Short title: Cultural competence and cultural safety BP

1. Introduction

The populations of Australia and Aotearoa New Zealand are diverse, representing people from many different backgrounds and cultures. Patients from different cultures experience health inequities, and the Australian and New Zealand College of Anaesthetists' (ANZCA's) statement on cultural competence and cultural safety (PS62(G)) seeks to challenge clinicians to address aspects of the delivery of health care that contribute to these inequities and strive to deliver culturally competent and safe care. As such, the statement endeavours to raise awareness of the impact of cultural diversity in the healthcare setting and to assist doctors to deliver culturally competent and safe care.

2. Background

2.1 PS62(G), written in 2017, was due for routine review. Furthermore, revision of the statement was required due to the recent evolution in concepts of cultural competence and safety in health care, including the following developments:

- 2.1.1 Publication of ANZCA's Reconciliation Action Plan supporting progress to reconciliation with Aboriginal and Torres Strait Islander peoples,[i]
- 2.1.2 Te Kaunihera Rata o Aoteraroa Medical Council of New Zealand statement requiring all doctors to meet cultural safety standards,[ii]
- 2.1.3 Publication by Te Kaunihera of Ngā Kāreti Rata o Aotearoa Council of Medical Colleges New Zealand of a cultural training plan for vocational medicine in Aotearoa,[iii]
- 2.1.4 Increasing government recognition of the need to address health inequities related to the LGBTQIA+ community.[iv]

3. Review of issues

3.1 Evolution in definitions of and concepts around culture competence and cultural safety

There is a plethora of recent literature examining culture competence, and related elements including culture safety, cultural sensitivity, cultural humility,[v] and intersectionality.[vi] Where there were conflicting definitions in the literature of these elements, the PS62(G) Document Development Group (DDG) favoured the approaches taken by Australian and New Zealand authors and the ratified and endorsed definitions used by the national medical councils.

Recent literature has focused more closely on concepts of cultural safety as distinct from cultural competence. Although both are of prime importance, this evolution informed modifying the title of PS62(G) to include cultural safety.

3.2 Broad range of cultures

One of the earliest proponents of cultural safety in health care was Irihapeti Ramsden, a Māori nurse, anthropologist and writer.[vii] Ramsden's work focused on the role of cultural safety in improving the health status of New Zealand people 'through the relationship between Māori and the Crown based on the Treaty of Waitangi'.[viii] However, she advocated for culture to be considered in its broadest sense, and for cultural safety to take account of differences between healthcare provider and patient with respect to ethnicity, age or generation, gender, sexual orientation, socioeconomic status, religious or spiritual belief, and disability.[ix] PS62(G) therefore similarly addresses this broader scope around cultural safety.

Cultural competence requires that clinicians are able to deliver high standards of care to all patients irrespective of their cultural background or beliefs. It includes the recognition that cross-cultural communication may need to extend beyond the patient to include families and networks.

3.3 Māori, First Nation's peoples and Pacific Island people

While the statement addresses all cultures, there are issues specific to the cultures of Māori, First Nation's peoples and Pacific Island people that are relevant to health care and health inequities. The College aligns with the UN Declaration of Indigenous Peoples[x] and acknowledges the rights of the first peoples of Australia, Aotearoa New Zealand and the Pacific Islands. The impact of colonisation on the health status of these peoples is recognised, and this document promotes the need for awareness of this matter.

3.4 Clinician's culture

Clinicians come from varied backgrounds, which may influence their interaction with other cultures. Self-awareness on the part of clinicians is central to ensuring they bring respect, open-mindedness and sensitivity to their care of patients, regardless of cultural differences.

3.5 Multi-level considerations of cultural competence and safety

Recent literature highlights that ensuring both patient care and healthcare environments are culturally safe requires focus at the level of government, healthcare organisations, departments and individual practitioners. PS62(G) has therefore incorporated additional considerations beyond the health practitioner level, including as they relate to the healthcare workforce.

There are particular considerations pertinent to different cultural groups, and PS62(G) is not intended to be an exhaustive manual or tool kit of requirements covering all cultural groups listed. Rather, the statement aims to draw together the overarching principles relevant to all cultures, illustrating many of them with specific examples drawn from different cultural groups.

4. Principles

The statement lists the principles that should be applied to all cross-cultural interactions, and recommends that they should be considered in the context of other guidelines and frameworks. The following principles have been considered in some detail:

4.1 Respect and understanding

This is based on trust and the statement provides insight into the various influences that may be active within communities.

4.2 Culturally appropriate communication

This identifies barriers to communication and simple measures to address these.

4.3 Patient-centred practice

This focuses on the individual needs and avoiding generalisations based on any cultural groups. It also addresses the balance between cultural safety and clinical safety.

4.4 Partnership

This clarifies the relationship between doctors and patients and the need to ensure understanding and address unexpressed concerns. It also highlights the healthcare environment, which consists of a team including colleagues, other health practitioners, and staff. Cultural competence and cultural safety must extend to include the working environment.

It must be emphasised that cultural competence does not demand forsaking quality of patient care in the face of perceived conflicts. On the contrary, care and communication delivered in a culturally competent manner and tailored to individual needs will contribute to the better understanding by

patients, irrespective of their cultural backgrounds, and enhance their acceptance of clinical advice and care.

5. Summary

With patient populations increasingly representing a broad range of cultural backgrounds, clinicians can improve the delivery of health care through an awareness of the differing needs of their patients.

The accompanying statement defines cultural competence and cultural safety, identifies the elements contributing to competence and safety, and communicates the expected standards.

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[i] Australia and New Zealand College of Anaesthetists, 'ANZCA Reconciliation Action Plan' (2023) <https://www.anzca.edu.au/safety-advocacy/indigenous-health/reconciliation-action-plan>.
[ii] Medical Council of New Zealand, *Statement on Cultural Safety* (October 2019) <https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/>.
[iii] Te Kaunihera o Ngā Kāreti Rata o Aotearoa Council of Medical Colleges New Zealand, *Cultural Safety Training Plan for Vocational Medicine in Aotearoa* (2023).
[iv] Australian Government Department of Health and Aged Care, 'Pathway to Better Health for LGBTIQA+ Communities', *Australian Government Department of Health and Aged Care* (text, 1 March 2023) <https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/pathway-to-better-health-for-lgbtiqa-communities>; NSW Government, *NSW LGBTIQ+ Health Strategy 2022-2027* (2022).
[v] Mark Lock et al, 'Are Cultural Safety Definitions Culturally Safe? A Review of 42 Cultural Safety Definitions in an Australian Cultural Concept Soup' [2021] *Research Square* <https://doi.org/10.21203/rs.3.rs-1179330/v1>.
[vi] Jenny Kingsley, Emily Berkman and Sabrina Derrington, 'The Disruptive Power of Intersectionality' (2021) 21(9) *The American Journal of Bioethics* 28.
[vii] Ronica Mukerjee, Linda Wesp and Randi Singer, *Cultural Safety Framework for LGBTQIA+ Communities* (Springer Publishing Company, 2021).
[viii] Elaine Papps and Irihapeti Ramsden, 'Cultural Safety in Nursing: The New Zealand Experience' (1996) 8(5) *International Journal for Quality in Health Care* 491.
[ix] Ibid.
[x] United Nations, *United Nations Declaration on the Rights of Indigenous Peoples* (2007).