

Considering difference: clinician insights into providing equal and equitable burns care for Aboriginal and Torres Strait Islander children

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A just and healthy society is reliant on the equitable distribution of health outcomes.¹ While different definitions exist, Whitehead² defines 'equity' as the absence of avoidable differences among groups of people, 'equality' as the state of being equal, especially as it relates to rights and opportunities, and 'inequities' as unfair differences. Health inequities are disparities in health that are unnecessary, avoidable, unfair and unjust.² Health inequities arise from the social and material circumstances in which people grow, live, work and age,¹ as well as through cultural exclusion.³ In Australia, Aboriginal and Torres Strait Islander children experience health inequities across many domains,⁴ including experiencing burn injury at disproportionately higher rates than non-Indigenous children. This is a longstanding inequity,^{5,7} associated with the social determinants of health,¹ that continues in today's society.³ It is important to understand more about this inequity as burn care transverses multiple health professionals in a complex health system, and for children, it often involves dislocation from family and Country. Furthermore, significant disparities are evident from the quality indicators for Aboriginal and Torres Strait Islander children

Abstract

Objective: To better understand issues driving quality in burn care related to equity of outcomes and equality of provision for Aboriginal and Torres Strait Islander children.

Methods: Seventy-six interviews with team members who provide care for Aboriginal and Torres Strait Islander children in six paediatric burn units across five Australian jurisdictions were completed. Interface research methodology within a qualitative design guided data collection and analysis.

Results: Three themes were identified: i) Burn team members who identify the requirement to meet the specific needs of Aboriginal and Torres Strait Islander children and deliver differential care; ii) Burn team members who believe in equal care, but deliver differential care based on the specific needs of Aboriginal and Torres Strait Islander children; and iii) Burn team members who see little need for provision of differential care for Aboriginal and Torres Strait Islander children and rather, value the provision of equal care for all.

Conclusion: Burn team members conflate equitable and equal care, which has implications for the delivery of care for Aboriginal and Torres Strait Islander children. Equitable care is needed to address disparities in post-burn outcomes, and this requires clinicians, healthcare services and relevant system structures to work coherently and intentionally to reflect these needs.

Implications for public health: Changes in health policy, the embedding of Aboriginal and Torres Strait Islander liaison officers in burn care teams and systems that prioritise critical reflexive practice are fundamental to improving care.

Key words: Australia, health equity, burn care, cultural safety, Aboriginal and Torres Strait Islander, Indigenous, children, quality

and non-Indigenous children following a burn injury.^{5,8}

High quality, purpose-built facilities and specialist multidisciplinary burn care are

required for the best health outcomes.⁹ In Australia, the burn services are centralised to major or state capital cities, increasing barriers and delays in access to this care for non-

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metropolitan dwelling people. For Aboriginal and Torres Strait Islander children, high-quality burn care includes the provision of healthcare that is culturally competent and relative to their context.¹⁰ Equitable care is required to address the specific health needs of Aboriginal and Torres Strait Islander children and families. Core to this is care that is experienced as culturally safe.¹¹ There are gaps concerning the quality and cultural safety of the models that currently inform burn care in Australia.¹² These include only limited aspects of cultural safety being addressed in the models, limited or no cultural consultation in their development, and descriptions or application of quality measures being inconsistent and incomplete.¹²

Furthermore, both system and individual factors are known to impact the experience of health professionals working with Aboriginal and Torres Strait Islander people.¹³ These factors are compounded by limited understanding of how health professionals make sense of – and implement principles of – equity. Little is known about the understanding of, or emphasis placed on, equitable healthcare by multidisciplinary burn teams in their management of Aboriginal and Torres Strait Islander children.¹⁴ A better understanding of these issues is required to enhance the ability of health professionals to work with Aboriginal and Torres Strait Islander people accessing burn care, and therefore contribute to addressing health equity challenges. The overarching aim of this study was to explore how burn care in Australia is delivered in and from tertiary burn units and to identify what informs care provision of the multidisciplinary burn care teams. This paper reports on one aspect of such care related to how healthcare professionals responded to an inquiry about the provision of different care when working with Aboriginal and Torres Strait Islander children and families.

Methods

The research is embedded in the conceptual framework of interface research¹⁵ and is guided by the principles of mutual respect, shared benefits, human dignity and discovery. Equity is at the core of these principles and informed this research.

Methodology

A disjuncture exists between the ways of knowing, being and doing of Indigenous

and non-Indigenous peoples.^{16,17} An interface research approach¹⁵ informed an exploration of the mismatch of knowledges related to burn care for Aboriginal and Torres Strait Islander children and families in Australia. Interface methodology provides an opportunity for integration and interfacing of Aboriginal and Torres Strait Islanders peoples' knowledge and Western concepts¹⁵ that would otherwise be limited. This methodological approach was integrated within a qualitative study design¹⁸ to investigate care provided to Aboriginal and Torres Strait Islander children and families following a burn injury. The qualitative design enabled research into healthcare professionals' understanding and enactment of burn care in a tertiary setting.

Study setting

Ethics approvals were received from Princess Margaret Children's Hospital, WA Aboriginal Health and Research Ethics Committee, Aboriginal Health and Medical Research Council Ethics Committee, Sydney Children's Hospitals Network Human Research Ethics Committee, Aboriginal Health Research Ethics Committee, Women's and Children's Health Network Human Research Ethics Committee, Flinders University SBREC, The University of Queensland Medical Research Ethics Committee, Children's Health Services Human Research Ethics Committee, Townsville Hospital and Health Service Human Research Ethics Committee, Central Australian Human Research Ethics Committee, Human Research Ethics Committee of Northern Territory, Menzies School of Health and the Department of Health Human Research Ethics Committee. Six tertiary hospitals in Australia were invited to participate and included the Royal Darwin Hospital, the Women's and Children's Hospital, Children's Hospital Westmead, Princess Margaret Hospital for Children, the Townsville Hospital and Health Service and the Queensland Children's Hospital. These sites were participating in the broader longitudinal study investigating burn injury in Aboriginal and Torres Strait Islander children,¹⁴ and as such were invited to participate in this project.

Data collection

Staff employed in multidisciplinary paediatric burn teams in the tertiary hospital sites were recruited using purposive sampling.¹⁸ Burn team members included a cross-section of medical, nursing, allied health and

administration staff proportional to team size and profession mix (see Table 1). A sample of $n=76$ dedicated burn team staff reported on burn care from a predicted available sample size of 120. Interviews varied in length from 30 to 80 minutes. Almost all participants ($n=65$) were specifically asked if they provide differential care for Aboriginal and Torres Strait Islander children compared with non-Indigenous children. Responses from these participants are presented in this paper. The eleven participants not asked about this matter were either Aboriginal/Indigenous Liaison Officers (A/ILO) or Aboriginal health practitioners (AHP) who were not asked due to their role being assumed to be working with Aboriginal and Torres Strait Islander families only. The other three participants were not asked due to time limitations. Data were collected from late 2016 to early 2017 in audio-recorded face-to-face interviews using a semi-structured interview guide (Supplementary File 1).

Data analysis

Interviews were transcribed verbatim, emailed to participants for reading and checking for accuracy, and then de-identified. Transcripts were imported into NVivo 11 qualitative analysis software (QSR International). An inductive content thematic method¹⁷ was used to analyse data. In line with interface research methodology, methods to ensure Indigenous knowledge consideration and inclusion were engaged. As such, contribution was sought for data analysis from author NK, an Aboriginal woman with family ties to the Ngarrindjeri and Ramindjeri people of South Australia and also the Alawa and Mara people of the Northern Territory. Author NK is an experienced health policy professional, external to the main project, yet linked closely through a cultural mentorship role to the main researcher, non-Indigenous author SF. Author SF grew up in rural South Australia and has experienced a western biomedical education through her university studies. Author SF engaged in reflexive activity during the course of the research project through journaling and critical reflection with author TM and the overall study's¹⁴ Aboriginal advisory group. During the initial thematic analysis of a sample of data, authors NK and SF met and deliberated over the coding of themes. Discussions identified consistencies and explored points of difference. A consensus was determined based on further

exploration and mutual understanding. Consistent with the coming together of Indigenous and western knowledge, these processes contribute to the reliability of data analysis and demonstrate our application of interface research methodology within a qualitative design.

Results

Results from the overall study investigating burn care with 76 participants are reported in full detail elsewhere,¹⁹ and in summary for context here. Burn team members described burn care as being delivered by multidisciplinary teams via three main care modalities: inpatient; outpatient; and telehealth, or by a combination of these modalities. Burn units were described to be resourced via activity-based or state government health funding, and availability of resources and specific service environments dictated the prioritisation of aspects of care.¹⁹ This meant there was limited opportunity for resourcing prevention activities and variation in care was evident between units, for example, the access to anaesthetic services in outpatient care settings and the availability of play therapists. Communication within teams was often directed through lead burn nurses within hierarchical team structures.¹⁹ Consumer care was reportedly enhanced through discussion of individual cases in multidisciplinary team meetings.¹⁹ Participants identified that evidence, resources and resourcing, decision making processes and values and beliefs informed the provision of burn care for Aboriginal and Torres Strait Islander children and families in Australia.¹⁹ The data relating to decision making processes and values and beliefs were complex and derived mostly from participants answering the question regarding differences in care provision for Aboriginal and Torres Strait Islander children. As such, this paper reports on the findings from the interview question regarding difference with 65 participants (see Table 1). Participant reports of care that is different (or not) for Aboriginal and Torres Strait Islander children and families than for non-Indigenous children were categorised into three main result themes. *Theme 1* – Burn team members who identify the requirement to meet the specific needs of Aboriginal and Torres Strait Islander children and deliver differential care; *Theme 2* – Burn team members who believe in equal care, but deliver differential care

Table 1: Summary of participant profession and result themes.

	n (asked if care is different)	Theme 1	Theme 2	Theme 3
Nursing	20	9 (45%)	6 (30%)	5 (25%)
Medical Officer	15	4 (27%)	2 (13%)	9 (60%)
Allied Health	27	17 (63%)	5 (19%)	5 (19%)
Administrative	3	3 (100%)	-	-
TOTALS	65	33 (51%)	13 (20%)	19 (29%)

based on the specific needs of Aboriginal children; *Theme 3* – Burn team members who see little need for the provision of differential care for Aboriginal and Torres Strait Islander children and value the provision of equal care above all (see Table 1). Due to the large amount of data for Theme 1, descriptive codes for the examples of different care provided were identified and are presented in Table 2 with corresponding quotes. All examples of different care are provided in the text for Theme 2. Examples of different care are not relevant for Theme 3. For transparency and context throughout, participants were identified by their health discipline abbreviation. These include RN – Registered Nurse, MO – Medical Officer, AH – Allied Health Professional and AO – Administration Officer.

Theme 1 – Burn team members who identify the requirement to meet the specific needs of Aboriginal and Torres Strait Islander children and deliver differential care

More than half of the participants described the provision of differential care for Aboriginal and Torres Strait Islander children: "...there are some changes to our practice...because that's more appropriate that you do that" (MO). Notwithstanding variations in wording, there was conceptual consistency in the descriptions of differential care that resulted in multiple examples of differential care being provided (Table 2). Many of the participants in this group responded assertively with words like "absolutely" and "definitely". Of the 27 allied health participants asked if they provide differential care, including all interviewed social workers and psychologists, more than two-thirds responded affirmatively to the provision of differential care.

There was broad consensus across specialties regarding the engagement and involvement of A/ILOs as an example of differential care for Aboriginal and Torres Strait Islander children and families. One participant said including the A/ILO in care was about "...ensuring the right people at the right time in the right

space to deliver the right care is also about including those key people" (MO). Very few participants talked about A/ILO involvement in case conferences or participation in relevant burn team meetings. When geography was considered by this group as leading to the provision of differential care, it was about understanding the socioeconomic context in which the family live and being respectful of the family's Country. Participants also described providing differential care based on the importance of family. This meant: "...including the family as a unit rather than directly working with maybe one parent" (AO) and "...allowing time for patients to go back and discuss matters with family which might not in other situations be needed" (MO). Consideration of "...the dislocation [from family] in Indigenous [people] is something that we have to be much more aware of" (AH) was described by one participant when talking about the provision of differential care based on family.

Decisions regarding discharge (or not) of Aboriginal and Torres Strait Islander children and families from tertiary care were different when compared to non-Indigenous children and included consideration of geography, infection, perceptions of compliance with care and prevalence of co-morbidities. This was summed up by one participant as:

I always lean towards keeping them kids in longer...we just don't know a lot of the time about what environment, it's so multifactorial...I suppose sometimes I feel that if we can keep them here, keep them really well-nourished, keep their dressings clean and all the rest of it, then we might sort of limit a lot of the long-term complications but that doesn't necessarily always happen because there's always a push for beds and strictly speaking they don't need to be here. (RN)

Such factors impacting decisions regarding differential care for discharge planning highlights the tensions held by health professionals.

Differential care was provided to Aboriginal and Torres Strait Islander children and families

in relation to communication, language and perceived comprehension. Participants said it was important to: "...listen to the whole story because management might change if I know where they're from and how they live" (AH). Furthermore, many participants said they engage interpreters and don't assume knowledge (AH), and multiple professions reported using different methods, like deep listening, to enhance understanding about care. A smaller number of participants also described changing their practice to be more culturally cognizant. For example, one participant said:

...so from the moment when you walk in the room if it is an Indigenous family you're thinking am I being culturally sensitive, am I being culturally appropriate to this family's needs, having that in the back of your mind... just making sure you're aware of that. (AH)

As a result of being asked about delivering differential care, participants also described understanding their own biases, having an awareness of the incongruences between the ways of Aboriginal and Torres Strait Islander families and that of the Australian health system, and knowledge of identified risk factors as reasons *why* they provided differential care. In terms of biases, participants described understanding their own culture, and knowledge (or lack of) and preconceived ideas about Aboriginal and Torres Strait Islander people that led to the provision of differential care. One nurse

described her own ignorance regarding language when providing care to a family.

English isn't his first language so his dad needs to interpret what we're saying and what he's saying to us and I think that's something that I've taken for granted because actually I see a little person who is Aboriginal and I think they're absolutely going to speak English... that's my own ignorance. (MO).

The incongruences between the ways tertiary health settings are structured and operate and the ways of Aboriginal and Torres Strait Islander peoples were described by participants who also talked about understanding history and its impact: "...historically Aboriginal people are much more guarded and don't really like to open up as much with government services" (RN). Furthermore, "European culture is very structured and doesn't fit necessarily so it can be a mismatch on how to provide care..." (RN). Participants also described confronting dominant structures like a large tertiary health service as daunting: "...this is a really foreign and scary environment... [their lives don't] often fit with the way wards are managed..." (RN) and as a reason for the provision of differential care. Understanding differences in priorities were also stated as a reason for the provision of differential care. "...being aware that their reasons for not attending may not be good enough for us but it is good enough for them" (AH). Understanding the challenges, like increased

incidence of other conditions, "...so while they're here it is an opportunity to make sure they get an ENT review..." (AH) and associated risk factors for Aboriginal and Torres Strait Islander children and families also accounted for the provision of differential care.

Theme 2 – Burn team members who believe in equal care, but deliver differential care based on the specific needs of Aboriginal and Torres Strait Islander children

One-fifth of participants said they did not provide differential care for Aboriginal and Torres Strait Islander children and families. However, it was with less conviction than by those participants who said they did provide differential care and they also proceeded to describe examples and circumstances of differential care.

I think we treat everyone fairly equal, the only thing that I think that we would maybe do differently is getting the ALO involved a bit more with the families from a social work point of view, but other than that I can't really think of anything. (RN)

After saying no to the provision of differential care, more than half of this group of participants including all professions said they do engage the A/LO if a child identifies as Aboriginal and Torres Strait Islander. This was said to be because they "...make sure that the ALO are aware that the family is here because that's very important to draw that family support again for them and obviously link up with their family groups that might be here..." (RN).

Other instances of differential care, similar to those described by participants in Theme 1, include consideration of geography in terms of access to food following discharge (AH), responding to gender differences for cultural reasons (RN), engaging interpreters (AH), providing extra attention for follow-up care (RN) and engaging in more applicable conversation relative to cultural background (2.12). One participant said, "I think the only thing we probably tolerate a little bit or are a little bit flexible with is time" (AH), while another said family commitments were considered.

There have been instances where we've probably pushed to get them home quicker than what we might normally do for other families because they're from a distance and have a lot of other family members at home needing them, that's probably a big one. (RN)

Some participants in this group expanded on seeking equal care, yet providing differential

Table 2: Examples of provision of differential care for Theme 1.

Descriptive codes	Examples of corresponding data evidence
Theme 1 – Burn team members who identify the requirement to meet the specific needs of Aboriginal children and Torres Strait Islander and deliver differential care	
Involvement	'I always engage and involve our ALO in the care ...' (RN) 'We share information with their local service ...' (MO)
Respect	'When I work with an Aboriginal family, I like to ask where they're from so that I can try and understand the welfare. ...and be respectful of Country. I also use telehealth' (AH) 'I'm mindful of being culturally appropriate and sensitive' (RN)
Appropriateness	'I have discussed in our dietician meeting about meeting culturally appropriate needs' (AH) 'I always think about being appropriate when it comes to responding to the gender of the child and when talking to the family' (RN) 'We have developed and now use Indigenous specific and resources' (AH) 'I might make a different discharge decision based on geography ... like where they're from' (MO) 'I use a more holistic approach with these families ...' (AH)
Flexibility	'There is a difference of importance put on time and we are flexible with our appointments' (AO) 'I like to think I make extra considerations around family in relation to the importance of their extended family ...' (RN) '... it is also important to include extended family in decision making' (RN) 'There is a need to consider that the family's needs outside of the hospital environment still need to be met and making allowances for care' (MO) 'I just make time. It is important to take those opportunities and make sure we're accessible' (AH)
Relationships	'I just spend a lot of time building relationships and rapport ... I make it a priority ...' (AH) 'I spend time deep listening and hearing a whole story' (RN) 'I use different language and different concepts to enhance the families understanding of the care' (AH)

care for Aboriginal and Torres Strait Islander children and families. When talking about being culturally respectful, one participant said, “the intervention essentially is typically the same but it’s about how we modify the delivery” (AH). Another participant said when describing how they refer to local Aboriginal health services for support with follow-up care:

...I don't think we individualise and it would be wrong to say that there's an overall policy difference between Aboriginal and Torres Strait Islander and non-Indigenous people and I think we like to think that each individual get as much or little care as they need. (MO)

Theme 3 – Health professional who see little need for the provision of differential care for Aboriginal and Torres Strait Islander children and value the provision of equal care for all

Close to one-third of participants reported the explicit intent and provision of the same burn care for Aboriginal and Torres Strait Islander children in comparison to non-Indigenous children. When differential care was provided, it was on the basis of geography, skin pigmentation, socioeconomic status and developmental age, not Aboriginality. Of the participants who reported treating everyone the same, almost half were medical participants, accounting for almost two-thirds of all medical participants asked about the provision of differential care for Aboriginal and Torres Strait Islander children.

The majority of participants in Theme 3 reported geography as a compounding factor to the provision of differential care as opposed to Aboriginality and was exemplified by one participant who said: “No. I think remoteness is more important” (MO). Another participant answered by saying:

I think overall for better or for worse there's no difference...to be honest, usually more of the issues relates to geography and logistics and that's the same whether you are of Aboriginal and Torres Strait Islander descent if you live in the remote location or you're not of Aboriginal, you know it's just a remote location... (MO)

One allied health and one medical participant explained that they did not provide differential care for Aboriginal and Torres Strait Islander peoples, however, they did for patients with darker pigmented skin. Another two participants said they considered differential care based on

socioeconomic status, while another considered developmental age in regards to the provision of differential care for patients, not Aboriginality.

For six participants, the provision of the same care for all patients was unequivocally important. These participants said “no” to the provision of differential care for Aboriginal and Torres Strait Islander children and families.

To be honest, I couldn't care less about their status because we're treating them all the same, and if they've got special requirements then you know we do that for every patient, as we don't have a different pathway for Indigenous children. (MO)

Discussion

Multidisciplinary burn team members showed different openness and sensitivity regarding the need to provide differential burn care for Aboriginal and Torres Strait Islander children and families. While the specific language of equity and equality was mostly missing from participant voices, the processes that participants described explicitly related to the provision of equal and/or equitable healthcare.² Data from *Theme 1* and *Theme 2* suggested that the approaches taken by multidisciplinary paediatric burn teams in Australia reflect aspects of equity more often than not; indicating engagement in quality healthcare practice²⁰ and progression towards professional cultural competency.¹⁰ *Theme 2* data also showed there is confusion over the constructs of equity and equality and how these might be operationalised in practice. This coincided with some unease regarding the provision of differential burn care based on Aboriginality: grounded in participant’s desire to do everything the same and aligning oneself within a domain of equality, yet seeking ways to address the needs of Aboriginal and Torres Strait Islander children and families. Data from *Theme 3* in this study also indicated the ideals and subsequent practice of some healthcare professionals are embedded solely in notions of equal care. This perceived mismatch in ideology may be real, or an artefact of expression. Issues of quality in burn care, a conflation of constructs, acceptance of discomfort through reflectivity, and challenging the status quo are discussed further, along with limitations and recommendations.

Quality burn care

High-quality care is consumer-centred, based on evidence, and is safe.²⁰ Such focus on consumer centeredness implies quality healthcare is equitable.² Data in this study showed the majority of burn care clinicians do consider context in the delivery of care for Aboriginal and Torres Strait Islander children and families. However, while high-quality and specialist multidisciplinary burn care is required for the best health outcomes following a burn injury,⁹ high-quality care for Aboriginal and Torres Strait Islander children is only sometimes being realised through the receipt of healthcare that is relative to their cultural contexts.

Clinical discipline may explain why some health professionals have an awareness of health inequities and social determinants of health and others don’t; although this is difficult to ascertain. The development of a tool to measure the quality and acceptability of care for Aboriginal and Torres Strait Islander children is required to identify gaps and inform improvement activities.

Conflation of constructs

Burn team members conflate the constructs of equity and equality as they relate to the provision of care for Aboriginal and Torres Strait Islander children and families. This is not surprising considering the multiple definitions across the literature.² While clinicians in this study did not use the language of ‘equity’ or ‘equality’, some identified that they need to provide differential or equitable care for Aboriginal and Torres Strait Islander children and families; at the same time considering this as providing equal care. The disjuncture¹⁵ between the biomedical model and the health and healing constructs of Aboriginal and Torres Strait Islander peoples is evident. Clinicians’ reports for striving for equal care and outcomes with limited understanding or consideration of equitable care are clear evidence of this disjuncture here. Nuances in these data further indicate a disjuncture of knowledges through the superior placement, recognition and dominance of Western biomedical health knowledge. One way to support the provision of equitable healthcare²¹ would be to structure the delivery of care so that principles of equity can readily be enacted, for example through policy change, and embedding of A/ILO in burn care teams to address this conflation.

Challenging the status quo

Provision of care that is respectful of culture and challenges the status quo of providing care that is regardless of culture² is an equitable approach to healthcare. Data in this study showed there is little insight into the need for culturally competent care to address health inequities when participants reported treating everyone equally. Medical care based on scientific measures is well reported in research literature²² and is important for best outcomes. However, the scientific evidence informing the normative approach to healthcare in Australia, i.e. the Western biomedical model, does not necessarily support or maintain an equity approach to healthcare with regards to Aboriginal and Torres Strait Islander peoples.²¹ This assertion of superiority of world views,¹⁶ conscious or otherwise, contributes to the unrecognised and ingrained lack of insight into equity in the delivery of burn care by some clinicians in the multidisciplinary burn team. The support of equality at the expense of equity in this study reflects the disjuncture of knowledges between the Western biomedical model and Aboriginal and Torres Strait Islander peoples constructs of health and healing. An equitable approach to healthcare is one that interfaces both knowledge systems,¹⁵ highlighting a need for cultural safety education that explicitly examines the disjuncture in knowledges²¹ and the impact on inequitable burn care outcomes. Changes in health policy, the embedding of A/ILO in burn care teams, and a healthcare system that is able to facilitate reflexive practice and support for individual practitioners to engage with these opportunities for reflexivity are required.

Accepting discomfort through reflexivity

In the context of personal development, feelings of discomfort are necessary and meaningful, because, without them, there is limited incentive for change. Healthcare professionals observed feelings of discomfort when being asked about how the provision of different care was primarily related to an understanding that the results of their standards of excellence are not being equally realised. These issues are explicit in the results when presenting data about Aboriginal and Torres Strait Islander health issues. An opportunity exists for clinicians to address this discomfort¹³ through engagement in reflexivity. Reflexivity has been used in research for critical reflection of oneself

to gain insight into one's own values and beliefs¹³ and is key to cultural safety.²¹ However, and similar to data in this study, evidence of how reflexivity is actualised in practice is limited, and is not supported in documents guiding burn care;¹² as such limiting the ability of healthcare for Aboriginal and Torres Strait Islander children to be equitable. Wilson¹³ suggests engagement in reflexivity may support healthcare professionals to become aware of the limitations of their practice, of which they are often unaware, and to develop new insight.¹⁹ Such insight might be that clinical expertise needs to include cultural competency for it to be experienced as best quality burn care by Aboriginal and Torres Strait Islander children and families. Practice such as this could be included in future models of care to support the actualisation of equitable healthcare.

Strengths and limitations

This is the first study to report on the constructs of equity and equality in burn care for Aboriginal and Torres Strait Islander children and families from the perspectives of multidisciplinary paediatric burn teams in Australia. We did not explore why clinicians did or did not do things differently for Aboriginal and Torres Strait Islander children and families, however, many participants offered insight into why (or why not). Not all of the people employed and working within burn teams were interviewed due to unavailability and the researcher only being onsite for one week at each site. Furthermore, A/ILOs and AHPs were asked about the provision of different care. However, the collection of a large amount of qualitative data from the face-to-face interviews with a broad range of professionals in the burn team enabled everyday practices to be comprehensively explored. Drawing on recruitment across multidisciplinary burn teams increased the likelihood that all professions involved in the care of Aboriginal and Torres Strait Islander children and families were represented. We recognise changes in policy or systems of care may have changed since the collection of these data, however, none are apparent to the authors. As data collected were from burn team members only, and did not include the viewpoints of families receiving care, the lack of understanding about how children and families felt about the burn care they received was a limitation of the study. Such data are being collected by other members

of the research team and will provide some insight into patient and family experiences. Data collection with clinicians was enhanced by the principal researcher being a registered nurse with a thorough understanding of health systems and processes. As the research was about health and healing for Aboriginal and Torres Strait Islander children, the process was potentially limited because the principal researcher was a non-Indigenous healthcare professional primarily educated within a medical standpoint. This limitation was purposely addressed through Aboriginal oversight and involvement in the research process, data analysis and reporting.

Conclusion

Equitable care is essential if we are going to make a transformational change to burn care in Australia for Aboriginal and Torres Strait Islander children and families. This care is now predominantly delivered by clinicians who place a high value on equitable care. However, the ability to provide equitable care is sometimes limited by healthcare professional confusion regarding the meaning and effect of their care. When there is no consideration of the need for differential burn care for Aboriginal and Torres Strait Islander children and families, the capacity to deliver the best-quality burn care for, and experienced as culturally safe by, Aboriginal and Torres Strait Islander children and families is limited. Furthermore, basing quality solely in terms of biomedical outcomes is against current notions of high-quality healthcare being consumer-centred.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary File 1: Semi-structured interview guide.