

Embedding cultural safety in Australia's main health care standards

Accreditation with nationally consistent standards for culturally safe clinical care will improve Indigenous health outcomes

In Australia, the existing health safety and quality standards are insufficient to ensure culturally safe care for Indigenous patients in order to achieve optimum care outcomes. Where “business as usual” health care is perceived as demeaning or disempowering — that is, deemed racist or culturally unsafe — it may significantly reduce treatment adherence or result in complete disengagement,^{1,2} even when this may be life-threatening.³ Peak Indigenous health bodies argue that boosting the likelihood of culturally safe clinical care may substantially contribute to Indigenous health improvement.⁴ It follows that a more specific embedding of cultural safety within mandatory standards for safe, quality-assured clinical care may strengthen the currently inadequate Closing the Gap mechanisms related to health care delivery.

The causes of inequitable health care are many. Western biomedical praxis differs from Indigenous foundational, holistic attention to the physical, emotional, mental and spiritual wellbeing of the person and the community.⁵ An article published in this issue of the *MJA*⁶ deals with the link between culture and language in improving communication in Indigenous health settings, a critical component of delivering cultural safety.

Integrating cultural safety in an active manner reconfigures health care to allow greater equity of realised access, rather than the assumption of full access, including procession to appropriate intervention. As an example of the need to improve equity, a South Australian study found that Indigenous people presenting to emergency departments with acute coronary syndrome were half as likely as non-Indigenous patients to undergo angiography.⁷ More broadly, Indigenous people admitted to hospital are less likely to have a procedure for a condition than non-Indigenous people.⁸

Cardiovascular disease is the leading cause of death in Indigenous Australians.⁹ Cancer is the second biggest killer: the mortality rate for some cancers is three times higher for Indigenous than for non-Indigenous Australians.¹⁰ Clinical leaders in these two disease areas have identified the need for culturally safe health care to improve Indigenous health outcomes.

Cultural safety is an Indigenous-led model of care, with limited, but increasing, uptake, particularly in Australia, New Zealand and Canada. It acknowledges the barriers to clinical effectiveness arising from the inherent power imbalance between provider and patient,¹¹ and moves to redress this dynamic by making the clinician's cultural underpinning a critical focus for reflection. Moreover, it invites practitioners to consider: “what do I bring to this encounter, what is going on for me?” Culturally safe care results where there is no inadvertent disempowering of



the recipient, indeed where recipients are involved in the decision making and become part of a team effort to maximise the effectiveness of the care. The model pursues more effective practice through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing the patient to determine what safety means.¹¹

Along with an emphasis on provider praxis, cultural safety focuses on how institutional care is both envisaged and delivered.¹² Literature on cultural safety in Australia is scant but growing.¹³ Where evidence is available, it identifies communication difficulties and racism as barriers not only to access but also to the receipt of indicated interventions or procedures.¹¹

There is evidence of means to overcome these barriers. An Australian study undertaken across ten general practices tested the use of a cultural safety workshop, a health worker toolkit, and partnerships with mentors from Indigenous organisations and general practitioners.¹³ Cultural respect (significant improvements on cultural quotient score, along with Indigenous patient and cultural mentor rating), service (significant increase in Indigenous patients seen) and clinical measures (some significant increases in the recording of chronic disease factors) improved across the participating practices.

In addition, a 2010 study by Durey¹⁴ assessed the role of education, for both undergraduate students and health practitioners, in the delivery of culturally responsive health service, improving practice and reducing racism and disparities in health care between Indigenous and non-Indigenous Australians. The study found that cultural safety programs may lead to short term improvements to health practice, but that evidence of sustained change is more elusive because few programs have been subject to long term evaluation.

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Newman and colleagues¹⁰ identified clinician reliance on stereotypical narratives of indigeneity in informing cancer care services. Redressing these taken-for-granted assumptions led to culturally engaged and more effective cancer care. In a similar manner, Ilton and colleagues¹⁵ addressed the importance of individual clinician cultural safety for optimising outcomes, noting that provider perceptions of Indigenous patient attributes may be biased toward conservative care. The authors, however, went beyond the clinician–patient interaction to stress the outcome-enhancing power of change in the organisational and health setting. They proposed a management framework for acute coronary syndromes in Indigenous Australians. This framework involved coordinated pathways of care, with roles for Indigenous cardiac coordinators and supported by clinical networks and Aboriginal liaison officers. It specified culturally appropriate warning information, appropriate treatment, individualised care plans, culturally appropriate tools within hospital education, inclusion of families and adequate follow-up.

Willis and colleagues¹⁶ also called for organisational change as an essential companion to individual practitioner development. Drawing on 12 studies involving continuous quality improvement (CQI) or CQI-like methods and short term interventions, they acknowledged evidence gaps, prescribing caution, and argued for such change to be undertaken in the service of long term controlled trials, as these would require 2–3 years to see any CQI-related changes. Sjoberg and McDermott,¹⁷ however, noted the existence of barriers to change: the challenge (personal and professional) posed by Indigenous health and cultural safety training may

not only lead to individual but also to institutional resistance.¹⁷ Dismantling individual resistance requires the development of a critical disposition — deemed central to professionalism and quality¹⁸ — but in a context of strengthened and legitimating accreditation specific to each discipline. The barriers thrown up by institutional resistance, manifesting as gatekeeping, marginalisation or underfunding, may require organisational change mandated by standards.

Cultural safety requires embedding in not only course accreditation for each health profession — including measures to reduce resistance — but also in the standards governing clinical professionalism and quality, such as the Royal Australian College of General Practitioners *Standards for general practices*,¹⁹ and the Australian Commission on Safety and Quality in Health Care *National safety and quality health service standards*.²⁰

Such commitment will need investment in clinician education and professional development, together with measures for accountability. The stewards of the National Aboriginal and Torres Strait Islander Health Plan⁵ (ie, the Department of Health and their expert implementation advisory group), accreditation bodies, and monitors of the existing frameworks of safety and quality standards in health care need to formally collaborate on a systematic revision of standards to embed culturally safe practice and develop health settings free of racism.

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