

# ‘We get so task orientated at times that we forget the people’: staff communication experiences when caring for Aboriginal cardiac patients

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## Abstract

**Objective.** The aim of this study was to describe the experiences of communication for staff providing cardiac care for Aboriginal and Torres Strait Islander patients in hospital and discuss potential improvements.

**Methods.** Focus group discussions were performed with 58 multidisciplinary staff who provide care for Aboriginal and Torres Strait Islander cardiac patients in two metropolitan and two regional hospitals in South Australia and Northern Territory. Inductive thematic analysis was undertaken to identify staff perceptions of communication challenges and strategies for improvement.

**Results.** There were five key themes: (1) communication is central to good care; (2) communication within busy clinical environments; (3) supporting a strong Aboriginal workforce; (4) a cultural as well as clinical focus; and (5) particular challenges working with patients from remote areas.

**Conclusions.** Providing effective communication that is both clinically and culturally appropriate is often challenging within a busy and non-adaptive hospital environment. Moving beyond clinical tasks, increased Aboriginal and Torres Strait Islander health workforce and cultural competency, supporting coordinated care and improved skills are required to meet the communication needs of Aboriginal and Torres Strait Islander patients.

**What is known about this topic?** Communication between patients, their families and hospital staff is crucial for health care quality and safety. There is little understanding of the challenges and opportunities for staff to meet the communication needs of Aboriginal and Torres Strait Islander cardiac patients to address disparities in acute care settings.

**What does this paper add?** This paper discusses the barriers and potential improvements, as identified by hospital staff providing care to Aboriginal and Torres Strait Islander cardiac patients in both metropolitan and regional settings.

**What are the implications for practitioners?** Practitioners should be trained and supported in providing both clinically and culturally safe care for Aboriginal and Torres Strait Islander patients. This requires adequate time, two-way communication and resources to support and facilitate effective communication.

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## Introduction

Cardiovascular disease is a major contributor to the health gap between Aboriginal and non-Aboriginal Australians, and there is a corresponding national focus on developing a targeted

approach to address this disparity.<sup>1,2</sup> Effective communication between staff, patients and their family members has been identified as crucial for ensuring quality healthcare and patient

safety.<sup>3</sup> Following a cardiac event, mutual understanding of treatment options and informed consent are vital.<sup>2,4-6</sup> However, achieving effective communication in busy clinical cardiac settings with time-critical interventions and rapid throughput of patients is often challenging.<sup>7</sup> In situations where the world views, experiences and resources of staff and patients are vastly different, serious miscommunication and misunderstandings are more likely to occur.

Aboriginal people from urban, rural and remote areas of Australia attend metropolitan and regional hospitals for cardiac care and experience both similar and different communication needs to other patients.<sup>8,9</sup> Nearly half the Aboriginal people in South Australia and three-quarters of Aboriginal people in the Northern Territory live in remote and very remote regions, often with English as a subsequent language.<sup>10</sup> Therefore, effective intercultural communication for these patients may require both an interpersonal and a systems-level response.<sup>3,11,12</sup> The aims of the Communicate Project were to better understand hospital communication experiences from the perspectives of Aboriginal patients with cardiac disease, their families and health carers, and to identify potential improvements. The authors respectfully recognise both Aboriginal and Torres Strait Islander peoples as Indigenous peoples of Australia. However, reference is only made to 'Aboriginal' patients as none of the staff identified caring for Torres Strait Islander patients, and none of the patient participants themselves identified as Torres Strait Islanders. This paper reports on the experiences of staff and their suggestions for improvements in regional and metropolitan hospitals in South Australia and the Northern Territory. The experiences of patients and family members will be described in an upcoming publication (A. Dowling, J. Kelly, K. McBride, W. Keech, A. Brown, unpubl.data).

## Methods

### *Ethics approval*

An Aboriginal Reference Group guided this project, with ethics approval received from the Aboriginal Health Research Ethics Committee of South Australia (Reference 04-15-610), SA Health Research Ethics Committee (Ref HREC/15/SAH/31) and the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (Reference 2015-2408).

### *Recruitment*

Staff participants were recruited via email, meetings and flyers at two hospitals in South Australia and two hospitals in the Northern Territory (one regional and one urban in each jurisdiction). Participation was voluntary and timed to minimise effects on staffing and patient care.

### *Data collection*

Semistructured focus groups were conducted, always by two members of the research team (always JK, accompanied by AD, WK or KM), from June to December 2015. Following the provision of informed written consent and agreement as to whether to audio record or note the conversation, staff were invited to discuss their experiences when communicating with Aboriginal cardiac patients and their families, and how their hospital responded to the nine themes that emerged from interviews with Aboriginal patients and family members (W. Keech, J. Kelly, A. Dowling, K. McBride A. Brown, unpubl. data; also see [Box 1](#)).

### *Analysis*

Inductive coding was undertaken to develop first-level categories by one Aboriginal (AD) and one non-Aboriginal (JK) researcher using NVivo version 11 (QSR International, Melbourne, Vic., Australia). The research team then reviewed first-level categories to develop high-level themes with associated subthemes. Site-specific results were extracted under the themes, and collective member checking was undertaken with each site. Feedback was incorporated into the overall results.

## Results

Fifty-eight participants attended eight focus groups across the four sites (two focus groups in each site), including a generalist physician, four pharmacists, eight Aboriginal Liaison Officers or Indigenous Liaison Officers (hereafter referred to as ALOs), with the remainder being allied health staff and nurses. Five key themes emerged both within each site and across the entire project, as detailed below.

### *Communication is central to good cardiac care*

Communication was recognised by most staff as being central to building respectful therapeutic relationships, and crucial for

#### **Box 1. Nine themes from Aboriginal cardiac patient and family member interviews**

The experiences of patients and family members were obtained in a separate study within the Communicate project (W. Keech, J. Kelly, A. Dowling, K. McBride, A. Brown, unpubl.data).

1. The impact on patients of positive and negative cardiac stories from previous patients
2. The importance for patients of being listened to
3. The usefulness of using models and pictures as well as written information in cardiac care
4. The importance of Aboriginal and Torres Strait Islander staff in cardiac units
5. The need for pharmacists to clearly explain medications using oral and written methods
6. The approach of doctors when explaining diagnosis and treatment, and whether they use a range of resources
7. Whether nurses provide quality clinical and cultural care
8. Level of information and communication style of postoperative and cardiac rehabilitation
9. Lack of information for patients on why decisions were being made by staff, and so actions perceived as racist

immediate care and future interactions with patients, their family and wider community members.

*Getting to know a person is actually a two-way process so when you know someone really well they are more relaxed and you're more relaxed. (S3)*

*Respect has to go both ways and if the...health professional doesn't respect the patients, their wishes and their views, you're never going to build that relationship. You're not going to get them to comply, to participate...they go back to the community and they give a story, another one...People don't want to come and be escorts. People just don't want to come to hospitals [as patients]... There's too many bad stories out there and not enough good ones. (S5)*

Staff who worked in wards or units with high numbers of Aboriginal patients, in hospitals located within geographic locations with a high percentage of Aboriginal people in the population and those with access to cultural training expressed most confidence and proficiency in communicating effectively with Aboriginal patients and their family members. The discussion with these staff focused on building trusting relationships before discussing clinical issues and consent. Staff who had previously worked closely with Aboriginal patients and communities in urban, rural or remote locations also expressed higher levels of proficiency.

*Before we get right to the point about what your medical condition is and why you're here, you start talking about family and country and then we have that beautiful winding conversation which is where you get the value, that's how you build the relationship, the trust. I've got two boys, have you got any children? Or you are from [remote location], that's a good spot. (S7)*

#### Communication within busy clinical environments

All staff discussed that it was often difficult to ensure that effective communication occurred within busy clinical settings across cardiac care, particularly when there were time pressures and high clinical loads. Even for staff with a higher level of experience and understanding, high workloads and extensive tasks meant that many staff were required to have a clinical focus, overlooking important cultural and communication elements.

*We get so task orientated at times that we forget the people – I like to think I'm fairly culturally sensitive but the last person I coordinated...was an emergency. I gave a really good education session. The whole family was there and I was explaining what had to happen 'we're going to do this, we're going to do that' and he said 'do I get a say in this?' and I just stood back and thought 'this whole time I'd forgotten that very core thing, that I'm doing all this for him but does he want it?' (S7)*

There was a sense that the only times staff could explicitly and legitimately sit and talk with patients were for informed consent, cardiac rehabilitation and discharge planning. At other times clinical and documentation tasks took precedence.

*It is not deemed okay to 'just sit and talk with a patient' when there are so many other tasks still to complete. (S4)*

#### Supporting a strong Aboriginal workforce

There was a noticeable lack of clinically trained Aboriginal and Torres Strait Islander staff in cardiac care in each location. None of the clinical staff in the focus groups identified as being Aboriginal, and there were no designated Aboriginal cardiac clinical positions.

There was generally poor understanding by cardiac staff about the exact role and capacity of ALOs to assist patients and staff. Most hospitals employed limited numbers of liaison staff who attempted to provide support to large numbers of Aboriginal patients and their family members who were experiencing complex social, cultural and financial needs.

ALOs were often called on to assist with communication, cultural translation, decision making and support.

*If in doubt, give the ALO a shout. They do patient education sometimes too. (S6)*

*She organises the community pathways and everything so we have the family meetings and then decisions are made and explained. (S6)*

However, many staff identified that it was often difficult to access liaison services due to limited numbers of positions, high demand and weekday office hour contract conditions.

#### Cultural as well as clinical focus

Both non-Aboriginal and Aboriginal staff identified their own, and their peers', different levels of cultural competency and confidence in communicating with Aboriginal patients and their family members from urban, rural and remote locations. This was often linked to previous experiences and interactions with Aboriginal people, both within the hospital and the broader community. Of concern, is that one hospital contained at least one cardiac staff member who felt so uncomfortable talking with Aboriginal patients that they avoided them, even though these patients were part of their care allocation.

*I am always on tenterhooks with Aboriginal patients, and so keep all conversation to a minimum. (S2)*

This overseas-born and -trained staff member had received no cultural training since beginning work in Australia. Only approximately half of all staff interviewed had attended any form of cultural training in their present workplace and had had minimal training as part of their undergraduate degree. Cultural training was mandatory in some hospitals, whereas in others it was available but not well attended or not available at all. Online modules were being introduced in some sites, with mixed responses from staff regarding the appropriateness and limitations of this delivery method. Generally, the preference was for face-to-face training that involved discussions and strategies to assist staff to know how to respond to particular situations and patient needs. Several staff expressed concern and frustration about the cultural competency level of other staff, both within their own hospital and when patients were transferred.

Staff conceptualisation of the difference between equity and equality (responsive care vs same care) and how this affects access and care outcomes was also variable, ranging from very little understanding to deep understanding. Some staff declared 'we treat everyone the same', appearing not to consider the effect of culture, age, gender and historical experiences. At times, it became apparent through deeper discussion that a number of staff were, in fact, providing additional and more equitable care, even though they initially framed this as caring for each person equally well. A few staff, usually those more experienced in working in Aboriginal health, clearly articulated their role in providing equitable care and ensuring access for Aboriginal patients who may be experiencing communication, access and social determinants of health challenges.

#### *Particular challenges identified when working with patients from remote areas*

Across each site, most staff focused on specific communication needs of Aboriginal patients from rural and remote areas, with few mentioning any specific communication needs that urban-based Aboriginal patients may have.

Staff from across all sites identified that working with Aboriginal patients from remote areas involved unique communication and consent challenges linked to differences in language and terminology, communication styles and world views. Staff responses to these challenges varied, with some including family and primary care providers in discussions and decision making, and using teleconference and videoconference resources proactively.

*We have a family meeting (using teleconference) and the key [family] decision maker says 'yeah, he'll stay and have treatment' and [the patient will] be like 'yeah, I'll stay and have treatment' because the right person within culture made that decision. (S7)*

In comparison, some staff only used such strategies 'when there was a problem' (S1). Some staff openly reported feeling frustrated with remote area patients when communication difficulties occurred.

*Some patients come down and are non-compliant. They shouldn't have come if they don't want the treatment. (S2)*

Staff also highlighted the challenge of trying to 'explain the inexplicable' (S5), such as describing Western medical treatments and roles that were completely foreign to that patient's life experience.

*Remote area patients may not understand the role of a 'medical doctor', and instead associate the word 'doctor' to a sorcerer or bad medicine. (S5)*

Staff first needed to explain their role and build relationships before trying to convey descriptions and ensure understanding of specific illnesses and treatment options. Hospitals and staff that interacted with a considerable number of Aboriginal patients were often more aware of these challenges, and adapted care to meet specific patient needs.

There were also challenges to seeking additional support for communication. Staff in each site spoke of interpreters being inaccessible, especially at short notice for emergencies. Telephone interpretation was often less than ideal due to poor telephone lines and hearing difficulties. Ongoing delays and limitations in interpreter access led many staff to lose confidence in the service, and instead use family members for interpretation.

*It's only one phone call but often you're on hold for a long time. . . obviously it takes a few hours to find somebody. In an emergency, you've lost us already. If we're not talking minutes then we're going to struggle to incorporate that as part of the culture of our service. (S7)*

To address some of these issues, one hospital employed interpreters onsite 2 days a week for ward rounds and out-patient clinics. This improved planned discussions, but emergency situations remained challenging.

## Discussion

Staff responses in this study highlighted similar communication issues as those reported in previous cardiovascular,<sup>8,9,13</sup> maternity,<sup>14,15</sup> renal<sup>16,17</sup> and cancer<sup>18</sup> studies. Staff highlighted a range of barriers and enablers to communication, which were affected by interpersonal and environmental health system factors. Variable skills and cultural competency levels, resources and processes were apparent within and across each site.

### *Moving beyond measurable clinical tasks*

The current Australian health system focuses strongly on the completion of measurable, clinical tasks for assessing quality and safety.<sup>4</sup> Patient experiences of communication, care and caring are less tangible and arguably more difficult to measure. Although most staff members understand the value of clear communication in the provision of quality person-focused care, they often feel unable and unsupported to provide this within busy clinical units, critical interventions and rapid throughput of patients. A move towards adopting patient-reported experience measures may support a shift towards improved focus on communication and care.<sup>19</sup>

### *Increasing cultural competency*

This study is consistent with other literature and national standards that recognise the need for improved cultural competency to support improved communication with Aboriginal patients.<sup>9,11,12,14,15,20</sup>

Increasing the Aboriginal and Torres Strait Islander workforce in clinical, liaison, support and administration roles is identified as a key activity to support increased competency.<sup>21</sup> The lack of Aboriginal and Torres Strait Islander clinical and liaison staff and translators was a key barrier identified in this study, as in other studies.<sup>6,9,11</sup> Complicating this was a poor understanding of the role of liaison staff, who were often under-resourced and often not used effectively.

Another key activity is increasing the capacity of all staff to provide culturally appropriate care. There are diverse opinions in Australia about the most effective approach to



cultural training,<sup>22</sup> with benefits and limitations to online modules compared with face-to-face sessions. With the introduction of revised national standards,<sup>12</sup> there is increased emphasis on hospitals and health systems demonstrating how they meet cultural competency standards. The findings of this study reinforce the need to ensure each service has cultural training for staff and, in addition, to move beyond single cultural awareness sessions to building an ongoing cultural competency approach. This will assist staff and health services to conceptualise and respond to individual patient needs more effectively.

#### *Using coordinated care approaches to improve communication*

From patient interview accounts in the other section of this study, it became apparent that patients (particularly from rural and remote areas) often relied on family or primary health carers to find out more information and make decisions. This communication was often not known or recognised formally by hospitals. One strategy to improve communication is to facilitate discussion between and involvement of patients, their family and health professionals providing care, both in hospital and in the community. In particular, involvement of primary care can support preadmission, informed consent and discharge planning.

#### *Increasing skills in communication*

This research reiterates the importance of having all staff skilled in communication with Aboriginal patients and their families. There was a noticeable variation in staff responses regarding their capacity to initiate effective two-way clinical and cultural communication. A communication model of factors that affect effective communication was developed from combined results of the patient and staff analysis (W. Keech, J. Kelly, A. Dowling, K. McBride A. Brown, unpubl. data). Other approaches such as 'clinical yarning', which consists of the social, diagnostic and management yarn, offer a framework to assist staff to better facilitate communication with Aboriginal patients.<sup>23</sup>

#### *Limitations*

Limitations of the study relate to the participation; only one doctor was able to participate and no cardiologists or cardiac surgeons were involved. In future studies, offering interviews as well as focus groups to staff participants may enable more and varied staff to be involved, with demographic and professional experience data collected from each participant.

#### **Conclusion**

Effective communication in cross-cultural hospital interactions requires both individual staff and system-level responses. Staff within busy clinical settings often struggle to effectively engage in the level of communication required for quality clinical and cultural care provision. Additional staff and patient support are required to effectively meet patient communication needs, but may not be readily available. Investments in the cultural capability of hospitals, as well as in the Aboriginal workforce, in both a support and clinical capacity, are required. The results of this study were provided to each site with key recommendations

and reported to the Heart Foundation (funders) to inform resource development. With revised national standards focusing on how systems respond to communication challenges,<sup>12</sup> this study and its findings are timely.

#### **Competing interests**

The authors declare that they have no competing interests.

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