The importance of cultural humility and cultural safety in health care

Cultural competency is the concept of understanding diverse cultural groups to provide high quality patient-centred care that is respectful of and aligned with the patient's cultural health beliefs, practices and value systems.[1] Application of this concept aims to alleviate health disparities affecting minority groups, including vulnerable populations such as immigrants, refugees, racial and ethnic minorities, and Aboriginal and Torres Strait Islander people. Cultural competency is a well established concept taught in medical schools, incorporated into hospital and professional accreditation frameworks, and embedded into government policy documents.[2]

However, we advocate that there is a need to focus on the more advanced conceptual frameworks of cultural humility and cultural safety. The term "cultural humility" reflects a shift from the mastering of understanding other cultures to an approach of personal accountability in advocating against the systemic barriers that affect marginalised groups,[3] especially recognising the systemic racism and intergenerational trauma that continues to affect First Nations people. It requires the individual to have the humility to recognise their own inherent biases and adopt a mindset of lifelong learning towards working with diverse communities.[4] Cultural humility in health care challenges the practitioner to consider each individual's identity and how it shapes their health beliefs, values and preferences. A health care professional who takes this approach recognises the historical and social determinants of health contributing to inequity,[5] actively working towards cultural safety. This involves addressing the power imbalances in the dynamic between patient and practitioner, fostering a health care environment that minimises racism and discrimination and instead prioritises safety and inclusivity.[6]

Health inequities within health care have been well documented, persistently revealing disparities among racial and minority communities when contrasted with their white counterparts — from misdiagnoses, diagnostic delays, and higher rates of emergency presentations through to greater rates of mortality after procedures.[7,8] The coronavirus disease 2019 (COVID-19) pandemic engendered significant fear and xenophobia; therefore, as we navigate through new phases of the pandemic, cultural humility becomes ever more important.

We have also seen COVID-19 cases and mortality disproportionately affect minority groups[9] in part due to health disparities.[10] The strict COVID-19 public health policies have more severely affected groups including First Nations people and people of colour,[2,11] who comprise the majority of lower socio-economic groups, who experience less access to secure work and housing, and face greater vulnerability in the face of institutionalised racism.[10]

Poor health literacy and limited exposure to health education during the pandemic has been associated with vaccination hesitancy.[12] International surveys reported lower COVID-19 vaccination rates among minority groups.[13] In Australia, there is a lack of diversity data for vaccination uptake,[14] but geographical data suggest socio-economically disadvantaged areas have been disproportionately affected by COVID-19, with vaccination rates below the national average.[15,16] Despite a successful initial public health response from Aboriginal Community Controlled Health Organisations (ACCHOs) and good uptake of the standard vaccine schedule,[2] the COVID-19 vaccination rates also lagged among First Nations people.[11] These data not only reflect an inadequacy in public health campaigns to equitably communicate health messages to a diverse population and cut through misinformation, but also reflect an erosion of trust through segregation and systemic discrimination.

At a contemplative level, cultural humility requires everyone to acknowledge the systemic barriers that have emerged during the pandemic and make concerted efforts to dismantle them. We must become self-aware of our own cultural background and the inherent assumptions we hold in our worldview. Through this understanding, we may be able to examine our personal and cultural biases and understand how they may differ from those of our patients. We must engage with diverse communities, hear their needs, and endeavour to communicate effectively.

At the community level, we need to continue to engage diverse communities through community group ambassadors and bilingual engagement officers at local government levels. Within the First Nations group, it is vital to understand the heterogeneity between the many varied nations and tailor responses through local ACCHOs to deliver culturally specific health responses. These health care services should be brought to points where communities feel safe. We must ensure that we provide information and resources in multiple languages, especially resources in multimedia formats appropriate to people of all literacy and health literacy backgrounds. As technology becomes the centre point of information access, we must bridge barriers in digital literacy for people with different accessibility needs.

In the health care realm, it is vital to continue accessing cultural and language interpreters, who do not just carry the pivotal role of translating language but also concepts, cultural worldviews, non-verbal cues, and patients' explanatory models for illness. Better still, we need to ensure our medical workforce reflects the cultural diversity of the community we serve. Studies have demonstrated race-concordant clinical interactions improve patient satisfaction, recall of medical information and treatment adherence. This ultimately improves health outcomes.[8] Services

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delivered should be flexible and tailored with live feedback from communities to adapt to changes in needs.

At the systemic level, we advocate for a shift away from the traditional didactic cultural competence teaching towards a standardised and comprehensive curriculum with cultural humility and cultural safety at its core. This education should be inclusive of First Nations people and culturally and linguistically diverse groups and be informed by key stakeholders from interdisciplinary and multicultural backgrounds. This aligns with expectations from the Australian Medical Council that medical specialist college curriculum and assessments incorporates cultural awareness, safety and competence training.[17]

At the organisational level, diversifying the health care workforce and striving for proportional representation of minority groups in all sectors of health care are also vital if we wish to improve health care outcomes for all. Most of all, it involves making policy changes that are fair and that adequately address the circumstances of vulnerable and diverse communities.

Improving our shared understanding and application of cultural humility and cultural safety stands as a key factor in minimising health disparities and optimising health outcomes for all Australians.

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