Training emergency medicine specialists in Indigenous health and cultural competency

Dr Alyssa Vass, Australasian College for Emergency Medicine, Australia and Aotearoa/New Zealand

Introduction

The Australasian College for Emergency Medicine (the College) is the peak professional organisation responsible for training emergency specialists and the advancement of professional standards in emergency medicine in Australia and Aotearoa/New Zealand. In 2013 the College established a two-year project to develop education resources for emergency medicine doctors that are related to Indigenous[1] health and culture. The Indigenous Health and Cultural Competency Project was funded by the Australian Government as part of a suite of projects aimed at improving Australia's emergency department (ED) medical workforce and in particular supporting international medical graduates.

The limited literature that specifically explores Indigenous peoples' experiences of emergency departments suggests that Indigenous patients can find emergency departments culturally unsafe.[2] This is due to a range of reasons, some specific to the emergency department and some a general reflection of non-Indigenous health care systems (e.g., Thomas, Anderson & Kelaher 2008; Einsiedel et al. 2013; Cunningham, Cass & Arnold 2005; Durey, Thompson & Wood 2012).

The unique context of emergency departments creates significant challenges in delivering culturally safe care to Indigenous patients. Emergency department care is delivered in a high-pressured, time-critical environment and continuity of care is greatly disjointed. This means that establishing rapport and an effective therapeutic relationship, so crucial for culturally safe care with Indigenous patients, is difficult. Due to its 24-hour a day, 7-day per week mode of operation, there is also restricted access to essential resources, such as Indigenous hospital liaison officers and interpreters, and difficulty in arranging appropriate follow-up with community services, such as Aboriginal Community Controlled Health Organisations. These factors are problematic and can contribute to a care environment that supports the dominant cultural paradigm, often to the detriment of colonised peoples.

Furthermore, due to the large numbers of complex presentations to emergency departments – especially those involving frequent attendance, drug and alcohol use, violence and mental health –

1 In this article, 'Indigenous' refers to Aboriginal and Torres Strait Islander peoples who the College acknowledge as the Traditional Owners of the many and diverse nations within Australia. The term is used except when referring to the education materials, where 'Aboriginal and Torres Strait Islander' or the local group name of Indigenous peoples were used, as this was the preference of the Aboriginal and Torres Strait Islander members of the project reference group.

2 The author acknowledges the complexity of, and contention surrounding, terminology in education related to culture and health practice. In this article, 'cultural competency' is used to refer to the attitudes, knowledge and actions of practitioners, and 'cultural safety' is used in relation to the experience of patients within the health care environment.

there can be a significant level of apathy, frustration, misunderstanding and negative stereotyping by emergency medicine staff when working with Indigenous patients.

There is also a lack of access to comprehensive educational resources aimed explicitly at overcoming these emergency-specific barriers. Those training options that are available are rarely applied to the emergency department context and, as such, do not address the unique challenges of delivering culturally safe care in this environment. Even where attendance at generic cultural safety programs is considered mandatory, there is limited uptake by emergency medicine doctors.[3] The reasons for this are multi-faceted, but the perceived irrelevancy of available training to daily practice in the emergency department is a factor.

Focus groups conducted during the needs-analysis phase of this project revealed that a proportion of emergency doctors do not see the immediate relevance of Indigenous health education to their practice. Some focus group participants held the view that the socio-economic determinants of health are the predominant causative factor in the disproportionate burden of ill health for Indigenous people, and that the responsibility for addressing Indigenous health issues, therefore, lies with the community sector. While the community sector is undoubtedly essential, Indigenous people attend emergency departments at over twice the rate of non-Indigenous Australians (Thomas, Anderson & Kelaher 2008). There are also very real factors that influence Indigenous peoples' experiences within emergency departments that impact on patient outcomes as well as access to care across the entire health system. It is, therefore, essential to address directly the misperception that a change in emergency department practice is not important in improving Indigenous health.

The College's Indigenous Health and Cultural Competency Project was initiated to provide applied learning in emergency-specific contexts to address this gap in education resources and delivery. In addition, a number of insights have emerged as a result of the project around the challenges and opportunities for improving postgraduate education in Indigenous health regardless of the speciality.

Aims and Objectives

The primary aim of the Indigenous Health and Cultural Competency Project was to transform attitudes, increase knowledge of culture and health, and improve the cultural competency skills of emergency medicine doctors thereby improving the likelihood of culturally safe care for Indigenous people.

A number of objectives were developed to meet this aim:

- Raise awareness of the importance of Indigenous health and cultural competency in emergency medicine contexts
- Incorporate Indigenous health and cultural competency vertically and horizontally within the College's training curriculum, including specialist training and continuing professional development
- Develop comprehensive educational materials specific to emergency medicine, with multiple access points, that would be relevant across the geographically and culturally diverse regions of Australia.

3 For example, attendance at the mandatory Cultural Practice Program delivered by Queensland Health is as low as 9 per cent for emergency doctors in one Queensland hospital, significantly lower than for other hospital staff (unpub. data).

Approach

A reference group was established that included members from peak organisations such as the Australian Indigenous Doctors' Association, the Centre for Ethnicity, Culture and Health, and the Leaders in Indigenous Medical Education Network. Membership also included Indigenous liaison officers with experience in emergency medicine, international medical graduates, Fellows and trainees of the College.

Focus groups and individual video interviews were conducted in several urban, rural and remote regions with emergency department doctors and nurses and Indigenous hospital liaison officers, interpreters, academics and cultural educators. The insights gained, alongside a broad literature review, facilitated the development of a detailed curriculum framework of emergency medicine-specific issues that were of importance to both patients and practitioners.

This curriculum framework informed the development of the central component of the project, a comprehensive 10-module e-learning series, both of which had two foci. The primary focus was Indigenous health, in which the ongoing impact of colonisation, institutional discrimination and racism on Indigenous health outcomes, and access to and experiences of, emergency departments were key learning objectives. The secondary focus centred on applying the principles of cultural competency and cultural safety to the delivery of care in the emergency medicine context.

Module series content

Section 1 of the e-learning series covered core skills such as inter-cultural communication, health literacy, health beliefs, patient-centred care, taking a 'cultural history' and working with interpreters. These were applied to common emergency department presentations, explored the challenges specific to the emergency department environment and suggested strategies to negotiate these.

Section 2 focused on a culturally competent approach to a range of emergency medicine-specific issues, such as disproportionately high rates of Indigenous patients' discharged against medical advice ('take own leave'), 'late' or delayed presentations, and frequent attendance at the emergency department. The historical and contemporary lived experience of Indigenous peoples was explored, including institutional discrimination and the impact of past policies such as those inflicted on the Stolen Generations. Also covered in Section 2 was the importance of collaborative care with Indigenous hospital liaison officers and family, establishing effective relationships between emergency departments and the Aboriginal Community Controlled Health Sector, and the unique challenges of dealing with death and dying in the emergency department, including how to negotiate a culturally safe space for grieving relatives.

Section 3 modules explored complex presentations, such as aggression, intoxication, victims of violence and self-harm. Practitioner attitudes were overtly addressed, including stereotypes perpetuated by these common presentations, through a process of separating out poverty and the colonial determinants of health from Indigeneity, and exploring the breadth of underlying factors associated with these presentations. Skills were introduced, including culturally safe de-escalation strategies and brief motivational interviewing for lessening drug and alcohol harm.

The central role of the practitioner's own culture in any and all clinical interactions was the foundation upon which all other learning was built. A case-based learning approach was used, linked to videos of expert stakeholders discussing their own experiences and approaches. These were supported by a range of critical reflective exercises that encouraged learners to extrapolate

principles of care to their own practice. This enhanced the relevance of the materials to the geographically and culturally diverse contexts of Australian emergency departments. The material was presented via a mix of multi-media, including animations, audio, text and interactive elements to ensure sustained engagement. The nature of clinical content in the modules was deliberately uncomplicated so as to maintain the focus on cultural safety.

Importantly, Indigenous voices were prioritised and all content was linked to the daily reality of Indigenous peoples and emergency medicine practice. For example, a video of Indigenous peoples talking about their own experience of the Stolen Generations was linked to the current experiences of anxiety and powerlessness Indigenous patients may face when contemplating attending and/or arriving at an emergency department, due to children historically having been forcibly removed within hospital settings. Learners were then encouraged to explore how understanding this reality could lead to a change in the way they interacted with their patients to reduce poor outcomes such as a patient 'taking own leave'.

Results

In its first year, more than 650 people began the e-learning series. Due to a staggered launch, the numbers of people completing each subsequent module steadily decreased, but the figures do indicate that people are continuing to work their way through the series (see Table 1). Given the reluctance of many emergency doctors to see this learning as relevant to their practice, prior to the project commencement, and that current membership of the College is a little more than 4000, the College considers these completion numbers over 10 months or less as quite successful.

Table1: E-learning series by module view

Module no.	Title	Release date	No. of module views as at 30/11/14
Section 1: Applying core concepts of culturally competent care in the Emergency Department (ED)			
1	Introduction to culturally competent care in the ED	31/01/14	665
2	Culturally competent communication in the ED	31/01/14	264
3	Understanding health literacy and diversity of health beliefs	31/01/14	155
4	Understanding language diversity and working with interpreters	31/01/14	116
Section 2: Caring for Aboriginal and Torres Strait Islander and other culturally diverse patients in the ED			
5	Improving ED access and experiences for Aboriginal and Torres Strait Islander patients	11/04/14	109
6	Collaborative practice: Understanding the role of Aboriginal Liaison Officers and families in ED care	11/04/14	64
7	Culturally competent discharge planning	11/04/14	64
8	Culturally competent end-of-life-care	25/09/14	34

Table 1 cont...

Module no.	Title	Release date	No. of module views as at 30/11/14
Section 3: A culturally competent approach to challenging presentations			
9	Aboriginal and Torres Strait Islander patients	25/09/14	32
10	Refugees, asylum seekers and migrant patients[4]	25/09/14	17

An initial evaluation of the e-learning series was conducted through user acceptance testing. Following the launch, participants completed voluntary surveys at the end of each module. Results from Likert scales and qualitative responses indicate that the modules significantly improved self-assessed knowledge and skills in Indigenous health of both trainees and specialists. Importantly, participants have found the learnings highly relevant and valuable to their daily practice. One trainee commented:

> *Up until now I haven't known how we can improve the quality of the care we give to our Indigenous patients. It's only since completing this module series that I can see they are a crucial tool for bridging that gap between the current care that we deliver and the ideal level of care that we'd like to practise. I've been really impressed with the detail, the case histories, the videos that are within the modules. Because for me it's the first time I've seen something that is as complete as this; that covers such a wide range of topics. These are the real, day-to-day cases that we treat in ED. The modules have really changed the way I think and make me want to improve the way I interact with all my future patients* (Emergency medicine trainee).

As with all teaching of this kind, it is difficult to measure the actual impact on health outcomes for Indigenous patients (Ewen, Paul & Bloom 2012) given the highly distributed nature of participants completing the modules – i.e. a self-selection of practitioners from emergency departments practising anywhere throughout Australia – and the need to monitor improved processes over time. However, some evidence gathered through the evaluations reveal instances in which the application of learning is having an impact on individual cases.

Discussion

Successes

One example from the qualitative feedback highlights an instance in which the course had an impact on the approach an emergency medicine trainee took with an Indigenous patient. The trainee was attempting to undertake an aerial retrieval from a rural community of an injured Indigenous man who was agitated, had a history of violence in the emergency department and was wanting to discharge against medical advice. The trainee was under pressure from senior staff to either forcibly sedate and transfer the patient, or simply let him leave.

4 The final module in the e-learning series focused solely on providing culturally competent care for complex presentations involving asylum seeker, refugee and migrant patients. Although the project reference group agreed to include diverse cultural groups in the e-learning series, this module is not detailed in this paper.

Instead, the trainee applied their learning about dealing with the significant time-pressures associated with emergency department care, and used their newly learned skills to establish a rapport with the patient by asking about the his family and Country. The trainee also asked the patient to describe why he was in hospital and his understanding and beliefs about his illness. It was thus discovered that there was a discrepancy between the patient's understanding of his illness and the doctor's, so the trainee explained in more detail the medical reasons why the patient needed a transfer. The trainee then asked the patient to repeat back what he had heard them say, to ensure that the patient fully understood the risks of leaving the department, with surprising results:

> *It was amazing to see what happened next. This aggressive, agitated man who was previously trying to pull out his intravenous lines and walk out of the emergency department, just lay back on the bed, closed his eyes and calmly said 'Doc, you can take me now'.*

The patient was transferred for further management without complications.

In developing the modules, the project team focused on creating usable, real-life examples of culturally safe care. The early and sustained collaborative contributions of both Indigenous and non-Indigenous experts in emergency medicine and Indigenous health education, as well as the broad participatory research phase, meant that the final product incorporated best practice adult education principles, was relevant to the experiences of the target audience, and respectful of Indigenous cultures and lived realities.

A key success of the project has been the development of robust working relationships with a number of peak Indigenous professional organisations, such as the Australian Indigenous Doctors' Association. The College now has external Indigenous representation on its Indigenous Health Sub-Committee, and a renewed commitment to supporting both the development of Indigenous trainees and the leadership aspirations of Indigenous Fellows within the College.

The active partnership between the College and Indigenous hospital liaison officers and cultural educators, established as a result of the project, has led to a broader understanding of the collegial nature of working with Indigenous professionals within the context of an emergency department.

The lessons learned from the module development process and the evaluations have also led to Indigenous health and cultural competency being included in other College programs such as the Quality Mentoring Initiative, which now has Indigenous content in both its face-to-face and online training.

Challenges

One of the challenges of developing this educational resource is that doctors come to postgraduate training with varied exposure to education in Indigenous health and cultural safety. Approximately 37% of the College membership, for example, is currently international medical graduates and overseas trained specialists, who may have limited or no understanding of Indigenous health issues. But even Australian-trained doctors, particularly more senior practitioners, may not have had any Indigenous health education either during their undergraduate or vocational training.

In order to address this, the e-learning series consistently invited learners to ask, 'What do I already know and do?', and then reflect upon the content presented (be it a case study, a video, the

evidence base etc.) and ask, 'What can I now do better?'. This approach, centred on critical self-reflection, recognises that, regardless of previous learning, all practitioners can continue to strive for improvement in the care they deliver. One participant commented that:

> *[the modules] are excellent and should be read by everyone who is working or dealing with Indigenous health. I spend regular time providing medical care to Indigenous communities and I found a lot of new and interesting information in the modules* (Overseas trained specialist, senior emergency department doctor).

Some content was explicitly optional and provided for those learners requiring more introductory knowledge, for example, international medical graduates new to the Australian health care context. While the e-learning series was developed such that each module built upon the learning in previous modules, learners could access them in any order. This allowed learners to enter the content depending on their interest and level of previous experience and knowledge.

The delivery of training is also challenging in the postgraduate setting. Specialist training in hospitals is delivered mostly by senior doctors, not cultural education specialists. As discussed, senior medical practitioners have a range of expertise, understanding and interest in this area. There is also distinct competition for teaching time, particularly for junior staff who are trying to 'learn the ropes' of their speciality.

In emergency medicine contexts, time pressures for training are further exacerbated by the highly shift-based nature of the work. To address this challenge, the modules were made freely available online so as to be accessible for a self-directed style of learning that is not reliant on senior staff time, expertise or interest. They were also distributed on USB sticks to more than 200 Directors of Emergency Medicine Training.

> *This online training is going to be really good for access for trainees, as on-the-job training is very difficult to fit into rostering* (Emergency medicine specialist).

Furthermore, a considerable effort was made in promoting both the project and the educational resources, and in particular the need for learning in this subject area at all levels of training and specialisation. Promotions via conference presentations, membership communications, social media and website presence prioritised the message that Indigenous health and cultural safety are relevant both in emergency medicine and for all doctors. The large numbers of module views in a short period of time is evidence of the success of this approach to encourage use of the e-learning series.

> *I thought it was going to be just another 'tick the box' module series, but I actually learnt something. They're fantastic. I'm going to get all my registrars to do them* (Emergency medicine specialist).

Conclusion

Indigenous health and cultural competency training at the postgraduate level should be designed specifically for each speciality. Continuing to provide generic or introductory content risks disengagement and irrelevancy, and will continue to posit Indigenous health and cultural safety education as a 'special interest' subject area rather than as a core learning for all doctors.

This project developed educational resources founded upon evidence and extensive consultation. The emphasis on experiential learning and critical reflection of the practitioner's own self supports learners to incorporate increasingly culturally safe practice at multiple levels of training and specialisation.

Most postgraduate medical training is undertaken on-site by senior doctors. However, when developing and delivering effective training in Indigenous health and cultural safety relying on these senior doctors alone is insufficient. Rather, the collaborative model developed by the College – including targeted focus groups, expert stakeholder interviews and a diverse reference group – could be used. Such a model could also be replicated across other speciality colleges, enabling close working partnerships with the relevant Indigenous health professionals to that speciality.

This project has begun to demonstrate that a speciality-oriented Indigenous health curriculum has the potential to engage learners, reveal the relevance of this skill base to their daily practice and teach new expertise in cultural safety.

References

Cunningham, J., Cass, A. & Arnold, P. C. 2005, 'Bridging the treatment gap for Indigenous Australians', *Medical Journal of Australia*, 16 May, vol. 182, p. 10.

Durey, A., Thompson, S. C. & Wood, M. 2012, 'Time to bring down the twin towers in poor Aboriginal hospital care: Addressing institutional racism and misunderstandings in communication', *Internal Medicine Journal*, vol. 42, no. 1, pp. 17–22.

Einsiedel, L. J., van Iersel, E., Macnamara, R., Spelman, T., Heffernan, M., Bray, L., Morris, H., Porter, B. & Davis, A. 2013 'Self-discharge by adult Aboriginal patients at Alice Springs Hospital, Central Australia: insights from a prospective cohort study', *Australian Health Review*, vol. 37, no. 2, pp. 239–45.

Ewen, S., Paul, D. & Bloom, G. 2012, 'Do indigenous health curricula in health science education reduce disparities
in health care outcomes?', *Medical Journal of Australia*, vol. 197, p. 50.

Thomas, D. P., Anderson, I. P. & Kelaher, M. A. 2008, 'Accessibility and quality of care received in emergency departments by Aboriginal and Torres Strait Islander people', *Australian Health Review*, vol. 32, no. 4, pp. 648–54.

For further information, contact:

Dr Alyssa Vass
E: alyssavass@hotmail.com

Or

Indigenous Health and Cultural Competency Project
Australasian College for Emergency Medicine
E: culturalcomp@acem.org.au