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

COMPETENCY STANDARDS FRAMEWORK FOR CLINICIANS
JANUARY 2019

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- Royal Australasian College of Medical Administrators
- Royal Australasian College of Physicians
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GLOSSARY

In this Competency Standards Framework,

Auslan means the language of the Australian Deaf Community. It is the preferred language of the majority of Deaf Australians. It is a highly visual language using signs, enhanced facial expressions and body language to communicate.

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.[1] 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.[2]

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'.[3]

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, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.[1]

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 interpreting it.[3]

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.[4,5]

Deaf interpreter, also known as a Deaf Relay Interpreter, means an individual who provides interpreting for those individuals who do not use standard Auslan. A Deaf interpreter is usually deaf, fluent in Auslan and written English, and may have additional familiarity with a foreign sign language or pidgin. They may work in tandem with Auslan/English interpreters and can provide a unique language or communication bridge for Deaf individuals whose communication mode cannot be adequately accessed by a standard Auslan/English interpreter.[6]

Health beliefs means a person's beliefs and past experiences that affect the way they view health, causes of illness and treatment.[8]

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.[1]

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.[1]

Interpreter means a practitioner, conveying spoken or signed information from one language into another language,[3] who has obtained certification issued by the National Accreditation Authority for Translators and Interpreters (NAATI)—the national body responsible for setting, maintaining and promoting standards for the translation and interpreting industry through its certification system for translators and interpreters—at one of the following levels:

- Certified Conference Interpreter
- Certified Specialist Interpreter (Health or Legal)
- Certified Interpreter
- Certified Provisional Interpreter
- Recognised Practising Interpreter (for some languages, in which NAATI certification is not available).

All NAATI credentialed interpreters are bound by the Australian Institute of Interpreters and Translators (AUSIT) code of ethics[9] or by the Australian Sign Language Interpreters' Association (ASLIA) code of ethics,[7] respectively, obliging them to maintain impartiality, objectivity and confidentiality.

Language includes Auslan and other sign languages.

Person or people from migrant backgrounds means person or people who are permanent migrants, including first generation (born overseas) and second generation (at least one parent born overseas) Australians, as well as temporary migrants. People from migrant backgrounds include people from culturally, linguistically and religiously diverse backgrounds.

Person or people from refugee backgrounds means person or people with refugee-like experiences, including people who are humanitarian migrants granted permanent or temporary protection, asylum seekers, and permanent or temporary migration program entrants.[10] People from refugee backgrounds include people from culturally, linguistically and religiously diverse backgrounds.

Person, persons or people means those individuals and healthcare consumers who have entered into a therapeutic relationship with a clinician, including patients, their family members and carers.[11]

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 persons and their carers, and is respectful of and responsive to the preferences, needs and values of persons and consumers.[12]

Preferred language means a language most preferred by a person for communication.[13] Preferred language may not be related to country of birth,[8] and may be a language other than English, even where the person can speak fluent English.[13]

Professional with bicultural skills means a professional employed in a range of positions within an organisation, and able and willing to use their cultural skills and knowledge to facilitate communication between the organisation and communities with whom they share similar cultural experiences and understandings. Some professionals with bicultural skills are employed specifically for their cultural skills.[14]

Professional with bilingual skills means a professional who is employed in a range of positions within an organisation, and is not an interpreter, but able and willing to utilise their proficiency in a language other than English as an additional skill. Some professionals with bilingual skills are employed specifically for their proficiency in a language other than English.[15]

Reflexivity means the clinician's ability to understand how their social positions and experiences of advantage and disadvantage have shaped their worldview—including their understanding of own biases and the larger systemic biases that may be embedded in policies and institutional arrangements—and how these can create unsafe environments for specific populations and thereby either exclude people from access to health care altogether, or result in diminished quality of care. Reflexivity informing clinical decisions can lead to improvements in healthcare provision and health outcomes.[16]

Register means a variety of language features used for a particular purpose or in a particular setting, including level (formal vs informal) and field (specialist vs general).

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

Simultaneous interpreting means a mode of interpreting where speech is interpreted while it is being spoken (usually with a delay of no more than a few seconds).[3]

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.[17]

Teach-back method means a way for a clinician to confirm that the clinician explained to the person what they need to know in a manner that the person understands by asking them to teach back directions.[18]

Translator means a practitioner who conveys written information from one language into another language in the written form.[3]

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.[19]

INTRODUCTION

Background to the Competency Standards Framework

As Australia's population becomes more diverse, clinicians increasingly interact with people from migrant and refugee backgrounds. 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. Neglect of culture in health and health care is the single biggest barrier to the advancement of the highest level of health care worldwide.[20]

The review of cultural responsiveness in clinical education, training and standard setting, undertaken by the Migrant and Refugee Women's Health Partnership (the Partnership), found that Australia's peak professional bodies for clinicians overwhelmingly recognise the positive impact that care delivered by clinicians in a culturally responsive way can have upon health access, experience and outcomes of people from migrant and refugee backgrounds.[21] The review also determined that more could be done to further embed cultural responsiveness in curricula and professional competency standards development in clinical education, training and practice.

Development of the Framework

The Framework was developed by the Partnership, a national initiative bringing together health professionals—through their respective peak professional and standard setting bodies—community sector representatives and government 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 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 people with limited English proficiency and working with interpreters in healthcare settings. Another Sub-Working Group provided specialist expertise with regard to working with people with refugee-like experiences and settlement.

The Partnership's work to develop the 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 healthcare system more broadly. Some of the elements of this Framework can serve as applicable practical responses to enable better access, experience and outcomes for both population cohorts. For example, *Annex: Practice points for clinicians working with interpreters in healthcare settings* and other provisions with regard to engaging and working with interpreters are applicable when providing care to Aboriginal and Torres Strait Islander People. However, it is critical that there is a dedicated focus on cultural safety in the provision of care to Aboriginal and Torres Strait Islander Peoples. The scope of this Framework is therefore specific to people from migrant and refugee backgrounds.

Purpose

The Competency Standards Framework (the Framework) establishes recommended and optimal cultural responsiveness competency standards for clinicians in all healthcare settings. The Framework is aimed exclusively at clinicians, and not health service organisations.

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

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

It is proposed that all clinical education, training and standard setting bodies consider and adapt the Framework to meet their respective needs, circumstances and context.

Principles

The Framework is underpinned by the following key principles:

- Person-centred and family-focused care
- Access and equity
- Quality and safety
- Dignity and respect
- Effective communication.

Provision of care that respects and is sensitive to different cultures is essential to the implementation of person-centred health care.[22] Such care is characterised by exploration, empathy, and responsiveness to people's needs, values, and preferences.[23] When working with people 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.[24]

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, some well-recognised barriers to health access may have a cultural dimension that needs to be considered, including cultural beliefs and language. Understanding these barriers to access is key to enabling equity in access to health care, quality of care delivered, experience of health care, and health outcomes.

Overview and format of the Framework

The structure of the Framework is based on the CanMEDS Physician Competency Framework model.[25]

CanMEDS was adopted by the Royal College of Physicians and Surgeons of Canada in 1996 and subsequently updated in 2005. CanMEDS is now used in dozens of countries world-wide in medicine and in other healthcare professions, including in Australia, making it the most recognised and most widely applied health care profession competency framework in the world.

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:

- One or more competency standard(s) and a list of competencies supporting and enabling the standard(s)
- Explanatory notes on the content of each standard, which provide the evidence-based best practice on cultural responsiveness in clinical practice.

The competency standards are to be read and applied with their explanatory notes, and with *Annex: Practice points for clinicians working with interpreters in healthcare settings*, which forms an integral part of this document.

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

Finally, the *Attachment*: *Resources* provides an overview of relevant guidance and documentation for further reference.

OVERVIEW OF COMPETENCY FRAMEWORK DOMAINS

Domain 1: Clinical Expert

Clinicians understand, and respond to, the diversity of individual characteristics and experiences, and ensuing barriers, as part of the provision of quality and safe person-centred and family-focused care to people from migrant and refugee backgrounds.

Domain 2: Communicator

Clinicians adopt effective communication practice to support people from migrant and refugee backgrounds in understanding and making informed decisions about their health, and to facilitate the provision of quality and safe care.

Domain 3: Collaborator

Clinicians work effectively with healthcare professionals and other relevant professionals, including with interpreters as members of a healthcare team, to provide timely, quality and safe care to people from migrant and refugee backgrounds.

Domain 4: Leader

Clinicians engage with their clinical and non-clinical colleagues and lead by example to contribute to the development of culturally responsive organisational and systemic processes that facilitate the delivery of accessible and equitable care to people from migrant and refugee backgrounds.

Domain 5: Health Advocate

Clinicians recognise barriers to access to health care experienced by people from migrant and refugee backgrounds and contribute to improving their health access by supporting enhanced health literacy and health system literacy in migrant and refugee communities.

Domain 6: Scholar

Clinicians are committed to providing evidence-based care, maintaining awareness of linkages between cultural diversity and population health, and facilitate sharing of information and knowledge to promote cultural responsiveness in the provision of care to people from migrant and refugee backgrounds.

Domain 7: Professional

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

DOMAIN 1: CLINICAL EXPERT

> Competency standard 1 –
> Clinicians understand, and
> respond to, the individual,
> cultural and social considerations
> in the provision of quality and
> safe care to people from migrant
> and refugee backgrounds

1.1 Clinicians respond sensitively and without assumptions to the diversity of individual characteristics and social determinants of health—including cultural, religious or spiritual and linguistic considerations, health beliefs, individual abilities, choices and preferences— and modify their approach as appropriate.

1.2 Clinicians recognise the impact of refugee-like experiences, including experiences of traumatic events and post-traumatic stress disorder, and take these experiences into account during the assessment, diagnosis, treatment and ongoing care to modify their approach as appropriate and to provide trauma-informed care.

1.3 Clinicians recognise ethno-specific variations and health disparities of people from migrant and refugee backgrounds.

1.4 Clinicians recognise the family and community context of people from migrant and refugee backgrounds and its impact on consent, treatment and follow up.

Explanatory notes

Diversity of individual experiences and cultural considerations

The 2016 census revealed that nearly half (49 per cent) of Australians were born overseas (first generation Australian) or have one or both parents born overseas (second generation Australian). More than one-fifth (21 per cent) of Australians speak a language other than English at home.[26]

The breadth of Australia's cultural and linguistic diversity requires a provision of care responding to the needs of all in the community—including people from migrant and refugee backgrounds—without discrimination. People from migrant and refugee backgrounds are a diverse group, and their state of health and access to health care can vary widely between different cultural and population groups.

Migration and ethnicity-related factors should be acknowledged as significant social determinants of health[27] that also intersect with, and impact upon, many other social determinants of health, including housing, education, and income and employment. Health disparities among people from migrant and refugee backgrounds are also related to prior environments, specific population-based risks, disproportionately higher disease burdens, and communication barriers.[28,29] Collectively, the social determinants of health of people from migrant and refugee backgrounds may contribute to deteriorating physical and mental health over time, and should be monitored as indicators of overall health and wellbeing.[30,31]

Cultural considerations—which may be influenced by ethnicity, religion, sexual orientation, gender, socio-economic factors, disability or age,[28] pre-migration experiences, migration status, and experience of trauma[32]—should be incorporated into care,[33,34] as they may impact on a person's:

- understanding and acceptance of health information
- understanding of health and illness
- access to health care
- response to healthcare interventions.[28,35]

For example, perception of pain (e.g. related to childbirth) may stem from cultural, spiritual or socio-environmental factors.[36] Similarly, religious and cultural considerations may inform the person's preference for gender concordance with their clinician.

Insensitivity regarding cultural expectations and failure of clinicians to acknowledge, understand, and manage sociocultural variations in the health beliefs and behaviours of people they work with may:

- impact negatively on the person's experience
- affect trust[37]
- lead to the person experiencing anxiety and apprehension about accessing health care[38]
- impede effective communication
- lead to the person's dissatisfaction and non-adherence to health advice[39]
- result in unsafe use of medicines[40]
- lead to failures with regard to obtaining consent[41]
- contribute to poorer health outcomes.[37]

However, clinicians making cultural assumptions also risk misinterpretation and can lead to negative outcomes.[38] It is important that clinicians are responsive to individual needs and preferences, and provide care without presumptions—while remaining aware of, and sensitive to, the impact of cultural considerations. Clinicians should respect and acknowledge individual values, beliefs and behaviours to support shared decision-making[42–44]—and to ensure customised and quality care[45] to meet individual needs and preferences.[46]

Clinicians should be aware of, and acknowledge, their own skills limitations and the impact of their own cultural values and beliefs to provide care in a way that reflects an understanding of the diversity between and within cultures.[47]

Clinicians should seek to adopt the explanatory model of care when providing care in cross-cultural settings and to elicit the person's understanding of illness and their condition.[43] This includes working with people and, where appropriate, their families to understand what matters most to them in the experience of illness and treatment. When working with people from migrant and refugee backgrounds, clinicians should recognise the person's ability to inform the clinician of how they choose to interact, and how their personal cultural and health needs intersect.

Impact of refugee-like experiences

People from refugee backgrounds—including those seeking asylum and other migrants with refugee-like pre-migration experiences—are a particularly vulnerable group.[48] They 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
- level of impoverishment and education.[28]

These experiences can have an impact on individuals' health and mental health status, their understanding of health issues and ability to adhere to treatment options, as well as access to, and experience of, care. People from refugee backgrounds may also experience communication issues, beyond language, requiring support from speech pathologists. There is a risk of re-traumatisation in the absence of trauma-informed approaches to care.[19] Further, experiences of trauma and depression can have an impact on an individuals' capacity to give a coherent history.[49,50] Therefore, 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.

Post-migration aspects of resettlement and acculturation can be difficult, resulting in people from refugee backgrounds—particularly those seeking asylum—often having increased rates of mental health conditions, such as anxiety, depression and post-traumatic stress disorders.[42,51–54]

Clinicians should consider the following individual situations and experiences:

- current or past experiences of immigration detention, including both held detention (i.e. detention centres), as well as community detention (indefinite in nature; severely restricts individuals' movement, their opportunities to reunite with family, their prospects of economic and/or social participation; and increases the risk of cumulative trauma and complex post-traumatic stress disorder)
- temporary protection status, which prolongs uncertainty for individuals and families about their status, the prospect of forced return to their country of origin, or removal to detention upon visa expiration. Temporary protection status may also result in feelings of isolation and guilt due to the inability to reunite with family members overseas who may be exposed to danger.

Health disparities

Factors contributing to health disparities of people from migrant and refugee backgrounds are multi-faceted and include:

- risks related to pre-migration environments (e.g. resource-poor situations, limited access to health care and screening, infectious diseases, nutritional deficiencies, anaemia, undiagnosed or untreated chronic illnesses, low immunisation rates)
- population-based risks (e.g. thalassaemia, diabetes mellitus)[29,55,56]
- settlement factors (e.g. mental health conditions)[51,57]
- exposure to injuries (e.g. female genital mutilation in some countries, trauma, civilian exposure to war).

Identifying and addressing any risk factors associated with a person's migration or refugee-like experience requires a person-centred, risk-based approach rather than universal screening for selected conditions.[42] Investigations for clinical conditions should be tailored to an individual's risk factors, source and transit countries, migration and social history, and examination findings.[42] However, a universal precautions approach to pre-migration trauma is recommended when caring for people from refugee backgrounds.[58]

Clinicians should know how to access evidence-based information addressing clinical risks specific to people from migrant and refugee backgrounds and the local population by analysing their health service organisation's patient data and publicly available information,[59] and accessing resources about ethnic communities, their histories and specific health issues as a context for understanding culture, religion and health interactions.[47]

Family and community context

Many people from migrant and refugee backgrounds come from collectivist communities in which healthcare decisions are shared decisions that involve family and community, contrary to the individualist approach.[60]

Clinicians should recognise the vital role of family when working with people from migrant and refugee backgrounds, and consider that:

- family members may need to be involved in discussions about health-related issues and decisions[60,61]
- obtaining consent may need family involvement beyond giving family information about the person's procedure because—in some cultures—the family needs to agree to the procedure, or older people may rely on family members for decision-making.

If a family member has an ongoing role in the day-to-day care of the person, it is generally advisable to include them in the person-clinician partnership and decision-making, including with regard to advance care planning, with the agreement of the person (if the person is able to give such permission).[59]

Involving family in decision-making processes can be complex. It may require clinicians to navigate family relationships and influences when planning care, including time management, appointments, screening, assessment and provision of care. It is also important to consider and support the capacity of the family to participate in the person's care[62] (e.g. their involvement in decision-making).

Competency standard 2 – Clinicians understand, and respond to, barriers to quality and safe care experienced by people from migrant and refugee backgrounds

2.1 Clinicians acknowledge and address barriers to discussing the risks and benefits of a proposed procedure, and obtaining informed consent.

2.2 Clinicians acknowledge and address barriers to quality use of medicines and ensure education about medication safety.

Explanatory notes

Informed consent

Consent for any procedure requires the person to be:

- 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
- able to raise any concerns about risks of particular relevance to them.[63]

Communication barriers between clinicians and people from migrant and refugee backgrounds may impact on the person's genuine understanding of the nature and effects of the procedure and their ability to access sufficient information and discuss alternatives, resulting in lower rates of appropriate informed consent obtained in healthcare settings.[41]

As a minimum, clinicians should:

- assess the person's understanding of the information provided to consent to treatment, taking into consideration both the complexity of the issues and the individual's English language proficiency
- engage an interpreter for people with limited English language proficiency.[64,65]

Safe use of medicines

For many people from migrant and refugee backgrounds, the safe use of medicines is affected by language and communication barriers, cultural factors, financial barriers, limited health literacy and health system literacy.[40] People with limited English proficiency are at greater risk of medication-related harm.[66]

Therefore, quality use of medicines for people from migrant and refugee backgrounds may require clinicians to:

- ensure effective communication when starting, or changing the dose of, a medicine
- consider the use of traditional medicines and other medicines that are being taken and potential side effects,[67] noting that clinicians' understanding of the use of traditional medicines and healing methods may facilitate mutual respect between the clinician and the person
- explain possible adverse effects, risks and benefits of each medicine
- consider the cost implications for individuals and financial assistance options
- provide clear instructions about dosage and delivery route for the medicines
- inform about the safe storage and disposal of medicines
- explain that medicines should not be shared with other family members and friends
- utilise various communication options, such as explanations and demonstrations, regarding therapeutic devices
- explain difference between medication for acute and chronic conditions.

Competency standard 3 – Clinicians are aware of medico-legal responsibility in ensuring effective communication when working with people with limited English proficiency and deaf people from migrant and refugee backgrounds

3.1 Clinicians understand the medico-legal risks of:

- failing to determine the need for an interpreter;
- failing to engage an interpreter, if assessed as necessary, even if the person does not request an interpreter; and
- failing to respond appropriately if the person refuses an interpreter.

3.2 Clinicians understand the medico-legal implications of failing to engage an interpreter especially when:

- assessing the decision-making capacity of the person;
- obtaining consent for a procedure; and
- starting or adjusting complex medications.

3.3 Clinicians do not engage minors and do not rely on family members, intimate partners, friends, and web-based translation applications to facilitate interpretation.

Explanatory notes

Responsibility to determine the need for an interpreter

Clear and effective communication underpins every aspect of good clinical practice.[11,24,68] Clinicians must ensure the person understands the discussion that takes place and the proposed care.[59]

Failure to determine the need for, and engage, an interpreter in consultations with people with limited English proficiency or Deaf people may be considered to be a breach in duty of care.[69–73]

Engaging interpreters in healthcare settings has been found to improve the delivery of preventative and primary care[74] and improve the person-centeredness of primary care encounters.[75]

Engaging interpreters is recognised as a best practice[76] and has been found to:

- decrease communication errors[77]
- increase the person's comprehension[77]
- improve the delivery of person-centred care in healthcare settings[74,75]
- reduce unnecessary tests and treatments[78]
- improve clinical outcomes[77]
- raise the quality of care to the same level as that for people without language barriers[77]
- improve the person's satisfaction associated with improved understanding of self-care and follow-up plans, reduced errors and better treatment adherence[77-79]
- largely improve the healthcare provider's satisfaction.[79]

In the event that an interpreter is not available, clinicians are responsible for assessing the risks of proceeding with the consultation without an interpreter as opposed to the risk of rescheduling the appointment to allow time to engage an interpreter.

In case of an emergency and when an interpreter is not available, this must be noted in the patient record and an interpreter should be engaged as soon as possible to ensure accurate information is communicated.[80]

If the person refuses an interpreter, the clinician should:

- address the person's concerns (e.g. confidentiality, gender-concordance or cost considerations)
- discuss the risks associated with misunderstandings or miscommunication
- inform the person that engaging an interpreter is of benefit to the clinician as much as to the person, and that family members can still be involved as support persons.

If the person still refuses an interpreter, or a particular interpreter, the clinician must document the discussions and outcome in the person's medical record.[80]

Risks in complex assessments

Clinicians should recognise the following three high-risk areas where a low threshold should be used for determining if an interpreter is required:

- assessing the person's competence to make decisions
- obtaining consent
- starting or adjusting medication.[81,82]

(1) Assessing the person's competence to make decisions

When working with people from migrant and refugee backgrounds, clinicians should ensure that they determine the need for an interpreter to facilitate communication while assessing the person's decision-making capacity. Assessing decision-making competence involves assessing a person'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.[83] A person's competence to decide is dependent on their own immediate context (illness, delirium, stress), and is evaluated specifically in relation to the clinical decision that needs to be made. Declines in the person's competence may be under-recognised, even when the clinician and the person speak the same language.[84] A temporary or permanent decline in decision-making competence in an elderly or psychologically unwell person may be missed with ad hoc individuals facilitating interpretation who sometimes compensate for, or 'fill in', limitations in comprehension demonstrated by the person.

(2) Obtaining consent

The clinician's duty of care includes clearly explaining the benefits and potential harm of specific clinical treatments and the consequences of not following a recommended management plan.[59,64] Engaging an interpreter is essential for obtaining informed consent from individuals with limited English proficiency or Deaf people from migrant and refugee backgrounds.

Consent may not be valid if it is obtained through third parties, including the person's family members, or professionals with bilingual skills facilitating interpretation.[80] These individuals' lack of interpreting competence and the possible breach of confidentiality or conflict of interest may render them inappropriate facilitators of interpretation.[85] There is particular risk of misleading information and miscommunication occurring when engaging family members or friends as facilitators of interpretation.[41] Minors should never be engaged to obtain consent from their parents for procedures.[86]

(3) Starting or adjusting medication

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

- Starting or changing the dose of high-risk medicines (e.g. anticoagulants, insulin, opioids, chemotherapy, digoxin and other medications with a narrow therapeutic range[87])

- Starting a medication that requires the use of therapeutic devices (e.g. spacers or injecting devices) that need to be explained by the clinician

- In situations where people are taking multiple medications or multiple daily doses, or their doses have been changed by other clinicians, or in another health service organisation.

Responsibility not to engage minors as facilitators of interpretation

Engaging minors to facilitate interpretation poses a number of ethical dilemmas, including undermining the parent's authority and potentially affecting family dynamics. Certain topics are out of bounds in some cultures and may result in breach of confidentiality and privacy for the parent.[88] Further, enormous emotional burden is placed on minors when facilitating interpretation for a parent about a serious or even terminal illness. In some situations, this may lead to further trauma for the minor, including negative emotional and psychological well-being.

Importantly, minors from migrant and refugee backgrounds may be fluent in English but not necessarily in their parents' first language and languages. Their knowledge of clinical terminology 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 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 hospital stay, or possible fatal outcomes.[72]

Risks of relying on family members, intimate partners, friends, and web-based translation applications as facilitators of interpretation

Clinicians must consider the potential ethical, professional and legal consequences and significant adverse outcomes of permitting personally involved individuals, including family members and intimate partners, to facilitate interpretation.[89] Failure to engage interpreters and, conversely, inappropriate engagement of family members to facilitate interpretation can lead to risks of harm[41] due to communication errors.[78]

Risks which could lead to inappropriate clinical decisions being made include:

- inaccurate and inadequate interpretation due to lack of interpreting skills, subject matter knowledge and specialised medical terminology

- inappropriate behaviour due to lack of professional ethics

- possibility of information being withheld or distorted because of family relationships; in view of potential family, domestic or intimate partner violence situations; or due to the emotional and sensitive nature of the health issues

- undermining the clinician's confidence that the necessary information is being communicated appropriately

- compromising confidentiality

- causing potential trauma to family members.

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 person's trust in their clinician, or lead to clinical errors. Web-based translation applications cannot be relied on for accuracy and pose a risk to the person's rights and health and safety.[90] Noting the risks, consideration may be given to using such applications in limited instances and in low-risk situations (e.g. in triage areas) as a short-term measure until an interpreter is engaged.

DOMAIN 2: COMMUNICATOR

Competency standard 4 –
Clinicians understand the
impact of linguistic differences
on communication and
respond to communication
needs of people from migrant
and refugee backgrounds

4.1 Clinicians respect people's right to communication assistance and ensure that an interpreter, appropriate to the person's language and gender-concordance preferences (including a Auslan/English or a Deaf interpreter), is engaged when assessed as necessary or requested by the person.

Explanatory notes

Assessing interpreter need and requirements

In the 2016 census, over 3.5 per cent of Australia's population have indicated that they do not speak English well or at all. This figure increases to 5.6 per cent for people aged 65 and above.[91]

Limited English proficiency presents major obstacles to access.[92] People with limited English proficiency tend to have inadequate access to care and preventative services, and are likely to suffer more frequent and severe adverse effects in hospital.[41] Quality of care is compromised when people with limited English proficiency require interpreting assistance but do not receive it.[78]

Importantly, language and communication barriers include the communication capacity of both the person and the clinician and are among the most serious obstacles to quality care.[27,93] Ineffective communication between the person and the clinician can result in limited, delayed, inefficient care,[70,94–96] leading to subsequent need for more costly treatment and intervention, as well as negatively impacting the person's understanding of, and trust in, the healthcare system at large. Both the person and the clinician may wish to have an interpreter available for communication support in a consultation.[11,24]

Clinicians should err on the side of caution when assessing whether an interpreter is needed.[97] A person's ability to engage in a general conversation in English is not a measure of their capacity to discuss and understand health related matters. People 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.[98,99] Even when complex terminology is not being used, health concepts require a sophisticated understanding of language, especially if the person is to have the opportunity to interrogate the information adequately and understand the impact of the health condition on their life. Further, people 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). The fact that a person, or their family member, does not request an interpreter does not mean that one is not required to assist with communication.[97]

In addition, clinicians should recognise that Deaf people from migrant and refugee backgrounds who use Auslan or another sign language require an Auslan/English interpreter or a Deaf interpreter.

When assessing the need for an interpreter, it is important to be aware of possible changes in the person's circumstances. 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.[73]

An interpreter should be engaged when the person requests one, even if the clinician does not consider one is required.

Engaging an interpreter

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. It is important to have necessary arrangements in place with an appropriate language service provider. Interpreters can be engaged either in person or via telephone, depending on circumstances. Engaging interpreters over telephone is particularly appropriate in regional and remote areas.

In requesting an interpreter, clinicians should consider the person's ethnicity, religion, language or dialect, and preference for gender of the interpreter.[82] The interpreter's ethnicity and religion may be important to some people, in view of a perceived bias if the interpreter is from an ethnic group which is or has been in conflict with the person's ethnic group.[82] Some people may request the same interpreter throughout their care or have preference for an interpreter of the same gender. This is particularly likely to occur in consultations related to sexual and reproductive health or, in some cases, mental health, and may be a high priority in people from some cultural backgrounds. In gender-discordant consultations, where the clinician and the person are not of the same gender, engaging a gender-concordant interpreter can improve the person's satisfaction with the consultation.[100] When the available interpreter is of a different gender than the person's preference, the person should be informed and telephone interpreting should be offered instead.

People from migrant and refugee communities may prefer interpreting services over the telephone, even when an interpreter is available in person, due to their confidentiality concerns if it is likely that the interpreter is from the same small and tight-knit community.[101] Telephone interpreting may also be preferred if the consultation involves a sensitive topic, such as mental or sexual health, and particularly if the available interpreter is of the opposite gender. Engaging a telephone interpreter, especially one from a different jurisdiction, can reduce confidentiality concerns for people with particularly sensitive issues.[102]

It may not be possible to accommodate all individual preferences with regard to interpreter requirements (e.g. ethnicity or religion), in view of language service provider policies. However, understanding people's concerns and informing them of available options, while clarifying the role of interpreters as facilitators of communication who are bound by confidentiality and impartiality, helps build trust and effective partnerships.

Competency standard 5 – Clinicians understand the impact of cultural and linguistic differences on participation of people from migrant and refugee backgrounds in their care and support their informed decision-making

5.1 Clinicians provide clear, accurate, culturally appropriate and timely information in appropriate formats to enable people to understand the health issues being discussed, including the diagnosis, management and recommended follow up.

5.2 Clinicians recognise that people may require involvement of their families in managing their health issues and provide adequate information to those whom the person wishes to include in their care.

5.3 Clinicians gather feedback from people in an appropriate manner and recognise the impact of language, literacy and cultural considerations on the person's participation in their care.

Explanatory notes

Impact of cultural considerations

Cultural considerations, as well as a person's religious and spiritual beliefs, are varied and may influence people's:

- health beliefs, including their understanding and acceptance of health, illness and healthcare interventions; notions of health problems; and realisation they may need professional help

- help-seeking behaviour, including their threshold for seeking help and the forms of help they regard as appropriate; stigma and social anxieties about disclosing or discussing certain health topics[27] (e.g. end-of-life, maternity and sexual health care are strongly culturally embedded[103] and there may be cultural stigma surrounding mental health and cancer).

Health beliefs and help-seeking behaviours of people from migrant and refugee backgrounds may diverge widely from those of the broader population,[56] and can impact on factors such as:

- the person's knowledge of the healthcare system and capacity to navigate it
- their understanding of healthcare consumer rights
- participation in their own care
- their ability to locate the necessary information and negotiate the required care.[104]

Factoring these considerations into the provision of care can enhance the communication with people from migrant and refugee backgrounds.[105]

Informed decision-making

Clinicians should consider language, literacy and health literacy when working with people from migrant and refugee backgrounds.[106] Lack of capacity to communicate effectively in healthcare settings and low levels of general and health literacy affect a person's ability to assess the information provided and to reach a decision. Misunderstandings can compromise care, while clear and effective clinician-person communication is linked to the person's satisfaction, adherence to clinical instructions, and health outcomes.[107,108]

During a consultation, people from migrant and refugee backgrounds experiencing language barriers and/or low health literacy may fail to provide the clinician with relevant information, and lack the confidence necessary to be active participants in the shared decision-making process.

People may have culturally-bound views of the clinician-person relationship, expecting the clinician to make decisions for them. This often leads to people becoming confused when given an opportunity to participate in decision-making and trying to direct the decision-making responsibility back to the clinician.

In addition to assessing the need for an interpreter to facilitate communication and assessing the person's understanding, clinicians should also take into account the person'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[43] and the teach-back method[18] to ascertain whether the person has understood the information provided.

Provision of quality information facilitates decision-making and supports an active role for people in managing their own health, leading to improvements in health outcomes[35] and health access.[109] Clinicians should know how to access a directory of evidence-based or best practice resources, visual and written aids, pictograms, online tools and websites for clinicians to provide to consumers in plain English or in languages other than English.[59] The tools and resources should enable people to understand, question, assess and actively participate in the health issues being discussed, including the diagnosis, management and recommended follow up.

If providing written material, the clinician should ascertain whether the person is able to read and understand the information. While written communication is useful, relying exclusively on non-verbal communication is inadequate, as people from migrant and refugee backgrounds may have limited literacy and numeracy in English or in their first language, limiting the effectiveness of written or translated resources.[110] Similarly, pictogram instructions for medicine use can be misinterpreted by people with low literacy,[111] especially in cross-cultural settings.

Providing information to people in a manner and a language they can understand allows them to participate in the decision-making, provided they are able and willing to do so, and to understand the health implications from their cultural perspective, rather than based on the clinician's framework.

Equally important is providing time for the person to consider the information with their family or community involvement, if important to them.

Verifying understanding

People have a right to understand the information and recommendations they receive from their clinicians.[112] This can be achieved by clinicians demonstrating respectful and culturally responsive two-way communication practices focused on information exchange.[47]

In addition to considering the person's linguistic background and the need to engage an interpreter to check that the person understands everything they have been told,[59] the clinician should consider the person's cultural background and how it may impact the person's understanding of health concepts (e.g. in some communities, health equates to experiencing happiness rather than losing weight to reduce obesity).

An effective way to confirm understanding is the teach-back method whereby the clinician asks the person to explain in their own words what they have been told.[18,113]

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 person.[114]

Feedback

There are a range of factors that can impact on the capacity or the willingness of people from migrant and refugee backgrounds to provide feedback or to complain, including language, health literacy and cultural norms. Certain feedback and complaint mechanisms, such as rating scales, may not be commonly used in certain cultures, and alternate avenues for feedback should be considered that are culturally appropriate.[47]

Both formal and informal feedback interactions are important. Feedback should be sought without assumptions, while ensuring dignity and respect.

People should be informed about their right to provide feedback or to complain, and the mechanisms for doing this should be clear and easily accessible. This may require documentation and resources to be translated, or for interpreters to be involved to discuss this information.

DOMAIN 3: COLLABORATOR

Competency standard 6 – Clinicians collaborate with other healthcare professionals within the health service organisation and across networks

6.1 Clinicians undertake effective handover of care, through both verbal and written communication, including information about relevant individual cultural and linguistic considerations, needs and preferences.

6.2 Clinicians build and use referrals—across community health and allied health sectors— to support the provision of quality and safe health care.

Explanatory notes

Handover of care

For some people from migrant and refugee backgrounds, providing a comprehensive history can be traumatic and culturally difficult, resulting in their hesitation to repeat the same sensitive information to a new clinician. To reduce unnecessary distress, it is important that the information is documented in a comprehensive, accurate and timely manner. When clinical care is transferred, the information that is handed over should be complete,[57] ensuring a comprehensive person-centred approach to quality and safe health care.[115] This includes information regarding cultural and linguistic considerations when working with the person.

Providing information beyond clinical requirements, including general individual information and migration and social history, may facilitate the continuity of culturally responsive care and contribute to building a person's trust in the healthcare system.[116]

Community health and allied health networks

Provision of culturally responsive care is a shared responsibility requiring partnerships across the health and human services, using systematic, evidence-based and sustained approaches,[117] and clinicians should seek to secure partnerships across sectors to share learnings and amplify benefits of other health strategies. Multi-sectoral networks, including with the community health and allied health sectors, support better coordination and integration of healthcare services.

Community health and allied health networks offer a wide variety of services and some are specialised in the particular needs of people from migrant and refugee backgrounds. Where possible, at-risk people should be referred to a culturally appropriate community resource or a specialist service that is best suited for the person (e.g. culturally sensitive education or intervention for drug and alcohol related problems; mental health related care,[47,57] occupational therapy assessment and intervention regarding the life skills required in the new setting,[118] or a long standing physical or mental health disability as it affects function in the new setting[119]). Further, collaboration between clinicians and pharmacists can support quality use of medicines.[40]

Clinicians may need to advocate for individuals within the healthcare system to enable them to access timely care. This may involve ensuring that all referrals include information about the person's language needs in order to facilitate the engagement of an interpreter for the consultation.

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

7.1 Clinicians recognise the role of interpreters in healthcare settings, including their skills, responsibilities and scope of practice.

7.2 Clinicians work effectively with interpreters, following *Practice points for clinicians working with interpreters in healthcare settings* (see Annex 1).

Explanatory notes

Interpreter's role and scope of practice

Clinicians should not request or expect interpreters to:

- assess any of the person's abilities, except for their linguistic abilities
- make a judgment as to the competence of the person or establish the person's understanding
- act as a chaperone for clinical examinations
- act as a professional with bicultural or bilingual skills, a carer or a health advocate for the person.

Interpreters relay the messages uttered by all parties as accurately as possible, without adding or omitting content or attempting to correct the person's style or grammar. This includes maintaining the person's tone of voice, style and manner of speech when interpreting into English (e.g. for people with mental illness who speak in incoherent ways), as well as maintaining the register of all parties' utterances.

Interpreters maintain and observe professional boundaries, and do not overstep their role to explain or to establish understanding.[9] 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 person to repeat what they were told to make sure that they understood.[120]

If the interpreter recognises a potential cross-cultural misunderstanding, or comprehension or cognitive difficulties on the part of the person, the interpreter may raise it with the clinician to allow the clinician to take appropriate steps with the person, such as rephrasing, clarifying, or asking further questions.[121]

While there are circumstances where it may be useful to engage a chaperone when working with a person, interpreters are not trained for this purpose, and acting as a chaperone would conflict with their impartial role.

An interpreter works within the consultation. It is not their function to act as a professional with bicultural or bilingual skills or a health advocate (e.g. an interpreter should not be expected to accompany a person beyond the consultation to assist at the local pharmacy). Similarly, clinicians should avoid engaging a professional with bicultural or bilingual skills or a health advocate to act as an interpreter as they are not qualified for such a role.

Translation and sight translation

Non-English speaking or Deaf people from migrant and refugee backgrounds may also be unable to read or write in English, and some may be illiterate in their own language. This makes filling out healthcare forms or questionnaires challenging. However, on-site interpreters should not be asked to provide written translations of material or fill out forms or questionnaires on behalf of the person. They are not always certified as translators and cannot provide translations of documents. Clinicians should request that such material be translated, if possible in advance, by a certified translator through a relevant translating service.

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

Alternatively, when necessary, an on-site interpreter may be asked to provide sight translation of written information (e.g. clinical instructions or letters related to the person's clinical history), thereby transferring a message written in one language into a message delivered orally in another language.[122] Sight translations must take place in the presence of the clinician, or their clinical and non-clinical colleagues. However, sight translation should be used sparingly and for brief documents only (200–300 words), and interpreters should not be required to sight translate consent forms, complex medical reports or documents with extensive information on conditions, procedures, options of treatment and risks.[121] Long, complex or technical documents—including documents associated with a person's participation in a clinical trial—are not suitable for sight translation and warrant written translation.

Practice points for working with interpreters in healthcare settings

The *Annex* is an integral part of this document and provides important evidence-based good practice points for clinicians working with interpreters in healthcare settings.

DOMAIN 4: LEADER

Competency standard 8 – Clinicians contribute to whole-of-organisation cultural responsiveness

8.1 Clinicians lead the creation of culturally responsive and accessible environments by informing whole-of-organisation practices that:

- recognise and respond to cultural differences in the provision of care;
- enable community input; and
- collect relevant data.

8.2 Clinicians promote a whole-of-organisation use of interpreting services by informing persons about their right to access interpreting services, and by ensuring that their clinical and non-clinical colleagues have information about:

- when an interpreter may be required;
- how to arrange for an appropriate interpreter; and
- the importance of documenting the need for an interpreter in the patient management system once the need is identified.

Explanatory notes

Culturally responsive environments

A culturally responsive environment is facilitated by whole-of-organisation practices that are considerate of people's rights, beliefs, and religious and cultural backgrounds when providing health care. As part of their commitment to the continual enhancement of their cultural responsiveness and the promotion of systemic change, clinicians should incorporate cultural responsiveness in every aspect of their practice and share these values with their clinical and non-clinical colleagues. Gaining skills in cultural responsiveness increases an organisation's ability to provide quality care that is equitable, respectful of a person's culture and beliefs, and that is free from discrimination.[59,123]

The creation and development of culturally responsive environments is supported by forming partnerships with local community groups and encouraging their input to inform the provision of health care.[27] Clinicians play an important role in identifying opportunities to establish such partnerships to inform whole-of-organisation practices,[60] and facilitate reciprocal relationships and trust with the local communities. Views and experiences of people from migrant and refugee backgrounds can inform the provision of care that is more accessible and appropriate.[124]

To implement a culturally responsive health service, it is essential for an organisation to understand the diversity of people from migrant and refugee backgrounds and identify their characteristics, including the individual's general information, and their migration and social history.

Data on people from migrant and refugee backgrounds, as well as on the diversity of the local population, contributes to the planning of a culturally responsive environment. It may be used to ensure that the person's needs, beliefs and preferences are taken into account during a consultation or procedure, or when choosing a treatment option. Clinicians should ensure that information about a person's cultural needs and preferences is included during history taking, and that the person is advised that the information helps the clinician to provide culturally responsive care.[59]

Use of interpreting services

Clinicians should ensure that people are informed of the interpreting services that are available to them when accessing health care, as well as collecting medication from a pharmacist, and that services are:

- provided by certified interpreters
- free for the person
- confidential.

The requirement to engage an interpreter may need to be determined outside of the person's encounter with the clinician, including when communicating with the clinician's clinical and non-clinical colleagues or making an appointment. Clinicians must ensure that their colleagues have guidance on how to assess when a person is likely to need an interpreter (i.e. when the person is unable to communicate effectively in healthcare settings due to having limited English proficiency or being Deaf) to enable an interpreter to be arranged in a timely fashion.

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

- whether an interpreter was provided when requested or identified as needed
- the person's preferred language
- the person's preferred gender of interpreter.

This information should be used to alert the clinician and colleagues of the need to request an interpreter for all future consultations.

DOMAIN 5: HEALTH ADVOCATE

Competency standard 9 –
Clinicians contribute to
enhancing health literacy
and health system literacy
of people from migrant
and refugee backgrounds

9.1 Clinicians incorporate health literacy,
preventative health education, and health
system literacy in their work, taking into
account relevant individual cultural,
linguistic and literacy considerations,
as well as pre-migration experiences.

9.2 Clinicians support migrant and refugee
communities to facilitate community-led
health literacy and preventive health activities
by actively seeking community insights on
their needs and by contributing to appropriate
responses, including education and resource
development.

Explanatory notes

Health literacy and health system literacy

People from migrant and refugee backgrounds face
greater challenges in accessing health care due to
a range of cultural and communication barriers,
exacerbated by systemic barriers, including visa class,
finance and transport.[125] Their health beliefs and
help-seeking behaviours, views on health, notions
of health problems and appropriateness of seeking
help (and in what form) may diverge strongly from
those of clinicians and the broader population.[56]
More generally, cultural beliefs and language,
among other factors, can influence a person's
health literacy.[106] People whose first language is
not English may have more difficulty understanding
English-based health information. Around a quarter of
Australians aged 15–74 years who spoke English as a

second language was found to have adequate health
literacy compared with 44 per cent of people whose
first spoken language was English.[126]

Individual experiences can impact on the person's
knowledge of the healthcare system and capacity
to navigate it, including their understanding of
their rights as consumers in the healthcare system,
i.e. their health system literacy. Some people may
need assistance to navigate Australia's healthcare
system as they may have differing perceptions or
misconceptions of the health system or limited
experience with different actors in the system.
They may require assistance to locate the necessary
information and negotiate the required care.[104]
Some people may come from countries with minimal
primary care services, or where services delivered
within the community are of limited quality.[42]

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 people. Many individuals do not
understand their right to confidentiality within clinical
encounters and that interpreters are trained in issues
of confidentiality.

Clinicians should evaluate access to health care
for people from migrant and refugee backgrounds,
as well as relevant risks and barriers, and recognise
disparity in the access and utilisation of health
services experienced by migrant and refugee
populations with a particular emphasis on rural,
low socio-economic and high need communities.[123]

Clinicians should identify and manage factors that are
barriers to access and continuity of care, including
by focusing on effective communication with people
from migrant and refugee backgrounds. Adopting
the explanatory model of care and informing people
about the Australian healthcare system and the role
of primary care can contribute to improved access
to preventive and appropriate health care.

Strategies can include using visual and written aids, translated resources and teach-back techniques to improve communication, understanding and health literacy.[127] In this regard, it is important to recognise that some people 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.[110]

Working with the community sector

Communities should be recognised as their own cultural experts and best placed to lead the development of strategies to address their community needs, including the development of health information.[60]

Clinicians should adopt a multi-faceted approach to providing care involving people, their families and, as necessary and appropriate, the broader community.[128] As such, it is important for a clinician to understand the demographics of the local community, the diverse groups served by their health service organisation, 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.[60]

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, as appropriate, to communicate effectively and in a culturally responsive manner with people and their families, and to provide them with support according to their cultural needs (e.g. community leaders can be engaged as trusted sources of information to facilitate education on quality use of medicines[40]).

DOMAIN 6: SCHOLAR

Competency standard 10 – Clinicians are committed to incorporating education about meeting the healthcare needs of people from migrant and refugee backgrounds in the provision of care and in their continuing learning activities

10.1 Clinicians continually learn and develop cultural responsiveness, including learning how to work effectively with interpreters, by attending courses, in-service programs and reading journals, and by demonstrating awareness of practical, informed and quality data and research regarding cultural diversity demographics and population health.

10.2 Clinicians maintain ongoing practice innovation through the use of resources, including technology, to facilitate the provision of culturally responsive care to people from migrant and refugee backgrounds.

Explanatory note

Continuous cultural responsiveness learning

Developing cultural responsiveness in one's clinical practice is an ongoing process.[129,130] Clinicians should embrace and develop cultural responsiveness in their work,[35] and continuously 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.[131]

Clinicians should seek to understand the demographics and cultural backgrounds of their local communities, their histories and specific health issues as required,[59] while maintaining flexibility and responsiveness when working with new and emerging communities for which little formal evidence exists, and recognising that there are intra-cultural and inter-cultural variations. Clinicians should facilitate sharing of web-based resources that encourage good practice and basic community-specific information relevant to cross-cultural health promotion.[60]

Technology to facilitate culturally responsive care

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

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

Competency standard 11 – Clinicians are committed to teaching others about the provision of culturally responsive care

11.1 Clinicians contribute to improving the cultural responsiveness of the profession, both within their own discipline and interprofessionally, through modelling appropriate conduct, teaching students, peer learning, review and practice support.

Explanatory notes

Commitment to improving cultural responsiveness in the profession

As part of their commitment to continuous education with respect to cultural responsiveness, health disparities, inequalities, and the overall performance of the health system,[123] clinicians should increase their cultural responsiveness and the cultural responsiveness of their professions by:

- facilitating teaching and learning approaches that promote cultural responsiveness[132]

- participating in cross-disciplinary forums that encourage information, skill-sharing, support and awareness of the value of increasing cultural competency

- promoting opportunities to improve or introduce cultural responsiveness into existing practices,[60] while avoiding clichés and stigma.

DOMAIN 7: PROFESSIONAL

Competency standard 12 – Clinicians are committed to cultural responsiveness, reflexivity and self-awareness in all aspects of practice

12.1 Clinicians develop and maintain an awareness of their own culture, beliefs, values and biases, and their impact on the clinician's interactions in healthcare settings.

12.2 Clinicians recognise the presence, and understand the impact, of systemic biases in institutional policies, resource allocation, and laws.

12.3 Clinicians adhere to high ethical standards and are committed to the principles of:

- person-centred and family-focused care;
- access and equity;
- quality and safety;
- dignity and respect; and
- effective communication

when providing culturally responsive care to people from migrant and refugee backgrounds.

Explanatory notes

Clinicians should respect the influence of culture on the healthcare decisions and choices of people from migrant and refugee backgrounds, be aware of their own cultural values and beliefs, and reflect on their own cultural background and how that influences their interactions. Clinicians should have the capacity to use reflection to self-assess their ability to provide flexible and responsive care to people from different cultures and to interact in a manner appropriate to that person and their culture.[133]

Clinicians should seek to minimise culturally insensitive practices that negatively impact health outcomes, such as bias, inadequate communication, prejudices and limited cultural knowledge.[130]

Clinicians should recognise the autonomy of people from migrant and refugee backgrounds over their care, and respect the influence of their culture on their healthcare decisions and choices.

ANNEX: PRACTICE POINTS FOR CLINICIANS WORKING WITH INTERPRETERS IN HEALTHCARE SETTINGS

> Practice point 1: 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

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 person in 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.[82] 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 consultations (e.g. if the person has a speech defect[121]), sensitive or difficult consultations (e.g. a mental health consultation, palliative and end-of-life consultations, delivering bad news), or in situations where additional occupational risks for the interpreter may be anticipated (e.g. consultations with regard to abuse or violence[88]).

Interpreters may also take a proactive approach and request the clinician to brief them if this is possible, in accordance with the AUSIT Code of Ethics, which encourages interpreters to "request [a] briefing and access to reference material and background information before their work commences."[9]

Opportunities to inform an interpreter may be limited in the event of a consultation interpreted via telephone, or a consultation interpreted via video for a Deaf person, and may only include flagging the nature of the consultation with the interpreter, if it is known.

A process of iterative briefing may also be needed, if the consultation moves to cover issues for which the interpreter was not prepared (e.g. sexual and reproductive health matters when the telephone interpreter is of a different gender to the person).

Practice point 2: Clinicians introduce the interpreter to the person and explain the role of the interpreter as a non-clinical member of the healthcare team, who is tasked with facilitating effective communication in the clinical consultation through accurate interpretation, is bound by confidentiality and maintains impartiality

Clinicians should begin the consultation by introducing the interpreter and explaining their role as a non-clinical member of the healthcare team who is:

- tasked with accurate interpretation
- bound to confidentiality
- bound to impartiality.[99]

Alternatively, the clinician can ask the interpreter to introduce themselves and state their role to the person.

It is good practice for clinicians to ensure that:

- conversations with other clinicians in the person's presence are always interpreted, and that the person's linguistic presence is maintained

- interpreters are never directed not to interpret particular segments of what is being said, as it would be a breach of the interpreter's ethical duty of accuracy

- whenever they engage in discussions with the interpreter, the interpreter is given an opportunity to inform the person of what is being discussed.

When the clinician leaves the room, the interpreter should not remain alone with the person but should also leave to ensure the role of the interpreter as a communication facilitator between the person and the clinician is enforced. Interpreters prefer not to stay alone with the person, so as not to engage in a private conversation, noting that anything discussed in the absence of the clinician remains confidential unless disclosure is mandated by law.

Practice point 3: When possible and appropriate, clinicians and interpreters may debrief and exchange feedback following a consultation

Clinicians and interpreters should be sensitive to situations when mutual debriefing and exchange of feedback between clinician and interpreter may be required (e.g. difficult and traumatic consultations, particular language observations).

Debriefing and exchange of feedback may be necessary to discuss the person's lexical, grammatical or speech errors, or other linguistic characteristics, particularly in speech pathology, neuropsychology or mental health settings.[120] The clinician may also need to clarify the person's body language and gestures throughout the consultation if they appear to be culturally confusing or framed by culture.

Both clinicians and interpreters in healthcare settings may participate in distressing encounters, deliver bad news, and experience emotional impacts from some consultations. 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 (e.g. counselling, domestic and family violence).[80,90,98] Mutual debriefing may be short, simply acknowledging the complexity and potential stressfulness of the consultation.

In the event of telephone interpreting, clinicians may choose to ask the interpreter to stay on the line following the consultation to clarify any elements of the consultation, or to acknowledge the potential impact of the consultation.

Vicarious trauma 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 through counselling services.[98]

Practice point 4: When working with an onsite interpreter, clinicians interact directly with the person, using direct speech, and maintaining appropriate body language and facial expressions

When assisted by an interpreter, either on-site or via telephone, clinicians should use direct speech and first-person pronouns with a non-English speaking person, to establish rapport and facilitate accuracy of interpreting.

Direct speech means speaking directly to the listener rather than asking the interpreter to relay questions, information, or instructions. For example:

- "I'd like to carry out some tests" rather than "Tell her I'd like to carry out some tests"

- "Is this area painful?" (by telephone: "Is the area I am examining now painful?") rather than "Ask him whether that area is painful"

- "Please raise your left arm" rather than "Ask her to raise her left arm".

It is equally important and reassuring to the person to maintain eye contact (if culturally appropriate), use facial expressions, gestures and congruent body language (e.g. nodding while the person is speaking or the interpreter is conveying the message). In addition, the interpreter should be acknowledged every now and then, as this includes them in 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 person to see each other, and that the interpreter be seated within the clinician's visual field.[121] This can take the form of a triangle arrangement: Clinician-Interpreter-Person.[99]

Practice point 5: When working with a telephone interpreter, clinicians use a speakerphone or a hands-free telephone

When working with a telephone interpreter, using a speakerphone or a hands-free telephone or portable video equipment makes the communication more efficient for all participants. All healthcare settings where interpreters are or may be engaged should be equipped with speakerphones or hands-free telephones. For Deaf people, video telephony equipment should be available and tested. 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 person, and to the person that the telephone should be handed back.

Practice point 6: When working with a telephone or video interpreter, clinicians interact directly with the person, ensure they manage turn-taking, and use adequate descriptive language

When working with a telephone or video interpreter, clinicians should continue to address the person directly and face the person during the interpreting session.

Telephone interpreting deprives interpreters of visual cues that give context and meaning to language. Clinicians can make up for this by using visual language to describe what is happening throughout the consultation or by indicating who is speaking if more than one clinician is present. The clinician should verbally comment on visual surroundings, movements, acts and intentions (e.g. when pointing to the X-ray that they are holding in front of the person).

While on-site interpreters can readily identify, by gestures and eye direction, if the clinician is breaking the consultation to address them directly, telephone interpreters need to be verbally notified that they are being addressed, rather than the person. If the clinician needs to directly talk to the interpreter (e.g. if they are explaining that the person has left the room and the interpreter should stay on the line), they should address them directly as 'Interpreter'.

Practice point 7: Clinicians speak clearly, use plain English and explain complex concepts and terminology to enhance the person's understanding

Speaking clearly, using simple language and avoiding colloquialisms, idioms, technical language and acronyms is important when working with interpreters,[81] as technical clinical terms and abbreviations, in particular, may complicate the interpretation. Interpreters may ask for clarifications or repetitions if needed. If technical terms are unavoidable, they should be explained in plain English so the interpreter can convey those explanations to the person. Clinicians should take responsibility for explaining complex concepts and terminology to the person, and not expect the interpreter to simplify or explain those.

While the interpreter can assist in bridging the language gap, the cultural meaning embedded within language adds further complexity to cross-cultural consultations. Languages are not equal in terms of available vocabulary, and some English clinical terms do not have a direct equivalent in other languages, resulting in the interpretation being a paraphrase of the information. This may take longer and does not indicate that the interpreter is adding an opinion or comment.

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

Practice point 8: Clinicians speak at a reasonable speed, with appropriate pauses and avoiding overlapping speech, so as to enable the interpreter to interpret

While Auslan/English interpreters mostly work in the simultaneous mode, spoken language interpreters work primarily in the consecutive mode (i.e. they start conveying the message from one language to the other after each speaker finishes their utterance). Speaking with reasonable pauses or breaks facilitates accurate interpretation. While some interpreters may use various strategies to manage long speech segments (e.g. taking notes, cutting in to interpret while speakers are talking, asking for repetitions, or interpreting simultaneously), it is best for the clinician to speak in manageable segments to avoid omissions in the delivery of the messages.

Practice point 9: 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 person

If interlocutors do not observe turn taking, this will result in overlapping speech and content loss, damaging the accuracy of interpretation.

Clinicians do not need to give the interpreter a turn to talk if they are talking amongst each other or with a family member. In these situations, interpreters keep the person informed by interpreting simultaneously in the chuchotage (i.e. whispering) mode. Interpreters have to keep people 'linguistically present' even when clinicians are having a discussion among themselves or with family members.

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

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ATTACHMENT: RESOURCES

Tailored clinical care

Australian Refugee Health Practice Guide (Victorian Foundation for Survivors of Torture in consultation with the Forum of Australian Services for Survivors of Torture and Trauma and the Refugee Health Network of Australia)

- The Guide focuses on primary care for people from refugee backgrounds, and contains information that has wider application, such as common health concerns, refugee population profiles, and refugee health assessment.

www.refugeehealthguide.org.au

Recommendations for Comprehensive Post-arrival Health Assessment for People from Refugee-like Backgrounds (Australasian Society for Infectious Diseases and Refugee Health Network of Australia)

- The Recommendations provide evidence-based advice and available Australian data on conditions detected on post-arrival health assessment in refugee-like populations, including infectious and non-infectious diseases.

www.asid.net.au/documents/item/1225

Evidence-based Clinical Guidelines for Immigrants and Refugees (K. Pottie, C. Greenaway, J. Feightner, et al., *Canadian Medical Association Journal*, 2011)

- The Guidelines address the importance of clinical preventive care informed by the person's region or country of origin and migration history, and well as factors of increased risk of a decline in health, and their consideration in the assessment and delivery of preventive care.

www.cmaj.ca/content/cmaj/early/2011/07/26/cmaj.090313.full.pdf

Quality use of medicines

Understanding Quality Use of Medicines in Refugee Communities in Australian Primary Care: A Qualitative Study (M. Kay, S. Wijayanayaka, H. Cook, and S. Hollingworth, *British Journal of General Practice*, 2016)

www.bjgp.org/content/bjgp/66/647/e397.full.pdf

Effective communication

Effective Cultural Communication in Oncology (UNSWelearning)

- Chinese patient
  www.youtube.com/playlist?list=PLHSlfioizVW3lZx9iBwMOr-2Y6qgMd8mk
- Arabic patient
  www.youtube.com/playlist?list=PLHSlfioizVW3vtbvYsb5FO-cvMGnIJnQ5

Interpreter – Royal College of Obstetricians and Gynaecologists (University Hospital Southampton NHS Foundation Trust)

www.vimeo.com/55940134

Access to interpreting services

Free Interpreting Service for private medical practitioners

www.dss.gov.au/settlement-services/programs-policy/settle-in-australia/language-services/free-interpreting-service/free-interpreting-service-for-private-medical-practitioners-0

- Doctors Priority Line, through TIS National, for private medical practitioners 1300 575 847 (further information at www.tisnational.gov.au)

Free interpreting services for pharmacists

www.dss.gov.au/settlement-services/programs-policy/settle-in-australia/language-services/free-interpreting-service/free-interpreting-service-for-pharmacies

National Auslan Interpreter Booking and Payment Service

www.nabs.org.au

- Free for private health care appointments for Deaf people who are not eligible for the National Disability Insurance Scheme

Working with interpreters

Using Interpreters—a Guide for GPs (C. Phillips, *Australian family physician*, 2010)

https://www.racgp.org.au/afp/201004/36589

Medical interpreting: Improving Communication with Your Patients (H. Tebble, 1998)

https://eric.ed.gov/?id=ED426614

Translated health resources

- Health Translations is an initiative of the Victorian Government, managed by Centre for Culture, Ethnicity and Health. The platform provides access to reliable, accurate, and up to date health information in many languages.

www.healthtranslations.vic.gov.au

Occupational therapy

Culturally Responsive Caring in Occupational Therapy (Occupational Therapy international)

www.onlinelibrary.wiley.com/doi/pdf/10.1002/oti.238

Mental health

Framework for Mental Health in Multicultural Australia (Mental Health Australia)

- The Framework was developed to assist organisations and individual workers to evaluate their cultural responsiveness and enhance their delivery of services for culturally and linguistically diverse communities.

www.mhima.org.au/framework

Community profiles

Multicultural Health, a Guide for Health Professionals (Queensland Health)

- Community profiles for 18 different multicultural communities in Queensland to help healthcare providers better understand the health beliefs, pre-migration experiences and communication considerations.

www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide

Community profiles for 14 different communities (ACT Health, based on the 2011 Census data)

www.health.act.gov.au/public-information/consumers/multicultural-health/community-profiles

Multicultural Clinical Support Resources: Health Care Providers' Handbook (Queensland Health)

- Sikh Patients
- Hindu Patients
- Muslim Patients

The handbooks cover a range of topics including faith and prayer, holy days, fasting and food requirements, hair removal, sexual and reproductive health and end of life issues.

www.health.qld.gov.au/multicultural/support_tools/mcsr

Healthy Holidays Guides for Health Professionals (ACT Health)

- Healthy Diwali
- Managing Diabetes During Ramadan
- Managing Diabetes During Yom Kippur

www.health.act.gov.au/public-information/consumers/multicultural-health/healthy-holidays

Resource collections

Subject Portal: Resources in Refugee and Migrant Health, Royal Australian College of General Practitioners

www.racgp.org.au/support/library/subject-portals/refugee/

Curated Collection: Refugee and Immigrant Health, Royal Australian College of Physicians

www.racp.edu.au/fellows/resources/curated-collections/refugee-and-immigrant-health

Resources, Refugee Health Network Queensland

www.refugeehealthnetworkqld.org.au/resources/