MIGRANT & REFUGEE
WOMEN'S HEALTH PARTNERSHIP

Consultation

Draft Competency Standards Framework
Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds

March 2018

Migrant and Refugee Women's Health Partnership is seeking feedback from all interested stakeholders on the public consultation draft of the Competency Standards Framework—*Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds*.

The draft Competency Standards Framework (the Framework) has been prepared by the Migrant and Refugee Women's Health Partnership (the Partnership) with a view to establishing recommended and optimal cultural responsiveness competency standards for clinicians in health care settings.

The impetus for the development of the Framework arose out of the recognition that there is a need for a comprehensive, consistent and flexible suite of competency standards for clinicians when working with patients from migrant and refugee backgrounds in health care settings. It is the Partnership's hope that, once finalised, the Framework will be considered and applied across professional education, training, continuing development and standard setting for clinicians.

Terms used in this document are defined in the *Glossary*. The Framework is to be read with the *Annex: Practice points for clinicians working with interpreters in health care settings*, which forms an integral part of this document.

The Partnership is seeking your feedback on all aspects of the Framework. Further, the Partnership is seeking your suggestions with regard to relevant tools and resources that would provide authoritative and practical guidance to clinicians to support the implementation of the Framework (these will constitute the *Appendix: Practice tools and resources).*

Comments and suggestions can be added to the PDF document using the Sticky-note feature or separately in writing.

Feedback should be directed to **secretariat@culturaldiversityhealth.org.au** or gulnara.abbasova@culturaldiversityhealth.org.au.

The deadline for the consultation is **Tuesday 15 May 2018**.

For further information about the consultation process, contact the Partnership Secretariat on 02 6162 0361.
To find out more about the Partnership, visit **www.culturaldiversityhealth.org.au**.

Culturally Responsive Clinical Practice: Working with People from Migrant and Refugee Backgrounds

Competency Standards Framework

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FOREWORD

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ACKNOWLEDGEMENTS

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GLOSSARY

In this Competency Standards Framework,

AUSIT means Australian Institute of Interpreters and Translators, the national association for the translating and interpreting profession. Interpreters who are members of AUSIT are bound by AUSIT's code of ethics, obliging them to maintain impartiality, objectivity and confidentiality.

ASLIA means Australian Sign Language Interpreters' Association, the national peak organisation representing the needs and interests of Auslan/English interpreters and Deaf interpreters in Australia. Interpreters who are members of ASLIA are bound by ASLIA's code of ethics, obliging them to maintain impartiality, objectivity and confidentiality.

Auslan means the language of the deaf community in Australia.

Bicultural worker means a person employed to work specifically with people or communities with whom they share similar cultural experiences and understandings, and who is employed to use their cultural skills and knowledge to negotiate and communicate between communities and their employing agency.[1]

Bilingual worker means a professional who agrees to communicate in English and a language other than English and who is not an interpreter.[2] A bilingual worker can be employed in a range of positions within an organisation and utilise their proficiency in a language other than English as an additional skill. Some bilingual workers are employed specifically for their proficiency in a language other than English.

Carer means a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged.[3] A person is not considered a carer if they are paid, a volunteer for an organisation or caring as part of a training or education program.[4]

Chuchotage means simultaneous interpreting in a whisper for the benefit of a person or small number of people listening to speech in a language in which they are not fluent. Chuchotage is also known as 'whispering' or 'whispered interpreting'.[5]

Clinician means a healthcare provider, trained as a health practitioner, including registered and nonregistered practitioners. Clinicians may provide care with a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They may include nurses, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.[6]

Consumer means a person who has used, or may potentially use, health services.[7]

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[1] Centre for Multicultural Youth, (2011). *Addressing the strengths and complexities of bicultural youth and family work*.
[2] Centre for Culture, Ethnicity and Health, (2014). *Managing bilingual staff*.
[3] Australian Commission on Quality and Safety in Health Care, (2017). National Safety and Quality Health Service Standards, 2nd ed.
[4] Commonwealth of Australia, (2010). *Carer Recognition Act 2010*.
[5] Australian Institute of Interpreters and Translators. *Interpreting: Getting it right*.
[6] Australian Commission on Quality and Safety in Health Care, (2017). National Safety and Quality Health Service Standards, 2nd ed.
[7] Australian Commission on Quality and Safety in Health Care, (2017). National Safety and Quality Health Service Standards, 2nd ed.

Consecutive interpreting means a mode of interpreting where the interpreter waits for the speaker to finish an utterance of reasonable length (given the interpreter's memory and/or note-taking skills) before translating it.[8]

Cultural responsiveness means the capacity of clinicians to provide care that is respectful of, and relevant to, the health beliefs, health practices, cultural and linguistic needs of diverse patient populations and communities. It describes the capacity to respond to the healthcare issues of different communities.[9] [10]

Other terms that are often used to capture the concept of cultural responsiveness or similar include: cultural competency, cultural sensitivity, and cultural safety.

Health beliefs means a person's beliefs and past experiences that affect the way they view health, causes of illness and treatment.[11]

Health literacy means skills, knowledge, motivation and capacity of an individual to access, understand, appraise and apply health-related information to make effective decisions about health and health care, and take appropriate actions.[12]

Health system literacy means skills, knowledge, motivation and capacity of an individual to access, understand, appraise and apply information about the health system and services to make effective decisions about health and health care, and take appropriate actions.[13]

Interpreter means a practitioner who conveys spoken or signed information from one language into another language orally.[14] Whenever 'interpreter' is used in this document, it is intended to mean 'qualified interpreter".

Language includes Auslan and other sign languages.

People from migrant backgrounds means people who are permanent migration program entrants, including first generation (born overseas) and second generation (at least one parent born overseas) Australians, as well as temporary migration program entrants.

NAATI means National Accreditation Authority for Translators and Interpreters, the national body responsible for setting, maintaining and promoting standards for the translation and interpreting industry through its certification system for translators and interpreters.

Patient means a person who is receiving care in a health service organisation.[15]

[8] Australian Institute of Interpreters and Translators. *Interpreting: Getting it right*.
[9] State of Victoria (Department of Health), Cultural responsiveness framework: Guidelines for Victorian health services, 2009.
[10] Queensland Government (Queensland Health), Refugee health and wellbeing: A strategic framework for Queensland 2016, March 2016.
[11] Centre for Culture, Ethnicity and Health, *Cultural considerations in health assessment*.
[12] Australian Commission on Quality and Safety in Health Care, (2017). National Safety and Quality Health Service Standards, 2nd ed.
[13] Australian Commission on Quality and Safety in Health Care, (2017). National Safety and Quality Health Service Standards, 2nd ed.
[14] Australian Institute of Interpreters and Translators. *Interpreting: Getting it right*.
[15] Australian Commission on Quality and Safety in Health Care, (2017). National Safety and Quality Health Service Standards, 2nd ed.

People from refugee backgrounds means people with refugee-like experiences, including people who are humanitarian program entrants granted permanent or temporary protection, asylum seekers, and permanent or temporary migration program entrants.[16]

Person-centred care means an approach to the planning, delivery and evaluation of health care that focuses on developing mutually beneficial partnerships between clinicians and patients and their carers, and is respectful of and responsive to the preferences, needs and values of patients and consumers [17]

Preferred language means a language most preferred by a person for communication.[18] Preferred language may not be related to country of birth,[19] and may be a language other than English even where the person can speak fluent English.[20]

Qualified interpreter means a practitioner who has obtained a formal qualification in interpreting or translating and/or certification issued by the National Accreditation Authority for Translators and Interpreters (NAATI). Ideally, practitioners will have both formal qualifications and NAATI certification. For languages of some new and emerging communities in Australia, a tertiary qualification or NAATI certification may not be available. In such cases, interpreters or translators may have received NAATI recognition.

NAATI certification levels include:

Certified Conference Interpreter;
Certified Specialist Interpreter (Health or Legal);
Certified Interpreter;
Certified Provisional Interpreter; and
Recognised Practising Interpreter.

Sight translation means the process whereby an interpreter or translator presents a spoken interpretation of a written word.

Simultaneous interpreting means a mode of interpreting where speech is translated while it is being spoken (usually with a delay of no more than a few seconds). Often performed with the aid of an interpreter's booth or some other method for acoustic isolation of the interpret from the speaker and listener/s so as not to distract them.[21]

Social determinants of health means the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces, including economics, social policies and politics.[22]

Teach-back method means a way for a clinician to confirm that the clinician explained to the patient what they need to know in a matter that the patient understands by asking them to teach back directions.[23]

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[16] State of Victoria (Health and Human Services), (2015). *Refugee and Asylum Seeker Health Services: Guidelines for the community health program.*
[17] Australian Commission on Quality and Safety in Health Care, (2011). *Patient-centred care: Improving quality and safety through partnerships with patients and consumers*.
[18] Australian Institute of Health and Welfare, Metadata Online Registry.
[19] Centre for Culture, Ethnicity and Health, *Cultural considerations in health assessment*.
[20] Australian Institute of Health and Welfare, Metadata Online Registry.
[21] Australian Institute of Interpreters and Translators. *Interpreting: Getting it right*.
[22] Australian Institute of Health and Welfare, (2016). *Australia's Health 2016.*
[23] Agency for Healthcare Research and Quality, (2015). *Use the teach-back method. Health Literacy Universal Precautions Toolkit*, 2nd Ed.

Translator means a practitioner who conveys written information from one language into another language in the written form.[24]

Trauma-informed care means care provision that is based on knowledge and understanding of how trauma affects people's lives and their service needs to ensure that individuals are not re-traumatised.[25]

[24] Australian Institute of Interpreters and Translators. *Translation: Getting it right*.
[25] Wall, L., Higgings, D. and Hunter, K., Australian Institute of Family Studies, (2016). CFCA Paper No. 37. *Trauma-informed care in child/family welfare services*.

INTRODUCTION

Background to the Competency Standards Framework

As Australia's population becomes more diverse, clinicians increasingly interact with patients from migrant and refugee backgrounds, as well as the patients' families and carers. Delivering quality care to people from migrant and refugee backgrounds requires clinicians to adopt culturally responsive practices and utilise competencies enabling them to communicate and work effectively with this cohort.

Cultural responsiveness needs to be embedded in clinical education, training, professional development and practice standards to ensure enhanced health and wellbeing outcomes for the Australian community. Culturally responsive clinical practice contributes to the equity of health access and outcomes for all Australians, and improves the quality and safety of health care.

The review of cultural responsiveness in clinical education, training and standard setting found that Australia's peak professional bodies for clinicians overwhelmingly recognise the positive impact that care delivered by clinician in a culturally responsive way can have upon health access, experience and outcomes of people from migrant and refugee backgrounds.[26] Cultural responsiveness considerations are appropriately gaining relevance in view of curricula and professional competency standards development in clinical education, training and practice.

Purpose

The Competency Standards Framework establishes recommended and optimal cultural responsiveness competency standards for clinicians in health care settings.

The purpose of the competency standards is to inform the development of clinical education, training, professional development curricula and competency standards for clinicians. The standards are intended to be flexible, and are designed to apply across a range of health care settings and across a range of curricula and competency standards models.

The Competency Standards Framework embodies the benchmark to which all clinicians in Australia should aspire in their education and practice. They do not justify a reduction in competency standards already in place across clinical education, training and professional development that exceed the standards.

It is proposed that all clinical education, training and standard setting bodies consider and adapt these competency standards to meet the needs, circumstances and context of their respective curricula or competency standards.

Principles

The Competency Standards Framework is underpinned by the following key principles:

- Person-centred care
- Access
- Equity
- Quality and safety
- Dignity and respect

[26] Migrant and Refugee Women's Health Partnership, *Overview of cultural competence in professional education, training and standard setting for clinicians*. August 2017.

Provision of care that respects and is sensitive to different cultures is essential to the implementation of person-centred health care,[27] and is characterised by exploration, empathy, and responsiveness to patients' needs, values, and preferences.[28] When working with patients from migrant and refugee backgrounds, this involves the acknowledgement of the social, economic, cultural and behavioural factors influencing health, both at individual and population levels.[29]

Access to health care for people from migrant and refugee backgrounds can vary widely between different groups, based on factors such as gender, age, pre-migration experiences, migration status, and other variables. These intersectional factors are critical when applying a person-centred lens with a view to ensuring responsiveness and appropriateness of care. In addition to structural barriers to health care access, some well-recognised barriers to health access may have a cultural dimension that needs to be considered, and there are a number of barriers that may be specifically related to a person's cultural background including cultural beliefs and language. Understanding the barriers to access is key to enabling equity in patients' access to health care, quality of care delivered, experience of health care, and health outcomes.

Development of the Standards

The Competency Standards Framework was developed by the Migrant and Refugee Women's Health Partnership (the Partnership), a national initiative bringing together health professionals—through their respective peak professional and standard setting bodies—and community representatives to address systemic barriers to health access and outcomes when delivering care to people from migrant and refugee backgrounds, while acknowledging and responding to the unique challenges faced by women within this cohort.

The development of the Competency Standards Framework was led by the Working Group of the Partnership, with support from the Partnership Secretariat. A specialist Sub-Working Group was established to develop the standards relating specifically to clinicians communicating effectively with patients with limited English proficiency and working with interpreters in health care settings. Another Sub-Working Group provided specialist expertise with regard to working with patients with refugee-like experiences.

The Partnership's work to develop the Competency Standards Framework was supported by the Australian Government, Ramsay Health Care Australia, Queensland Government, and Migration Council Australia.

Aboriginal and Torres Strait Islander Peoples

The Partnership acknowledges that Aboriginal and Torres Strait Islander Peoples, as First Peoples of Australia, have a singular place within Australia's culturally diverse society. It is further recognised that Aboriginal and Torres Strait Islander Peoples and people from migrant and refugee backgrounds have vastly distinct starting points and experience different access challenges when engaging with clinicians and the health care system more broadly. While some of the elements of this Framework would serve as applicable strategic responses to enable better access, experience and outcomes for both population cohorts, it is critical that there is a dedicated focus on Aboriginal and Torres Strait Islander cultural safety in the provision of clinical care. The scope of this Framework is therefore specific to people from migrant and refugee backgrounds.

[27] Australian Commission on Safety and Quality in Health Care, (2010). *Australian Safety and Quality Framework for Health Care*.
[28] Betancourt, J. R. (2004). Cultural Competence – Marginal or Mainstream Movement? *New England Journal of Medicine*, 351(10), pp.953-955.
[29] Medical Board of Australia, (2014). *Good Medical Practice: A Code of Conduct for Doctors in Australia*.

Overview and format of the standards

The Competency Standards Framework is structured based on the CanMEDS Physician Competency Framework model[30]. The domains of the Framework draw on the clinician's competencies intrinsic to the roles consistent with CanMEDS and comprise the following: Clinical Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional.

Each domain contains:

- A description of the domain which outlines its intent and key objectives;
- One or more competency standard(s) and a list of competencies supporting and enabling the standard(s); and
- Explanatory notes on the content of each standard.

The competency standards are to be read and applied with their explanatory notes, comprising the Annotated Standards, which provide the evidence-based best practice on cultural responsiveness in clinical practice. Further, the standards are to be read and applied with the *Annex: Practice points for clinicians working with interpreters in health care settings*, which forms an integral part of this document.

Terms used in this document are defined in the *Glossary*.

The *Appendix: Practice tools and resources* provides an overview of relevant guidance and documentation for further reference.

[30] Royal College of Physicians and Surgeons of Canada, *CanMEDS 2015 Physician Competency Framework.*

CURRICULUM FRAMEWORK DOMAINS

Clinical Expert

Clinicians understand, and respond to, the impact of individual, cultural and social considerations, and ensuing barriers, on patients' circumstances and expectations as part of the provision of high-quality and safe person-centred care.

Communicator

Clinicians adopt effective communication practice to support patients, their families and carers in understanding and making informed decision about their health, and to facilitate effective health care and reduce harm for patients with limited English proficiency.

Collaborator

Clinicians work effectively with health care professionals and other relevant professionals, both within the health service organisation and across networks, to provide timely and high-quality care to patients from migrant and refugee backgrounds, including working with interpreters as members of a health care team.

Leader

Clinicians engage with others and lead by example to contribute to the development of systemic organisational processes that facilitate the delivery of equitable and high-quality care to patients from migrant and refugee backgrounds and maximise cultural responsiveness of the health care system.

Health Advocate

Clinicians appreciate health determinants and health inequities affecting patients from migrant and refugee backgrounds and contribute to improving health outcomes for individuals and communities through advocacy at all systems levels, including professional, health services, and government.

Scholar

Clinicians are committed to maintaining awareness of linkages between cultural diversity and patient health, and facilitate sharing of information and knowledge to promote cultural responsiveness in the provision of care to patients from migrant and refugee backgrounds.

Professional

Clinicians maintain culturally responsive clinical practice as an integral part of the safe and high-quality care, ethical conduct, and adherence to professional standards.

COMPETENCY STANDARDS

Domain 1: Clinical Expert

Competency standard 1 – Clinicians understand and respond to the impact of cultural and linguistic differences on the delivery of quality health care and respond to individual patient circumstances and complexities.

1.1	Clinicians respond sensitively, without assumption, to the diversity of patient characteristics, including social determinants of health, cultural, religious or spiritual, and linguistic considerations, health beliefs, individual abilities, choices and preferences, and modify their approach accordingly.
1.2	Clinicians modify their approach to patients with refugee-like experiences, including those who have experienced traumatic events and symptoms of posttraumatic stress disorder, and take into account the impact of such experiences during the assessment, diagnosis, treatment and ongoing care of these patients.
1.3	Clinicians recognise ethno-specific variations and responses to treatment, including the impact of immunosuppression on potentially undiagnosed chronic infections.
1.4	Clinicians recognise the family, carer and community context of the patient that may impact on consent, treatment and follow up.

Competency standard 2 – Clinicians understand and respond to barriers to health access experienced by patients.

2.1	Clinicians apply the principles of person-centred care with patients of migrant and refugee backgrounds while anticipating and addressing the cultural, linguistic and structural barriers to their care, and their health literacy needs, to improve health access and mitigate risks.
2.2	Clinicians acknowledge and address barriers to obtaining informed consent, and explaining the risks and benefits of a proposed procedure or therapy when delivering clinical care to patients from migrant and refugee backgrounds.
2.3	Clinicians acknowledge and address barriers to quality use of medicines for patients from migrant and refugee backgrounds and ensure education about medication safety.

Competency standard 3 – Clinicians are aware of medico-legal responsibility when working with patients with limited English proficiency and those who use Auslan or another sign language.

3.1	Clinicians understand the medico-legal risks of failing to determine the need for an interpreter and failing to engage an interpreter, including engaging family and friends as interpreters and using web-based translation applications instead, even in the event that the patient with an assessed need for communication assistance

	does not request interpreting assistance or refuses it.
3.2	Clinicians understand the medico-legal implications of failing to engage interpreters for people with limited English proficiency and those who use Auslan or another sign language when delivering health care, especially when assessing the decision-making capacity of the patient, obtaining consent for an operation or procedure, and when starting or adjusting complex medications.
3.3	Clinicians do not rely on family members, especially children, to facilitate communication between the clinician and the patient with limited English proficiency and the patients who uses Auslan or another sign language.

Domain 2: Communicator

Competency standard 4 – Clinicians meet patient communication needs.

4.1	Clinicians respect patients' right to communication assistance and ensure that an interpreter in the patient's preferred language, including Auslan or another sign language, is engaged when necessary to address linguistic barriers, including when requested by the patient.
4.2	Clinicians proactively develop the skills to assess when an interpreter is required and understand how to engage an interpreter.
4.3	Clinicians effectively communicate with patients with the assistance of interpreters when linguistic barriers exist based on best practice guidelines (Annex 1: *Practice points for clinicians working with interpreters in health care settings*).

Competency standard 5 – Clinicians understand the impact of cultural and linguistic differences on communication within the therapeutic relationship.

5.1	Clinicians assist patients to make informed decisions about their health care recognising how cultural considerations and expectations, English language proficiency and health literacy can impact on these decisions.
5.2	Clinicians provide clear, accurate, culturally appropriate, timely information to enable patients to understand the health issues being discussed, including the diagnosis, management and recommended follow up.
5.3	Clinicians provide resources, in appropriate formats, that enable patients' understanding, recognising that patients may require support from their families and carers in managing their health issues so adequate information needs to be available to those whom the patient wishes to include.
5.4	Clinicians gather consumer feedback from their patients in an appropriate manner that enables people with limited English proficiency, low literacy levels, and different cultural considerations to participate.

Domain 3: Collaborator

Competency standard 6 – Clinicians collaborate with other health care professionals across networks.

6.1	Clinicians build and utilise referrals—across community health and allied health sectors—to support their delivery of care, ensuring that these networks are effective in meeting the particular needs of patients from migrant and refugee backgrounds in a culturally responsive manner.
6.2	Clinicians undertake safe handover of care, through both verbal and written communication, including information about patients' cultural needs, complexities and expectations.

Competency standard 7 – Clinicians collaborate with interpreters as members of a healthcare team and within the scope of the interpreter's practice.

7.1	Clinicians recognise the role of the interpreter in the clinical setting, their skills, their responsibilities and their scope of practice.
7.2	Clinicians recognise that the on-site interpreter cannot be asked to provide written translations of material, but may be asked to do a sight translation.
7.3	Clinicians inform interpreters on the nature of the consultation prior to its commencement where possible, recognising the need to assist the interpreter to prepare for the information that may need to be interpreted.

Domain 4: Leader

Competency standard 8 – Clinicians contribute to organisational cultural responsiveness.

8.1	Clinicians lead the creation of welcoming, user-friendly and accessible environments that recognise and respond to cultural differences in the delivery of care to patients from migrant and refugee backgrounds.
8.2	Clinicians enable input from patients, their families and carers from migrant and refugee communities to inform whole-of-organisation practices that facilitate the delivery of quality care.
8.3	Clinicians facilitate data collection for patients with migrant and refugee backgrounds that captures appropriate demographic data to enable improved delivery of culturally responsive care such as recording of country of birth, preferred language, the need for an interpreter, year of arrival in Australia, and ethnicity.
8.4	Clinicians work with their clinical and non-clinical colleagues to meet the patient's communication needs by ensuring that the colleagues have: ▪ information about when an interpreter may be required; ▪ guidance on how to assess when the patient is likely to need an interpreter due to their limited English proficiency or use of Auslan or another sign language; and ▪ information about how to arrange an interpreter.

8.5	Clinicians work with their clinical and non-clinical colleagues to ensure that once the need for an interpreter is identified, it is then documented in the patient management system.

Domain 5: Health Advocate

Competency standard 9 – Clinicians contribute to the promotion of health literacy within refugee and migrant communities.

9.1	Clinicians incorporate health literacy and preventative health education in their work with patients, their families and carers, taking into account the relevant cultural considerations and pre-migration experiences.
9.2	Clinicians support migrant and refugee communities' capacity to facilitate health literacy and preventive health activities within their communities by contributing to education and resource development for local communities.

Competency standard 10 – Clinicians develop community and multisectoral partnerships.

10.1	Clinicians establish and maintain multisectoral networks, including with the community sector, to ensure coordination and integration of healthcare services that enable the delivery of high quality, culturally responsive care.

Competency standard 11 – Clinicians facilitate the uptake of interpreting services.

11.1	Clinicians inform patients with limited or no English proficiency and those who use Auslan or another sign language of their right to access interpreting services.

Domain 6: Scholar

Competency standard 12 – Clinicians are committed to including education about meeting the needs of migrant and refugee communities in the delivery of care and in their continuing learning activities.

12.1	Clinicians continually learn and develop cultural responsiveness by demonstrating awareness of existing and emerging data and research regarding cultural diversity demographics and population health.
12.2	Clinicians maintain ongoing practice innovation through the use of resources, including technology, to facilitate culturally responsive care provision to patients from migrant and refugee backgrounds.

Competency standard 13 – Clinicians are committed to teaching others about the delivery of culturally responsive quality health care.

13.1	Clinicians contribute to improving the cultural responsiveness of the profession through teaching students, peer learning, review and practice support.

Domain 7: Professional

Competency standard 14 – Clinicians are committed to cultural responsiveness and respect in all aspects of practice.

14.1	Clinicians adhere to high ethical standards and are committed to the principles of person-centred care, access, equity, quality and safety, and dignity and respect in practicing culturally responsive care when working with patients from migrant and refugee backgrounds.

ANNOTATED COMPETENCY STANDARDS

Domain 1: Clinical Expert

Clinicians understand, and respond to, the impact of individual, cultural and social considerations, and ensuing barriers, on patients' circumstances and expectations as part of the provision of high-quality and safe person-centred care.

Competency standard 1 – Clinicians understand and respond to the impact of cultural and linguistic differences on the delivery of quality health care and respond to individual patient circumstances and complexities.

1.1	Clinicians respond sensitively, without assumption, to the diversity of patient characteristics, including social determinants of health, cultural, religious or spiritual, and linguistic considerations, health beliefs, individual abilities, choices and preferences, and modify their approach accordingly.
1.2	Clinicians modify their approach to patients with refugee-like experiences, including those who have experienced traumatic events and symptoms of posttraumatic stress disorder, and take into account the impact of such experiences during the assessment, diagnosis, treatment and ongoing care of these patients.
1.3	Clinicians recognise ethno-specific variations and responses to treatment, including the impact of immunosuppression on potentially undiagnosed chronic infections.
1.4	Clinicians recognise the family, carer and community context of the patient that may impact on consent, treatment and follow up.

Explanatory notes

Diversity of patient characteristics

Migration- and ethnicity-related factors form part of the social determinants of health.[31] They also impact upon many other social determinants of health, including housing, education, and employment. Conditions surrounding migration and settlement may exacerbate health inequities and expose individuals to increased health risks and poorer health outcomes, in view of the disproportionately higher burdens of disease and greater risk of receiving culturally unsafe care.[32]

In addition to recognising ethnic origin or migrant experience in the provision of care, cultural safety encompasses sensitivity to the patient's gender, and religious or spiritual beliefs, among other considerations.[33] Cultural considerations and religious beliefs may impact on the patient's understanding and acceptance of health information, health maintenance behaviours and their

[31] World Health Organization, (2017). *Promoting the health of refugees and migrants: Draft framework of priorities and guiding principles to promote the health of refugees and migrants*.
[32] Australasian College for Emergency Medicine, (last revised March 2015). *Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicin*e, p.3.
[33] Williams, R. (1999). Cultural safety – what does it mean for our work practice? *Australian and New Zealand Journal of Public Health*, 23(2), pp.213-214.

decisions with regard to health access and adherence to medical recommendations,[34] [35] and should be incorporated into management modalities in a culturally sensitive manner.[36] [37] Further, religious and cultural considerations may inform the patient's preference for gender concordance with their healthcare provider or interpreter.

Clinicians should seek to adopt the explanatory model of care when delivering health care in cross-cultural settings and elicit patients' understanding of illness and their condition.[38] This includes working with patients and, where appropriate, their families and carers to understand what matters most to them in the experience of illness and treatment. Clinicians should consider individual preferences, needs, values and expectations, and ensure that these are acknowledged to support the shared decision-making process,[39] [40] [41] and that care is customised according to the individual patient's needs and wishes.[42]

Clinicians should avoid using stereotypes and assumptions to guide their cultural understanding and recognise their patients' ability to provide an understanding of how they choose to interact, and how their personal cultural and health needs intersect.

Patients with refugee-like experiences

People from refugee backgrounds, including those seeking asylum and other migrants with refugee-like experiences prior to migration, have often experienced traumatic events and losses, have undergone hardship during journeys of escape, and may have symptoms of post-traumatic stress disorder. Such experiences depend on the country of origin; the context of pre-arrival health care; the degree of war, displacement, trauma and torture, and immigration detention experience; and level of impoverishment and education.[43] This can have an impact on how newly-arrived migrants access health care, as well as the health issues they may be experiencing.

With the majority of refugees and asylum seekers coming from resource poor situations with limited access to health care, there are increased rates of infectious diseases, nutritional deficiencies and undiagnosed or untreated chronic illnesses. Immunisation rates are often low. Further, post-migration aspects of resettlement and acculturation can be difficult, resulting in

[34] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, (last revised November 2014). *RANZCOG Statement: Cultural Competency*.
[35] Australasian College for Emergency Medicine, (last revised March 2015). *Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicin*e, p.1.
[36] Faculty of Pain Medicine, (2014). *Pain Medicine Training Program: 2015 Curriculum*.
[37] Australian and New Zealand College of Anaesthetists, (2016). *Anaesthesia Training Program: Curriculum*.
[38] Kleinman, A., Eisenberg, L. and Good, B. (1978). Culture, illness, and care: clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine*, 88(2), pp.251–88.
[39] Chaves, N.J., Paxton, G., Biggs, B.A., Thambiran, A., Smith, M., Williams, J., Gardiner, J. and Davis, J.S., on behalf of the Australasian Society for Infectious Diseases and Refugee Health Network of Australia Guidelines writing group, (2016). *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*, 2nd ed., p.11.
[40] Australian Nursing and Midwifery Accreditation Council, (2014). *Midwife Accreditation Standards 2014*, p.29.
[41] Kleinman, A. and Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS Medicine*, 3(10), e294.
[42] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, (last updated April 2017). *RANZCOG Curriculum: A framework to guide the training and practice of specialist obstetricians and gynaecologists*, 3rd ed., pp.65-66.
[43] Australasian College for Emergency Medicine, (last revised March 2015). *Statement on Culturally-Competent Care and Cultural Safety in Emergency Medicin*e, p.3.

refugees and asylum seekers often having increased rates of certain mental health conditions, such as anxiety, depression and post-traumatic stress disorders.[44] [45]

Clinicians should consider pre-migration and settlement factors that are specific to patients with refugee-like experiences and may affect their health status, understanding of health issues and ability to adhere to treatment options.

Clinicians should be aware of the need for trauma-informed care approaches, incorporating such factors as person-centred communication and care, maintaining safe clinical environments and knowing when to refer for trauma screening.

Ethno-specific variations and responses to treatment

Factors contributing to health disparities are multi-faceted but may include specific risks related to prior environments (for example, infectious diseases and anaemia), or specific population-based risks (for example, thalassaemia, diabetes mellitus, previous female genital mutilation).[46] [47] [48]

It is appropriate to adopt a person-centred care approach and a risk-based approach, rather than universal screening for selected conditions.[49] However, clinicians should be aware that only limited screening takes place for many patients of refugee backgrounds prior to arriving in Australia, and should be aware of the clinical conditions, both overt and occult, that may impact on the individual patient's health. With the exception of specific circumstances, investigations for clinical conditions should be tailored based on individual risk factors, source and transit countries, and history and examination findings.[50]

Clinicians should know how to access clinical information about their practice population and emerging conditions relevant to patients from refugee-like backgrounds by analysing practice data, using publicly available information,[51] and accessing resources about ethnic communities, their histories and specific health issues as a context for understanding culture, religion and health interactions.[52]

Family, carer and community context

Clinicians should recognise the roles that culturally diverse families have in decision-making may be very different to those within other Australian communities. Similarly, many patients from

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[44] Bradby, H., Humphris, R., Newall, D. and Phillimore, J. (2015). Health Evidence Network synthesis report 44, *Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region*.

[45] Chavez, N.J., Paxton, G., Biggs, B.A, Thambiren, A., Gardiner, J., Williams, J., Smith, M. and Davis, J.S., on behalf of the Australasian Society for Infectious Diseases and Refugee Health Network of Australia Guidelines writing group. (2017). Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds: an abridged outline. *The Medical Journal of Australia*, 206(7), pp.310-315.

[46] Pottie, K., Greenaway, C., Feightner, J., et al. (2011). Evidence-based clinical guidelines for immigrants and refugees. *CMAJ*. 183(12), E824-E925.

[47] Correa-Velez, I. and Ryan, J. (2012). Developing a best practice model of refugee maternity care. *Women and Birth*, 25(1), pp.13-22.

[48] Almeida, L.M., Caldas, J., Ayres-de-Campos, D., et al. (2013). Maternal Healthcare in Migrants: A Systematic Review. *Maternal and Child Health Journal,* 17(8), pp.1346-54.

[49] Chaves, N.J., Paxton, G., Biggs, B.A., Thambiran, A., Smith, M., Williams, J., Gardiner, J. and Davis, J.S., on behalf of the Australasian Society for Infectious Diseases and Refugee Health Network of Australia Guidelines writing group, (2016). *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*, 2nd ed., p.10.

[50] ibid., 12.

[51] Royal Australian College of General Practitioners, (2017). *Standards for General Practices*, 5th ed. Core standard 2 – Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.

[52] Australasian College for Emergency Medicine and College of Emergency Nursing Australasia, (2015). *Quality Standards for Emergency Departments and Other Hospital-Based Emergency Care Services*. Objective 1.10.4: Care of the culturally and linguistically diverse patient.

migrant and refugee backgrounds need to involve family and community in discussions about health-related issues and decisions with regard to health service utilisation.[53] [54]

If a family member or carer has an ongoing role in the day-to-day care of the patient, it is generally advisable to include the family member or the carer in the patient-clinician relationship with the permission of the patient (if the patient is able to give such consent).[55]

Competency standard 2 – Clinicians understand and respond to barriers to health access experienced by patients.

2.1	Clinicians apply the principles of person-centred care with patients of migrant and refugee backgrounds while anticipating and addressing the cultural, linguistic and structural barriers to their care, and their health literacy needs, to improve health access and mitigate risks.
2.2	Clinicians acknowledge and address barriers to obtaining informed consent, and explaining the risks and benefits of a proposed procedure or therapy when delivering clinical care to patients from migrant and refugee backgrounds.
2.3	Clinicians acknowledge and address barriers to quality use of medicines for patients from migrant and refugee backgrounds and ensure education about medication safety.

Explanatory notes

Understanding barriers to health access

People from migrant and refugee backgrounds face greater challenges in accessing health care in view of a range of cultural and communication barriers, further exacerbated by systemic barriers, including visa class, finance, and transport.[56]

Limited English language proficiency presents major obstacles to access.[57] People with limited English proficiency tend to have inadequate access to care and preventative services, and ineffective communication between patients and clinicians can result in delayed or inefficient care.[58] This can result in the subsequent need for more costly treatment and intervention, as well as serious risk of negatively impacting a patient's understanding of, and trust in, the health care system at large.

Migrants' and refugees' health beliefs and help-seeking behaviours, their views on health, notions of health problems and appropriateness of seeking help (and in what form) may diverge strongly

[53] Australasian College for Emergency Medicine, (2015). *ACEM Curriculum Framework*, v. 2, pp.44-46.
[54] National Health and Medical Research Council. (2006). *Cultural Competency in Health: A Guide for Policy, Partnerships and Participation*, p.39.
[55] Royal Australian College of General Practitioners, (2017). *Standards for General Practices*, 5th ed. Core standard 2 – Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.
[56] Derose, K.P., Escarce, J.J, and Lurie, N. (2007). Immigrants and health care: sources of vulnerability. *Health Affairs*, 26(5), pp.1258-1268.
[57] Phillips, C. (2016). Improving Health Outcomes for Linguistically Diverse Patients. *The Medical Journal of Australia*, 204(6), pp.209-210.
[58] Wilson E, Chen AH, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. Journal of General Internal Medicine 2005; 20 (9): 800-806.

from those of clinicians and the broader population.[59] Individual experiences can impact on the patient's knowledge of the healthcare system and capacity to navigate it, including their understanding of their rights as consumers in the healthcare system. Lack of knowledge and skills to navigate Australia's health care system (health system literacy) is often related to migrants' and refugees' differing perceptions or misconceptions of the health system. This can result in the inability to locate the necessary information and negotiate the required care.[60] Many people of refugee backgrounds come from countries with minimal primary care services and services delivered within the community are often of limited quality.[61]

Clinicians should be aware that during a consultation, patients from migrant and refugee backgrounds with limited English proficiency and/or low health literacy skills may fail to provide the clinician with relevant information, and lack the confidence necessary to be active participants in the shared decision-making process.

The patient's cultural and communication barriers may impact on the patient's genuine understanding of the nature of procedure or treatment, and their ability to access sufficient information to provide informed consent.

Clinicians should be aware of the key barriers to quality use of medicine that may be experienced particularly by patients from refugee backgrounds, including language and communication, cultural barriers, limited health literacy, financial barriers and health system barriers.[62] Some of these barriers are also relevant to patients from migrant backgrounds.

Underutilisation of health services may also be caused by anxiety about potential reactions within migrant and refugee communities. Fear of disclosing one's private details or sensitive problems to a clinician (or an interpreter when one is required) can also be a barrier for some patients. Many patients do not understand their right to confidentiality within clinical encounters and that interpreters are trained in issues of confidentiality. Clinicians should be aware that requesting a telephone interpreter, especially one from a different jurisdiction, can reduce confidentiality concerns for some patients with particularly sensitive issues.[63]

Mitigating risks associated with barriers to health access

As part of their commitment to safety and quality improvement in the provision of care, clinicians should evaluate access to health care for patients from migrant and refugee backgrounds, as well as relevant risks and barriers. Clinicians should recognise disparity in the access and utilisation of health services experienced by migrant and refugee populations with a particular emphasis on rural, low socioeconomic and high need communities.[64]

Clinicians should identify and manage factors that are barriers to access and continuity of care, including by engaging interpreters where necessary and enshrining cultural responsiveness into their practice. Focus should be placed on supporting the capacity of health practitioners to

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[59] Almeida, L.M., Caldas, J., Ayres-de-Campos, D., et al. (2013). Maternal healthcare in migrants: A systematic review. *Maternal and Child Health Journal*, 17(8), pp.1346-1354.
[60] Australian Commission on Safety and Quality in Health Care. (2013). *Consumers, the health system and health literacy: Taking action to improve safety and quality*. Consultation Paper.
[61] Chaves, N.J., Paxton, G., Biggs, B.A., Thambiran, A., Smith, M., Williams, J., Gardiner, J., and Davis, J.S., on behalf of the Australasian Society for Infectious Diseases and Refugee Health Network of Australia Guidelines writing group, (2016). *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*, 2nd ed.
[62] Kay, M., Wijayanayaka, S., Cook, H., and Hollingworth, S. (2016). Understanding quality use of Medicines in refugee communities in Australian primary care: A qualitative study. *British Journal of General Practice*, 66(647), e397-409.
[63] Phillips, C. (2013). Remote Telephone Interpretation in Medical Consultations with Refugees: Meta-Communications about Care, Survival and Selfhood. *Journal of Refugee Studies,* 26(4), pp.505-515.
[64] Royal Australasian College of Medical Administrators, (2013). *RACMA Position Paper: Cultural Competence for Medical Administrators in Australia and New Zealand*, p.3.

communicate with patients from migrant and refugee backgrounds. Clinicians should consider adopting the explanatory model of care, including informing patients about the Australian health system and the role of primary care. This can result in improved access to preventive health care and easier access to appropriate care. Engagement of bicultural or bilingual workers can also improve use of, and access to, health services.[65]

Addressing barriers to quality use of medicines experienced by patients from migrant and refugee backgrounds may involve consideration of patients' use of traditional medicines, awareness of cost implications and financial assistance options, provision of information about the safe storage of medicines, and advice not to share medicines with other family members and friends. Supporting patients in using medicines safely and effectively requires the information exchange to go beyond dosage instructions and include what other medicines are being taken and potential side effects.[66]

Competency standard 3 – Clinicians are aware of medico-legal responsibility when working with patients with limited English proficiency and those who use Auslan or another sign language.

3.1	Clinicians understand the medico-legal risks of failing to determine the need for an interpreter and failing to engage an interpreter, including engaging family and friends as interpreters and using web-based translation applications instead, even in the event that the patient with an assessed need for communication assistance does not request interpreting assistance or refuses it.
3.2	Clinicians understand the medico-legal implications of failing to engage interpreters for people with limited English proficiency and those who use Auslan or another sign language when delivering health care, especially when assessing the decision-making capacity of the patient, obtaining consent for an operation or procedure, and when starting or adjusting complex medications.
3.3	Clinicians do not rely on family members, especially children, to facilitate communication between the clinician and the patient with limited English proficiency and the patients who uses Auslan or another sign language.

Explanatory notes

Responsibility to determine the need for an interpreter

The *Good Medical Practice: A Code of Conduct for Doctors in Australia* states that "Good communication underpins every aspect of good medical practice".[67] Clinicians must ensure there is clear and effective communication in the patient-clinician relationship so that they can effectively manage the patient's healthcare. The patient needs to understand the discussion that takes place and needs to understand the proposed management and treatment.[68] Engaging

[65] Russell G, Harris M, Cheng I, Kay M, Vasi S, Joshi C, et al. Coordinated Primary Health Care for Refugees: A Best Practice Framework for Australia (2013).
[66] Avery, A.J., Sheikh, A., Hurwitz, B. et al., (2002). Safer medicines management in primary care. *British Journal of General Practice 2002*, 52(Suppl), S17-S22.
[67] Medical Board of Australia, (2014). *Good Medical Practice: A Code of Conduct for Doctors in Australia*, p.5.
[68] Royal Australian College of General Practitioners, (2017). *Standards for General Practices*, 5th ed. Core Standards 2: Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.

interpreters in health care settings, has been found to improve the delivery of preventative and primary care[69], and improve the patient-centeredness of primary care encounters.[70]

Clinicians must consider the potential ethical, professional and legal consequences and significant adverse outcomes of permitting an unqualified interpreter, such as a family member, to interpret. Risks, which could lead to inappropriate clinical decisions being made, include:

- inaccurate and inadequate interpretation due to lack of knowledge of terminology and lack of interpreting techniques;
- possibility of information being withheld or distorted because of family relationships or the emotional and sensitive nature of the issues;
- undermining the clinician's confidence that the necessary information is being communicated appropriately; and
- compromising confidentiality.

While web-based translation applications are becoming more prevalent and continuously improving, clinicians should assess the risks of using such applications as inaccuracies could lead to confusion, embarrassment, or cultural improprieties and affect the patient's trust in their clinician or even lead to medical errors.

It should be noted that web-based translation applications cannot be relied on for accuracy and pose a risk to clients' rights and health and safety.[71]

Taking into consideration the risks of web-based translation applications, consideration may be given to using such applications in limited instances, such as in triage areas as a short-term measure until an interpreter arrives.

If a patient refuses an interpreter, the clinician should attempt to address the patient's concerns, which may include confidentiality considerations or cost implications for the patient, and explain the risks associated with misunderstandings or miscommunication. The clinician should explain that engaging an interpreter is of benefit to the clinician as much as to the patient. If the patient still refuses an interpreter, the clinician must document the discussions and outcome in the patient's medical record.[72]

In case of emergency when an interpreter is not available, this must be noted in the medical record and an interpreter should be engaged as soon as possible to ensure accurate information is communicated.[73]

In the situation where there is perceived to be increased medico-legal risk or clinical uncertainty, clinicians should arrange for an interpreter to communicate with their patient when they're identified as needing an interpreter. In the event that an interpreter is not available, clinicians are responsible for assessing the risks of proceeding with the consultation without an interpreter.

In situation of a low-risk consultation where an interpreter is not available, the clinician should assess the risk of pursuing with the consultation as opposed to the risk of rescheduling the appointment to allow time to engage an interpreter.

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[69] Jacobs, E.A. et al. (2001). Impact of Interpreter Services on Delivery of Health Care to Limited-English-proficient Patients. *Journal of General Internal Medicine*, 16(7), pp.468-474.
[70] Henbest, R.J. and Fehrsen, G.S. (1992). Patient-centeredness: Is it applicable outside the West? Its measurement and effect on outcomes. *Family Practice*, 9(3), pp.311-317.
[71] Government of Western Australia (Department of Health), (2017). *WA Health System Language Services Policy Guidelines*, p.28.
[72] State of NSW (NSW Ministry of Health), (2006). *Policy Directive: Standard procedures for working with health care interpreters*, p.10.
[73] ibid., 9

A clinician should engage an interpreter when the patient requests one, even if the clinician does not consider one is required.

Medico-legal risks in complex assessments

Failure to engage an interpreter in consultations with people with limited English proficiency may be considered to be a breach in duty of care.[74] Clinicians should recognise the following three high-risk areas where a low threshold should be used for determining if an interpreter is required: assessing a patient's competence, obtaining consent, and starting or adjusting medication.[75] [76]

(1) Assessing a patient's competence to make decisions

When working with patients from migrant and refugee backgrounds, clinicians should ensure that they assess the need for an interpreter to facilitate communication while assessing the patient's decision-making capacity. Assessing decision-making competence involves assessing a patient's capacity to understand, retain and believe the information about the treatment options; and their ability to weigh the information to reach a decision and to communicate that decision.[77] A person's competence to decide is dependent on their own immediate context (illness, delirium), and is evaluated specifically in relation to the medical decision that needs to be made. Clinicians tend to under-recognise declines in patients' competence, even when they speak the same language.[78] A temporary or permanent decline in decision-making competence in an elderly or psychologically unwell person may be missed with ad hoc, or family interpreters, who sometimes compensate for, or 'fill in" limitations in comprehension demonstrated by the patient.

(2) Obtaining consent

In all instances, consent for medical and surgical procedures requires that patients are:

- fully informed about the underlying illness or disease, the nature of the procedure, the consequences of not having the procedure, the degree of certainty about the outcome, the time for recovery and the cost; and
- able to raise any concerns about risks of particular relevance to them. [79]

The clinician's duty of care includes clearly explaining the benefits and potential harm of specific medical treatments and the consequences of not following a recommended management plan.[80] [81] Engaging an interpreter is essential for obtaining informed consent from individuals with limited English proficiency.

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[74] Royal Australian College of General Practitioners, (2016). *Curriculum for Australian General Practice*, p.11.
[75] Phillips, C.B. (2010). Using interpreters: a guide for GPs. *Australian Family Physician*, 39(4), pp.188-195.
[76] Australian Psychology Society, (2013). *Working with Interpreters: A Practice Guide for Psychologists*. 4.3 Implications of working with an unaccredited interpreter, 7.
[77] Snow, H.A. and Flemming, B.R. (2014). Consent, capacity and the right to say no. *The Medical Journal of Australia*, 201(8), pp.486-488.
[78] Sessums, L.L., Zembrzsuka, H. and Jackson, J.L. (2011). Does this patient have medical decision-making capacity? JAMA, 306(4), pp.420-427.
[79] National Health and Medical Research Council, (2004). *General Guidelines for Medical Practitioners on Providing Information to Patients*.
[80] Royal Australian College of General Practitioners, (2017). *Standards for general* practices, 5th ed. Core standard 2 – Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.
[81] Royal Australian College of Surgeons, (2014). *Position Paper: Informed Consent.* https://www.surgeons.org/media/312206/2014-08-29_pos_fes-pst-042_informed_consent.pdf

Consent may not be valid if it is obtained through family members, other patients, visitors, or non-accredited staff acting as interpreters.[82] Their lack of understanding and the possible breach of confidentiality or conflict of interest may render them inappropriate interpreters.[83]
Minors should never be engaged to obtain consent from their parents for procedures.[84]

(3) Starting or adjusting medication

At minimum, clinicians should ensure an interpreter is engaged when:

- Starting, or changing the dose of a high-risk medicine;
- Starting a medication that requires the use of a therapeutic device that needs to be explained by the clinician; and
- In settings where patients are taking multiple medications or multiple daily doses, or their doses have been changed by other clinicians, or in another health service organisation.

People with limited English proficiency are at greater risk of suffering medication related harm.[85] Some medicines carry high risks of serious consequences, including death, for the patients if taken incorrectly, and require particular care in communicating with patients. Examples of high-risk medicines include anticoagulants, insulin, opioids, chemotherapy, digoxin and other medications with a narrow therapeutic range.[86]

Medications, which require therapeutic delivery devices (for example, spacers or injecting devices) require special attention and need to be carefully explained, demonstrated, and the patient given the opportunity to clarify and ask questions.

Responsibility not to rely on children

Engaging children as interpreters also poses a number of ethical dilemmas. Having children facilitate communication for parents undermines the parent's authority and may affect family dynamics. Certain topics are out of bounds in some cultures and may result in breach of confidentiality and privacy for the adult.[87] Further, enormous emotional burden is placed on children when asked to facilitate communication for a parent about a serious or even terminal illness. This may lead to trauma or lasting psychological impact on the child's wellbeing.[88] Importantly, there is often no recourse to address any trauma or distress caused by the interaction.[89]

Further, children of a non-English speaking patient may be fluent in English but not necessarily in their parents' first language. Their knowledge of medical terminology in English, let alone in another language, may be very limited or non-existent. The risks are therefore high and range from omitting to interpret to misinterpreting the diagnosis or proposed treatment, or to telling a

[82] State of NSW (NSW Ministry of Health), (2006). *Policy Directive: Standard procedures for working with health care interpreters*, pp.11-12.
[83] Government of South Australia (SA Health), (2015). *Policy Guideline: Consent to Medical Treatment and Health Care Policy Guideline*, p.5.
[84] Quan, K., and Lynch, J. (2010). *The high costs of language barriers in medical malpractice*. National Health Law Program, Berkeley CA.
[85] Agency for Healthcare Research and Quality, (2012). *Improving Patient Safety Systems for Patients with Limited English Proficiency*, p.3.
[86] Australian Commission on Safety and Quality in Healthcare, (2012). *Safety and Quality Improvement Guide*. Standard 4 Medication Safety, p.5.
[87] Royal Australian College of General Practitioners, (2014). *Clinical Guidelines, Abuse and violence: Working with our patients in general practice*, 4th ed.
[88] State of NSW (NSW Ministry of Health), (2006). *Policy Directive: Standard procedures for working with health care interpreters*. Standard 1.1.1.5b Professional Interpreter Services.
[89] State of Queensland (Department of Communities, Child Safety and Disability Services), 2016. *Language Services Guidelines*.

parent to sign a consent form without interpreting the information about the procedure and its risks. This may lead to an erroneous procedure, unnecessary tests, extended length of stay, possible fatal outcomes, or increased cost to the health care system.[90]

If no alternative option is available, clinicians should ensure limited engagement of children to facilitate communication with the patient; and ensure the safety and care of the child. In urgent situations, when no alternative is available and while waiting for an interpreter to arrive, clinician may agree to have a child facilitate communication. In this very limited instance, no confidential or ethical matter should be communicated via the child.

[90] Bird, S. (2010). Failure to use an interpreter. *Australian Family Physician*, 39(4), pp.241-242.

Domain 2: Communicator

Clinicians adopt effective communication practice to support patients, their families and carers in understanding and making informed decision about their health, and to facilitate effective health care and reduce harm for patients with limited English proficiency.

Competency standard 4 – Clinicians meet patient communication needs.

4.1	Clinicians respect patients' right to communication assistance and ensure that an interpreter in the patient's preferred language, including Auslan or another sign language, is engaged when necessary to address linguistic barriers, including when requested by the patient.
4.2	Clinicians proactively develop the skills to assess when an interpreter is required and understand how to engage an interpreter.
4.3	Clinicians effectively communicate with patients with the assistance of interpreters when linguistic barriers exist based on best practice guidelines (*Annex: Practice points for clinicians working with interpreters in health care settings*).

Explanatory notes

It is important to have necessary arrangements in place to engage interpreters, when necessary, through an appropriate language service provider. Not doing so may open clinicians to medico-legal redress.[91] [92] [93]

Assessing interpreter need and requirements

Clinicians should be aware that they should err on the side of caution when assessing whether an interpreter is needed.[94] A patient's ability to engage in a general conversation in English is not a measure of their capacity to discuss and understand health related matters. Even when complex terminology is not being used, health concepts require a sophisticated understanding of language, especially if the patient is to have the opportunity to interrogate the information adequately to understand the impact of the health condition on their life. The fact that a patient, a family member or a carer does not request an interpreter does not mean that one is not required to assist with communication.[95]

Patients may appear to have sufficient English proficiency for every-day social engagement but insufficient English to understand technical terms, medical terminology and procedures, or pharmaceutical information.[96] Patients may have gaps in confidence and competence between receptive English (understanding what a clinician says) and expressive English (being able to ask questions in English). Both patients and clinicians may wish to have an interpreter available as back up communication support in a consultation.[97]

[91] Dean, J., Loh, E., and Lorenz, K. (2017). Lost in translation: ad hoc interpreter use. George v Biggs. *Royal Australian College of Medical Administrators Quarterly*.
[92] Bird, S. (2008). Lost without translation. *Australian Family Physician*, 37(12), pp.1023-1024.
[93] Bird, S. (2010). Failure to use an interpreter. *Australian Family Physician*, 39(4), pp.241-242.
[94] ACT Government (ACT Health), (2015). *Procedure: Language Services – Interpreters*, p.4.
[95] ACT Government (ACT Health), (2015). *Procedure: Language Services – Interpreters*, p.4.
[96] The State of Queensland (Department of Communities, Child Safety and Disability Services), (2016). *Language Services Guidelines*, p.5; Government of Western Australia (Department of Local Government and Communities), (2014). *Western Australian Language Services Policy 2014 and Guidelines*, p.9.
[97] Nursing and Midwifery Board of Australia, Code of Conduct for Nurses (effective 1 March 2018), 8; Medical Board of Australia, Good Medical Practice: A Code of Conduct for Doctors in Australia (2014), 8.

When assessing the need for an interpreter, it is important to be aware of possible changes in the patient's circumstance. That is, while an interpreter may not be deemed necessary at the onset of a consultation or procedure, clinicians should be prepared to engage an interpreter should circumstances change during the course of the consultation or procedure.[98]

Once the need for an interpreter has been established, it is the clinician's responsibility to ensure that steps are taken to engage an interpreter. Where required, clinicians should provide the necessary information and tools to their relevant clinical and non-clinical colleagues.

In selecting an interpreter, clinicians should consider the patient's ethnicity, religion, education, literacy, language or dialect, and preference for gender or country of the interpreter.[99] The interpreter's ethnicity and religion may be important to some patients, particularly in situation of inter-ethnic or inter-religious conflict.[100] Additionally, patients may have concerns about confidentiality with interpreters from the same small and tight-knit communities. In situations where the interpreter is known to the patient, such as in rural areas, or with smaller language groups, engaging a telephone interpreter may be more appropriate.[101]

Sometimes patients have preferences for gender-concordant consultations (where the interpreter is of the same gender as the patient). This may be a high priority in some cultures. In gender-discordant consultations, where the doctor and patient are not of the same gender, engaging a gender-concordant interpreter can improve a patient's satisfaction with the consultation.[102] This is particularly likely to occur with consultations related to sexual and reproductive health or, in some cases, mental health.

When the interpreter is of a different gender than the patient's preference, the patient should be informed and telephone interpreting should be offered instead. Patients may be more likely to accept an interpreter of a different gender when they are not present in the room.

Annex: Practice points for working with interpreters in health care settings

The Annex is an integral part of this document and provides important evidence-based good practice points for clinicians working with interpreters in health care settings, including:

- Interpreter's scope of practice and role in the consultation;
- Vocabulary use when working with an interpreter;
- Speech rate, pause and turn taking when working with an interpreter;
- Interaction with the patient; and
- Interaction with the interpreter.

[98] Dean, J., Loh, E., and Lorenz, K. (2017). Lost in translation: ad hoc interpreter use. George v Biggs. *Royal Australian College of Medical Administrators Quarterly*.
[99] Australian Psychology Society, (2013). *Working with Interpreters: A Practice Guide for Psychologists*. p.4.
[100] ibid., p.6.
[101] The Victorian Foundation for Survivors of Torture (Foundation House), 2013. *Promoting the engagement of interpreters in Victorian health services*.
[102] Bischoff, A., Hudelson, P., and Bovier, P.A. (2008). Doctor-patient gender concordance and patient satisfaction in interpreter-mediated consultations: an exploratory study. *Journal of Travel Medicine*, 15(1), pp.1-5.

Competency standard 5 – Clinicians understand the impact of cultural and linguistic differences on communication within the therapeutic relationship.

5.1	Clinicians assist patients to make informed decisions about their health care recognising how cultural considerations and expectations, English language proficiency and health literacy can impact on these decisions.
5.2	Clinicians provide clear, accurate, culturally appropriate, timely information to enable patients to understand the health issues being discussed, including the diagnosis, management and recommended follow up.
5.3	Clinicians provide resources, in appropriate formats, that enable patients' understanding, recognising that patients may require support from their families and carers in managing their health issues so adequate information needs to be available to those whom the patient wishes to include.
5.4	Clinicians gather feedback from their patients in an appropriate manner that enables people with limited English proficiency, low literacy levels, and different cultural considerations to participate.

Explanatory notes

Informed decision-making

It is important to recognise that by giving all patients the ability to make informed choices, better outcomes can be achieved for the health service, the health care providers, and patients, irrespective of cultural backgrounds of any person involved.[103]

To ensure a patient is making an informed decision, clinicians should assess the need for an interpreter to facilitate communication and assess the patient's understanding. Clinicians should also take into account the patient's cultural and religious beliefs which may influence their understanding and acceptance of the information received, and their ability to weigh the information to reach a decision. Clinicians may consider explanatory models of care[104] and the teach-back[105] method can help to ascertain whether the patient has understood the information provided.

If the patient is provided with written material, the clinician should ascertain whether the patient is able to read and understand the information provided.

Many patients come from collectivist communities in which health care decisions are shared decisions. Providing the patient with the opportunity to discuss their decision with their family or community leader may be important for some patients. Equally important is providing the information to the patient so that there is time for them to consider this information with such support. Failure to appreciate how to support a patient in making their health care decisions can contribute to poorer health outcomes.

[103] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, (2014). *College Statement: Cultural Competency*.
[104] Kleinman, A., Eisenberg, L. and Good, B. (1978). Culture, illness, and care: clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine*, 88(2), pp.251–88.
[105] Agency for Healthcare Research and Quality, (2015). *Use the teach-back method. Health Literacy Universal Precautions Toolkit*, 2nd Ed.

Verifying understanding

Patients have a right to understand the information and recommendations they receive from their practitioners.[106] This can be achieved by clinicians demonstrating respectful and culturally responsive two-way communication practices focused on information exchange.[107] An effective way to confirm understanding is the teach-back method whereby the clinician asks the patient to explain in their own words what they have been told.[108] [109]

When delivering information to a patient, clinicians should consider the patient's linguistic background and the need to engage an interpreter to check that the patient understands everything the clinicians has told them.[110] Performing teach-back through an interpreter reinforces good communication practices and is an appropriate way to check that the message has successfully been transferred via the interpreter to the patient.[111]

Patient feedback

Both formal and informal feedback interactions are important. Feedback should be sought without assumptions, while ensuring dignity and respect. Clinicians should provide patients, their families and carers with culturally safe avenues for feedback.[112] Rating scales are not commonly used in certain cultures and clinicians should consider alternate methods for feedback that are culturally appropriate.

Further, clinicians should ensure that patients are involved in the error reporting process in a culturally safe way.[113]

[106] Hollander, M.J., Kadlec, H., Hamdi, R., and Tessaro, A. (2009). Increasing value for money in the Canadian healthcare system: New findings on the contribution of primary care services. *Healthc Q*, 12(4), pp.32-44.
[107] Australasian College for Emergency Medicine and College of Emergency Nursing Australasia, (2015). *Quality standards for emergency departments and other hospital-based emergency care services*. Objective 3.1.1: Communication.
[108] Agency for Healthcare Research and Quality, (2015). *Use the teach-back method. Health Literacy Universal Precautions Toolkit*, 2nd Ed.
[109] Perrenoud, B. et al. (2015). The effectiveness of health literacy interventions on the informed consent process of health care users: A systematic review protocol. *JBI Database of Systematic Reviews and Implementation Reports*, 13(10).
[110] Royal Australian College of General Practitioners, (2017). *Standards for general practices*, 5th ed. Core Standard 1 - Communication and patient participation, Criterion C1.3 – Informed patient decisions.
[111] North Western Melbourne Primary Health Network and Centre for Cultural, Ethnicity & Health, (2017). *Using teach-back via an interpreter*.
[112] Australasian College for Emergency Medicine and College of Emergency Nursing Australasia, (2015). *Quality standards for emergency departments and other hospital-based emergency care services*. Objective 2.6.4: Patient experience.
[113] ibid, Objective 2.8.5: Patient involvement in error reporting.

Domain 3: Collaborator

Clinicians work effectively with health care professionals and other relevant professionals, both within the health service organisation and across networks, to provide timely and high-quality care to patients from migrant and refugee backgrounds, including working with interpreters as members of a health care team.

Competency standard 6 – Clinicians collaborate with other health care professionals across networks.

6.1	Clinicians build and utilise referrals—across community health and allied health sectors—to support their delivery of care, ensuring that these networks are effective in meeting the particular needs of patients from migrant and refugee backgrounds in a culturally responsive manner.
6.2	Clinicians undertake safe handover of care, through both verbal and written communication, including information about patients' cultural needs, complexities and expectations.

Explanatory notes

Community health and allied health networks

Community health and allied health networks offer a wide variety of services and some are specialised in the particular needs of patients from migrant and refugee backgrounds.

Clinicians are encouraged to build networks to refer at-risk patients to a resource that is best suited for the patient, such as a community resource for culturally sensitive education or intervention for drug or alcohol related problems, or mental health. [114] Another example is the collaboration between healthcare providers, including pharmacists and practice nurses, to support quality use of medicines.[115]

Safe handover of care

Clinicians should ensure that all information relevant to the quality and safety of migrant and refugee patient care is provided to a health partner during handover of care.[116] This includes information regarding the patient's linguistic and cultural background to ensure continued care and enshrine the patient's trust in the healthcare system. Some patients may be hesitant to repeat the same sensitive information to a new clinician, if the full information is provided during handover of care, it will ensure a comprehensive person-centred approach to safe and quality healthcare.

Clinicians may need to advocate for their patients within the health care system to enable their patients to access timely care. This can involve ensuring that all referrals include information

[114] Australasian College for Emergency Medicine and College of Emergency Nursing Australasia, (2015). *Quality standards for emergency departments and other hospital-based emergency care services*. Objective 1.10.7: Care of patients with drug and alcohol problems.
[115] Kay, M., Wijayanayaka, S., Cook, H., and Hollingworth, S. (2016). Understanding quality use of Medicines in refugee communities in Australian primary care: A qualitative study. *British Journal of General Practice*, 66(647), e397-409.
[116] WHO Collaborating Centre for Patient Safety Solutions, (2007). Communication during patient handover. *Patient Safety Solutions*, 1(3).

about the patient's need for an interpreter and the required language in order to facilitate the booking of the interpreter for the consultation.

Competency standard 7 – Clinicians collaborate with interpreters as members of a healthcare team and within the scope of the interpreter's practice.

7.1	Clinicians recognise the role of the interpreter in the clinical setting, their skills, their responsibilities and their scope of practice.
7.2	Clinicians recognise that the on-site interpreter cannot be asked to provide written translations of material, but may be asked to do a sight translation.
7.3	Clinicians inform interpreters on the nature of the consultation prior to its commencement where possible, recognising the need to assist the interpreter to prepare for the information that may need to be interpreted.

Explanatory notes

Interpreter's role and scope of practice

Interpreters relay the messages uttered by all parties as accurately as possible. This includes mimicking the patient's tone of voice, interpreting their body language, rendering their incoherent thoughts into English (for example, for patients with mental illness who have distorted thoughts), as well as maintaining the register of all parties. Interpreters will not add, omit or attempt to correct patients' language or cognitive deficits.

Interpreters respect the professional boundaries of other participants[117]. This implies that, while the interpreter removes the communication barrier, the responsibility for establishing understanding rests with the clinician. Using the teach-back method through the interpreter, clinicians can ask the patient to repeat what they were told to make sure that they understood.[118]

If the interpreter recognises a potential cross-cultural misunderstanding, or comprehension or cognitive difficulties on the part of the patient, the interpreter may raise it with the clinician to allow the clinician to take appropriate steps with the patient, such as rephrasing, clarifying, or asking further questions.[119]

For further information, see *Annex: Practice points for clinicians working with interpreters in health care settings, Practice point 1 – Interpreter's scope of practice and role in the consultation.*

Translation

Non-English speaking patients may also be unable to read or write in English, and some may be illiterate in their own language. This makes filling out medical forms or questionnaires challenging. However, interpreters should not be expected to fill out forms or questionnaires on behalf of the patient, as their role is to facilitate communication by rendering messages from one language to another orally. They are not certified to provide formal translations of documents.

[117] Australian Institute of Interpreters and Translators, (2012). *AUSIT Code of Ethics*, p.10.
[118] State of NSW (NSW Ministry of Health), (2006). *Policy Directive: Standard procedures for working with health care interpreters*, p.9.
[119] This is consistent with AUSIT Recommended guidelines for health professionals working with interpreters with reference to special interpreting contexts such as a mental health and speech pathology, section 3.4.

If it is necessary to fill out a written document, or to inform a patient of the contents of a document (for example, information about a procedure), the clinician or their clinical and non-clinical colleagues should read the questions to the patient through the interpreter. Clinicians, or their clinical and non-clinical colleagues, may also complete the form according to the patient's answers as conveyed by the interpreter.[120]

Alternatively, when necessary, interpreters may provide sight translation of information written in English or other languages, such as medical instructions or letters related to the patient's medical history. Sight translation is "a transposition of a message written in one language into a message delivered orally in another language".[121] Sight translations must take place in the presence of the clinician, or their clinical and non-clinical colleagues. However, long or technical documents may not be suitable for sight translation and warrant written translation. Requests for translation of any material that may be necessary for a patient's consultation should be referred to a relevant translation service.

Informing the interpreter on the nature of the consultation

Interpreters will be in a better position to accurately interpret if they have a clear understanding of the purpose of the consultation and have an overview of the session, including, as appropriate, a description of the activities that will take place and whether the consultation may be distressing.[122] If it is anticipated that the consultation will include counselling, or other complex matters, the clinician should inform the interpreter before the consultation.

Informing the interpreter is particularly relevant for highly specialised, sensitive or difficult cases or in situations where additional occupational risks for the interpreter may be anticipated. Examples include cases when the patient has difficulty with their speech[123], mental health consultations, complex or chronic conditions, delivering bad news to the patient, palliative care and end of life care, or when abuse and violence is an issue.[124]

The clinician may choose to inform the interpreter about the anticipated assessment strategy and to gain insights into any relevant cultural and linguistic issues. Interpreters may also take a proactive approach and request the clinician to brief them. In order to ensure high quality work, the AUSIT Code of Ethics encourages interpreters to "request [a] briefing and access to reference material and background information before their work commences".[125]

Where possible and relevant, clinicians should provide brief information to interpreters describing the context of the consultation immediately before it occurs. This is to ensure quality and effective communication, and achieve best possible outcomes for the patient in the consultation.

However, the opportunities to inform an interpreter are limited in the event of a telephone interpreting appointment and may be limited only to flagging the nature of the consultation with the interpreter. Telephone interpreters represent a particular case, in that they are often connected at the beginning of a consultation whose nature may be as yet undetermined. A process of iterative briefing may also be needed, if the consultation moves to cover issues for

[120] State of NSW (NSW Health Care Interpreter Services), (2014). *Interpreting in healthcare – Guidelines for Interpreters*.
[121] Lambert, S. (2004). Shared Attention During Sight Translation, Sight Interpretation and Simultaneous Interpreting. *Meta*, 49(2), pp.294-306.
[122] Australian Psychology Society, (2013). *Working with Interpreters: A Practice Guide for Psychologists*. 5.4 Pre-consultation meeting, p.9.
[123] Australian Institute of Interpreters and Translators, (2007). *Recommended guidelines for health professionals working with interpreters with reference to special interpreting contexts such as a mental health and speech pathology*.
[124] Royal Australian College of General Practitioners, (2014). *Clinical Guidelines, Abuse and violence: Working with our patients in general practice*, 4th ed., p.94; State of NSW (NSW Ministry of Health), (2006). *Policy Directive: Standard procedures for working with health care interpreters*, p.13.
[125] Australian Institute of Interpreters and Translators, (2012). *AUSIT Code of Ethics*, p.11.

which the interpreter was not prepared. Examples include sexual and reproductive health matters when the telephone interpreter is of a different gender to the patient.

Domain 4: Leader

Clinicians engage with others and lead by example to contribute to the development of systemic organisational processes that facilitate the delivery of equitable and high-quality care to patients from migrant and refugee backgrounds and maximise cultural responsiveness of the health care system.

Competency standard 8 – Clinicians contribute to organisational cultural responsiveness.

8.1	Clinicians lead the creation of culturally responsive, user-friendly and accessible environments that recognise and respond to cultural differences in the delivery of care to patients from migrant and refugee backgrounds.
8.2	Clinicians enable input from patients, their families and carers from migrant and refugee communities to inform whole-of-organisation practices that facilitate the delivery of quality care.
8.3	Clinicians facilitate data collection for patients with migrant and refugee backgrounds that captures appropriate demographic data to enable improved delivery of culturally responsive care such as recording of country of birth, preferred language, the need for an interpreter, year of arrival in Australia, and ethnicity.
8.4	Clinicians work with their clinical and non-clinical colleagues to meet the patient's communication needs by ensuring that the colleagues have: ▪ information about when an interpreter may be required; ▪ guidance on how to assess when the patient is likely to need an interpreter due to their limited English proficiency or use of Auslan or another sign language; and ▪ information about how to arrange for an interpreter.
8.5	Clinicians work with their clinical and non-clinical colleagues to ensure that once the need for an interpreter is identified, it is then documented in the patient management system.

Explanatory notes

Culturally responsive environments

As part of their commitment to the continual enhancement of their cultural responsiveness and the promotion of systemic change in developing culturally responsive environments for all patients, clinicians should incorporate cultural responsiveness in every aspect of their practice and share these values with their colleagues, and their clinical and non-clinical colleagues. Gaining skills in cultural responsiveness increases an organisation's ability to provide quality care for everyone in its catchment population.[126]
Clinicians should seek to contribute to creating and maintaining a cultural safety policy, and to ensure that all clinical and non-clinical colleagues are required to provide service that is respectful of a person's culture and beliefs, and that is free from discrimination.[127]

[126] al Australasian College of Medical Administrators, (2013). *RACMA Position Paper: Cultural Competence for Medical Administrators in Australia and New Zealand*, p.6.
[127] Royal Australian College of General Practitioners, (2017). *Standards for General Practices*, 5th ed. Core Standards 2: Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.

Clinicians should be aware of the importance of first impressions and support a welcoming environment to empower patients, their families and carers to take full advantage of the healthcare service offered.[128] This may include displaying posters that reflect diversity or are adapted for language and signage and indicate the availability of interpreters.

Clinicians should strive to facilitate patient access to resources that are culturally appropriate, translated, and in plain English.[129] Clinicians can maintain a directory of resources, online tools and websites to help them provide information, including printed copies or reference to websites, in languages other than English.[130]

Patient and community input

Clinicians should identify opportunities to form partnerships with community groups and ethno-specific organisations to inform more culturally responsive policies and processes,[131] establish reciprocal relationships and trust with the community being served and assist in creating welcoming environments.

Data collection

Clinicians should ensure that information about a patient's cultural needs and preferences is included during history taking. When asking a patient about their cultural identity and beliefs in order to update the patient details, it is beneficial to explain that this helps the practice to provide culturally responsive care.[132] Data may be used to ensure that the patient's needs, beliefs and preferences are taken into account during a consultation or procedure, or when choosing a treatment option.

Clinicians should ensure that their clinical and non-clinical colleagues clarify a patient's preferences for an interpreter of a particular gender and are aware of any other preferences such as ethnicity. If an interpreter meeting the patient's preferences is not available, the patient is informed and asked if they would consent to communicating through the available interpreter.

Informing clinical and non-clinical colleagues about patient communication needs

Determining the need for an interpreter may happen at any stage of a consultation, including at the onset when communicating with the clinician's clinical and non-clinical colleagues. Clinicians must ensure that their practice staff and colleagues have guidance on how to assess when a patient is likely to need an interpreter due to their limited English proficiency or hearing limitations to enable an interpreter to be arranged in a timely fashion, ideally when the appointment is being made. The engagement of the interpreter should be noted in the records of the patient.

Documenting the need for interpreting

Clinicians should work with their clinical and non-clinical colleagues to ensure that the need for an interpreter is clearly and visibly documented in the patient management system. Information

[128] Australasian College for Emergency Medicine and College of Emergency Nursing Australasia, (2015). *Quality Standards for Emergency Departments and Other Hospital-Based Emergency Care Services*. Objective 2.6.4: Patient experience.
[129] ibid., Core Standard 1: Communication and patient participation, Criterion C1.4 – Interpreter and other communication services.
[130] ibid.
[131] National Health and Medical Research Council, (2005). *Cultural competency in health: a guide for policy, partnerships and participation*, p.34.
[132] Royal Australian College of General Practitioners, (2017). *Standards for General Practices*, 5th ed. Core standard 2 – Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.

should include: the patient's preferred language or dialect spoken, and the preferred gender or ethnicity of the interpreter.

For deaf patients, the need for an Auslan or another sign language interpreter should be recorded.

Where possible, flagging should be built into the electronic medical record to alert the clinician and their associate and support personnel of the need to request an interpreter for all future consultations.

Domain 5: Health Advocate

Clinicians appreciate health determinants and health inequities affecting patients from migrant and refugee backgrounds and contribute to improving health outcomes for individuals and communities through advocacy at all systems levels, including professional, health services, and government.

Competency standard 9 – Clinicians contribute to the promotion of health literacy within refugee and migrant communities.

9.1	Clinicians incorporate health literacy and preventative health education in their work with patients, their families and carers, taking into account the relevant cultural considerations and pre-migration experiences.
9.2	Clinicians support migrant and refugee communities' capacity to facilitate health literacy and preventive health activities within their communities by contributing to education and resource development for local communities.

Explanatory notes

Health literacy and preventative health education

Clinicians' support and contribution to health literacy increases the patient trust in the healthcare system and reduces barriers to access to healthcare.

Strategies can include using visual and written aids, translated resources and teach-back techniques to improve communication, understanding and health literacy.[133] In this regard, it is important to recognise that some patients have had limited access to education in their own language and may have low literacy and numeracy skills. Therefore, although written information is useful, poor literacy in a person's first language can limit the effectiveness of translated resources.[134]

Similarly, relying exclusively on non-verbal communication is inadequate. For example, pictograms to support instructions on medicines for consumers with low literacy can be misinterpreted,[135] especially in cross-cultural settings.

Competency standard 10 – Clinicians develop community and multisectoral partnerships.

10.1	Clinicians establish and maintain multisectoral networks, including with the community sector, to ensure coordination and integration of healthcare services that enable the delivery of high quality, culturally responsive care.

Explanatory notes

[133] Riggs E, Yelland J, Duell-Piening P, Brown SJ. Improving health literacy in refugee populations. Medical Journal of Australia 2016; 2014 (1): 9-10.
[134] Young, H.N., Dilworth, T.J., Mott, D.A. et al. (2013). Pharmacists' provision of information to Spanish-speaking patients: a social cognitive approach. *Research in Social & Administrative Pharmacy*, 9(1), pp.4–12.
[135] Davis, T.C., Wolf, M.A., Bass, P.F. et al. (2006). Low literacy impairs comprehension of prescription drug warning labels. *Journal of General Internal Medicine*, 21(8), pp.847-851.

Working with the community sector

Clinicians should adopt a multifaceted approach to providing health care involving patients, their families and carers, and, as necessary and appropriate, the broader community and health providers.[136] As such, it is important for a clinician to understand the demographics of the local community and the diverse groups served by their health service and the implications for the health care provided. This can be done through exchanges of information across networks based on analysis of diverse community needs.[137] Building relationship and networks with the community supports the delivery of culturally responsive care, recognising that communities are their own cultural experts and are able to facilitate a community development approach.[138]

Clinicians should develop and maintain networks to harness resources available in the local community to improve outcomes of care. This includes seeking the assistance of key community contacts and networks, as appropriate, to communicate effectively and in a culturally safe manner with patients, their families and carers, and to provide them with support according to their cultural needs. For example, community leaders can be engaged as trusted sources of information to facilitate education on quality use of medicines.[139]

Working with multisectoral networks

Increasing cultural responsiveness is a shared responsibility requiring partnerships across the health and human services, education, and research sectors, using systematic and sustainable approaches.[140]

Clinicians should seek to secure partnerships across sectors in a systemic and sustained way to share learnings on cultural responsiveness. Shared learning amplifies the benefits of other health strategies, helps avoid mistakes and allows successes to be expanded and taken up across services more efficiently.

Competency standard 11 – Clinicians facilitate the uptake of interpreting services.

11.1	Clinicians inform patients with limited English proficiency and those who use Auslan or another sign language of their right to access interpreting services.

Explanatory notes

Access to interpreting services

Clinicians should ensure that patients with limited or no English proficiency are informed of the interpreting services that are available to them when accessing health care, as well as collecting medication from a pharmacist. Further, clinicians should ensure that patients understand the services to be:

[136] Woodland, L., Burgner, D., Paxton, G. and Zwi, K. (2010). Health service delivery for newly arrived refugee children: a framework for best practice. *Journal of Paediatrics and Child Health*, 46(10), pp.560-567.
[137] National Health and Medical Research Council, (2005). *Cultural competency in health: a guide for policy, partnerships and participation*, p.28.
[138] ibid., p.39.
[139] Kay, M., Wijayanayaka, S., Cook, H., and Hollingworth, S. (2016). Understanding quality use of Medicines in refugee communities in Australian primary care: A qualitative study. *British Journal of General Practice*, 66(647), e397-409.
[140] Correa-Velez, I., Gifford, S.M. and McMichael, C. (2015). The persistence of predictors of well-being of refugee youth eight years after settlement in Melbourne, Victoria. *Social Science and Medicine*, 142, pp.163-168.

- conducted by qualified interpreters;
- free for the patients and consumers; and
- confidential.

Domain 6: Scholar

Clinicians are committed to maintaining awareness of linkages between cultural diversity and patient health, and facilitate sharing of information and knowledge to promote cultural responsiveness in the provision of care to patients from migrant and refugee backgrounds.

Competency standard 12 – Clinicians are committed to including education about meeting the needs of migrant and refugee communities in the delivery of care and in their continuing learning activities.

12.1	Clinicians continually learn and develop cultural responsiveness by demonstrating awareness of existing and emerging data and research regarding cultural diversity demographics and population health.
12.2	Clinicians maintain ongoing practice innovation through the use of resources, including technology, to facilitate culturally responsive care provision to patients from migrant and refugee backgrounds.

Explanatory note

Continuous cultural responsiveness learning

Clinicians embrace and develop cultural responsiveness in their work.[141] Clinicians update and enhance their knowledge, skills and performance required for safe and appropriate contemporary practice and cultural responsiveness with regard to their relevant community demographics.

Clinicians understand the demographics and cultural backgrounds of their patient population to provide them with the most appropriate care.[142]

Clinicians acquire knowledge and can access information about communities, their histories and specific health issues as required. Clinicians share web-based resources that encourage good practice and provide basic community-specific information relevant to cross-cultural health promotion.[143]

Technology to facilitate culturally responsive care

The use of technology will increasingly become more part of health care, evidenced currently by the development and dissemination of electronic health records, and transition to videoconference consultations and video-interpreting.

Clinicians should take cultural, linguistic and literacy considerations into account when assisting patients, their families and carers to identify, access, and make use of proven information and communication technologies to support their care and manage their health.

[141] Royal Australian and New Zealand College of Obstetricians and Gynaecologists, (2014). *College Statement: Cultural Competency*.
[142] Royal Australian College of General Practitioners, (2017). *Standards for General Practices*, 5th ed. Core Standards 2: Rights and needs of patients, Criterion C2.1 – Respectful and culturally appropriate care.
[143] National Health and Medical Research Council, (2005). *Cultural competency in health: a guide for policy, partnerships and participation*, p.40.

Competency standard 13 – Clinicians are committed to teaching others about the delivery of culturally responsive quality health care.

13.1	Clinicians contribute to improving the cultural responsiveness of the profession through teaching students, peer learning, review and practice support.

Explanatory notes

Commitment to improving cultural responsiveness in the profession

Clinicians should train and support the profession to deliver culturally responsive care. Clinicians should ensure teaching and learning approaches promote cultural safety in patient management and healthcare delivery.[144]

As part of their commit to continuous education with respect to cultural responsiveness, health disparity, inequalities and the overall performance of the health system,[145], clinicians should increase their cultural responsiveness and the cultural responsiveness of the profession by participating in cross-disciplinary forums that encourage information, skill-sharing, support and awareness of the value of increasing cultural competency. Clinicians recognise the need to discuss with colleagues, opportunities to improve or introduce cultural competency into existing practices,[146] while avoiding clichés and stigma.

[144] Australian Nursing and Midwifery Accreditation Council, (2015). *Nurse Practitioner Accreditation Standards 2015*, p.15.
[145] Royal Australasian College of Medical Administrators, (2013). *RACMA Position Paper: Cultural competence for medical administrators in Australia and New Zealand*, p.2.
[146] National Health and Medical Research Council, (2005). *Cultural competency in health: a guide for policy, partnerships and participation*, p.59.

Domain 7: Professional

Clinicians maintain culturally responsive clinical practice as an integral part of the safe and high-quality care, ethical conduct, and adherence to professional standards.

Competency standard 14 – Clinicians are committed to cultural responsiveness and respect in all aspects of practice.

14.1	Clinicians adhere to high ethical standards and are committed to the principles of person-centred care, access, equity, quality and safety, and dignity and respect in practicing culturally responsive care when working with patients from migrant and refugee backgrounds.

Explanatory notes

Clinicians should seek to protect and advance the health and wellbeing of individuals through person-centred and goal-oriented care, thereby advancing the wellbeing of communities and populations.

Clinicians should be aware of their own cultural values and beliefs, and of cultural factors that impact on the needs of patients. Clinicians should have the capacity to use reflection to self-assess their ability to provide responsive care to people from different cultures and to interact with people in a manner appropriate to that person's culture.[147]

Acknowledging the limitations of one's own skills, clinicians should have a process to adapt service provision so that it reflects an understanding of the diversity between and within cultures.[148]

[147] Australian Medical Council, (2015). *Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australia Medical Council*. Standard 3.
[148] Australasian College for Emergency Medicine and College of Emergency Nursing Australasia, (2015). *Quality Standards for Emergency Departments and Other Hospital-Based Emergency Care Services*. Objective 1.9.9 Cultural competence.

ANNEX: PRACTICE POINTS FOR CLINICIANS WORKING WITH INTERPRETERS IN HEALTH CARE SETTINGS

Practice point 1 – Interpreter's scope of practice and role in the consultation

Actions

1.1	Clinicians introduce the interpreter to the patient and explain their role as a member of the health care team and a partner in the clinical consultation.
1.2	Clinicians recognise that the interpreter should not be requested or expected to assess any of the patient's abilities, except for their linguistic abilities; to make a judgment as to the competence of the patient; or to establish the patient's understanding.
1.3	Clinicians recognise that the interpreter should not be requested or expected to act as a chaperone for clinical examinations.
1.4	Clinicians recognise that the interpreter should not be requested or expected to act as a bicultural or a bilingual worker, a carer or a health advocate for the patient.

Explanatory notes

The clinician should begin the consultation by explaining the role of the interpreter as a member of the health care team who is tasked with accurate interpretation, bound by confidentiality and maintains impartiality.[149] Alternatively, the clinician can ask the interpreter to introduce themselves and state their role to the patient. It is essential that the clinician ensure the patient understands the interpreter is bound by confidentiality and impartiality, and that the interpreter will interpret with accuracy which may include mimicking the patient's tone of voice or interpreting their body language.

While there are circumstances where it may be useful to engage a chaperone when examining a patient, interpreters should not to be asked to act as chaperones. Interpreters are not trained for this purpose, and if they were to act as a chaperone this would conflict with their impartial role.

When a clinician leaves the room, the interpreter should not remain alone with the patient but should also leave to ensure the role of the interpreter as a communication facilitator between the patient and the clinician is enforced.

An interpreter works within the consultation. It is not their function to act as a bicultural or bilingual worker or a health advocate—an interpreter should not be expected to accompany a patient beyond the consultation, for example, to assist at the local pharmacy. Similarly, clinicians should avoid engaging a bicultural or bilingual worker or health advocate to act as an interpreter as they are not qualified for such a role.

Practice point 2 - Vocabulary use

Action

[149] Government of Western Australia, (2014). *Western Australian Language Services Policy 2014 and Guidelines*, p.20.

2.1	Clinicians endeavour to speak clearly and use plain English rather than clinical terminology, to maximise the ability of the interpreter to provide effective services and enhance the patient's understanding of clinical concepts.

Explanatory notes

Speaking clearly is important as it is hard to interpret something that was not understood in the first place. Using simple language and avoiding colloquialisms, idioms, technical language and acronyms is important to ensure the interpreter can provide effective services.[150] Technical clinical terms and abbreviations, in particular, may complicate the interpretation. Interpreters may ask for clarifications or repetitions if needed.

While an interpreter can assist in bridging the language gap, the cultural meaning embedded within language adds further complexity to cross-cultural consultations.

Where a clinician assesses a patient on intimate, sexual or family violence matters, they may have to address the patient using a certain descriptive vocabulary, employing terms and descriptions of intimate body parts or acts. In these situations, it is important to warn the patient, including the interpreter, that the questions that are about to be asked could be quite sensitive ones. If there is gender discordance, it is important to ensure that the patient is comfortable enough to have the conversation about these sensitive issues.

Practice point 3 - Speech rate, pause and turn-taking

Actions

3.1	Clinicians speak at a reasonable speed, with appropriate pauses and avoiding overlapping speech, so as to enable the interpreter to interpret.
3.2	In the context of a multidisciplinary team consultation, clinicians ensure adequate speech rate, pauses and turn taking for all parties to facilitate good quality and accurate conveyance of messages to the patient.

Explanatory notes

Speaking with reasonable pauses or breaks facilitates accurate interpretation, and subsequent accurate medical history, diagnosis and treatment. Some interpreters may use various strategies to manage long speech segments, including taking notes, cutting in to interpret while speakers are talking, asking for repetitions, or interpreting simultaneously. Others might find it difficult, even when they are not coping, to utilise those or other strategies. It is therefore best to speak in manageable chunks to avoid omissions in the delivery of the messages.

Interpreters work in the consecutive mode, that is they start conveying the message from one language to the other after each speaker finishes their utterance. If interlocutors start talking on top of each other and cutting each other's speech, this may impede accuracy. Interpreters strive to convey the whole message, and interruptions may result in omissions of what might be relevant or valuable information.

Clinicians do not need to give the interpreter a turn to talk if they are talking among each other or with a family member or carer. In these situations, interpreters keep the patients informed by

[150] Phillips, C.B. (2010). Using interpreters: a guide for GPs. *Australian Family Physician*, 39(4), pp.188-195.

interpreting simultaneously in the chuchotage (whispering) mode. Interpreters have to keep patients 'linguistically present' even when clinicians are discussing their case among themselves, or family members or carers are asking questions or providing answers related to their health. If clinicians use technical medical terms when talking among each other, then the interpreter will use simpler language to let the patients know, through the interpreter, what was discussed.

Should an interpreter experience difficulty interpreting in the consultation that involves carers, a number of family members as well as a multidisciplinary team, they will indicate this by raising their hand and asking participants to speak one at a time.

Practice point 4 - Interaction with the patient

Actions

4.1	When working with an onsite interpreter, clinicians interact directly with the patient, using the first person point of view, and maintaining appropriate body language and facial expressions.
4.2	When working with a telephone interpreter, clinicians use a speakerphone or a hands-free telephone.
4.3	When working with a telephone interpreter, clinicians interact directly with the patient, and ensure they manage turn-taking and use adequate descriptive language.

Explanatory notes

Using direct speech, or first-person point of view, with a non-English speaking patient, when assisted by an interpreter either onsite or via telephone, is important in establishing rapport. It is equally important and reassuring to the patient to maintain eye contact (if culturally appropriate), use facial expressions, gestures and congruent body language, for example, nodding while the patient is speaking or the interpreter is conveying the message. Cultural responsiveness helps clinicians tailor their speech and actions appropriately in order to achieve the best outcome for the consultation, establish rapport and avoid offending non-English speaking patients. In addition, the interpreter can be acknowledged every now and then, by maintaining eye contact with them, as this makes them feel part of the team.

When working with an onsite interpreter, it is recommended that the participants position themselves in a way to allow the clinician and the patient to each other, and that the interpreter be seated within the clinician's visual field.[151] This can take a form of a triangle arrangement Clinician-Interpreter-Patient.[152]

When working with an offsite interpreter, using a speakerphone or a hands-free telephone makes the communication more rapid and efficient for all participants. All health care settings, where interpreters are or may be engaged should be equipped with speakerphones or hands-free telephones. If the clinician is obliged to use a telephone without a speaker function in hand-passing mode, they should indicate to the interpreter when the telephone is handed over to the patient, and to the patient that the telephone should be handed back.

[151] Australian Institute of Interpreters and Translators, 2007. *Recommended guidelines for health professionals working with interpreters with reference to special interpreting contexts such as mental health and speech pathology*.
[152] Government of Western Australia, (2014). *Western Australian Language Services Policy 2014 and Guidelines*, p.19.

Telephone interpreting deprives interpreters of visual cues. Health providers can make up for this by using visual language to describe what is happening through the consultations. The clinician should verbally comment on visual surrounding, movements, acts and intentions.

If clinicians need to directly talk to the interpreter (for example, if they are explaining that the patient has left the room and the interpreter should stay on the line) they should address them directly as "Interpreter". Onsite interpreters can readily identify by gestures and eye direction if a clinician is breaking the consultation to address them directly. Telephone interpreters need to be verbally notified that they are being addressed, rather than the patient, when the consultation is being broken.

Clinicians continue to address the patient directly and face the patient during the interpretation session.

Practice point 5 - Interaction with the Interpreter

Action

5.1	When necessary and appropriate, clinicians and interpreters may debrief and exchange feedback following a consultation.

Explanatory notes

Clinicians and interpreters should be sensitive to situations when debriefing and exchange of feedback may be required (for example, difficult consultation, particular language observations).

Debriefing and exchange of feedback may be necessary to discuss the patient's lexical, grammatical or speech errors, or other linguistic characteristics, particularly in speech pathology, neuropsychology or mental health settings.[153]

Both clinicians and interpreters in health care settings may experience emotional impacts from some consultations. In an ordinary working day in the health care setting, both clinicians and interpreters may have to deliver bad news on multiple occasions and participate in some very distressing encounters.

In particularly distressing or disturbing situations, there may be a need for both the interpreter and the clinician to debrief together about their experience. Debriefing is of particular importance in situations where individuals may experience vicarious trauma as a result of the engagement, such as counselling sessions, domestic and family violence cases, and in some healthcare situations.[154] Mutual debriefing may be short, simply acknowledging the complexity and potential stressfulness of the consultation.

For telephone interpreted consultations, clinicians may choose to ask the interpreter to stay on the line after the conclusion of a consultation to clarify any elements of the consultation, or to acknowledge the potential impact of the consultation.

[153] State of NSW (NSW Health Care Interpreter Service), (2014). *Interpreting in Healthcare – Guidelines for Interpreters*, p.22.
[154] State of Queensland (Department of Communities, Child Safety and Disability Services), (2016). *Language Services Guidelines*, p.15; State of NSW (NSW Health), (2006). *Standard Procedures for Working with Health Care Interpreters*, p.13; Government of Western Australia, (2014). *Western Australian Language Services Policy 2014 and Guidelines*, p.22.

Interpreters, like clinicians, may experience vicarious trauma triggered by particularly sensitive consultations. This presents an occupational health and safety issue, and organisations commissioning interpreting services and interpreting service providers are encouraged to provide formal avenues to address instances of work-related trauma among interpreters, including counselling services for interpreters.[155]

[155] State of Queensland (Department of Communities, Child Safety and Disability Services), (2016). *Language Services Guidelines*, p.15.

ATTACHMENT: PRACTICE TOOLS AND RESOURCES

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