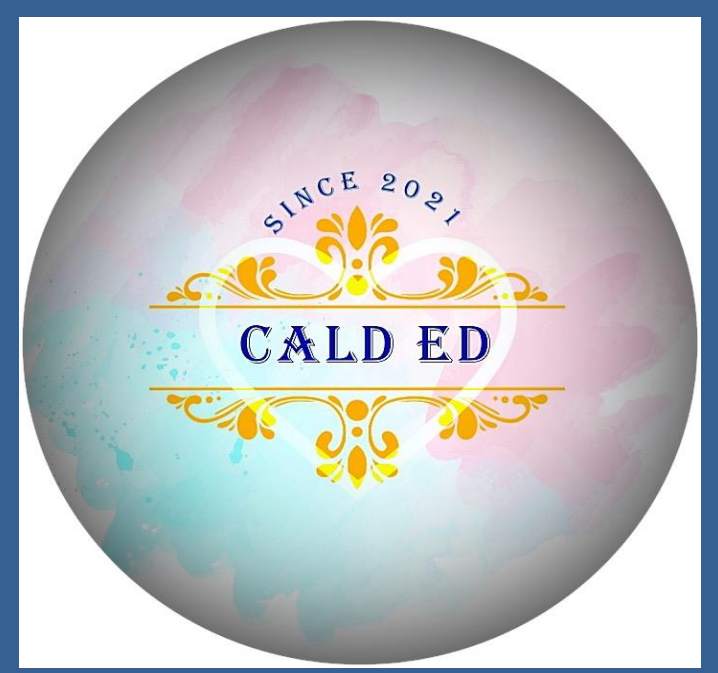


# Cultural and social influences in care delivery to culturally and linguistically diverse patients in the emergency department



Presenter: Dr Ya-Ling Huang<sup>1,2,3,4</sup>, RN PhD

Dr Shahina Braganza<sup>4</sup>; Dr Dinesh Palipana<sup>3,4</sup> OAM; Ms Amy Sweeney<sup>4,5</sup>; Mr Robert Lee<sup>6</sup>; Prof. Wietske Blom-Ham<sup>7</sup>; Ms Marina Chand<sup>8</sup>; Dr Ping Zhang<sup>3</sup>; Prof. Cindy Shannon<sup>4</sup> AM; Prof. Julia Crilly<sup>3,4</sup> OAM

## Background

Australia has one of the largest culturally and linguistically diverse (CALD) populations with different cultural values and social beliefs. 50% of Australians are either born overseas or have one/both parents born overseas [1]. Figure 1 describes Australian population born overseas [2]. Emergency department presentations made by people from CALD backgrounds is increasing. The delivery of effective emergency care to this population can be challenging for clinicians because of the complexity of social and cultural dimensions.

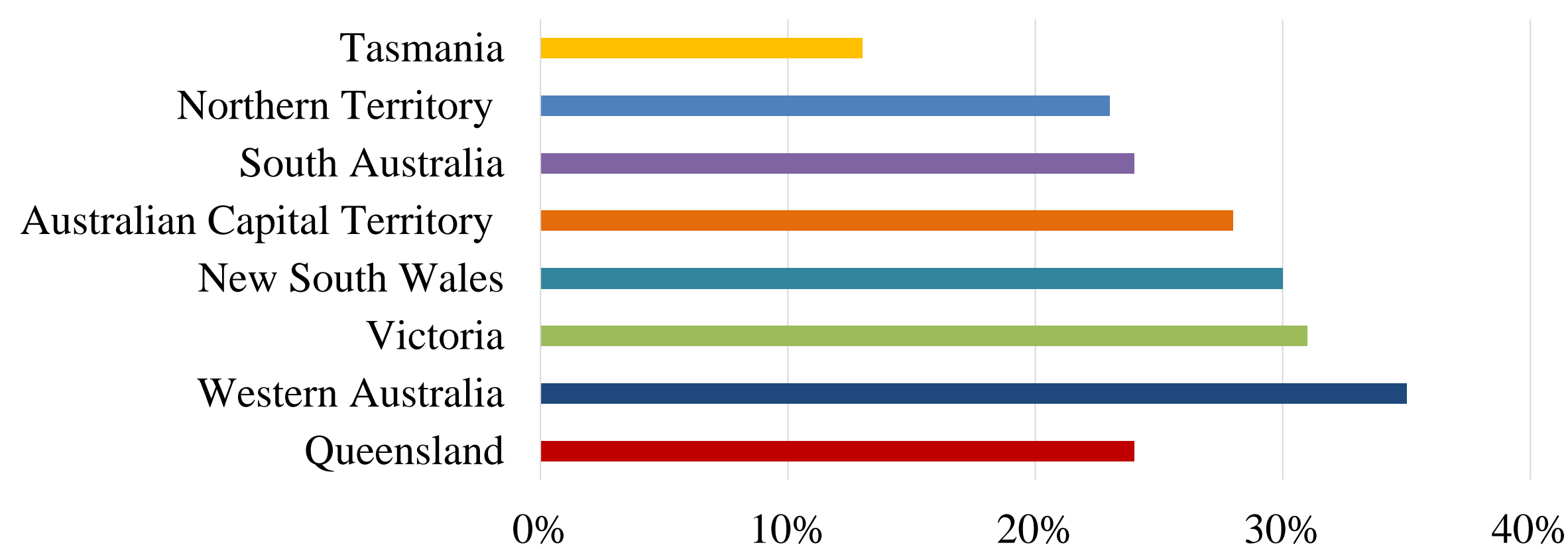


Figure 1. Australian population born overseas by states and territories

## Aim

This study aims to explore clinicians' experiences and perspectives on the broader cultural and social factors that shape the clinical practice in care delivery to patients from CALD backgrounds who present to the emergency department.

## Methods

Situated within two-phase mixed methods design, this qualitative study used the broader concept of social ecological perspectives from a Social Ecological Model [3] to guide this investigation.

Purposive and snowball sampling strategy was used to recruit clinicians from two public hospital emergency departments in Southeast Queensland, Australia. A semi-structured interview approach was used with audio recording. Data analysis was guided by the concept in the Social Ecological Model [3] with a specific focus on the understanding of cultural and social influences in care delivery to patients from CALD backgrounds who present to the emergency department.

## Findings

Seventeen clinicians from two public emergency departments participated in the semi-structured interviews. These included nine nurses and eight doctors. Age ranged from 24 years old to 54 years old. Clinical experiences in the emergency department ranged from 8 months to 25 years. Around half of participants (n=8) were born in Australia. Others (n=9) were born in other countries including Canada, England, Germany, Kenya, Malaysia, New Zealand, Poland, Saudi Arabia and South Africa (Figure 2).

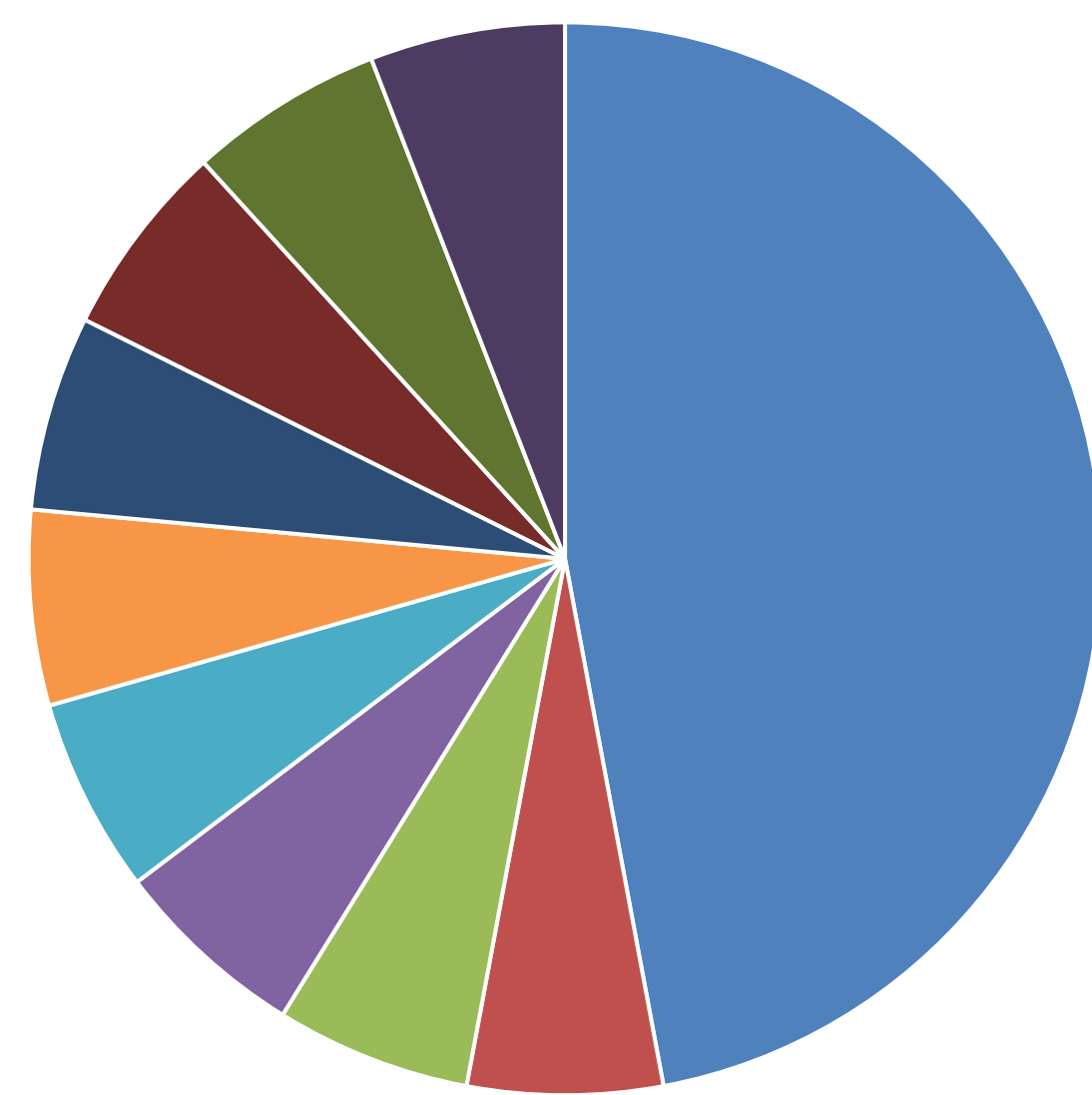


Figure 2. Country of birth of seventeen participants

Three main themes (Table 1) generated from the interviews convey participants' experiences and perceptions of cultural and social influences in care delivery to patients from CALD backgrounds.

Table 1. Themes, categories and subcategories

Themes	Categories	Subcategories
Cultural, religious diversity and challenges in care delivery	Cultural diversity and positive environment in the ED	Diverse experience and positive work environment
	Different cultural norms, expectations and religious custom	Cultural norm and expectation
		Folk beliefs
		Accommodating cultural and religious practices
Challenges related to cross-cultural communication and prejudice	Cultural barriers to communication	
	Stereotypes and prejudice	
	Social interactions and communication in clinical care	
Social interaction with patient and family in clinical care	Communication and interaction with patients	
	Involving family in clinical care	
	Involving family in interpreting	
Social interaction with team and learning from others	Interaction within the team	
	Learning from others	
Perception about care delivery, service and support	Knowledge of available service and support	Interpreter service
		Resources and support
	Personal beliefs in culturally appropriate care	Cultural awareness
		Culturally sensitive and holistic care

Table 2. Exemplars of subcategories with participants' voices

Exemplars of subcategories	Exemplars of codes	Exemplars of participants' voices
Cultural norm and expectation	Cultural beliefs: gender role	"Some cultures that might not necessarily...want a female to look after them, for example...I looked after a Muslim gentleman who didn't like [a female nurse]. It was weak for a woman to be looking after him because he was very stoic man that wasn't willing to accept our help." (Clinician 12, Nurse)
Accommodating cultural and religious practices	Death and dying	"The ED is just not the best place for [supporting dying process]. In some cases, we have had the patient go up to depending on the availability of the Intensive Care Unit...if they're going to die, but the fact we're waiting on family members to arrive, and we might put them on some supportive treatments to keep them alive until family members arrived from various places. They can do that sort of the dying process as a big family group." (Clinician 3, Doctor)
Cultural barriers to communication	Put a blanket over the head	"Some cultures that I work with, they would put a blanket over their head, and you'd think they were asleep. Our natural reaction was really frustrated. They wouldn't speak to us. They wouldn't engage with us...I learned somewhere down the track that for that particular culture, that's quite a normal way of responding to pain, whereas we were reacting to it as in Oh...they're obviously fine. You know, I'll come back later, or they obviously can't be in too much pain if they're acting like that." (Clinician 9, Doctor)
Stereotypes and prejudice	Doing it on purpose	"It was a woman...from Venezuela...She came in with back pain and her English is quite good but very thick accent and obviously her English was not like perfected. For her culture, she didn't want to eat...because she wanted to fast and pray. That was part of what she wanted to do. I came on in the morning and I was handed over that she was incontinent of urine in her bed, but they were saying that she was doing it on purpose cause that was the language and cultural kind of you know...Later she ended up getting admitted to hospital because she had cauda equina [syndrome]...That's a like spinal emergency." (Clinician 16, Nurse)
Communication and interaction with patients	Extra layer of barrier to care	"I knew very few words in Italian so I could ask her very basic things if she needs toilet or if she's hungry. I feel like she could understand what I'm asking and she had an impression that I can understand her and she was chatty, and she's smiling. I'm thinking, wow, maybe she is in her mind, maybe she is there, what she was. Her daughter got to us hours later and she said no mom is completely confused [and she has dementia]. She has no idea where she is." (Clinician 13, Nurse)

## Conclusion

The findings provide insight into clinicians' experiences and perspectives on how cultural, religious and social aspects as well as personal beliefs shape the care delivery to patients from CALD backgrounds in the emergency department. These findings provide guidance which help inform appropriate strategies to support clinicians for the clinical practice in the emergency department.

## References

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First and corresponding author: Dr Ya-Ling Huang; [ya-ling.huang@unisq.edu.au](mailto:ya-ling.huang@unisq.edu.au)

