Building cultural bridges and two-way understanding: working with Australian Aboriginal people within mainstream renal services

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Abstract

Providing culturally competent treatment and care for Aboriginal people with renal failure requiring haemodialysis within mainstream renal services remains complex, challenging and poorly informed. This paper reports recommendations for improving cultural competence within renal units which emerged from a renal nurses’ doctoral study conducted in rural NSW. This research project aimed to inform service improvement for Aboriginal renal patients. Provision of the knowledge, skills and cultural understanding to enable renal staff to deliver treatment and care that are acceptable to and appropriate for Aboriginal patients is discussed. Employment of Aboriginal health workers within renal units as patient advocates and to provide a cultural bridge between Aboriginal patients and their families and renal clinicians is promoted. Aboriginal patients, family members and Elders delivering on-site cultural education to the staff within renal units is recommended, with the goal of increasing two-way understanding and building strong and positive relationships. Alternative models of culturally competent care from remote northern Australia and a New Zealand model for culturally safe care of Maori people within renal units are also discussed.

Keywords

Aboriginal patients, Aboriginal health workers, cultural competence, renal nurses, renal units.

Introduction

When I started work as a renal nurse in a busy haemodialysis (HD) unit in regional NSW, I was immediately astounded at the high numbers of Aboriginal people requiring dialysis. Approximately 20% of the patients receiving in-centre HD were Aboriginal and most were 20–30 years younger than our non-Aboriginal patients. With Aboriginal people comprising 3.4% of the population in the region where I work, these were alarming statistics. As I became immersed in the day-to-day routine of delivering dialysis to our Aboriginal patients, I became increasingly aware of the disconnection between them and

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many of the renal staff. On every shift I saw the challenges facing Aboriginal people, forced to spend every second day connected to a dialysis machine in a highly biomedical environment isolated from their families, communities and their culture. From tea room chats with my colleagues, I also began to realise how challenging it was for many clinicians to work with Aboriginal people without access to the cultural knowledge and experience that is necessary to enable health professionals to provide care and treatment that is acceptable to Aboriginal people. I began journalling about this issue and trying to reflect on what was occurring in my workplace. I reflected on the lack of two-way understanding between the nurses and Aboriginal patients and the unspoken ‘us and them’ culture that often exists as a result. I also began to talk informally with patients about how they perceived their care and treatment within the renal unit. Several years of ‘yarning’ and developing deepening relationships with Aboriginal renal patients and their families convinced me that something had to be done to address this distressing situation. This was the start of a research journey, which became a larger and more services-focused research project.

**Brief summary of methods**

The project’s qualitative research methods combined an Indigenist paradigm, where researchers (from any cultural background) attempt to view the world through the philosophy of the Indigenous people with whom they are working (Wilson, 2007), with principles of community-based participatory research (D’Alonzo, 2010) and high levels of researcher reflexivity, heavily reliant on journalling (Rix, Barclay & Wilson, 2014). Using yarning and story-telling style interviews (Bessarab & Ng’andu, 2010), the stories of 18 of the 21 Aboriginal HD patients in the region where the study took place were gathered. A purposive sample of 29 health professionals providing treatment, care or support for those same patients were interviewed about their attitudes and perspectives working with Aboriginal patients, using semi-structured interviews. The results of these two data sets were published separately (Rix et al., 2014 a; Rix et al., 2013). The research team also identified a high level of congruence between the perspectives of these two groups. Further analysis of the combined data sets focused on renal service delivery and how this may be improved. From this analysis, a suite of recommendations emerged for improving the experience of renal services for Aboriginal people living in rural areas (Rix, Barclay et al., 2014). The research findings highlighted minimal levels of individual racism from both the patients and provider groups. A strong theme emerged however of a lack of opportunities for both Aboriginal patients and their clinicians to develop a level, two-way understanding that may allow for the building of improved therapeutic relationships.

In this paper the findings of that study as they relate to increasing the cultural competence of renal services for Aboriginal patients are presented. Providing renal staff with cultural education that can instil the knowledge, skills and understanding to enable them to deliver treatment and care that are acceptable to and appropriate for Aboriginal patients is discussed.

One of my fellow researchers and two Elders who were members of the Community Reference Group which guided this research agreed to work with me on this paper. According to the Indigenist research paradigm used to conduct our study I must introduce the co-authors of this paper to you. This is in accord with the principles of relational accountability and the co-generation of new knowledge, which is viewed as not owned by individuals, but rather shared and acknowledged by all (Rix, Barclay & Wilson, 2014; Wilson, 2007). Shawn Wilson is an Indigenous scholar from the Opaskwayak Cree Nation in Northern Manitoba, Canada. His area of expertise is Indigenous ways of knowing and the development of Indigenous research methodologies. His contribution as a member of the research team was pivotal in conducting the study using methodologies that are appropriate for working with Aboriginal people.

Uncle Charles Moran is an Elder of the Bundjalung nation. Uncle Charles’s story could take us weeks to tell; however, he has published his biography (Moran & Moran, 2004). He is one of the last of his generation who has lived his people’s culture and grown up speaking the Bundjalung language. To Uncle Charles, culture is survival and living off the land; language sitting down and listening, while being taught by the old tribal men. Russell Kapeen, also a Bundjalung Elder from Coraki, has been on dialysis for over seven years, doing his own dialysis at home for most of that time. To Russell an Elder is a person who is respected by the community and helps everybody in need.

**Defining terms**

Cultural awareness, safety and competence are all terms used to describe and articulate some of the developments and influences on health care delivery and the education of health professionals working with cultures other than their own (Taylor & Guerin, 2010). Cultural awareness is defined by the Health Education and Training Institute as: “sensitivity to the similarities and differences that exist between two different cultures and the use of this sensitivity in effective communication with members of another cultural group” (HETI, n.d.).

Cultural safety is a term coined by Maori nurses in New Zealand who were leaders in the original cultural safety movement in New Zealand in 1990 (Ramsden, 1990). It has been defined as: “an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of
who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together” (Williams, 1999). Cultural competence is a phrase created in the United States in 1989 and is defined as: “a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals; enabling that system, agency or those professionals to work effectively in cross-cultural situations” (Cross et al., 1989). Successfully implementing cultural awareness, competency and safety in clinical situations should result in culturally acceptable care.

**Background**

Providing culturally acceptable care and treatment for Aboriginal people with end-stage kidney disease (ESKD) requiring renal replacement therapy remains complex and challenging and, despite several decades of research, is not yet well understood. There is no shortage of policy documents defining the principles and practice of providing culturally competent care to Aboriginal people. These publications, however, do not appear to have contributed to the cultural competence of health care providers, or the cultural safety for Aboriginal patients within mainstream health services, in particular hospitals. Studies in rural, remote and metropolitan regions have all found shortfalls in both the cultural safety of Aboriginal dialysis patients and the cultural competence of the organisations delivering their renal services (Burnette & Kickett, 2009; Cass et al., 2002; Preece, 2010).

Australian Aboriginal and Torres Strait Islander people are experiencing an epidemic of chronic disease across the country. Accessing care and treatment within mainstream health services remains fraught with fear and apprehension for most Aboriginal people, still traumatised or affected by their own or their ancestors’ experience of overtly racist treatment within health services (Aspin et al., 2012; Durey, 2010). Cultural safety, cultural competence and culturally appropriate services are words and rhetoric used in the context of cross-cultural care in the health care setting. It doesn’t matter what language is used, because unless those words result in real change, they have no meaning. There is an abundance of policies and guidelines describing the necessity for culturally shaped and sensitive health care services for Aboriginal people (National Health and Medical Research Council, 2006; NSW Health, 2011). These documents are complemented by the goodwill and desire of most front-line clinical staff to provide better services to Aboriginal patients. Despite this, many renal nurses providing long-term and ongoing care for Aboriginal people with ESKD still struggle to access practical training in the skills and knowledge required to build positive relationships that can result in care that better serves the needs of Aboriginal patients (Rix et al., 2014b).

**Disconnection between Aboriginal cultural values and services**

There is an apparent disconnection between the cultural values of Aboriginal renal patients and clinicians providing treatment and care. Our research has shown that this disconnection extends beyond individual relationships to the mainstream health organisation providing renal services and its institutional culture. Mainstream health systems appear to lack knowledge and understanding of the history and antecedents of Aboriginal people’s fear and avoidance of accessing health services. Originating at colonisation and exacerbated by previous experiences of open, institutionalised racism, Aboriginal people have shown reluctance to engage with government organisations in general (Alford & Muir, 2004; Durey et al., 2012).

In our study, both patients and service providers described their awareness of fear and avoidance of mainstream renal services by rural Aboriginal people, many of whom have witnessed family members’ suffering and early death on HD or from their untreated ESKD. This fear, however, is also fuelled by the history of blatant racism, separation from family and country, and the discriminatory policies of government organisations. While both Aboriginal renal patients and individual service providers reported their willingness and desire for positive relationships and increased two-way understanding, there is little opportunity within the current health system for this. Increasingly busy workloads and inadequate resources within the public health system have seen funding for provision of cultural education to clinicians being given little priority (Rix et al., 2014; Cass et al., 2002). With health services under increasing fiscal pressure, the cost of backfilling renal nurses to attend one-day, off-site training in cultural education is prohibitive.

Studies in Australian hospitals have found this one-day training to be of limited effectiveness with critics claiming it can have a negative impact on attitudes of some attendees (Farrelly, 2009; Franks, 2011; Mooney et al., 2005). Long (2012), however, found that regardless of delivery method, cultural education training can increase the cultural awareness of nurses. She argues the effectiveness of strategies such as cultural immersion through: clinical experience; lectures; group discussions; mentoring; educational partnerships between clinicians and community members; and reflective journaling. Lack of cultural competence of clinicians can result in: high levels of miscommunication; patients not accessing timely medical care; increased incidence of hospitalisation and length of stays; increased fail to attend rates and reduced confidence in health care providers (Delgado et al., 2013, Omeri & Raymond, 2009; Cass et al., 2002).
Evaluating different models of cultural training for clinicians remains a challenge, with the literature providing little guidance (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007; Thackrah & Thompson, 2013). A recent literature review on this topic clearly demonstrated the current cultural awareness training model within NSW Health is under-resourced and that at the systems or organisational level a coordinated and comprehensive plan to change institutional culture is lacking (Westwood & Westwood, 2010). This review cited the need for research findings that can be translated into “policy which is sufficiently robust and flexible to adapt to locally identified priorities” and cited serious barriers to improved health care created by communication difficulties between Aboriginal people and non-Aboriginal staff at an institutional level (Westwood & Westwood, 2010, p. 425). In order to have broad-reaching and sustainable change, to make the health system better serve Aboriginal clients, we need to address improvements in hospital culture in general, that will then be expressed in the work of individual clinicians. A recent research project in Australia aimed to improve the cultural competence of hospitals for Aboriginal people (Willis et al., 2010). A major recommendation of this work was the provision of opportunities for clinicians to gain exposure to the ‘real world’ of Aboriginal Health via direct care and treatment experience with Aboriginal people as part of a sustained approach to cultural education. Cultural safety will require more than just talk; it needs intensive listening and taking on board what Aboriginal people are saying. We believe that in the context of renal care, one way to achieve this is to introduce Aboriginal health worker (AHW) positions into renal units to drive this change.

AHWs as cultural bridges

AHWs employed in acute hospital settings provide significantly more than clinical support to Aboriginal patients. Their presence is known to enhance engagement for Aboriginal patients with their treatment in mainstream health facilities (Coffin, 2007; The Australian Health Ministers’ Advisory Council, 2011). They provide patients a stronger voice and enhance rapport and relationship building between Aboriginal patients and health care professionals. A number of key policies and papers recommending collaborative approaches to the care of Aboriginal people within hospitals have all cited the centrality of Aboriginal personnel to improving health care delivery and outcomes (Aspin, et al., 2012). AHWs are known to initiate the building of positive relationship between care providers and Aboriginal patients and their families.

Employing AHWs in renal units is one of a suite of strategies identified by this research project aimed at improving Aboriginal people’s experience of and engagement with mainstream renal services (Rix, Barclay, Wilson, Stirling, & Tong, 2013). Importantly, the AHW role would ideally be introduced in nephrologist’s rooms when the diagnosis of chronic kidney disease is communicated to an Aboriginal patient. The presence of the AHW at that point is viewed as key to engaging the patient and their family with preventative strategies. The AHW can leave the rooms with the patient and reinforce information delivered by the nephrologist, explaining how relatively simple lifestyle changes in this pre-dialysis phase can hold off the need for dialysis or even avoid it altogether. Introducing AHWs in a pre-dialysis support role, in conjunction with design and implementation of an Aboriginal-specific pre-dialysis pathway are two strategies identified in our research that can provide a cultural bridge between Aboriginal renal patients, mainstream health care providers and institutions (Rix et al., 2014b). Explanations delivered by an AHW as to why lifestyle modifications are necessary, rather than simply telling people what to do may better encourage Aboriginal people to make some relatively simple, yet necessary changes.

Proposing a new model of staff cultural education/experience

At the systems, organisational or programme level, a coordinated and comprehensive plan needs to be in place to support a model of cultural training for clinicians that is both affordable and sustainable. From Aboriginal patients and Elders in our area, a new model of positive cultural awareness raising for renal staff has been proposed, with the goal of increasing two-way understanding and building strong and positive relationships between the two groups. This new model involves Aboriginal HD patients, family members or Elders delivering cultural education to their own renal clinicians (Rix et al., 2014). As one participant receiving in-centre HD said:

There be no good just any old black fella coming and talking to our staff about this because that fella don’t have a clue what a dialysis machine looks like, he wouldn’t have a clue what’s going through the Aboriginal’s mind … so we need a dialysis patient to work at doing that with the staff … partners or the mother to come in and talk about the cultural issues from the dialysis patient perspective. [Man, 50s]

The study findings indicated that a less formal and more cost-efficient style of cultural education would be achieved by enabling Aboriginal patients and/or family members to deliver ‘in-service style’ sessions with staff on-site at their treating renal units. Inclusion of paid Elders to deliver their cultural knowledge and expertise was viewed as an acceptable and appropriate means of cultural competence training and education to renal clinicians that may increase understanding of the cultural and family obligations of the patients with whom they are working. This style of patient-driven cultural education is aligned and in accord with a new and innovative model emerging from the Northern Territory, where Australian Aboriginal dialysis patients...
Building cultural bridges and two-way understanding: working with Australian Aboriginal people within mainstream renal services

contribute to supporting the treatment and care for their own people. The Patients as Paid Preceptors programme currently being implemented by the Western Desert Ngarampa Walytja Palyantjaku Tjutaku (WDNWPT) Aboriginal Corporation involves Aboriginal dialysis patients being paid to act as preceptors to new Aboriginal patients forced to relocate to urban centres to commence dialysis (Senate Select Committee on Health, 2015). This model is not only highly culturally appropriate, it also gives recognition and respect to the established Aboriginal HD patients for passing on their knowledge and experience of mainstream renal services.

Australia is learning from New Zealand in providing culturally sensitive care to Aboriginal renal patients. In 1997 Hoffman published a paper in which she described a Maori model of culturally sensitive care in Wellington Hospital. Maori health care workers deliver cultural education to both patients and their health care providers, with the importance of historical events and the vital role of the ‘whanau’ (family) given priority. Maori people receiving HD in Wellington Hospital have been supported by their own health workers since the 1990s. To illustrate this: when a Maori person passes away in the renal unit, a ‘Kaumataua’ (Elder) performs a traditional cleansing ritual, a vital cultural tradition. This provides other Maori people some comfort when having to return to their renal unit, and reduces the fear and grief associated with the passing of one of their people with the same condition as them. Many Maori patients and their families have responded positively to this style of culturally sensitive approach (Hoffman, 1997). This style of culturally shaped and sensitive care is being adopted in health care delivery in rural and remote Australia. One example is a randomised controlled trial in rural north Queensland, which is testing a pragmatic model of care involving AHWs as case managers in a family-centred chronic care model for Aboriginal people suffering chronic disease (Schmidt et al., 2012). The success of these culturally sensitive approaches in the treatment and care of Aboriginal people suffering high levels of chronic disease give strength to our argument for a more accessible and affordable model of cultural education and experience for renal nurses working with Aboriginal HD patients. Utilising local Aboriginal cultural knowledge would also acknowledge and address the uniqueness and diversity of each Aboriginal community across Australia.

Conclusion

This paper has proposed strategies aimed at improving the delivery and acceptability of mainstream renal services for Aboriginal people in rural and regional Australia with ESKD requiring dialysis.

Improving the cultural competence of individual non-Aboriginal health care providers, inclusion of AHWs in renal units and the implementation of an Aboriginal-specific pre-dialysis pathway are some of the strategies which emerged from our research. Achieving this requires a commitment by health institutions to providing resources and opportunities for the building of relationships based on increased two-way understanding and respect. Working with and listening to each other with mutual respect will encourage culturally competent care for Aboriginal patients.

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16

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