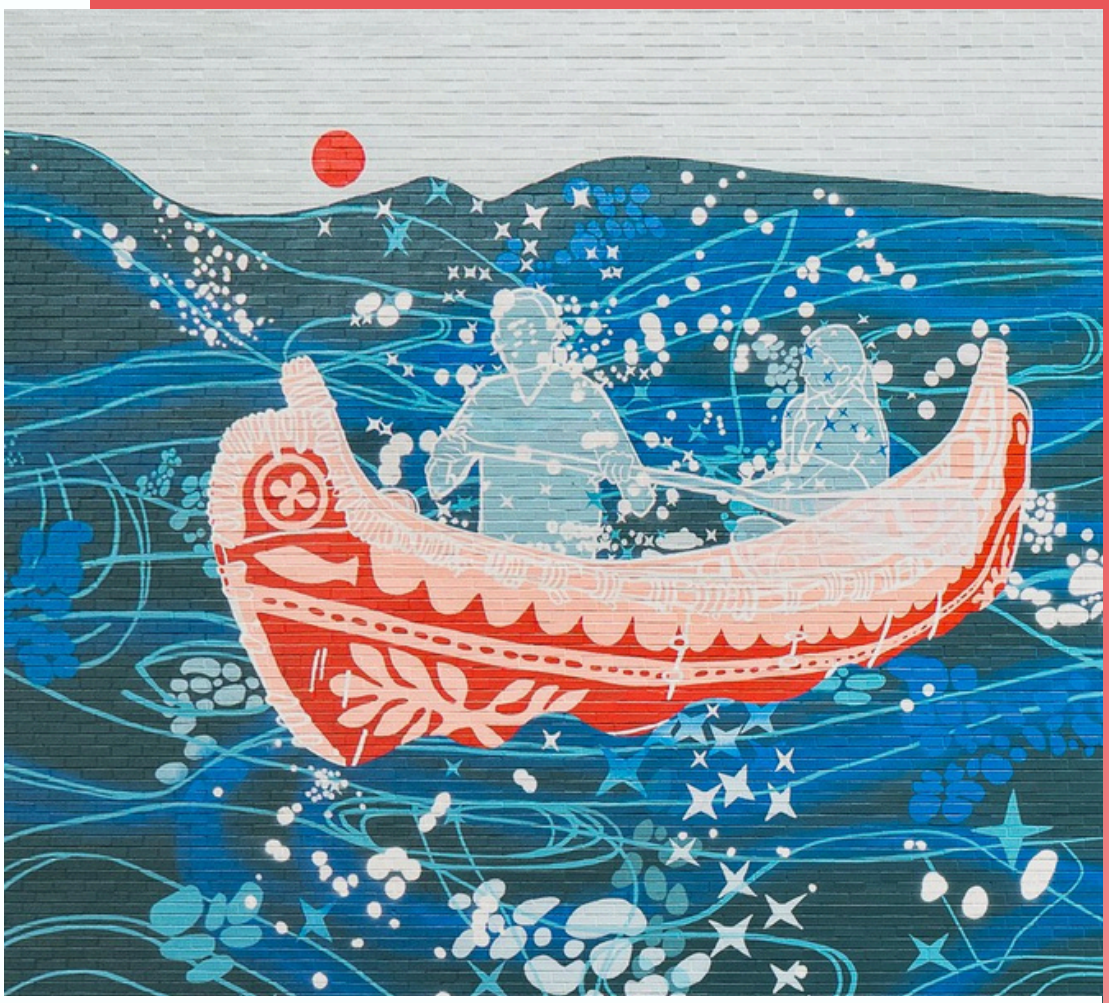
Cultural safety in Emergency Departments : Literature Review



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CREMIS, CIUSSS du Centre-Sud-de-l'Île-de-Montréal, Native Friendship Centre of Montreal, Indigenous Support Workers Project, Indigenous Health Centre of Tiohtià:ke, and Montreal Indigenous Community Network. 2025.

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- Native Friendship Centre of Montreal;
- The Indigenous Support Workers Project;
- Indigenous Health Centre of Tiohtià:ke;
- Montreal Indigenous Community Network.

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Table of Contents

Synthesis

This literature review aims to understand the state of cultural safety in emergency departments (ED). It is set in a national context where the consequences of colonization are still felt today in healthcare settings and ED, and where racism has a negative impact on the health of Indigenous people. Many organizations, including CREMIS, have set up projects to study, develop, and encourage the implementation of effective, culturally safe practices in the healthcare system. A literature search revealed key themes related to cultural safety: communication between patients and practitioners and community support, the importance of staff training on Indigenous realities and historical trauma, capacity constraints in emergency departments, and the impact of racism and discrimination on Indigenous health.

Introduction

Racism affects access to healthcare in Emergency Departments (ED) across the globe (Castner, 2021; Govindasamy & Carlin, 2022; Pilarinos et al., 2023; Varcoe et al., 2022). The land now known as Canada is no exception. Specifically anti-Indigenous racism in healthcare and ED settings has resulted in a multitude of adverse effects on Indigenous patients seeking care, including death (Leclerc et al., 2018; Wylie & McConkey, 2019). While unfortunately not a new phenomenon and an ongoing consequence of the colonization of this land, the response to these cases has resulted in many projects being launched focusing on studying, developing, and encouraging effective culturally safe practices in the healthcare system. CREMIS is undertaking one of these projects and this systemic literature review seeks to answer the question 'what is the state of cultural safety in hospital emergency departments?' Irihapeti Ramsden introduced the phrase 'cultural safety' to nursing academic literature in 1992, noting that practitioners often move through phases of cultural awareness and cultural sensitivity before being able to truly offer culturally safe services. Cultural competence is another similar concept that is unique and often differentiated from cultural safety. Broadly, cultural competence implies the idea that one can attain a state of 'competence' through acquiring cultural knowledge differing from one's own. This is unique from a culturally safe approach where the starting point is to turn inwards and look critically at one's own culture to be able to recognize the ways our choices and actions are influenced. In a review investigating the concept of cultural safety in nursing literature from 1988-2012 Blanchet Garneau and Pepin (2012) observed that, although cultural safety held theoretical value, it had not been implemented into practice. This inhibited its ability to be utilized effectively and improve healthcare services for First Nations, Inuit and Métis patients.

A scoping review from 2018 by Berg et al. was identified and thus the focus of this review is literature from after that date. The search, conducted in June 2023, therefore covered the period of 2018 to June 2023 and included English and French language peer-reviewed journals. The databases searched were Medline, PsycINFO, CINAHL Complete, and Global Health, using the EBSCO platform; EBM Reviews using the Ovid Platform as well as Scopus. Google Scholar was used to cross-reference citations of key articles in English and identify key literature in French. For the EBSCO platform the following search terms were used (indigen* OR aborig* OR native* OR Inuit* OR metis OR "First Nations") AND "Cultural safety" AND (emergency OR ER). For the Ovid Platform the search term “Cultural Safety” was sufficient. For Scopus "Cultural Safety" AND emergency AND indigen* OR aborig* was used. For Google Scholar “sécurisation culturelle autochtone hôpitaux urgence québec” was entered into the search engine, the search proceeded until 100 unsuccessful hits occurred after the last successful identified hit.

The databases searched via EBSCO yielded 30 results, Ovid generated 8 results while Scopus produced 16. I excluded some of the results after reading the abstracts when it was clear they did not address the research question directly. I included papers that involved data collection and ones that did not. I completed a full text review of all the articles selected following the abstract review. This resulted in the removal of some papers beyond the scope of this review as well as the addition of some others identified in reference lists. While the search did not initially limit the articles to the Canadian context, ultimately the ones informing this review most prominently are from that grouping: of the papers identified in the search 12 in English engaged the research question, as did 9 written in French. English language documents covered the state of cultural safety in the colonial provinces called Alberta, British Columbia, Ontario and Quebec while the French language documents were exclusively focused on Quebec.

Themes identified in this grouping of literature are similar to themes found by Berg in 2018 which were communication between patient and provider, and community supporting the patient and care provider, training, capacity, and racism and discrimination. In the more recent literature, the theme of relationships shifts a little to become more centered around and emphasize the importance of communication. Training and capacity continue to be important themes, as does racism though in more recent works it is more often framed by the potential and impact of anti-racist approaches.

Communication between, and Community supporting, the patient and care provider

Participants from a few different studies expressed that the way a health practitioner communicates is central to defining an experience in a healthcare setting as culturally safe or unsafe (Carter et al., 2021; Johnson & Hasan, 2021). Participants valued practices such as active listening and using plain language (Carter et al., 2021; Collie & Yergeau, 2023). Language differences can be a barrier to culturally safe care. A nurse who was asked to provide guidance on how to provide culturally safe services explained that she invited patients to stop her when she was speaking if there were any questions, or in case she was speaking too fast (Collie & Yergeau, 2023). In cases where patients believed that their care provider was not listening to them, this sometimes led to misdiagnosis and at all times resulted in a poor experience (Carter et al., 2021). If patients do not feel safe communicating symptoms, it means the practitioner cannot provide proper treatment (Johnson & Hasan, 2021; Pilarinos et al., 2023).

In addition to the relationship between patient and provider, other avenues of communication need to be strengthened to support a culturally safe care environment. This includes between the hospitals, physicians, and providers in communities utilizing existing methods of communication including patient charts, discharge summaries, test results, prescriptions, etc. (Carter et al., 2021; Johnson & Hasan, 2021). Some Indigenous (and more specifically Inuit) perspectives on health also believe care is a community issue and when a small group arrives with a patient to receive care, this can be at odds with policies relating to number of visitors or people accompanying a patient (McCready et al., 2023).

Training

Most articles that were grouped into the training theme agreed that healthcare practitioners need more robust and specific training to offer culturally safe services. The unique and shared history of Indigenous people in this land we now call Canada is not like any other group and in order to provide culturally safe services a practitioner has to understand the full context in which an Indigenous patient is seeking care, including the role that health institutions have played in the colonization of Indigenous people (Leclerc et al., 2018; McLane et al., 2020; McLane et al., 2022). Practitioners must be trained in trauma informed care to provide appropriate care in the face of historical trauma (Carter et al., 2021; Collie & Yergeau, 2023; Johnson & Hasan, 2021; Varcoe et al., 2022). Some of the literature advocated for training in cultural safety and trauma informed care to be mandatory (Johnson & Hasan, 2021; Pilarinos et al., 2023; Wylie et al., 2021) as other studies noted as many as 90% of the respondents had not received any cultural safety training (Leclerc et al., 2020).

Making training mandatory, however, cannot guarantee the integration of culturally safe practices that comes after the training via “follow-up with managers and/or employers to debrief and discuss learnings” (Wylie et al., 2021). While online mandatory training on Indigenous realities has recently been introduced in the context of Quebec health and social services network, the impact is not clear and has not been comprehensively studied. What is clear is that even with training available, there are still members of the Indigenous community who receive unsafe care in Emergency departments. Mandating training is also not the same as implementing it and a one-time introduction to Indigenous cultural safety training is not enough to support healthcare workers to implement culturally safe practices (Filion et al., 2020; Leclerc et al., 2018). Other recommendations for training topics included “de-escalation training, self-reflection on cultural humility; and Indigenous perspectives, practices, teachings, and storytelling” (Johnson & Hasan, 2021).

The recognition of the impacts of colonialism by healthcare providers is necessary to improve the care provided to Indigenous patients and healthcare providers want education that includes concrete direction on how their practice should change (Filion et al., 2020; McLane et al., 2022). Consciousness raising among ED staff is not enough as “the culture of the health system itself remain[s] unexamined and [are] thereby implicitly positioned as the norm” (Wylie et al., 2021). Appropriate training, however, can increase staff confidence and improve patients’ experiences (Varcoe et al., 2022), while care must be taken to acknowledge that training is not the only part of the journey to culturally safe knowledge, skills, and ability to provide effective healthcare (Filion et al., 2020; Wylie et al., 2021).

Capacity

EDs operate on conditions of limited resources and the fast pace of the ED impacts patients’ experiences (McLane et al., 2022).

Continued staff shortages and leadership changeover make it challenging to commit resources to consistently implement equity-oriented intervention strategies at the organizational and systems levels (Varcoe et al., 2022). It is also critical that these environmental factors do not become barriers to providing culturally safe services.

Racism and Discrimination

It is important that EDs promote equity in healthcare (Varcoe et al., 2022). Racism is a pervasive issue that impacts Indigenous health (Filion et al., 2020; Leclerc et al., 2018; McCready et al., 2023; McLane et al., 2022; Pilarinos et al., 2023; Wylie et al., 2021). “Experiences of discrimination are considered a root cause for the health inequalities that exist among Indigenous peoples” (Wylie & McConkey, 2019). Concerns of racist treatment impact Indigenous people’s “expectations of care and care seeking” (McLane et al., 2020). This can lead to higher rates of leaving the ED without being seen as well as general healthcare avoidance, which can later result in more usage of the ED (Carter et al., 2021; Wylie & McConkey, 2019). Racism from healthcare providers can take the form of discrediting traditional Indigenous medicines or Indigenous perspectives on health (Pilarinos et al., 2023). Providers in the ER may also judge a patient for not seeking care sooner or seemingly not taking any preventative measures without any understanding of the context they have been living with a health concern (Collie et Yergeau, 2023; McCready et al., 2023). This can include assuming that Indigenous people are homeless and/or drug and alcohol users which often turns into not treating the patient with dignity or respect.

Conclusion

Based on the findings of this review, it is evident that the term ‘cultural safety’ has moved from the theoretical realm and there is a desire to integrate the concept into healthcare practice. If anything, the term now runs the risk of becoming a buzz word that is co-opted by institutions and hollowed out of any real impact that it carries. No matter what term is used, the fact remains that public healthcare in the province of Quebec and across Turtle Island is largely inaccessible at best and actively hostile at worst when it comes to Indigenous patients seeking emergency healthcare.

Some promising practices that emerged from the literature that can be seen in the current landscape of culturally safe healthcare in Quebec includes the idea of ‘two-eyed seeing’/Etuaptmumk (TES) as well as partnerships between Indigenous community organizations and the healthcare system. TES has iterations in many fields and disciplines, introduced by Mik’maq Elders Albert and Dr. Murdena Marshall with Dr. Cheryl Barlett to scholarly application in 2004 (2012). Albert Marshall describes this concept as an approach “from one eye with the strengths of Indigenous ways of knowing, and to see from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together” (Moorman et al., 2021).

The idea of TES comes up in a few articles under review, most recently by McCready et al., who affirm that in order to provide culturally safe health services, a practitioner must approach an interaction with Indigenous patients with 2 perspectives, one coming from the mainstream health institution and one that considers the unique reality and context in which the patient is seeking care (2023). Many articles emphasize that culturally safe programming needs to be co-constructed by the health institution and local Indigenous community, and if done effectively the ability to utilize the approach of TES is a potential result (Collie & Yergeau 2023).

Many articles focused on Quebec discussed the success of “Mino Pimatisi8in” a clinic that opened as a partnership between the health authority and the Val D’Or friendship centre (Collie & Yergeau, 2023). This clinic was also held up as a model of healthcare excellence in the Viens Commission report (2019). The Viens Commision report was the result of an Inquiry into relations between Indigenouus communities and health and social services in Quebec. The report includes 142 calls for action. “Mino Pimatisi8in” aims to provide wraparound healthcare services to their Indigenous community members which in turn circumvents some of the problems the Indigenous community experiences when trying to access health services. For example, patients who access primary care services vi the clinic are less likely to ignore a health concern in its early phases so it can be treated sooner when it is hopefully less critical and more manageable. Three clinics with similar approaches have recently opened in Montreal, one operated by Native Montreal, an urgent care centre opened by the Indigenous Health Centre of Tiohtià:ke; and finally an Inuit specific clinic, Qavvivik. These clinics will build relationships and make connections with existing healthcare services to provide care to their respective Indigenous communities. Funding for both the Val D’Or and Montreal clinics is a mix of private and public funding which could impact accessibility and other factors.

While undeniably an excellent initiative to improve healthcare for the urban Indigenous population, the presence of these clinics does not take any pressure off existing health establishments, including hospitals and more specifically emergency departments, to provide culturally safe services. These clinics will hopefully alleviate some of the demands on emergency services through early treatment and prevention, however, the fact remains that First Nations, Inuit, and Métis patients will continue to need to access public emergency services and must be able to do so comfortably, without fear of being mistreated or finding themselves in a worse state due to discriminatory practices that are accepted as the norm.

Working in an emergency department is a fast-paced, frequently stressful environment which at present does not translate easily to the care and attention needed to ensure culturally safe interactions for Indigenous patients. The consequences of racist attitudes from healthcare staff can and have been deadly. Dell (2016), however, points out that front-line service providers, including Emergency Department staff, are well situated to intervene on inequities. What lacks is the knowledge, confidence, and thus ability to do so.

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