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Understanding the Experience of Healthcare Workers in Delivering Emergency Care to Racial and Ethnic Minority Patients: A Qualitative Study

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Research Article

Keywords: culturally and linguistically diverse, ethnic minority, cultural humility, emergency department, emergency care, phenomenological study, health service delivery

Posted Date: July 7th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9949686/v1

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Additional Declarations: No competing interests reported.

Abstract

Background: International migrants experience healthcare inequities in the Emergency Department (ED), and little is known about the care delivery of healthcare workers (HCWs) to this population. This study aimed to explore the experience of HCWs in delivering care to patients from racial and ethnic minority backgrounds in Emergency Department.

Methods: This study was conducted during the first stage of a five-year experience-based codesign project, employing a qualitative approach. Eligible participants were Australian registered HCWs or non-clinical staff who support or manage clinical care delivery and had worked in the nominated EDs for at least three of the past 12 months. Semi-structured interviews and focus groups took place either in-person or via videoconference. Audio recordings were transcribed for inductive thematic analysis. The COREQ checklist was used to guide the design and conduct of the study.

Results: A total of 39 participants (26% doctors, 46% nurses, 5% allied health professionals and 23% non-clinical staff) shared their experience in caring for racial and ethnic minority patients. Three overarching themes were generated: 1) language barriers; 2) diverse cultural norms; 3) poor health system literacy. All participants reported that the biggest challenge was lack of a common language, which presented a barrier to delivering quality care throughout the patient's journey in the ED. Many HCWs tended to use informal and unregulated interpretation strategies, attributed to the episodic nature of patient communications and interactions and the relative inaccessibility, inconsistency, unavailability, unfeasibility and inaccuracy of formal interpretation services. The diverse cultural norms and poor understanding of ED care procedure were also raised as barriers to delivering person-centred ED care.

Conclusions: Understanding HCW experiences of delivering care for this population provides the first step in system improvement to make care delivery safe, culturally sensitive and accessible. Opportunities to make ED care culturally sensitive include extending the capacity and ease of access to interpretation/translation, through both formal services and complementary strategies. Partnering with patients and cultural community centres could offer a feasible approach to co-design and disseminate health system literacy education.

Registration

Language barriers created a hindrance for ED clerks to collect basic information from CALD patients for registering them into the system.

Background

International migration has been increasing, with migrants comprising 281 million (3.6%) of the global population in 2020 (1). As one of the top ten migration destinations globally, over seven million people (three in ten) in Australia were born overseas in 2021(2), and more than 568,000 people emigrated to Australia in 2024–2025(3). There is no consensus on the terminology to position international migrants

within the host population, but the term ‘racial and ethnic minority’ population is widely used in the United States, while ‘Culturally and Linguistically Diverse (CALD)’ is commonly used in Australia. The term CALD has a broader definition in Australia, referring to any population group distinguishable from the majority population through one or more characteristics such as cultural tradition, geographic origin, language or religion(4). In this paper, we use the Australian term ‘CALD’ in reference to people who were born overseas, have a parent born overseas and/or who speak a language other than English at home, and the term is interchangeable with ‘international migrants’ or ‘immigrants’.

While most immigrants are healthier on arrival than the average Australian resident on arrival, this ‘healthy immigrant effect’ diminishes with longer residency in Australia, with the prevalence of chronic health conditions increasing across all conditions for immigrants from most countries(2). Compared to the non-migrant population in Australia, international migrants go on to experience a disproportionate burden of ill-health, particularly in non-communicable diseases and mental health problems(5). For example, people born in Pacific countries, South Asia and the Middle East have a higher prevalence of heart disease, stroke, diabetes and kidney disease than the Australian-born population(2). This healthy disparity could be partially explained by the distinctive challenges immigrants encounter in seeking health services, predominantly attributed to a language barrier, cultural differences, and difficulties navigating two different health systems between the origin country and Australia(6–8).

The Emergency Department (ED) may be the first and only contact point with the health system for many international migrants (9). The utilisation of the ED as an access path to healthcare services by international immigrants has risen worldwide(10). In Australia, ED presentations among people from the CALD population varied from 53.7% (in the state of New South Wales) to 21.6% (in the state of Victoria) of total presentations(11–13). A large population-based study found that patients from CALD backgrounds ≥ 75 years were more likely to use the ED than their Australian counterparts(12). However, international migrants experience healthcare inequities in the ED. For example, the CALD population tends to have a longer ED stay and higher 30-day mortality than the majority Australian population(14). Similarly, in the US, migrants experienced longer waiting times, lower acuity triage scores and higher mortality rates, compared to the general population(12, 15, 16). Healthcare system, particularly ED care process, must be addressed so that existing health inequities are not perpetuated(17).

Given the growing number of CALD populations and their increasing ED presentation, it is critical to understand the Healthcare workers’ (HCWs) experience in care delivery to this population to improve the ED care outcome among CALD patients. However, few qualitative studies have explored the experiences or challenges of HCWs in delivering emergency care to immigrant populations, specifically in the ED context, which is distinct from that in other healthcare settings regarding its fast-paced and high-risk nature. Two studies, one from the USA (18) and one from Sweden(19), were conducted more than 15 years ago and exclusively focused on nurses’ experience of providing emergency care to international migrants. One recent study from Australia explored the influence of cultural and social factors on HCWs care delivery to CALD patients in the ED, although this was limited by its study design using a Social Ecological Model and a small sample size of 17 clinicians (20). Thus, we aimed to comprehensively

understand and report the experience of healthcare providers and non-clinic staff in delivering emergency care to CALD patients, as part of a larger program of work to improve the experience of ED care for underserved populations and improve health equity.

Methods

Study design

This study was conducted in the first stage of a five-year experience-based codesign (EBCD) project (short title: MyED), aiming to improve ED performance, patient outcomes and patient experience for those cohorts who disproportionately have worse ED outcomes, by co-developing new or adapted models of ED care with ED HCWs and patients(21). In stage one of the project, a qualitative approach was employed to explore and understand in depth the experience or challenges of ED HCWs in delivering care for four patient cohorts. In this paper, we refer to one cohort, adults with a CALD background. In accordance with naturalism and constructivism, a qualitative descriptive approach supports findings that remain close to participants' thoughts, perspectives, and lived experience, without providing interpretation beyond the explicit details(22). This pragmatic approach focuses on answering research questions and uses the generated findings to develop interventions, which is valued in health services and policy research(23, 24). The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research(25). The study protocol was approved by the relevant Local Health District Higher Research Ethics Committee (XXX).

Study setting and participant sampling

The research was conducted in three EDs within one local health district (LHD) in metropolitan Australia. In the study LHD, the population of around one million people is growing annually and includes the largest migrant population in Australia. In 2022, 49.8% of people were born overseas, and 54.1% of households spoke a language other than English at home(4). A full description of the LHD community, the EDs, and the research team is available elsewhere(26).

Eligible participants for this study were: 1) Australian registered healthcare providers (e.g. medical, nursing, and allied health personnel), or non-clinical staff who support or manage clinical care delivery (e.g., clerks and orderlies); 2) who had worked in one or more of the three study EDs for at least three of the past 12 months. A pragmatic approach to recruit participants from these three EDs was used to accommodate the clinical constraints of the ED setting and approval of the ED Heads of Department. The research team attended the three EDs to introduce the research project at their staff meetings. Staff were able to 'drop in' to an interview room, as time allowed, to be interviewed or arrange an online interview at another time. Recruitment continued until data saturation was reached; that is, until no new information emerged from participants during the interviews(27).

Data collection

Data were collected from March 2023 to April 2024, through both semi-structured interviews and focus groups in either face-to-face or videoconference, depending on the participants' preferences and availability. Research team members (working in pairs) booked an ED meeting room for an interview or focus group for the ED staff drop-in. Prior to an interview, participants were required to complete a questionnaire in REDCap for collecting demographic and clinical practice information, as well as to provide formal consent. An interview guide developed for this study, pilot-tested with two ED staff, was used to guide both interviews and the focus group (see supplementary file). Interviews and focus groups were conducted by one of four senior qualitative experts with PhD credentials (CC, LT, EA and RCW), and LR assisted. All interviews were audio-recorded with participant consent.

Data analysis

The audio files were transcribed verbatim using a professional research transcription agency. Following de-identification and verification against the audio recording by research team members (Clark et al., 2017), transcripts were imported into NVivo V.20 software. Data analysis was guided by Braun and Clarke's six-phase thematic analysis framework (Braun and Clarke, 2006; Braun and Clarke, 2013). Inductive thematic analysis was applied with no predetermined list of codes (Clarke & Braun, 2017). Data collected from interviews and focus groups were integrated to generate complementary insights into participants' experience. A qualitative analyst (LZ) repeatedly read the data sentence by sentence to gain an understanding of ED healthcare providers' experience in providing care for CALD patients and generate related codes. These codes were categorised into sub-themes and broader themes as they developed. The initial coding results were checked by two other qualitative researchers (RCW and MGA) to ensure the accuracy of the interpretation of the interviews and discuss and refine major and minor themes. Any conflict was resolved via team discussion until agreement was reached. An example of the data coding process is presented in Table 1.

Trustworthiness

In line with the trustworthiness criteria developed by Lincoln and Guba (1985) for achieving credibility, peer debriefing meetings were held regularly to check on the study process, and an audit trail was recorded. A detailed description of the study participants and the context of the research setting was provided to ensure the transferability of learning from these results. In terms of dependability and confirmability, data transcription, translation, and analysis were conducted independently and cross-checked by team members who are qualitative experts. Any disagreements were resolved through discussion among the research team. The first author, who coded the data, is a registered nurse and a bilingual researcher who shares some culture with the CALD community and is experienced in conducting CALD research. The researcher held a non-judgemental and open attitude when analysing the data with using a descriptive approach. The author had no contact with any participants before the research project and was objective toward the interview and data analysis process.

Results

Characteristics of participants

A total of 52 participants were interviewed in stage one of the EBCD ED project, encompassing 45 semi-structured interviews (ranging from 7 to 53 minutes with mean duration 26.5 minutes) and one focus group (96 minutes). Of the 52 participants, 39 participants (26% doctors, 46% nurses, 5% allied health professionals and 23% non-clinical staff) shared their experience of providing care to CALD patients, in 32 semi-structured interviews and one focus group (six patient experience coordinators). Participant demographic details are shown in Table 2.

Thematic analysis of the data generated four overarching themes: 1) Language barriers; 2) Diverse cultural norms; 3) Poor health system literacy. Results are reported below by **Theme**, *Category* and Sub-category (see Table 3).

Theme One: Language barriers

Most ED HCWs in this study reported that the biggest challenge in providing care to CALD patients was the language barrier. Communication challenges significantly impacted their clinical practice throughout CALD patients' whole ED journey, leading to poor therapeutic communication and dissatisfaction with their care delivery to the CALD patients. The nature of ED care involves episodic communication and interactions. Formal interpretation services tended to be used for medical procedures and consent due to access processes and time constraints, compelling staff to seek informal and unregulated translation strategies. Some good practices were recommended by these ED HCWs to overcome the language barriers for better communication, such as using pictorial tools and support for accompanying family.

Impacts on the ED care journey

Language barriers significantly impacted HCWs' care delivery to CALD patients from the time of patients' arrival to discharge in the ED care journey. The common moments in the ED journey are described below with examples of the challenges for CALD patients (see Figure1).

Navigation

Participants reported that CALD patients could not find their way to the ED entry at times due to wayfinding signage only in English, which added unnecessary stress for patients and carers. After arrival at ED, CALD patients could also be confused with the ED interior environment due to a lack of language appropriate signage, such as door operation signs to safely exit the ED. HCWWs perceived this could evoke a sense of being humiliated and belittled for CALD patients, which could negatively impact patient satisfaction.

"If our second top line is patient satisfaction, and they've been humiliated by just being unable to open a door, we can fix that by putting on someone else's shoes. How would I feel if I couldn't figure out how to open a door? But I know that not everyone is thinking in the same line. But that's why systems should be

impartial. The system is there for everybody's safety, and it will stop you tipping into a consequence." (Nurse practitioner)

Registration

Language barriers created a hindrance for ED clerks to collect basic information from CALD patients for registering them into the system.

Triage

The biggest impact of language barriers on the ED care journey, was the triage process, where senior nurses must elicit a history of the presenting complaint and allocate an urgency category to the patient within minutes. Compounded by the high-stress and fast-paced triage process, it was challenging for triage nurses to collect accurate or sufficient information from CALD patients who could not speak English in the short triage assessment timeframe, which compromised the accuracy of categorising patients. Due to language barriers, HCPs perceived CALD patients struggled to vocalise reasons for their ED presentations and the severity of their symptoms, such as the level of pain, which also generated frustration among triage nurses. Some participants strongly expressed their concerns that any under-triaging could result in treatment delay and worse outcomes among these patients, such as delayed clinical responses to heart attack and stroke.

I think they probably suffer the worst outcomes when it comes to it, just because their pathology is often underestimated in terms of how they present. Their conditions aren't necessarily taken as seriously if they can't speak English. Not that I think by any intentional bias, but it's the lack of urgency that they can present themselves with. So they are unable to say I'm in extreme pain. I'm dying of a heart attack right now. Instead, they might come in and just point to the chest and be unable to tell much more. (Emergency medicine consultant)

Waiting room

In the waiting room, HCWs in this study raised a safety issue that CALD patients could not inform ED staff if their condition deteriorated due to the language barriers. Identification error could also occur, attributed to ED HCWs' poor pronunciation or calling the wrong name of CALD patients when it was their turn to be seen.

He didn't speak English. He was Mandarin. He put his hand up and he was going like this. I was like, this is weird. I went over to him, and he went, 'I bleed'. I went, 'pardon?' He went, 'I bleed'. He showed me a picture of a tissue, just a little bit of blood on it. I went to the triage nurse and said, this man doesn't look very well... When I looked behind him, there was a massive pool of blood. He had a big PR [per rectal] *bleed…He got taken straight to resus. But he didn't have English. All he could say was, 'I bleed'. (Patient experience coordinator group)*

Treatment

Participants expressed concerns that the language barrier could lead to unmet needs among CALD patients. It was commonly reported that it was extremely time-consuming and difficult to collect accurate and comprehensive medical and medication histories from CALD patients, stemming from the language barriers and back-and-forth interpretation. This further compromised CALD patients' diagnosis and treatment plan and affected the provision of timely care to other patients.

Participants also raised a concern about elder abuse among the CALD community, attributed to their financial issues and loss of autonomy related to language barriers. HCWs conveyed their moral and professional imperative to help, but it was difficult to pick up nuances sufficiently to identify issues accurately, such as domestic violence, due to the cultural and linguistic obstacles and the loss of detail in interpretation.

"First, there are time constraints. People with those, sort of, backgrounds, need a lot more time. We need to take the time, we need to call an interpreter, we need to do all these things…they also have a lot of comorbidities that they're not able to let us know about, and because of those language barriers, the time constraints, a lot of things get missed." (Senior registered nurse)

Discharge

Some participants reported that a lack of time to call an interpreter service resulted in poor and vague communication of discharge instructions to CALD patients. Accordingly, the lack of understanding or sufficient information, such as following up with community General Practitioners or taking medications appropriately, could undermine the patients' adherence to prescribed care, contributing to ED re-presentations and poorer health outcomes.

"You might close that initial history-taking interview, but then later on, when it comes to discharging them with advice, if they are being discharged with specific advice, again, you need to get the interpreter back, and I think that's one of the things that we don't do as well for these groups of patients. I think that part is often overlooked, and so they're not getting the best advice on discharge, and that could potentially lead to poorer outcomes. (ED specialist 1)

Translation-related issues

HCWs reported the inaccessibility, inconsistency, unavailability, unfeasibility and inaccuracy of existing professional interpretation services. Thus, HCWs often employed quicker but informal and unregulated strategies, such as using family member or carer, online translation tools (such as Google Translate), and bilingual co-workers (see Figure 2).

Interpretation service inaccessibility

Nearly half of the participants reported their hesitancy or unwillingness to call for an interpreter service due to the perceived inaccessibility of an interpreter. Rather than talking to the patient straight away, it was cumbersome and time-consuming to wait for an interpreter to become available and call back,

particularly for some rare or unusual languages, as the interpreter services processes did not align well with the fast-paced, high-pressure and episodic nature of ED care, and the sheer volume of patients waiting to be seen. It was especially challenging to request an interpreter during the 5-minute triage window, although collecting detailed information from patients is central to accurate triage.

"We've got an interpreter but it takes a while…. It will - you still have to find someone that can speak here [a staff member who speaks the language] *but there are times when there is none. So that's when the doctor needs to call an interpreter or we can call interpreter but with so much, the number of patients, it's really the doctor who will have to call." (Nurse unit manager)*

Interpretation service inconsistency

The failure to integrate interpretation services consistently throughout the entire patient ED journey was mentioned by participants. Interpreters are usually called for a specific moment of time, but the reality of interpretation needs in ED is back-and-forth, with multiple conversations between one patient and different HCWs at each stage of the ED care process. HCWs needed to be well-prepared for a conversation with an interpreter to ensure nothing was missed, as they assumed that they could not make the time to request the interpretation service again. The interpretation service facilitates essential conversations, such as formal consent for operation and procedures, rather than everyday care tasks and processes. Some HCWs reported not feeling as though they were authorised to call interpretation services, believing that only ED physicians could access them for these mandated conversations.

"I think people often think that it's just one-off conversation with an interpreter to get what you need, but then it's really difficult to then be able to explain it to the patient as well. It requires multiple conversations". (ED specialist 2)

Interpretation service unavailability

Difficulty obtaining professional interpreters in rare or unusual languages or the absence of after-hour Interpreters compounded communication issues. This frustrated HCWs, who turned to other informal means.

"With very common languages, it's definitely very easy. You'll get them in 10 or 15, 20 minutes. Some of the other languages — I can't think of any good examples right now — but you might have to wait an hour or so and if someone's having a heart attack, that's a really long time [laughs]. *So you just have to – yeah. That's one challenge I find." (Clinical nurse educator 1)*

Interpretation service infeasibility

Although phone interpretation services were becoming the predominant mode, rather than face-to-face interpretation, this mode also had challenges. Firstly, the phone interpretation service was not suitable for CALD patients with hearing impairment. Secondly, participants reported that it was challenging and

frustrating to find an available portable phone that could be brought to the patient's side, with some HCWs forced to use their personal phones.

"Sometimes if you get them on the phone, sometimes they have dementia, sometimes they can't hear, they're at the speaker phone as well. There's a lot of instances we don't have a phone. Sometimes they're broken." (Registered nurse 1)

"The only downside is because there are no portable phones in ED, I've got to use my personal mobile and my personal data to do that." (Medical officer)

Interpretation service inaccuracy

Some participants were sceptical about the accuracy of the interpretation service. Some nuanced information, such as non-verbal signals and body language, could be missed when using a phone interpretation service, which was perceived could affect the accuracy of interpretation. For some interpreters, what HCWs considered important did not seem to align with the interpreter's responses, and some HCWs felt interpreters might selectively interpret some information, leading to misunderstanding between HCWs and CALD patients.

"What the interpreter thinks is important and what you think is important might not be the same thing or they might think – they might answer on behalf of the patient without actually asking the patient and you're saying, no, no you actually need to ask them because they don't know what the bowels have been doing for the last three days, for example. They say, 'oh yeah, yeah everything's fine', but yeah, it definitely presents a challenge and it's more time-consuming and mistakes are made if the history is not good." (Medical officer)

Using other translation strategies

Due to challenges for HCWs accessing professional interpretation at each important moment during the ED stay, HCWs opted for quicker but informal strategies, some of which are not endorsed by local health policy and regulation. For example, HCWs heavily relied on family or carers for interpreting or gaining a collateral medical history, but family may not be present for all the stay. The dilemma of using online machine translation tools (such as translation websites) was raised by participants due to legal, ethical and professional conflicts. Reported misinterpretation by translation tools was a concern for some participants. It was common for HCWs to get assistance from coworkers who shared the same or similar language or cultures with CALD patients. However, being called on to assist with the interpretation added to the bilingual coworker's workload and created role conflicts.

"I guess, looking at the legal side of things, I'm guessing the hospital or the healthcare department doesn't want us to use it [translator website]. *A lot of people tend to refrain from doing so because there is a big risk. A lot of the time, especially us junior nurses or the newer nurses, we do tend to use simple things like toilet, water, and translate it from Google so it makes our lives a little bit easier." (Registered nurse 2)*

Recommended practices

Patient-level

Many participants believed that having family or carers accompany CALD patients would be beneficial to their care delivery, such as assisting in collecting basic demographic information at registration, accommodating their basic needs during waiting time and helping an interpreter with their specific dialects. CALD patients were also encouraged to be prepared for ED presentation by bringing their medical profiles, which could assist the HCWs' care delivery process.

Staff-level

Some participants suggested that it would be useful to have pictorial tools available in ED to resolve the communication gap with CALD patients on basic nursing care (toileting, drinking water and taking medications) or simple medical procedures (blood taking and X-ray). Sign language and handwriting were also recommended by participants to facilitate quick communication. Being tolerant and empathetic and taking the time to explain the care process, keeping CALD patients updated, avoiding the use of medical terminologies, and empowering patients to get involved in their care were perceived as strategies that would mitigate the tension from language and cultural barriers and improve patient satisfaction.

"I think it's just the way you communicate with them. Communicating, like just trying to in more depth, explain to them the process, or try and get them to understand how the system works here in the hospital. I reckon it's just the communication." (Administration officer)

System-level

Better signage was suggested by participants to help CALD patients navigate the ED environment. To close the communication gap, many participants suggested utilising a fast-track phone interpretation service to improve service accessibility, as well as allowing the use of verified online translation tools for providing basic information and care. Employing a multi-cultural workforce representative of the population was proposed to facilitate communication. Having standby interpreters on-site was also suggested. Participants also highlighted that offering multilingual discharge fact sheets or pictograms were warranted for safely discharging CALD patients.

"I suppose, before I speak about the barriers, you are absolutely right, we've got a big multi-cultural CALD workforce. At any point we need, for example, a translator, we'd often just get a staff member to do it for us, like they're important to care, they're a trusted source, so I suppose in that sense it can be a bit easier." (Clinical nurse consultant 1)

Theme Two: Diverse cultural norms

Diverse cultural beliefs, practices and social norms among this cohort also challenged HCWs to provide culturally appropriate care.

Cultural worldviews

Collectivism refers to a culture that prioritises family obligation or community duties over personal aspirations, which is deeply ingrained in some CALD groups such as Pacific Islanders, Indian and Chinese communities. When someone was sick, the entire family or friends came together to the ED to visit the patient, which breached the hospital visitation rule that one visitor was allowed at a time (depending on different hospitals). It was overwhelming for some participants to deal with a group of visitors crowded in a small ED. Lack of effective communication to understand cultural perspectives sometimes led to visitor frustration and agitation. Crowding from many visitors also created a hindrance to providing safe care to other patients. Conversely, some CALD groups from individualistic cultures (referring to a culture focussed on personal goals, achievement and independence) were observed as having no support person during their ED presentation.

"The Arabic population, it's a very, very family-centred culture. They will have 50 people show up if someone's critically unwell or has died. That's a huge thing because we don't really have a lot of space for that, but as best as we can... So, depending on which background it is, so one background could be like ten; another could be five, and then you have a couple with no support." (Clinical nurse educator 1)

Culturally communicative style

Each cultural group has its own way of expressing emotion, pain, and perspectives. Patients and their families in some cultures tended to speak in a loud tone and a forceful way, which was sometimes misunderstood by HCWs as an aggressive behaviour. On the other hand, some cultural groups were emotionally reserved and shy to vocalise their needs, trying not to bother others, or were passive out of respect for professional authority. Passivity prevented some patients from calling for help until their medical condition deteriorated, which would worsen the outcomes.

"The expectation of screaming, yelling, and I think also the interpretation. You know, they could be speaking in a nice way, but just their tone is – because culturally or the language that's how they…they sound abrupt, but that's just how they talk, where we have to try and sort of diffuse and think, calm down, that's just their way of communicating."(Administration officer)

Gender preference

Participants stressed that culturally related gender dynamics could challenge their care delivery because patients in some cultures requested HCWs of the same gender. For example, some female patients' culture only allowed them to be examined and touched by female clinicians, and attire may also be prescriptive. Participants reported trying their best to meet patients' needs for gender preference, but it was impossible to guarantee it, depending on the staffing resources in ED.

"I haven't had – look, on the very occasion, there will be a Muslim lady come in and wants to see a female doctor; that's not always possible. We try and – it hasn't happened to me recently, but we try and fulfil their wishes if at all possible, but it's not always possible." (Medical officer)

Cultural bereavement

Grief and mourning among family, relatives or friends was discernibly different depending on the individual's unique cultural bereavement norms. In terms of emotional expression, family in some cultures reacted vocally and vigorously by punching the dead body. Some family members fainted or collapsed at the ED, which challenged HCWs to provide extra care to these families, on top of their already stretched workload. At the other end of the spectrum, families in some cultures, were emotionally contained to the loss of a loved one and they preferred to quickly move the body to the morgue. Collective grief was common in some cultures, where family or friends came into the ED and grieved collectively, which was reported to be challenging for HCWs to manage the wide variation in cultural practices and meet these needs within the ED environment.

"When we've looked after Arabic families in the resus bay and somebody has passed away, that's very challenging. Because we then now need to care for them as well because they're fainting or collapsing on the ground or you know, hitting the body, hitting the patient, because the patient passed away. It's very challenging. It's happened a few times." (Clinical nurse educator 2)

Cultural health belief and practice

Health beliefs and practices could differ culturally, affecting HCWs care delivery. Specifically, a holistic health belief was endorsed by some cultures, while ED HCWs with a strong focus on biological mechanisms and investigation felt challenged to offer culturally appropriate holistic care. It was also a struggle for HCWs to talk about advance care planning with families from cultures that do not accept end-of-life care. Patients in some cultures may also use traditional remedies, which could potentially complicate treatment and undermine medical compliance.

"In India that operation probably wouldn't occur and they would put turmeric on it, you know, turmeric being a traditional remedy." (Nurse practitioner)

To provide culturally responsive care, it was helpful to have ED colleagues sharing the same culture with CALD patients to provide culturally appropriate care. For HCWs not understanding the culture, participants highlighted the importance of cultural humility; being sensitive to, showing respect for, and being responsive to an individuals' unique needs. Cultural awareness training was reported to improve their cultural sensitivity and safety practices.

"I find it's not just communication that's the problem, it's comprehension and understanding…I think we're quite good at accommodating diverse cultural needs, I think that has got a lot better over the time that I've been here. We appreciate that and we accommodate that." (Clinical nurse consultant 2)

Theme Three: Poor health system literacy

Some participants suggested that poor health system literacy among CALD patients created a hindrance to providing optimal ED care. Specifically, it was commonly reported that CALD patients misunderstood the purpose of the ED and presented inappropriately for low acuity needs. Lack of knowledge of how the ED worked, such as the register and triage processes upon arrival, contributed to frustration and agitation among CALD patients, as they did not understand that they could not be seen immediately.

"I think it is a public health issue in that people don't know exactly what an emergency department is for, and I don't think people quite understand exactly what an emergency is… I think for them they don't quite understand our health system, so they don't understand that some cultures you get seen straight away and we're like no, no this is the Australian health system, the one you don't pay for, it's got a lot of people here. Some of them will even go, 'I'll pay you money', and it's like, 'no that's not how this works,' it's not." (Clinical nurse educator 3)

Apart from keeping patients updated during waiting time, it was suggested that providing them with information brochures in multiple languages would help.

"Yeah. It would just literally cut down probably 50 per cent of the enquiries you get at the triage window, because people just say, how many more people in front of me? When's my turn? What am I waiting for? So if you just had a sheet, we'd just go, here you go, here's an FYI. Frequently asked questions just in all the different languages that are common to this area would be super helpful."(Clinical nurse educator 1)

Discussion

To our knowledge, this is the first study to provide comprehensive insight into the experiences of HCWs, including allied healthcare and non-clinical staff, providing emergency care to patients from CALD backgrounds. All participants reported that the biggest challenge was the language barrier. Although patients with limited English proficiency should have access to professional interpretation services, many HCWs tended to use informal translation strategies, such as translation software. Participants acknowledged the diverse cultural norms among CALD patients and suggested cultural awareness training to improve their cultural sensitivity and competency. It was also highlighted that poor ED health system literacy among CALD patients led to misunderstandings and frustration.

One recent Australian study found that only 1.5% of CALD patients who did not speak English and needed professional interpretation services received the interpretation service in the ED, indicating the significant gap between the requirement and utilisation of interpretation services (11). The findings of the current study provide the *why* - revealing that formal interpretation services (while excellent for legal procedural consent) are not aligned with the nature of ED work, which involves an episodic series of conversations and interactions. Virtual or/and video interpreter service is a solution to fill the language gap, but in-service education on this interpreter service is warranted to improve the uptake among ED staff. Rapid advances in Artificial Intelligence (AI) that augment professional interpretation services with after-hours and low-risk conversation assistance tools, offers a promising solution(28). While inaccuracy is often cited as the reason not to use online tools, the current study revealed that inaccuracies can also

occur when interpreters are used, and it is not feasible to have an interpreter in every language available at any time. Thus, the use of online adjuncts could be reasonable, while continuing to minimise disadvantages to both HCWs and patients.

Participants provided examples of how diverse cultural norms among CALD patients impact emergency care delivery, which is echoed in existing studies (9, 10, 20, 29). Lack of knowledge of patients' cultural background, such as cultural practices, beliefs and social norms, can result in poor care among ED HCWs (7). Cultural awareness training was perceived as helpful in providing responsive, appropriate and safe practice to patients from CALD backgrounds. In addition, having a multicultural workforce in healthcare settings, particularly in ED, is a strategic imperative that could mitigate the language and cultural gaps, improve inclusion and mitigate health inequities(30).

Participants suggested that poor ED health system literacy among CALD patients, misunderstanding of the purpose of the ED in the overall health system, resulted in inappropriate access to the ED with low acuity presentations. This is supported by a recent publication from the Australasian College for Emergency Department (31). Moreover, the misconception of the ED process as a first-come, first-served basis was perceived to cause CALD patients high levels of anxiety and aggression if needing to wait in the waiting room. According to existing review evidence endorsing the important role of health system navigation program in reducing fragmentation in care (32), improving ED health system navigation among CALD communities, including the function of the ED, non-hospital alternatives to manage urgent but non-life-threatening conditions, ED triage, and care procedures, may assist in better understanding and utilising ED services. Collaborating with General Practices, cultural community centres and public libraries to co-design and disseminate ED health system literacy education would be feasible and reach more people from CALD backgrounds in non-urgent contexts.

Study limitations

There are some limitations when interpreting and generalising our findings. Firstly, as ED HCWs recruited in this study were from one local health district with a comparatively low socioeconomic status population, and high density of residents with CALD backgrounds in metropolitan Australia, the context-specific experiences may not apply in other areas with higher socioeconomic status or a more homogenous CALD population. The generalisation of findings in the paper could be enhanced with explanation of the health systems and the ED models of care in different migrant countries. Secondly, our sample included diverse members of the ED HCW team, including allied health, and administration staff. While the interview transcripts were not returned to participants for validation due to their heavy workload in the ED, the findings were reviewed by clinical team members.

Conclusions

HCWs in this study highlighted the challenges in delivering high-quality care to patients from CALD backgrounds with language barriers, diverse cultural norms and poor health system literacy. Adaptive and accessible tools to assist HCWs in addition to the existing formal interpretation services are needed

to facilitate episodic communication between HCWs and patients. The study indicates the lack if embedding of health system literacy principles in the system and way in which care is delivered. Partnering with CALD patients and cultural community centres or public libraries offers a feasible approach to co-design and disseminate health system literacy education to improve public awareness of the Australian health system. The current study provides insights into why the current design of the ED system is not meeting the needs of ED HCW and CALD patients. It provides a critical first step in improving ED care experiences for CALD patients and enhance the health equity in accessing emergency care.

Declarations

Ethics approval and consent to participate

All procedures involving human participants were conducted in accordance with the standards of the Australian National Statement in Ethical Conduct in Human Research 2023 and was approved by the Western Sydney Health District Higher Research Ethics Committee (REF: 2022/PID02749-2022/ETH02447). Informed consent to participate was obtained from all of the participants in the study. Participation was voluntary, confidentiality and anonymity of their personal information was guaranteed, as well as the freedom to withdraw from the study without providing explanations and at any time. No human experiments were conducted in this study.

Availability of data and materials

The interview transcript data will be only accessed with participants' permission, aligning with Human Research Ethics Committee approvals.

Consent for publication

Not Applicable

Competing interests

The authors declare that they have no competing interests.

Funding

Funding was provided by the Australian Government Medical Research Future Fund (2022:APP2018361)

Authors' contributions

LZ: formal analysis, writing-original draft, writing-review & editing; CC: conceptualization, data curation, formal analysis, investigation, methodology, project administration, supervision, writing-review& editing; LR: conceptualization, data curation, investigation, methodology, writing-review & editing; EA: conceptualization, funding acquisition, investigation, methodology, writing-review & editing; MM: funding

acquisition, resources, validation, writing-review & editing; RH:conceptualization, funding acquisition, writing-review & editing; AC: funding acquisition, writing-review & editing; RCW: conceptualization, formal analysis, funding acquisition, investigation, methodology, supervision, writing-review& editing.

Acknowledgements

It was greatly appreciated to all the health care providers who participated in this research. We would also like to acknowledge the MyED project partners: the Australian Institute of Health Innovation at Macquarie University, the Western Sydney Local Health District (WSLHD), the University of the Sunshine Coast, the University of New South Wales, the NSW Agency for Clinical Innovation (ACI), the Department of Social Services (DSS), the NDIS Quality and Safeguards Commission and Health Consumers NSW. We sincerely thank Dr Matthew Vukasovic and Aaron De Los Santos for their valuable guidance on this study.

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Tables

Table 1: An excerpt of coding illustrating process

Data extraction	Codes	Sub-themes	Theme
"I think the hardest sometimes is actually figuring out why they're actually here. Or sometimes they think they know why they're here and then you get a GP letter and it's completely different as to what they think they're here for."	Triage	Impact on care delivery	Language barriers
"For us, time is very critical. Instead of holding onto a phone waiting for - because you have to stay on hold for a certain period of time and then get the translator to translate."	Interpretation service inaccessibility	Interpreter-related issues	

Table 2: The characteristics of participants for stage one experience-based co-design project (N=52)

		Number (Percentage)
	Age group (years)	
≥54	13 (25.0%)	
34-53	18(34.6%)	
≤33	15(28.8%)	
No reply	6 (11.5%)	
	Gender	
	Male	18 (34.6%)
	Female	34 (65.4%)
	Years worked in Emergency Department	
	0-2	8 (15.4%)
	3-6	10 (19.2%)
	7-10	9 (17.3%)
	11-14	7 (13.5%)
	15 or more	18 (34.6%)
	Speak English at home	
	Yes	48 (92.3%)
	No	4 (7.7%)
	Role in Emergency Department	
	Nurse	23 (44.2%)
	Registered nurse	8 (15.4%)
	Advanced practice nurse[1]	9 (17.3%)
	Nurse practitioner	1 (1.9%)
	Nurse unit manager	3 (5.8)

	Other	2 (3.8%)
	Doctor	14 (26.9%)
	Junior doctor	2 (3.8%)
	Registrar	2 (3.8%)
	FACEM[2]	6 (11.5%)
	Other	4 (7.7%)
	Allied health professionals	3 (5.7%)
	Non-clinical staff (Clerk, administration staff and patient experience coordinator)	12 (23.1%)

[1]Advanced practice nurse: clinic nurse consultant, clinic nurse educator, clinical initiative nurse, associate nurse unit manager

[2] FACEM: Fellowship of National College Emergency Medicine

Table 3: The results of thematic analysis

Themes	Categories	Subcategories /codes
Language barriers	*Impacts on ED care delivery*	ED navigation
		Registration
		Triage
		Waiting room
		Treatment
		Discharge
	Translation-related issues	Problems with the interpretation service
		Interpretation service inaccessibility
		Interpretation service inconsistency
		Interpretation service unavailability
		Interpretation service infeasibility
		Interpretation service inaccuracy
		Using other translation strategies
		Family or carers
		Translator software
		Bilingual coworkers
	Recommended practices	Patient-level
		Staff-level
		System-level
Diverse cultural norms	*Cultural worldviews*	Collectivism
		Individualism
	Culturally communicative style	Loud and forceful tone
		Reserved traits

	Gender preference	Same gender healthcare provider Attire culture
	Cultural bereavement	Vigorous reaction to death Reserved emotional response
	Cultural health beliefs and practices	A holistic health belief Unacceptable end-of-life plan Traditional remedies
Poor health system literacy		Misconception of ED role Lack of knowledge on ED procedure

Figures

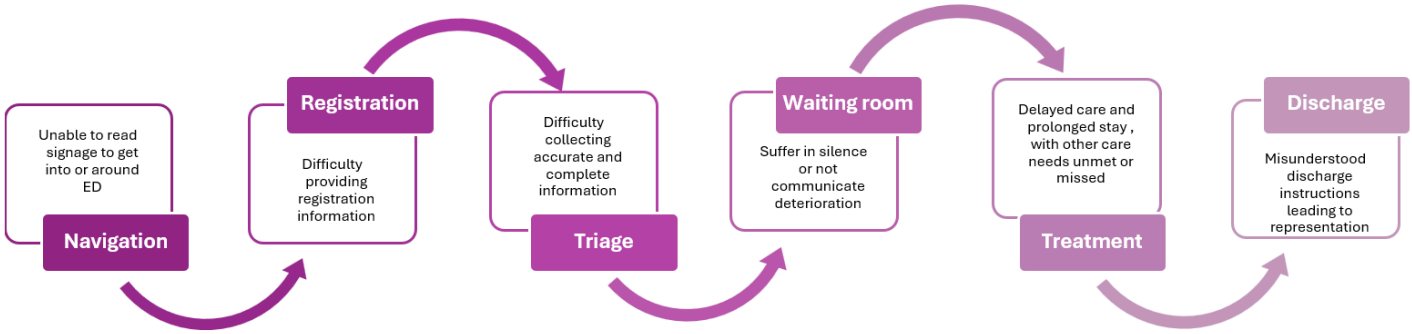


Figure 1

Summary of HCW perspectives on the impacts of language barriers on ED care delivery journey

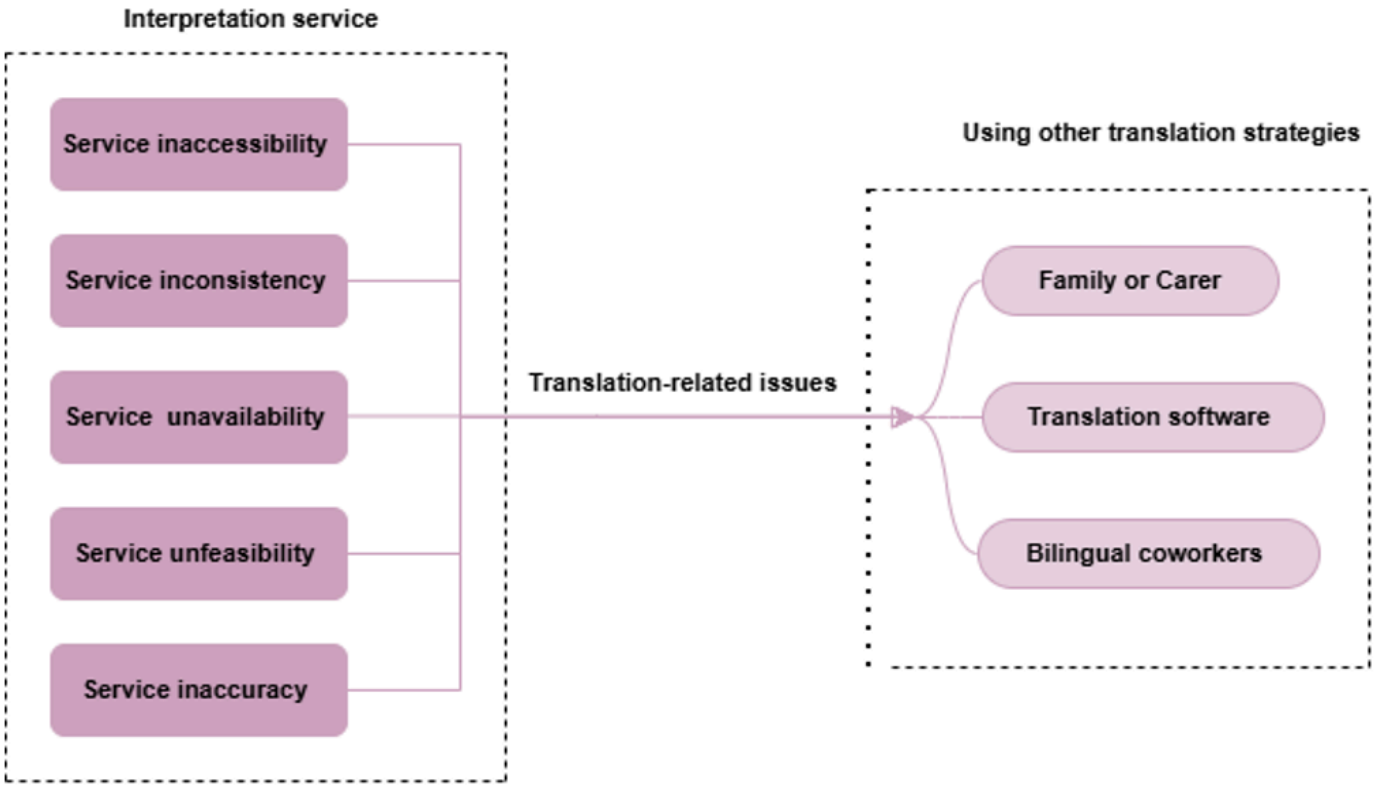


Figure 2

Translation-related issues

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- COREQChecklist.pdf
- Supplementaryfile.docx