Cultural Responsiveness Framework for Optometrists

2021

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Optometry AUSTRALIA

This framework outlines the background behind the need for 'culturally responsive' optometry practice and what it encompasses. A tool-kit table can be used to evaluate the level of cultural responsiveness at the patient-practitioner level, practice/organisational level, professions level and community level.

Resources are provided to help you, your practice and/or organisation to improve and strengthen your cultural responsiveness.

Background

Australia is a diverse and multicultural country. Almost half (45% or 10.6 million) of the population were either born overseas or have one or both parents who were born overseas.[1] Twenty-one per cent of Australians speak a language other than English at home and increasing proportions of migrants arriving in Australia are coming from China and India. Therefore, many optometrists are providing eye care services to culturally and linguistically diverse (CALD) Australians. Many optometrists themselves are from CALD backgrounds (as first/second/third/etc. generation Australians or recent migrants). The proportions of Australia's health workforce that are born overseas is increasing. For optometry, 42% of optometrists were born overseas in 2016 compared with 36% in 2009.[2,3]

Definition of CALD

CALD is defined as: people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as "main English-speaking countries". The main English-speaking countries identified by the ABS are: Australia, Canada, Republic of Ireland, New Zealand, South Africa, United Kingdom and the USA. However, in some contexts, CALD is used as a broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, dress, traditions, societal structures and religious characteristics.

In healthcare, culture is often used interchangeable with race and ethnicity. This results in 'culture' being defined in a narrow way that focusses on differences based on visible or audible markers such as skin colour, accents and surnames.[4] Furthermore, there has also been a tendency to view culture and cultural difference negatively - that culturally-based customs and beliefs act as barriers to clinical practice and healthcare delivery.[5,6] An alternative viewpoint is that 'culture' encompasses multiple categories and processes that are strongly linked to economic, political, religious, psychological and biological conditions.[7] Additionally, culture should not be viewed as something homogenous or fixed.

Culture and health care

Culture is important in health care because it provides a framework through which individuals and communities interpret the world, negotiate their health behaviours and make decisions about their health care. Culture generally refers to knowledge, beliefs, traditions, values, or the way of life of a particular people, society or nation.[8] Thus, optometry-related knowledge, values and practices also comprise a distinct culture.

In the optometry context, there is a lack of research examining the impact of culture and cultural difference in eye care access and delivery. A recent study of vision specialists in the UK examining challenges in providing eye health care to children found that socio-cultural factors can play a role in clinical counters, for example, when there is a social stigma among some cultures around allowing children to wear glasses or patches.[9] An earlier pilot study conducted in Australia found that optometrists can experience challenges when providing care to patients from different cultural backgrounds.[10] Optometrists interviewed in this study described language difficulties with patients that resulted in the need to adjust their management advice or spend more time explaining things to patients. Some optometrists expressed feeling frustrated at times when they encountered patients who prioritised their spectacle needs and ignored or downplayed advice given about their eye conditions (e.g. cataracts, retinal detachment) which were seen as more important by the practitioner.

Within optometry, other health professions and our broader health system in Australia, health-related beliefs, practices and policies are centred on the biomedical model and traditional Anglo-Australian concepts of health and health care. Therefore, when people from non-Western societies migrate to places such as Australia, they are confronted with a health system which may differ and conflict with their own health beliefs, practices and experiences. Delivering quality health care may necessitate negotiation in situations where health beliefs and standard practices between patients and practitioners are in conflict. Practitioners also need to understand and manage variations in how patients explain and describe their clinical symptoms and illness experiences.

Health disparities

In Australia, there are significant health disparities that exist between non-Indigenous and Aboriginal and Torres Strait Islander people. While the poorer health experience of people from CALD communities is less well documented, there is evidence of poorer mental health in children[11], poorer oral health[12] and higher rates of diabetes[13]. People from some CALD backgrounds have poorer healthcare experiences and can find it challenging accessing health services for a variety of reasons, including communication difficulties[14], poorer health literacy[15] and lack of culturally appropriateness health services[16].

As a result, governments, health professions, healthcare organisations and health practitioners are increasingly aware of the need to provide more culturally responsive health care to our diverse individuals and communities.

A note of caution

There are differing views on the merits of considering 'culture' in health and health care. On one hand, knowledge of specific cultural beliefs and attitudes can be useful in informing health practitioners about different values, beliefs and practices that exist in a community.[17, 18] Some believe that this can improve patient-provider communication because it enables health providers to anticipate barriers to access and thus devise strategies to improve health care access and service delivery. On the other hand, others have advised caution against using culture as something prescriptive as this approach can reinforce stereotypes and labelling or lead to an over-emphasis on cultural factors which can lead to poorer quality of care.[4,7,19]

It is important to recognise that cultural influences are often implicit in people's behaviours, and people are often unaware of their culturally related beliefs, attitudes and traits. **In the health care setting, it is often health practitioners who have greater awareness of cultural differences than patients/clients.** Behaviours and beliefs are not always expressed in the same way by all who may identify as belonging to a particular cultural group, despite there being some commonalities amongst members. Additionally, individual expressions of attitudes, beliefs and behaviours will vary according to age, gender, personal experiences, circumstantial factors, and they are, in turn, influenced by family, group and community influences.[20]

Culturally competent and culturally responsive optometry practice

Cultural competency and cultural responsiveness are approaches that can be used to improve the effectiveness and accessibly of health services for patients from CALD backgrounds.[21,22] Encouraging health practitioners to be better at delivering equitable care by taking account of their own personal and professional cultural perspectives is viewed as fundamental to improving health care for minorities such as refugees, CALD communities, Aboriginal and Torres Strait Islander peoples.

Increasing numbers of organisations and professional bodies in the health care sector are incorporating this into professional accreditation and health service planning. Cultural competency and cultural responsiveness should be an integral part of service delivery, administrative practices and health policy and planning.

While **'cultural competency'** has been the most widely used term and model in this area, there have been other similar terms such as cultural responsiveness, cultural sensitivity and cultural safety. For the purposes of this framework and to adopt contemporary thinking and work in this area, we adopt the term **'cultural responsiveness'**.

This also aligns with the recently released Competency Standards Framework: *Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds* which was developed to address the "distinct challenges when considering the health of Australia's migrant and refugee population".[23] This framework was produced following 2 years of extensive collaboration and consultation and has been endorsed by the majority of Australian medical colleges and other health sector peak bodies, including the Optometry Council of Australia and New Zealand (OCANZ).[23]

However, this framework goes further than the Competency Standards Framework, which is solely focusses on clinicians. This framework is broader in scope and applies to optometry practices and organisations as well, a critical part of health care delivery. Organisational and community level factors and issues can have a strong influence and impact on how health services are delivered and ultimately, patient health outcomes.

Alignment with 'cultural safety' and 'patient-centred care'

Cultural safety is a model for health care practice that recognises the importance of culture in the delivery of health care to Indigenous peoples such as Aboriginal and Torres Strait Islander people in Australia and Maori peoples in New Zealand. In the Australian context, cultural safety has been defined as "the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism".[24] There is some overlap with elements of cultural competency and cultural responsiveness, however there is a greater focus on the impact of racism, power and privilege in health care encounters. Furthermore, the leading principle of cultural safety is that cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

Another approach or model of care that can be used to improve health care delivery for patients from CALD backgrounds is **'patient-centred care'**. In patient-centred care, the health care provider elicits and engages a patient/client's values, beliefs and experiences, including cultural values and perspectives, to individualise the care they provide.[25] There are many similarities between patient-centred care and culturally responsiveness care, however patient-centred care is more focussed on individual factors such as basic communication and health beliefs.

All of the aforementioned approaches, frameworks and models underscore the need for practitioners to identify and negotiate different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and discrimination.

The alignment of efforts to provide culturally responsiveness and patient-centred care have the potential to improve health care provision for all patients, not just those from a CALD background.

Business case for culturally responsive optometry practice

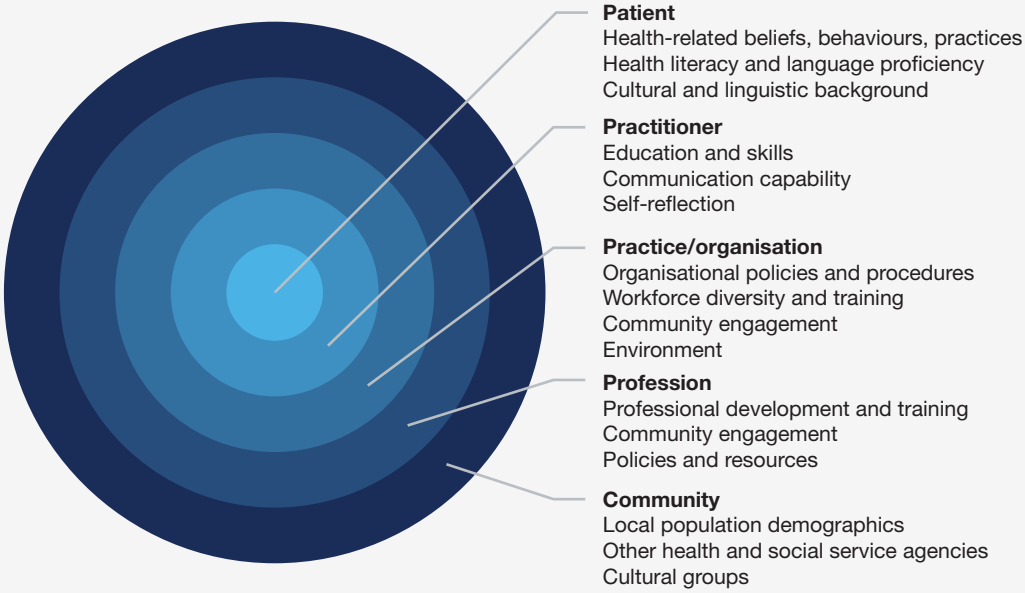
Practitioners and optometry practices that are responsive to the needs of the diverse communities within which they practice will likely attract a broader clientele and patient base. As Australia diversifies at a rapid pace and CALD groups increasingly become a larger proportion of the population, there is a growing number of patients with health care needs that are potentially not being met by traditional and mainstream optometry practices.

Better quality and more efficient eye care services can be enhanced by providing culturally responsive care to patients from diverse backgrounds. Organisations that strive to be more culturally responsive and inclusive will improve their organisational performance.[26] **Adopting organisational strategies such as recruiting diverse staff, community engagement and supporting staff to participate in diversity and cultural responsiveness training (e.g. how to use interpreters) are vital.**

Definition and conceptual framework:

'Cultural responsiveness' refers to: the capacity of clinicians and healthcare organisations to provide care that is respectful of, and relevant to, the health beliefs, health practices, linguistic and cultural needs of patients and communities. (Adapted from Migrant & Refugee Women's Health Partnership 2019)

The following framework recognises that culturally responsiveness optometry practice is multi-level and multi-dimensional. There are interrelationships and interconnections between the multi-level factors. The framework is structured in layers from individual (in the centre) to community (outermost layer).



At the **'Patient/Consumer'** level, it is important to consider the personal context that influences an individual's decision to use a health service, such as cultural background, geographic location, financial situation, health literacy and English language proficiency and religion. For example, if a patient is from a particular cultural or religious group which limits interactions based on gender, then the person may not use the service if their requests for specific practitioners (e.g. female or male) are not met.

At the **'Practitioner'** level, factors such as education and skills, and communication capability are influential. For example, friends or family members may recommend an optometrist based on their professional and responsive clinical and communication skills. Additionally, interactions with friendly and caring support staff may increase the likelihood that follow up or future appointments are attended.

The values, policies and practices of an **'Organisation'** can determine whether patients from CALD backgrounds feel comfortable utilising services. An organisation that values and respects cultural diversity can engage with clients and/or community groups to review the appropriateness and relevance of their services. Hiring and training staff that reflect the local community is a positive step.

The broader **'Community level'** is also an important influence on health service utilisation. Strong relationships with other health and social service agencies (e.g. refugee and migrant services, councils) are vital to developing collaborative care pathways.

Decisions made by patients from CALD background to use health care services are based on multiple factors, of which culture may be one amongst many. Hence, the use of a model that situates the patient in the middle with the different levels/layers is necessary to ensure that the patient's unique context is recognized and taken into consideration rather than assumed to be largely determined by cultural factors. There is an assumption of interaction and connectedness among the levels and therefore improvement at the individual level is dependent upon action at the other levels, not only the individual level. Hence, appropriate changes in the other levels of the environment can also influence changes at the individual level.

Cultural responsiveness toolkit

This toolkit provides practical resources to guide you, your practice and/or organisation in ensuring you are being culturally responsive. They are aligned to each section of the framework for ease of use.

Do you know of a great resource that is not in our toolkit? Please let us know.

Levels	Indicators	Examples	Suggested resources
Patient	Patients have access to eye resources in their preferred language	Provide translated materials in languages other than English e.g. patient pamphlets & videos.	▪ Vision Initiative – download multilingual pamphlets, posters & videos ▪ Medline - Pamphlets in multiple languages
	Health literacy is assessed by the practice/organisation to aid in communication	Practice's new patient questionnaires include some questions to ascertain patient's health literacy level e.g. "Do you need help understanding and reading medical or health materials?"	▪ Centre for Culture, Ethnicity & Health – health literacy resources
	Feedback mechanisms available to obtain patient feedback	Conduct patient feedback surveys (anonymous)	▪ RACGP patient feedback template ▪ RVEEH patient feedback form ▪ Survey Monkey how to create patient satisfaction survey
Practitioner	Cultural responsiveness training is undertaken by optometric and practice staff	Undertake professional development related to cultural responsiveness 1. How to use an interpreter effectively 2. Complete self-reflective checklist periodically to assess change over time	▪ Cultural Diversity Health - Clinicians Guide for working with interpreters ▪ Optometry Australia: Self-reflection checklist ▪ Complete CPD module on CALD responsiveness within Institute of Excellence (coming later in 2021)
Practice/ organisation	Practice audits or reviews are conducted regularly	▪ Practice manager and staff completes self-reflective checklist ▪ How does my practice promote and advertise to patients our cultural and linguistic competency? ▪ Conduct practice environmental and systems assessment – is the practice wheelchair accessible? Is there appointment book flexibility to allow for longer consultations? ▪ Conduct a review of your practice or organisation's level of cultural responsiveness using this tookit	▪ Optometry Australia: Self-reflection checklist ▪ National Centre of Cultural Competence – self assessment for primary care practitioners
	Community engagement	▪ Attend/sponsor community and cultural events in a professional capacity. ▪ Conduct educational talks on eye health to community groups	▪ Australian Government – Community engagement strategy ▪ Optometry Australia – Download suite of editable PowerPoint presentations for community talks

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Levels	Indicators	Examples	Suggested resources
Professions	Resources	▪ Share resources that members can use in their practices to assist patients e.g. develop eye care information sheets in different language, develop short videos of diverse people explaining a medical procedure. ▪ Provide opportunities for members to share resources ▪ Help members facilitate community engagement activities	Vision Initiative – download multilingual pamphlets, posters & videos Cultural Diversity Health – competency standards framework for clinicians ASCO (USA) – Guidelines for culturally competent vision and eyecare Advancing cultural competence in optometry
	Organisational audit	Conduct a review of the practice or organisation's level of cultural responsiveness	CXO – Advancing cultural competence in optometry
	Professional development and training	Provide members opportunities to upskill their cultural responsiveness practices	Optometry Australia – Culturally responsive practice webpage collates CPD resources
Community	Seek local demographic characteristics and statistics	Obtain demographic information of the local community to identify any groups that require more targeted engagement	Demographic profiles of 300+ local communities in Australia
	Collaborate with local social service and health agencies	▪ Build relationships with other agencies such as migrant resource centres, community health, primary care centres	Contact your local Council to find out the relevant agencies in your area.

Self-reflection checklist - cultural responsiveness

For optometrists and optometry practices

Fundamental to being a culturally responsive optometrist is 'knowing yourself'. This checklist is intended to enhance your awareness and sensitivity to the importance of cultural responsiveness in healthcare provision. It provides examples of the kinds of beliefs, attitudes, values and practices which foster cultural responsiveness.

There is no answer key with correct responses. However, if you frequently responded 'not at all', 'rarely' or 'sometimes', you may not necessarily demonstrate beliefs, attitudes, values and practices that display culturally responsiveness.

Checklist may be conducted periodically to assess change over time.

Tip: Use this checklist to prompt interactive discussions during your team meetings or case discussion grand rounds. We encourage all staff to engage in self-reflection.

1. Self-awareness	Not at all	Rarely	Sometimes	Often	Always
I am aware of my own cultural heritage and belief systems	1	2	3	4	5
I am aware of my biases and assumptions	1	2	3	4	5
I am aware of differences within my own cultural group	1	2	3	4	5
I am aware that patients of different cultural backgrounds can receive insensitive and sub-standard health care	1	2	3	4	5
I am aware of that patients can have different perceptions of the role of the optometrist	1	2	3	4	5
I understand that there are both differences and similarities between cultural groups	1	2	3	4	5
I understand that cultural sensitivity and awareness is important when providing health care	1	2	3	4	5
I understand that patients have different worldviews that impact their health-related attitudes, beliefs and practices	1	2	3	4	5

2. Values and attitudes	Not at all	Rarely	Sometimes	Often	Always
Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.	1	2	3	4	5
I recognize that the meaning or value of eye care treatment and health education may vary greatly among cultures.	1	2	3	4	5
I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.	1	2	3	4	5
I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural groups.	1	2	3	4	5
I accept and respect that male-female roles may vary significantly among different cultures (e.g. who makes major decisions for the family).	1	2	3	4	5
I intervene in an appropriate manner when I observe other staff or clients within my practice/organisation engaging in behaviours that show cultural insensitivity, racial biases, and prejudice.	1	2	3	4	5

Checklist continued over page

3. Knowledge and education	Not at all	Rarely	Sometimes	Often	Always
I keep abreast of the major eye health and health concerns and issues for diverse client populations residing in the geographic area served by my practice or organisation.	1	2	3	4	5
I am aware of the socio-economic and environmental risk factors that contribute to health disparities or other major health problems of culturally and linguistically diverse populations served by my practice or organisation.	1	2	3	4	5
I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, and linguistically diverse groups.	1	2	3	4	5
I am aware of specific eye health and health disparities and their prevalence within the communities served by my practice or organisation.	1	2	3	4	5

4. Communication style	Not at all	Rarely	Sometimes	Often	Always
When interacting with individuals and families who have limited English proficiency, I always keep in mind that:					
▪ limitations in English proficiency are in no way a reflection of their level of intellectual functioning.	1	2	3	4	5
▪ their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.	1	2	3	4	5
▪ they may neither be literate in their preferred language nor in English.	1	2	3	4	5
For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words so that I am better able to communicate with them during assessment, treatment or other interventions.	1	2	3	4	5
I use bilingual/bicultural or multilingual/ multicultural staff, and/or personnel and volunteers who are skilled or certified in the provision of medical interpretation services during treatment, interventions or other events for individuals and families who need or prefer this level of assistance.	1	2	3	4	5
For those who request or need this service, I ensure that all notices and communiqués to individuals and families are written in their language of origin.	1	2	3	4	5
I understand the implications of health literacy within the context of my roles and responsibilities.	1	2	3	4	5
I am flexible and adaptable in my approach when I examine, communicate and manage my patients.	1	2	3	4	5
I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my practice or organisation.	1	2	3	4	5

Checklist continued over page

5. Practice's physical environment, systems, materials & resources	Not at all	Rarely	Sometimes	Often	Always
My practice has a flexible appointment book that can enable longer appointment times if individuals and families require.	1	2	3	4	5
I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of clients served by my practice or organisation.	1	2	3	4	5
I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by my practice or organisation.	1	2	3	4	5
I ensure that printed information disseminated by my practice or organisation takes into account the average literacy levels of individuals and families receiving services.	1	2	3	4	5

This Checklist was adapted from:

1. ASCO Guidelines for Culturally Competent Eye and Vision Care
2. Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services (National Centre for Cultural Competence)

Glossary of terms

Cultural competence	A set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations[27].
Culturally and linguistically diverse (CALD)	A broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, dress, traditions, food, societal structures, art and religion characteristics. CALD people are generally defined as those people born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as "main English speaking countries" (i.e. Canada, the Republic of Ireland, New Zealand, South Africa, the United Kingdom and the United States of America.[28]
Culture	Refers to the distinctive ideas, customs, social behaviour, products, or way of life of a particular nation, society, people, or period[29].
Cultural responsiveness	the capacity of clinicians and healthcare organisations to provide care that is respectful of, and relevant to, the health beliefs, health practices, linguistic and cultural needs of patients and communities. (Adapted from Migrant & Refugee Women's Health Partnership 2019)
Cultural safety	Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. (AHPRA 2020)
Determinant of health	A factor or characteristic that brings about change in health, either for the better or for the worse
Ethnicity	Refers to status in respect of membership of a group regarded as ultimately of common descent, or having a common national or cultural tradition; ethnic character[30]
Health inequality	The generic term used to designate differences, variances and disparities in the health achievements of individuals and groups[31].
Health literacy (individual)	The 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 (National Safety and Quality Health Service Standards.)
Migrant/immigrant	any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country (UNESCO 2015).
Reflexivity	An individual's ability to reflect upon and understand how their social position, experiences, attitudes and biases shape their worldview and influence their interaction with others.

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