the consultation, and to demonstrate the high level of health literacy necessary to ensure patients are able to make informed health decisions.

5.3.5 There may be rare occasions when the clinician senses that tailoring clinical practice to achieve culturally appropriate care could potentially compromise clinical safety. In this situation the practitioner should effectively discuss this with the patient to ensure that both parties are comfortable with the suggested diagnostic and therapeutic approach. That is, clinical care should ensure that both cultural safety and clinical safety are achieved, without one taking priority over the other. Such effective communication is likely to include the involvement of third parties.

5.4 Partnership

5.4.1 The role of partnership can only develop on a basis of a good working relationship, an appropriate communication strategy and an understanding of the patient's needs and wishes.

5.4.2 Partnership may take on different definitions within different cultural groups/realities. It is normal in some communities to revere doctors and not to challenge or disagree with an authority figure. In these circumstances, doctors need to be sensitive to situations that may arise, in which a person seems

uncomfortable with advice but does not say so; or fails to comply with guidelines when they have expressed understanding of the information provided. Positive approaches might include politely asking the patient to share their thoughts with you, or asking them to explain the treatment plan in their own words. Shyness and fear can often be overcome by respect, and the willingness to work with a patient.

5.4.3 Anaesthetists work as part of a team providing care to a patient. The importance of cultural competence extends to their working relationships with medical colleagues, with nursing, midwifery and allied health staff, and with trainees.

5.5 Issues specific to anaesthesia

5.5.1 Anaesthesia and sedation frequently involve patients being placed in a vulnerable situation amongst strangers. In many situations it will not be possible for support people to accompany the patient. For patients this can increase feelings of vulnerability, and heighten common concerns that include dignity, the preservation of modesty, and observance of any specific rituals or processes. These issues can be discussed with the patient and family at the pre-anaesthesia assessment and consultation.

5.5.2 Pain management can be particularly challenging in a cross-cultural environment. Communication of pain can be affected by verbal and non-verbal indicators of pain, where 'expected' pain behaviours are misunderstood because of different underlying beliefs or concerns. This can also affect treatment. A more detailed discussion is found in the ANZCA publication *Acute Pain Management: Scientific Evidence 4th Edition, Section 10.3*.

This document is accompanied by a background paper (PS62BP) which provides more detailed information regarding the rationale and interpretation of the Statement.

Related ANZCA documents

The ANZCA publication Supporting Anaesthetists' Professionalism and Performance – A guide for clinicians is another resource that provides examples of good and poor behaviour within all ANZCA Roles including matters of cultural competence. Accessible at www.anzca.edu.au/resources/professional-documents

References

1. Royal Australasian College of Physicians. An introduction to cultural competence. . 2004. http://www.racp.edu.au/docs/default-source/advocacy-library/an-introduction-to-cultural-competency.pdf Accessed on October 28, 2015.

2. United Nations Educational Scientific and Cultural Organization. Mexico City Declaration on Cultural Policies. 1982. http://portal.unesco.org/culture/en/files/12762/11295421661mexico_en.pdf/mexico_en.pdf Accessed on October 28, 2015.

3. Medical Council of New Zealand. Statement on cultural competence. August 2006. https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf Accessed on October 28, 2015.

4. Richardson, Ivor and Cook, Len and Durie, Mason and Ballin, Ann and Bruce, Marlon and Noonan, Rosslyn, Preface: The April Report: Report of the Royal Commission on Social Policy (1988). Royal Commission on Social Policy, Wellington, 1988; Victoria University of Wellington Legal Research Paper Series Richardson Paper No. 25.

5. Secretariat of National Aboriginal and Islander Child Care Working and Walking Together: Supporting Family Relationship Services to Work with Aboriginal and Torres Strait Islander Families and Organisations. March 2010**.** http://www.snaicc.org.au/_uploads/rsfil/02497.pdf Accessed on October 28, 2015.

6. Acute Pain Management: Scientific Evidence 4th Edition, Section 10.3.

Further reading

1. Australian Medical Council (2010) Good Medical Practice: a code of conduct for doctors in Australia. Accessible at: http://www.amc.org.au/index.php/about/good-medical-practice

2. Australian Charter of Healthcare Rights (2008). Accessible at: http://www.health.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01

3. The Code of Health and Disability Services Consumers' Rights 1996 (New Zealand). Accessible at: http://www.hdc.org.nz/the-act--code/the-code-of-rights

4. National Health and Medical Research Council (Australia): Cultural Competency in Health: A guide for policy, partnerships and participation (2005). Accessible at: http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/hp19.pdf

5. Australian Health Ministers' Advisory Council (2005). The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health. Accessible at: http://www.health.vic.gov.au/__data/assets/pdf_file/0019/270154/cultural-respect-framework.pdf

6. Medical Council of New Zealand: Statement on Cultural Competence (2006). Accessible at: http://www.mcnz.org.nz/portals/0/guidance/cultural%20competence.pdf

7. Medical Council of New Zealand: Best Health Outcomes for Māori: Practice implications. Accessible at: http://www.mcnz.org.nz/Default.aspx?tabid=269

8. Medical Council of New Zealand: Best Health Outcomes for Pacific Peoples: Practice implications. Accessible at: http://www.mcnz.org.nz/portals/0/publications/Best%20health%20outcomes%20for%20Pacific%20Peoples.pdf

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the College website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated: 2016
Reviewed: 2017
Date of current document: September 2017

ANZCA website: www.anzca.edu.au