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Patient centred care

Cultural safety in indigenous health

Background

The terms 'cultural safety' and 'cultural competence' are used widely in indigenous and culturally and linguistically diverse health contexts. They form the basis for effective patient centred care and the professional advocacy role of the general practitioner.

Objective

This article discusses the concepts of cultural safety and cultural competence. A checklist of cultural competency practice is also provided for health practitioners.

Discussion

Cultural safety is the experience of the recipient of care. It is comparable to clinical safety, allowing the patient to feel safe in health care interactions and be involved in changes to health services. It has been suggested that cultural safety training may be one mechanism to reduce disparities in indigenous health status. Cultural competence is a broader term that focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.

■ **The disparity between Indigenous and non-Indigenous Australians' health status and care has been extensively documented.¹ The causes of these disparities are multifactorial; with the largest contributors related to social and environmental determinants of indigenous health.² It has been suggested that providing cultural safety training to health care providers may be one mechanism to reduce these disparities.^{3,4} This reasoning stemmed from frequent observations that poorly handled cross cultural interactions often resulted in negative clinical consequences including patient noncompliance,⁵ delays in obtaining informed consent,⁶ and ordering of unnecessary tests.⁷ Consequently, effort is underway to provide health professionals with the knowledge and skills to address cross cultural challenges in the clinical encounter through an integrated indigenous health curriculum in undergraduate and postgraduate medical education.^{8,9}**

Cultural competence is an important foundation for effective clinical and patient centred care. As a concept, it enhances the professional and ethical role of health practitioners. Cultural competence is crucial for health professionals who strive to deliver the highest level of quality care to all patients. Thus, although the following discussion focuses on the indigenous context, it is equally applicable to culturally and linguistically diverse (CALD) populations.

Cross cultural concepts in health service provision

There is a myriad of terms used in cross cultural education and practice. For indigenous health, the recent and most important concept is 'cultural safety'. Cultural competence is another concept in continuous development, evolution, scrutiny and acceptance by researchers, educators and practitioners. The conceptual origins of cultural safety was conceived and practised mainly within the context of indigenous health, whereas cultural competency is not so limited in its scope and has wider application.



Table 1. Steps to cultural safety (using indigenous men's health as an example to highlight differences)

Cultural awareness	It is interesting to know that men's business exist within Aboriginal culture and is still practised in some but not all Aboriginal communities. Men's business involves, among other things, an initiation of boys to manhood which involves, among other things, subincision and circumcision. This ceremony is secret and should not be discussed or revealed to women or uninitiated males. Boys and men can 'disappear' from the community for days to weeks to engage in this custom
Cultural sensitivity	Using the men's business experience of some Aboriginal groups, we note that men don't come to the clinic because there are too many women present and that nurses and AHWs are mostly women. A culturally sensitive GP would voice that the clinic must be more male friendly to get this group to access clinic services. For example, the GP would advocate for a separate space and/or time for male patients, a 'men's clinic' with football posters, male AHWs, doctors and nurses
Cultural safety	Men in a community want a separate men's area; not just a men's clinic. They comment that the men's clinic developed for their use is too close to the main clinic and that is why they feel uncomfortable there and do not attend. They comment that still too many people see them go in. They want a space and service that deals with their concerns of living and not just the western medical concerns regarding their physical health. This space would function not unlike a women's centre down the road in the women's area. It should provide a meeting place for men who may not seek medical care. It should provide planned activities and resources relevant for what men want to do and enjoy. It should provide information and perhaps training in skills that increase employment opportunities How the GP responds to this request is secondary to the fact that the patients have felt 'safe' (or safe enough) to voice their wish in a practical sense for improved care

Cultural safety

In understanding cultural safety, we need to distinguish it from 'cultural awareness' and 'cultural sensitivity'.

Cultural awareness is the initial step toward understanding 'difference' – what constitutes a cultural group, their rituals, customs, behaviours and practices.¹⁰ One of the criticisms of cultural awareness is that it promotes the stereotyping of cultural groups. It does not, for example, acknowledge the diversity of behaviours and values within cultural groups, nor does it seem to acknowledge the idea that culture is dynamic, and individuals are agents of change within their culture (*Table 1*).

Cultural sensitivity brings the practitioner one step further, as it is the stage at which there is acceptance of the legitimacy of differences in realities and experiences (emotional, social, economic, political, historical). It marks the beginning of the process of self exploration in understanding how personal attitudes and experiences impact on the lives of others, namely their patients (see *Case study*).

Where cultural awareness and cultural sensitivity assist practitioners in recognising their personal attitudes and prejudices in a clinical context, cultural safety provides a framework for engagement with patients so that patients can assert power and control over their own health and wellbeing.

Cultural safety goes well beyond cultural awareness and cultural sensitivity. It gives people the power to comment on care leading to reinforcement of positive experiences. It also enables them to be involved in changes to health services and programs. Cultural safety explicitly acknowledges the experience of the recipient of care. Its focus is on the level of clinical care interaction, focusing on the individual patient (based on feelings of being safe in health care interactions) and the practitioner's personal attitude (implying that personal attitudinal changes will of itself positively alter the health care situation).

Cultural safety has its roots not in academic theorising but from the experiences of nurses in New Zealand, and was designed to contribute to positive change to the health status of the Maori of New Zealand. The term 'safety' is used deliberately to mean 'actions to protect from danger and/or risk to patient/client/community from hazards to health and wellbeing. It includes regard for the physical, mental, social, spiritual and cultural components of the patient and the community'.¹¹ Cultural safety, it is argued, is comparable to clinical safety and thus is crucial to health professional training.

Cultural safety as a concept is of particular significance to indigenous health. In focusing on clinical interactions, particularly on the power relations between patient and health professional, it calls for a genuine partnership where power is shared between the two individuals and/or cultural groups involved in health care. In doing so, both individuals and/or cultural groups recognise the historical, political and sociocultural realities in indigenous health and wellbeing.¹²

One fundamental criticism of cultural safety practice has been that effective change in health outcomes for patients on a larger scale may not follow from the health professional's personal attitudinal change; no matter how readily they can be moulded.¹¹ It needs to go beyond this level to involve structural changes in organisational and systemic layers of indigenous health.

Cultural competence

Cultural competence focuses on the capacity of the health system to improve health and wellbeing by integrating culture into health service delivery. Consequently, cultural competence is measured at all levels of the health care system.

It is a 'set of behaviours, attitudes and policies that come together in a system, agency or among health professionals and enable that system, agency or those professionals to work



Table 2. Examples of cultural competence practice at different levels of the health care system as it relates to indigenous health

Dimensions	Requirements	Example
Systemic	Development of policies and procedures, mechanisms for monitoring and gaining and maintaining sufficient resources to foster culturally competent behaviours and practice at other levels	Henry, Houston and Mooney challenge us to look around us and the place that we work in and acknowledge that 'institutionalised racism' exists. Endorsing that equity is 'equal access to equal care for equal need' is not culturally competent. For a system to be culturally competent, it needs to recognise that indigenous people may 'need more access to more care for the same health problem than those with more money, better social supports and better opportunities' ¹⁶ The Australian Medical Council for the first time, centrally locates Indigenous Australian people within its assessment and accreditation framework ¹⁷
Organisational	Effective management of programs and staff to create and maintain a culture where cultural competency is valued as integral to core business	Regional training providers are guided by national policy on regionalisation and indigenous health. NTGPE defined the learning contexts to target effective training and curriculum delivery in general practice with particular emphasis on indigenous health ¹⁸ The integrated antenatal 'Mums and babies' program capitalises on cultural safety aspects of an Aboriginal medical service and the co-location of mental health, dental and social services in its delivery of culturally competent care to an indigenous antenatal cohort of Townsville ¹⁹
Professional	Production of cultural competence standards to guide professionals and operational outcomes of organisations. The professions are responsible for curriculum framework and continuing professional development in cultural competence	The RACGP aims to improve support and training for GPs working in indigenous health by delivering and supporting educational tools and resources, forums and networks ²⁰
Individual	Contemporary knowledge, skills and behaviours that define effective cultural competent behaviour. Individuals need to feel supported to work in the cross cultural context: by their profession, employing organisation, and the health system	Wenitong and Panaretto described the role and function of the GP in ACCHSs as one that requires considerable cultural safety skills: cross cultural communication; patient centred care and empowerment of the patient; flexibility within clinic processes; and leadership through quality improvement ²¹

effectively in cross cultural situations'.¹³ Cultural competence focuses on four levels (systemic, organisational, professional and individual) and addresses collective issues of equity in health care access and health outcomes. The four levels inter-relate so that cultural competence at the individual or professional level is underpinned by systemic and organisational commitment and capacity. Examples of cultural competence are listed in *Table 2*.

The evidence for cultural competent practice

Due to the large number of potentially confounding variables, it is difficult to show a direct link between a cultural competence and cultural safety intervention, and health status improvements and/or cost savings. It is possible however, to link together a number of intermediary outcomes that may contribute to health status improvements and/or cost savings¹⁴ (*Figure 1*).

The evidence for cultural competence training

The evaluation goals of cultural competence intervention are to

determine whether learners gained attitudes, knowledge, skills and behaviour to provide effective care to patients from CALD or indigenous communities. Most studies using instruments to measure cultural competence have not been rigorously evaluated.¹⁵

Most instruments that assess cultural competence rely on self assessment of knowledge.¹⁵ When asking learners to comment on characteristics of a group, there is a real danger that teachers are asking learners to stereotype and categorise the group. This is an outcome the teacher would wish to avoid. Similarly, skills self assessment is not likely to be an objective. A high rating of confidence can suggest arrogance or lack of awareness of one's limitations rather than actual ability. There are also poor examples of measurements of behaviour, which also tend to be self disclosing rather than through direct objective observation and assessment by teachers.

Studies that look at measuring attitudes towards sociocultural issues tended to ask questions that were not covered in cultural competence programs. Learners tend to select the most desirable

Table 3. Checklist for the culturally competent GP^{22,23}

Attitude

- Are you open to cultural differences and different ways of doing things?
- Do you respect diverse practices and requests without judgment?
- Do you react adversely to patients' accents and language styles?

Skills

- Do you recognise, elicit and actively accommodate patients' choices about their care?
- Do you facilitate your CALD/Aboriginal and Torres Strait Islander patients' access to the available resources and support?
- Do you use an interpreter when interacting with a patient from a CALD/Aboriginal and Torres Strait Islander background whose proficiency in English is inadequate?
- Do you integrate culturally influenced health protective/prevention factors in your practice?
- Do you integrate the following in diagnostic protocols:
 - knowledge of diverse values and belief systems to health and disease?
 - individual's perception of what caused their disease/illness?
 - culturally relevant information from family members?
 - screening/diagnostic tests based on age?
 - screening/diagnostic tests based on race/ethnicity?
 - screening/diagnostic tests based on gender?

Knowledge

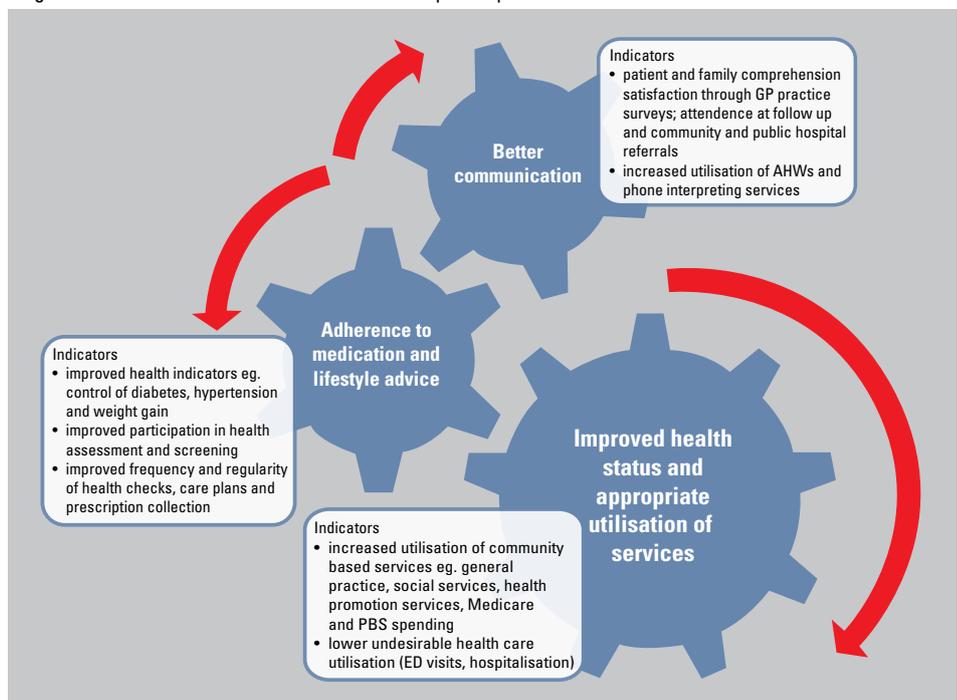
- Are you aware that you are legally liable if you do not organise an interpreter when necessary?
- Are you aware of the sources of extra social support, community organisations and resources available to CALD or Aboriginal and Torres Strait Islander patients to overcome barriers such as lack of English proficiency or support networks?
- Are you aware of the impact of family dynamics on health care decisions (eg. high value placed on decisions of elders, differing gender roles, role of extended family)?
- Are you aware of the influence of spirituality or religiosity on perceptions of health and wellbeing?
- Are you aware of the impact of the social and environmental indicators on the health and wellbeing of the communities you serve?

answers rather than their own beliefs. Explicit attitudes may not reflect implicit attitudes. Further, how explicit and implicit attitudes correlate and how it translates to specific behaviours needs exploration.

Nevertheless, a list of questions for reflective practice may be useful to guide personal and professional development in cultural competence in the health practitioner (Table 3).

Conclusion

The introduction of cultural safety and cultural competence in undergraduate and postgraduate education is moving forward. The challenge is to evaluate these interventions and their relationship to perceived gains in health outcomes. Cultural safety and cultural competence are key concepts that have practical meaning for indigenous and CALD people. They form the basis for effective patient centred care and the professional advocacy role of the GP.

Figure 1. Inter-related outcomes of cultural competent practice¹⁴



Case study

JA is an Aboriginal man living in a remote community in the Northern Territory. He is 50 years of age, married to an Aboriginal woman, with his children dispersed in another state. He rarely presents to the community health service. He does have intermittent health checks, which note that he is free from chronic disease.

The previous year had seen a stable health team with the employment of a resident GP. JA and the GP have built up a good therapeutic relationship from the point of view of the GP. To JA, the GP is doctor and 'son'. The GP and JA agree that JA has 'lung problems' due to long term smoking. JA says it's 'too hard' to give up and he is 'too old' to try. The GP and JA agree to use inhalers to control JA's breathlessness on exertion and cough at night time.

A few months later JA presents with increasing cough and flecks of blood in his spit. The GP tells JA that further tests are needed so that he can give the right treatment. JA agrees to travel to a regional town for an X-ray.

A chest X-ray and sputum cytology confirm lung cancer.

JA is told the diagnosis. The GP thinks JA looks calm, although concerned. When asked what he is concerned about, JA says that he is afraid of big cities and being away from family. He hopes that the GP won't make him go to Darwin or Adelaide. Although the GP respects JA feelings, he asks JA whether he would like him to help him give his family 'the true story'. JA agreed and immediately left to get his family. Two hours later, JA comes back to see the GP and asks him to go to his 'camp' as the family is waiting. The GP informs the practice manager and she suggests the GP take the male Aboriginal health worker (AHW) to the family meeting. The GP also takes a portable whiteboard. The family meeting involved 20 people, not counting the children who came and went. The GP and AHW sat down on the ground at the back of JA's home facing the family. The GP asked the AHW to stop him if he needed to clarify whether the family understood what he was saying and to ask questions if the AHW himself didn't understand. The GP used the whiteboard to explain lung cancer, JA's prognosis and the usual management for lung cancer.

A management plan was negotiated between the GP, AHW, JA, JA's wife and the family. JA's wife and family want JA to go to Darwin for treatment, while acknowledging his reluctance to be away from family and country. The GP can see from JA's body language that he is unhappy with the family's decision, although he does not argue with the plan. The GP suggests that JA will need to go to Darwin to have more tests and get specialist advice, and that he could talk to the specialist to see whether the clinic could care for JA in the community after that assessment (palliative care management). The GP explains that the clinic can care for JA with services and advice from Darwin if the specialist can 'get rid of the cancer'. The family is reassured and all agree to the plan.

The clinic organises for a family member in Darwin to meet JA at the hospital, and the family instructed them to attend to JA's needs while in Darwin. The GP wrote a referral letter to the specialist, outlining the management so far, including the family meeting. The GP coached JA to insist on the Aboriginal liaison officer and family coming with

him to see the specialist. The GP also advised JA to say what is on his mind and in his heart when they talk about his management.

Two weeks later, JA is back in the community. He has inoperable lung cancer. He told the specialist he did not want active treatment away from the community and the specialist respected this position. The palliative care team was notified and visited 1 week later. The team brought aids for the home and for JA to assist mobility.

Six months later, the GP was called to JA's home by his wife, who was very concerned that JA refused to eat. JA had asked for the GP. The GP looked at JA, who lay by the campfire on a mattress in the backyard. They held each other's hands. JA said a weak 'thank you' and smiled.

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