A piece of the puzzle — the role of ethnic health staff in hospitals

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Abstract

The role of ethnic health staff in hospitals has not been clearly articulated for managers and practitioners. This paper describes findings from a study based on ethnic and allied health staff interviews and observations of ethnic health staff interactions. Care was provided to language concordant patients directly and by assisting practitioners to work within the patient's cultural paradigms and family schema. The scope of practice involved: engaging patients in a therapeutic relationship, patient assessment, linking assessment with care options, facilitating communication between patients and practitioners, education, smoothing hospital experiences, referral and interpreting. Ethnic health staff displayed a range of specialised skills that managers need to harness within multidisciplinary teams to reach patients from diverse backgrounds.

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What is known about the topic?

Initial funding for the Ethnic Health Worker program was provided in the 1980s under cost-sharing arrangements between the Commonwealth and the states. Over time, the funding and organisation of health care have changed and the role of ethnic health staff in the hospital setting has become unclear and therefore potentially under-utilised by health care practitioners and managers.

What does this paper add?

This study aimed to further understanding of the practice of ethnic health staff, and found that ethnic health staff had a range of specialised skills that were respected by the practitioners they worked with. The ethnic health staff demonstrated dual roles of direct care provider and paraprofessional or communication facilitator, which corroborated previous assessments of the role.

What are the implications for practitioners?

Health care managers need an understanding of the competencies, skills and expertise of ethnic health staff and to consider their employment in health teams (for example, in diabetes care, maternal and child health, renal, cardiac, or disability services). Ethnic health staff have been shown to be an effective bridge that is, by mediating the patient–practitioner–organisation divide, enhancing patient capacity to negotiate the unfamiliar world of the hospital, informing better case management by exposing practitioners to the patient world view, and providing one-to-one and group education.

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AUSTRALIA IS A COUNTRY of great diversity. In 2001 almost 50% of its people were born overseas or had one or both parents born overseas.[1] The diversity of language, culture and religion across the country stands in stark contrast to the dominance of Anglo-Celtic traditions in Australian institutions, including health care organisations. Misunderstandings and miscommunication related to this diversity have been found to impede quality of care, such as lack of recognition of the need for particular tests, misdiagnosis, patient misunderstanding of their diagnosis and

treatment, ineffective education and poor compliance with treatment,[1-6] increasing costs through lengthened hospital stays and greater reliance on tests.[7] Further, ignoring optimal communication with patients who have limited English language proficiency and cultural and religious values that differ from the dominant host society poses serious threats to the provision of culturally safe practice, appropriate health outcomes and patient satisfaction.[8-10]

In Australia, barriers to care for migrants were formally acknowledged in the early 1970s[11] prompting the establishment of two nationally funded programs — the Health Care Interpreter Service and the Ethnic Health Worker program — designed to ameliorate some key factors impeding care.[12] Health care interpreters reduce the language barrier through language assistance in a triadic relationship between the client and health professional.[13] Ethnic health workers use their language, cultural insight and relationship with the community to encourage access to health and other related services and foster better health outcomes by facilitating the client through the system. The facilitation role was designed to support the client through the unfamiliarity of Australian health care systems, facilitate the provision of culturally sensitive care by practitioners, and ensure referral to appropriate follow-up services. The ethnic health worker ameliorates cultural barriers to care through direct service provision and by working with practitioners as a paraprofessional, reducing ignorance of cultural difference and inability to provide information.[12] This paraprofessional role assists the practitioner to attain better health outcomes by negotiating treatment and management decisions that are mutually acceptable to both patient and practitioner.

Evolution of the Ethnic Health Worker program

Initial funding for the Ethnic Health Worker program was provided in the 1980s under cost-sharing arrangements between the Commonwealth and the states. As responsibility for provision of hospital services is retained by states, it is difficult to determine how many ethnic health workers are employed throughout Australia. Some may not have an ethnic worker title, although may have similar roles within clinical services. At its peak the Ethnic Health Worker program was heralded as a success and funding was enhanced.[14] However, later reviews based on staff interviews identified that ethnic health staff (EHS) had become overburdened with providing direct care in a system that simply pushed the care of "foreigners" onto similarly "foreign" health service providers.[14,15] Over 10 years ago Fuller called upon nursing staff, in particular, to rectify this situation by better understanding the role of EHS as paraprofessionals, that is, EHS sharing service delivery responsibility and assisting nurses to negotiate mutually desirable health outcomes.[15]

Most ethnic health workers have since either chosen or been directed to work in the community within a health promoting context, with each state determining their priorities or individual focus.[16] Work within the hospital setting dwindled into virtual non-existence until the early 1990s, when the role resurfaced with a need to provide more culturally and linguistically appropriate maternity services in health regions with a high proportion of clients from culturally diverse backgrounds. This essentially excluded rural, regional and remote Australia, and indeed more recently developed urban areas. In the late 1990s an area in Sydney's south western suburbs funded additional ethnic health positions to work in identified hospital settings with similarly high numbers of patients from diverse backgrounds. The nomenclature, ethnic health staff, is used to describe staff in this paraprofessional role in maternity and other hospital settings.

Given the changes to funding and organisation of health care, the role of EHS in the hospital setting has become unclear and is often misunderstood and therefore potentially under-utilised by health care practitioners and managers. This study aims to further understanding about the practice of EHS and to describe and analyse their roles in the hospital setting using three perspectives — that of the EHS and the allied health staff

in the units in which EHS work, and from observation of their work.

Methods

Multiple methods were used to understand the scope of EHS practice with triangulation of data sources that were captured over a 4-year time period (1999–2003) as part of two separately funded studies and a quality review of allied health staff working with ethnic health staff in hospital settings. These included: Study 1 — direct observation of patient–EHS and patient–EHS–practitioner interactions ($n = 16$); Study 2 — one-to-one interviews with EHS ($n = 14$); and Study 3 — one-to-one interviews with allied health staff working in units where EHS were employed ($n = 12$). Ethics approval for the observations was received from the Area Health Service's Ethics Committee. Staff interviews were conducted as a quality review under the Evaluation and Quality Improvement Program (EQuIP), Australian Council on Health Care Standards accreditation process.[17]

Observations

Study 1 used a qualitative research design based on a case study approach[18] to observe participant interactions within multi-site naturalistic settings — maternity, paediatric, rehabilitation and outpatient services in three Sydney hospitals. In this environment the observer is known to the participants as a researcher, but does not take an active part in the events.[19] This awareness of being observed is a limitation of this methodology as it is likely to influence participant behaviour.[20] However, while these "reactivity effects" cannot be fully eliminated it is difficult to change normal behaviour and to sustain that change for long periods.[21] As this study was part of a larger project (observing patient–interpreter–practitioner, patient–bilingual practitioner, patient–ethnic health staff and patient–ethnic health staff–practitioner interactions), the choice of languages was designed to increase the opportunity for potential matches and was thus based on the major languages used by patients. Four bilingual research officers were trained by the project manager to record the content of the interaction; the associated non-verbal behaviour; and to clarify discrepancies between words and actions[22] (observations and interviews) using unstructured interviews with participants at the end of the interaction.[23] An observation sheet that included the main elements to be recorded was developed.

Ethnic health staff who spoke the selected languages and worked in the hospital setting were invited to participate in the observation study. Verbal consent was obtained from staff who agreed to participate (100%). Ethnic health staff then selected patients, obtained a translated written consent and negotiated appropriate times for interactions to be observed by the bilingual research officers.

Interviews

Research staff conducted in-depth individual interviews using semi-structured questionnaires designed to facilitate the exploration of roles. The questionnaires were provided before interview. In units where EHS were employed, all 17 allied health staff (AHS) were invited to participate. Of the 15 who consented, 12 were interviewed and 3 completed the semi-structured questionnaire. Two were unavailable at the time of interview. In Study 2, EHS were asked to describe a key project or area of work that they were involved in, to discuss what they considered to be their main role and the difficulties of this role. In Study 3, allied health staff were asked to focus on the types of cases seen and key issues for patients; difficulties faced in their role; attaining better patient outcomes; and the use of EHS and their contribution (or not) to case management. Interviews were tape-recorded, transcribed and coded using qualitative thematic analysis in both studies. Extensive notes were taken in one interview when taping was refused.

Analysis

The data from each study were analysed using NUD*IST (Non-numerical Data Indexing Searching Tool).[24] In Study 1 the coding system was based on categories previously identified by the

1 Quotes from the transcripts illustrating the major themes derived from ethnic and allied health staff interviews: perceptions of ethnic health staffs' practice

	Perception of role and functions	
Content	**Ethnic health staff (EHS) *n*=14**	**Allied health staff (AHS) *n*=12**
Paraprofessional	Being a link between the patient and the staff, so making the staff become aware of patient needs	Get information from families and clients that would be impenetrable for me
	Identify cultural needs that could be impacting on or blocking or interfering in the therapy or treatment	Provider of cultural knowledge and as a means of access into the client or family's viewpoint or situation
	We see things that they don't perceive	Support worker — adjunct to mainstream staff
	More of whole picture rather than the understanding of the language	Bridge of the community – hospital divide
	Try to remind the practitioner . . . if they don't have the language problem they probably still have the cultural problem . . . and just don't assume "Oh, you know, she can perfectly understand what I'm saying so she will be okay."	Liaise with the family
	Bridge to help the practitioner understand the patient more	Much better understanding of the culture of the patient
	Also to help the patient . . . because in Australian health system they work this way	Suss it out for us
		Get a bit more co-operation – definitely benefits in that
		Able to alert me to patient concerns that I may not have been aware of
		Aware of cultural issues throughout the exchange and in terms of proposed interventions
Education	[Of practitioners] It's like someone's looking through fog and now they can see. Before it was like "What's happening?" but when you explain things they feel like "Oh, now we know why this and that and this situations happened."	Foster knowledge of health issues and services
	[Of patients] [scenarios provided in most interviews]	Contribution to patient gaining knowledge
Problem solving	Explain events before the meeting	Contribution to management of client
	Determine reasons appointments not attended . . . can't really understand what the treatment is for . . . think the treatment is not useful	Liaison with the family
	Practitioners refer clients if they identify patients have difficulty relating to cultural or language background . . . work with ethnic health staff to find out . . . how to help them overcome barriers	Because they have a much better understanding of the patient
Advocacy	Because I was able to talk to them [patient] I was able to identify there was an issue there	Able to alert me to patient concerns that I may not have been aware of
	When they say "You have to do this and you have to do that" and patient says "No, I don't want to do it" and then practitioner says "Why?" so I have to explain reason why	Aware of cultural issues throughout the exchange and in terms of proposed interventions
Support	From a culture where communication and social interrelations is very important not having support while in hospital can be a big issue	Support people for both the staff and the client who access the units in which they [EHS] are based
		Ability to follow-up on treatment and rehabilitation . . . continuity of care
Referral	Big network outside the hospital	Links they had developed with other ethno-specific services in the community
	Accessing services outside the hospital	Networks in community to refer clients

authors,[25] with a number of additional themes emerging. In Studies 2 and 3 the coding system was developed from the statements, events and phenomena in the transcripts. One author used these themes to code all transcripts. Transcripts were re-coded independently of the original coding, with confirmability an average of 80%. The transcripts were re-read and new or regrouped categories determined. This iterative process clarified major themes and issues emerging from the data, facilitating consensus on differences in coding interpretations.

Results

Of the total 18 EHS participating in the observation study or interviews:

- all were employed as hospital-based EHS (EHS, like many allied health staff, are managed within professionally based teams, in this case an ethnic health team, and work as part of a multidisciplinary team in specific units of the hospital);
- 78% had completed degrees in health disciplines in their source countries that were not recognised in Australia (50% in medicine and 29% in social work);
- two had nursing qualifications from overseas and had attained midwifery qualifications in Australia, and were employed on a graduate award;
- two participants did not have tertiary qualifications;
- all were proficient in English and their language/s other than English, an essential and tested pre-requisite of employment; and
- two staff had also gained formal translating and interpreting accreditation.

As this is a small group working within the Sydney region, information that could possibly identify them, such as language/s spoken, is excluded.

Perceptions of EHS practice were categorised according to six key themes derived from all the interviews. These were: paraprofessional; educator; problem solver; advocate; support; and referral roles. Box 1 highlights quotes from the transcripts that illustrate these roles. There was congruence between allied health and ethnic health staffs' perception of practice. There was consistency of themes with previous evaluations of the role.[14,15] Of all the roles, that of "bridge" or "link" between the client and the practitioner was the most commonly referred to when describing the role. There was evidence of appreciation by allied health staff of EHS' presence: of their understanding of the patient and input into decision making regarding treatment options, case management and patient care. As one allied health participant stated:

> There are so many different cultural practices that one mind can never hope to understand. You can have a sense of a lot of different cultures but never fully understand every one. I find that it is a really big issue because you are trying to help the family and solve a problem, but there are so many different factors impinging on that family's situation that you can make a suggestion and they can be completely useless, or aren't respected, or whatever ... I can be giving advice and then it's not followed through and the child does not start to improve and I start to question my clinical decision making and sometimes forget it might be other factors impinging on them.

And another allied health participant:

> We have seen huge gains with those families when we have ethnic health workers involved. It seems to be that last piece in the puzzle, or maybe the first piece. It gets the puzzle underway and just brings it all together. It is so crucial.

The observations validated the paraprofessional, educator, problem solver, advocate, support and referral roles identified through the interviews. However, additional themes emerged. These were captured by comparing these themes with eight categories previously identified by the authors to describe bilingual health staff's use of their language other than English,[25] and then combining the results. Overall, nine themes outlined in Box 2 were identified to incorporate all

2 Content of observations* (*N* = 16)

Type of content	No. of occasions this occurred within all observations
Patient assessment	11
Education/provision of information	11
Explanation of procedure or treatment	9
Ongoing treatment/review	9
Problem solving — identification of and sorting out of a problem related to hospitalisation, treatment or condition	5
Paraprofessional — assisting health professional with assessment or procedure	5 (+2 practitioners working with EHS in group education)
Referral	4
Interpreting	2
Advocacy	1
Consent for treatment or procedure/release of information	0
Counselling and therapy	0

* An observation was defined as the period from when the staff member approached the patient to when the staff member left the room or bedside. Some observations were coded for more than one category, so the number of occasions does not tally to 16.

content, including four additional themes — assessment; explanation of procedure or treatment; ongoing treatment/review; and interpreting. Support was subsumed within a number of these existing themes.

There was evidence from the observation study that EHS function within two main modes, featuring a range of activities, in the provision of quality health care. First, EHS act as direct care providers in dyadic patient–EHS relationships. Second, their competencies, skills and expertise are used by practitioners and patients within triadic patient–EHS–practitioner relationships. The observations also provided insight into the techniques used by EHS to collect and reflect on information that linked patient vulnerability with options for care, and to smooth the patient's experience of hospitalisation. In particular, there was evidence of ascertaining difference between individuals that "belong" to the "same" linguistic group. This empirical knowledge was gained through an assessment process that appeared critical to identifying the relevance and subsequent use of select factors in patient care, either directly or through assisting practitioners to make informed decisions. For example, collecting information on individual characteristics that may prove vital to later education, such as assisting a patient to practice healthier behaviour, was illustrated in an interaction where the EHS learns that the mother only breastfed her first child for 2 months:

> EHS: Did your mother support breastfeeding for your baby? Did your husband's mother like the idea of breastfeeding for your baby?

Details collected by EHS during assessment were: patient demographics; religious affiliation; financial status (eg, ability to pay for childcare or transport to attend clinics); dietary practices; English language proficiency; length of time in Australia; previous use of hospital in Australia/other country; the patient's understanding of the health problem; understanding of and follow-through with treatment instructions; identification of the main caregiver and decision maker; family support of suggested intervention; and evidence of previous behaviour that supports the intervention. Separate assessments were conducted for details specific to the unit, for example assessment for postnatal depression. Assessment of patients' language other than English (LOTE) literacy was evident in EHS overseeing completion of forms.

Interestingly, assessment demonstrated the breadth of "invisible" work[26] conducted by EHS — invisible in that it was not raised by allied or ethnic health staff during the interviews as an activity of EHS, yet, as shown in Box 2, it occurred in two-thirds of the observations. Assessment was predominantly conducted in dyadic relationships between patients and EHS at the initial interview and continued throughout ongoing relationships to update and complete the

assessment process. Other invisible work evident in the observations included EHS' consideration of factors that might present challenges to overseas-born patients and their efforts to minimise these effects. Examples included the following.

Pre-empting misunderstandings due to inherent differences between health systems

> EHS: Here in Australia, we encourage patients to be independent. That means, from right after the birth the mother will be responsible for looking after the baby.
>
> Patient: Oh really? That sounds quite hard.
>
> EHS: No, it's not hard. Midwives in postnatal ward will tell you what to do . . .
>
> Patient: Oh, things are very different in [country]. In [country], when you just had a baby in a hospital nurses would look after the baby for you until you were ready to go home.

Clarifying questions that would be asked by practitioners

> EHS: Later a midwife will call you into her room to collect a medical history from you.
>
> Patient: Medical history? I haven't got anything in writing. What do you mean by a medical history?
>
> EHS: Medical history means what ever diseases or operations you had before. The midwife will ask you some questions. You only need to answer her verbally . . .

Practitioners acknowledged the importance of this explanatory role. During one observation, the practitioner specifically allocated time to facilitate this role.

> Practitioner to EHS: My colleagues may ask many questions about the child. There are many things to look at in order to assess the child. I'll make an appointment so you [EHS] can explain them [to the patient].

EHS exhibited other behaviours that quietly negotiated the hospital experience for the patient and coincidentally minimised disruption to practitioners. For example:

Preventing escalation of miscommunication

> Patient: I am really worried because my baby has not eaten anything since she was born, and according to the record from the nurse she ate at 8am and drank milk which is also not true.
>
> EHS: Let me see. I'll check the record to see what has been written and I will talk to the nurse if necessary. [EHS comes back reading the record.] Yes, here it says . . .
>
> Patient: That is not true [not allowing the EHS to finish reading the record].
>
> EHS: Do not worry, here it says . . .

Clarifying misunderstood treatment instructions

> Patient: Yes, I have washed them [stitches] with hot water once.
>
> EHS: But you have to wash them three times a day.
>
> Patient: Ahh! I thought it was just once.

Ethnic health staff achieved these outcomes by building trust, thereby engaging patients and their families in therapeutic relationships. Trust allowed patients to share their fears with EHS, with the relationships often continuing over time, for example from previous pregnancies.

In addition to this crucial smoothing process, EHS also provided education to individuals and groups. Education was introduced in most one-to-one encounters. It was initiated by EHS to cover information related to the patients' care and occurred in response to questions raised by patients. Practitioners and EHS worked together within a multidisciplinary setting to implement a cardiac rehabilitation program. The EHS conducted the program in a LOTE while a registered nurse measured clinical parameters and a physiotherapist supervised exercise sessions. Ethnic health staff referred to other team members in the presentation — ". . . if you want to know something about a dish that you really like, just tell me and I will contact the dietitian to find out. . ." Another group invited a registered nurse as a guest speaker to one session in a series of eight sessions, designed and conducted in the LOTE by the EHS.

An unexpected observation was that of voice-box interpreting in a triadic patient–EHS–practi-

tioner relationship.[13] This was unexpected, as interpreting is formally delineated as an interpreter's role and outside of the guidelines for EHS practice. However, the two situations exemplified sensible use of EHS and competence in voice-box interpreting. These were: the serendipitous use of EHS in a patient–doctor interview before the interpreter arriving, preventing the loss of an appointment timeslot; and the prearranged use of EHS in a cognitive assessment of a patient when an interpreter was unavailable. In the second case, the EHS was observed to have content knowledge and an ongoing relationship with the patient and the patient's family. This knowledge probably aided the interpreting process, reinforcing the importance of using this skill within familiar areas of work.[13]

Discussion

Ethnic health staff were observed to have a range of specialised skills that were respected by the practitioners they worked with. These ethnic health staff functioned through the dual roles of direct care provider and paraprofessional or communication facilitator, corroborating previous assessment of the role[14,15] and indicating established pathways to providing health care. The interviews highlighted practitioners' improved understanding of the role since Fuller's earlier assessment. The observations confirmed the mutual benefit of combining the two roles, and the advantages for patient and practitioner alike.

The main activities identified within these roles through interview and observation were:

- assessment;
- education/provision of information;
- explanation of treatment or procedure;
- ongoing treatment and review;
- problem solving;
- referral;
- support; and to a lesser degree
- advocacy; and
- interpreting.

Importantly, all work was underpinned by an assessment process that was fundamental to strategically placing the patient at the centre of care. This process allowed EHS to capture empirical information on the diversity within diversity — such as illiteracy in the preferred language, financial circumstances affecting the ability to afford transport to attend appointments or to join support groups; estimation of the level of acculturation; or the effect of others on decision making; and to use this knowledge to facilitate the appropriate linking of patient attributes with care options.[27]

Within the paraprofessional role, EHS coupled this assessed understanding of the patient with their knowledge and experience of the health care context to focus on the patient perspective. EHS could then tackle the dissonance between Western medical practice and individual patient characteristics and beliefs. This ability to straddle the patient–practitioner–organisation divide was critical to engaging the patient and the practitioner in a meaningful care process. It reduced the complexity of the interaction to be mediated and enabled negotiation to attain the best possible outcomes for the patient. The legacy of ignoring or not bridging this divide is clearly identified in health care literature,[1-6] emphasising the relevance of this communication facilitation role as a professional practice of EHS.

Within the direct care context, difference is still negotiated but with less background distraction. Provision of direct care allowed trust and rapport to be established; facilitated discussion of the idiosyncrasies of Australian health care; provided opportunities for patients to raise concerns, have issues clarified and resolved, and to discuss treatment options within the sensitivities of cultural paradigms, family schema, socioeconomic, trauma and other individual characteristics that may affect uptake of care; and provided targeted individual or group education that considered these attributes.

This frequently invisible patient–EHS negotiation needs to be brought to the attention of practitioners and managers, providing the opportunity to reflect on practice and to gain new skills in working with patients from diverse backgrounds. Thus EHS can assist health care organisations to become more culturally safe as discussed by other researchers.[8,9] The amount of

time EHS spend on education, both expediently as issues arise and as part of pre-designed programs, with associated print and/or audio-visual materials, developed directly by these staff in the preferred language and with consideration of cultural and other patient attributes, also requires greater acknowledgement. Using EHS to deliver health messages is productive, time efficient and allows for more effective use of other health care practitioners in a busy health setting.

While interpreting is the role of professional health care interpreters and should not be a core activity of EHS, it was observed to be a small but important component of the role.

Today's model of hospital-based EHS is of a highly specialised workforce, with a diverse range of health expertise, often gained in their source country, who can plan and implement health care directly in their LOTE, and, as communication facilitators, assist other health care providers to contribute to patient safety and quality health care. The scope of practice involves the following expertise:

- engaging patients in a therapeutic relationship, through building rapport and trust;
- conducting systematic assessment relevant to the clinical discipline in which staff are employed;
- synthesising the findings to link patient vulnerability with options for care;
- facilitating communication between patients and practitioners in a relationship that incorporates this synthesis and contributes to the formulation of the care plan;
- pre-empting and smoothing challenging hospital experiences through explanation, problem-solving, advocacy and support;
- providing education that engages patients in managing self-care;
- ensuring appropriate referral using knowledge of community networks; and
- interpreting.

This study, while pointing to the benefits of EHS, does not provide evidence that the presence of EHS improves health outcomes for patients from culturally and linguistically diverse backgrounds. A Cochrane review of the lay health worker, defined as workers who are not certified health care professionals but trained to promote health and provide health care services, showed that these programs were effective for some kinds of health care.[28] Studies of linkworkers, who provide a cultural bridge between health care providers and patients, are similarly mixed.[29] Adequate funding for larger-scale research is required to evaluate these longer-term outcomes of employing EHS. This study provides a starting point by delineating the required scope of practice that is associated with improving health outcomes.

Conclusion

EHS are a highly specialised group within an embryonic domain of work that requires firmer embedding within the health care system. This study illustrates the value of their employment in multidisciplinary teams in select units with high numbers of patients from particular linguistic and/or cultural backgrounds. Within Australia there is great diversity of professional skills within refugee and migrant groups that can be harnessed productively to provide better health care. Health care managers need to have an understanding of the competencies, skills and expertise of EHS and, after identifying their patient/population base and current gaps in service delivery, consider their employment in health teams (for example, in diabetes care, maternal and child health, renal, cardiac, or disability services). EHS have been shown to be an effective bridge — that is, by mediating the patient–practitioner–organisation divide, enhancing patient capacity to negotiate the unfamiliar world of the hospital, informing better case management by exposing practitioners to the patient world-view, and providing one-to-one and group education. The model, if managed well, has the capacity to reduce other team members' workloads, reduce stereotyping, miscommunication and misunderstandings and contribute to patient safety and quality health care. In conclusion, EHS are a key piece in the puzzle of culturally safe service provision to diverse patients.

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Competing interests

The authors declare that they have no competing interests.

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