Batji-gum dilba

(Good talk medicine)

Improving culturally safe communication between doctors and Aboriginal patients in the Northern Territory of Australia

Vicki Kerrigan

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

(PhD)

Menzies School of Health Research,

Charles Darwin University

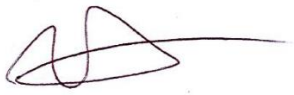
2022

Statement of Originality

This thesis is submitted to Charles Darwin University in fulfilment of the requirement for the degree of Doctor of Philosophy (PhD). I certify that the intellectual content of this thesis is the product of my own work and that all assistance received in preparing this thesis has been acknowledged. To the best of my knowledge, the thesis contains no material previously published or written by me or another person, except when this material is acknowledged in the thesis. This thesis contains no material that has been submitted for any other degree or diploma at any university.

I consent to this copy of my thesis, once deposited in the Charles Darwin University Library, to be available to loan, photocopy, and access online.

Signature



Vicki Kerrigan **Date:** 5th May 2022

As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements included above are correct.

Signature

Anna P Ralph **Date:** 5th May 2022

Abstract

In Australia's Northern Territory (NT) the repercussions of colonisation on Aboriginal peoples, the oldest continuous cultures on earth, are evident in healthcare. Most people who access NT hospitals are Aboriginal and most doctors are White. Many doctors struggle to communicate effectively and respectfully with patients. Poor communication is a common way patients experience racism and has resulted in patients dying. Miscommunication is also a major stressor for doctors, who often feel unprepared to work in the NT.

Conducted on Larrakia country, this Participatory Action Research is based on qualitative data from White and Aboriginal doctors, Aboriginal patients, and Aboriginal language interpreters regarding culturally safe communication at Royal Darwin Hospital (RDH). Cultural safety aims to dismantle the power imbalance present in clinical interactions; it places the onus for change onto the health professionals who hold power. To be a culturally safe practitioner doctors must develop their critical consciousness, which may be fostered by listening to Aboriginal people's stories outside power-laden clinical interactions. The concept of critical consciousness and the power of stories to address racism links cultural safety with Freirean pedagogy and Critical Race Theory. These three decolonising philosophies provide the research framework.

Australian governments have committed to addressing racism in health care by endorsing culturally safe care. However, a policy-practice gap exists. The purpose of this thesis is to provide evidence regarding the challenges and opportunities to improve culturally safe communication in the NT.

A baseline evaluation of more than 600 cultural awareness training feedback forms from NT healthcare providers informed two interventions. The evaluation revealed that training was considered an invaluable entry point and the personal stories shared by Aboriginal educators was a highlight. Healthcare providers wanted more opportunities to improve their communication skills and critically reflect on their own bias.

The first intervention aimed to improve culturally safe communication by embedding a Yolŋu Matha and Tiwi interpreter in an RDH medical team for 4 weeks. After having consistent access to trusted interpreters, patients who had felt "stuck" became satisfied with care.

Aboriginal interpreters who previously felt unwelcome at RDH reported feeling valued as skilled professionals. Doctors developed critical consciousness, which led to them adapting work routines to better suit patient needs and ensure collaborative relationships with interpreters.

The second intervention built on and extended the baseline cultural awareness training. I created and evaluated a podcast: *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare* in which Aboriginal leaders answer doctors' questions about working with Aboriginal patients. After listening to the podcast, doctors changed their communication style with patients and were better equipped to recognise system failures. This cultural education, which addressed issues specific to the local context and delivered "counterstories" from Aboriginal peoples, encouraged critical consciousness.

This thesis demonstrates that locally designed, clinically relevant interventions created together with Aboriginal stakeholders and health services can support the development of critically conscious doctors. When doctors become critically conscious, they change their behaviour which leads to a more culturally safe health service. Scaling up findings from RDH, to implementation across the NT health service, is the current focus of ongoing collaborative research.

Table of Contents

List of Figures

List of Tables

Acknowledgements

Ngana ludju nganigi respect to the Gulumerrdgen biyilirra and their Darriba Narri gudlagwa, yilanggwa and nimangwa.

– Larrakia acknowledgment of country, shared with permission from Aunty Bilawara Lee and the Larrakia Nation.

This research was conducted on the unceded lands of the Larrakia people, the custodians of the lands around Gulumoerrgin which was re-named by colonisers as Darwin, Northern Territory, Australia. I would like to acknowledge and pay my respect to Larrakia Elders, past and present, particularly senior Larrakia Elder Aunty Bilawara Lee who supervised my PhD work and was one of the podcast "Specialists". Aunty Bilawara also gave this thesis it's title: Batji-gum dilba which directly translates to "Good talk medicine" in the language of the Larrakia people which Aunty Bilawara and others are working to revive. Regarding the title Aunty Bilawara said:

> *In traditional medicine talking and listening are very important intangible healing tools, so clear cross-cultural communication is critical between patient and medical practitioner for better health outcomes.*

It seems wrong that a PhD is awarded to one person because producing a body of work like this is not an individual task. I have been incredibly lucky to be supported by the most generous, smart and funny people who have guided and inspired me to do this work.

My team of supervisors: what an honour to be included in this nest of knowledge and kindness. Thank you for opening so many doors of opportunity and for believing in my abilities when I really doubted it. Anna Ralph, I scored big time when you agreed to be my primary supervisor! Thank you for listening, advising, sharing your expertise and counselling me. Thank you for the eggs from your chooks and all those extra bits you did to make me feel so supported. Marita Hefler, thank you for your beautifully considerate insights and for reading draft upon draft upon draft of manuscripts. Thank you for laughing at me when I took it all too seriously and for the Turkish Delight chocolate. Alan Cass, thank you for taking on an ex-radio broadcaster with no previous experience in healthcare; you made me feel like I belong, and that I have something to contribute. To Aunty Bilawara, thank you for sharing your wisdom and keeping it real in this weird academic world and thank you for promoting our work everywhere you go (and I mean everywhere!).

To all my research participants, collaborators and co-authors, there are too many of you to name, and some of you I'm not allowed to, but thank you all for your commitment, contributions and belief in this work. Special mention to my co-researcher Stuart Yiwarr McGrath, the one I call "rock star". None of this work was possible without you. Thanks for taking a chance on this old white chick and for continuing to work with me 4 years later! Rarrtjiwuy Melanie Herdman, you are unstoppable, and I am honoured that in your insanely busy schedule you find time to stop with me. Pirrawayingi Puruntatameri, your wisdom blows me away. I aspire to be as gracious and humble as you. Thanks to all those incredible individuals who worked with us from NT health and the NT Aboriginal Interpreter Service especially Sean Taylor, Mandy Ahmat and Michelle Walker. Special thanks to my PhD pomodoro writing partner Emily Armstrong who kept me sane and dancing and to Associate Professor Anne Lowell who was not officially my supervisor but supported me like I was one

of her own! Finally, thank you to my family especially my sister Susan and my Mum. I'm pretty sure Mum doesn't know what this PhD is about, and I am certain my sister knows too much about it! Thank you both for your ongoing support and encouragement.

Funding

I am incredibly grateful for the financial support provided by an Australian Government Research Training Program Scholarship (June 2018- June 2021) and a Menzies School of Health Research PhD top up scholarship (February 2020-June 2021). My co-researcher Stuart Yiwarr McGrath was supported by an Indigenous Development and Training Award (2019-2021) from an NHMRC Special Initiative 'Improving Health Outcomes in the Tropical North' (HOT North, GNT1131932). Podcast production was funded by a 2020 Menzies School of Health Research small grant which I was awarded in 2020

Ethical approvals

Approval to conduct the study was provided by the Northern Territory (NT) Department of Health and Menzies School of Health Research Ethics Committee (reference number: 2019-3295). Reciprocal ethical approval was granted by Charles Darwin University (reference number: H19024). Permission to conduct research at NT health sites was granted by the NT Health Research Governance Office (reference number: 2019/222-07).

Abbreviations

ACAP: Aboriginal Cultural Awareness Program

AHP: Aboriginal Health Practitioner

ALO: Aboriginal Liaison Officer

DAMA: Discharge Against Medical Advice

CRT: Critical Race Theory

ICU: Intensive Care Unit

MDT: Multi-Disciplinary Team

NT: Northern Territory

NT AIS: Northern Territory Aboriginal Interpreter Service

PAR: Participatory Action Research

RDH: Royal Darwin Hospital

TEHS: Top End Health Service

Terminology

Throughout this thesis, I will use the term “Aboriginal” to refer collectively to the original occupants and unceded owners of mainland Australia where this research was conducted. I recognise the term Aboriginal only exists in relation to colonisation and does not capture the diversity of cultures across the continent. [1] When writing about Aboriginal peoples, I will use plural ‘s’ to indicate that Aboriginal peoples are culturally diverse and consist of distinct nations. [2] When appropriate, the distinct nations to which individuals belong will be used, for example, Larrakia, Tiwi, Yolŋu and so on. The term Indigenous will be used to refer to First Nations people of any colonised country globally.

Readers may notice that I have used two phrases to refer to people who do not identify as Aboriginal. During the initial stages of my candidature, I used the phrase “non-Indigenous” as a catch all phrase however as my understanding of Whiteness developed, I replaced “non-Indigenous” with “White”. I chose to use the term White because it helps to “counter the invisibility of race within the dominant population that is implicit in terms such as ‘non-Indigenous’”. [3 p.369] In this thesis White is capitalised in line with Whiteness studies which emerged from the work of DuBois. It is also capitalised, not to indicate dominance, but to show that this is a socially constructed racial category because the concept of race is generally only attached to minorities. In Australia, White refers to a social category which describes individuals who, knowingly or unknowingly, participate in a racialized society that positions them as superior or White in comparison to Aboriginal peoples. [2, 4]. My use of the term White follows Kowal’s work [4] who referred to non-Indigenous research participants as “White” even though they may not identify as White nor do they have white skin. In using this term in this manner, I acknowledge that colonialist Australia is culturally and ethnically

diverse, and that participation in "White" society in Australia does not preclude experiencing racism and discrimination. A nuanced discussion of White and Whiteness is presented in Chapter 2.

Publications

This thesis consists of four published manuscripts. I am the lead author on all publications in the main body of this thesis. Publication details are summarised in Table 1. My primary PhD supervisor Professor Anna Ralph and auxiliary supervisors Associate Professor Marita Hefler and Professor Alan Cass co-authored all four publications. Supervisor Aunty Bilawara Lee co-authored three publications and was a key collaborator on the research output: *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare* podcast. Other co-authors were practitioners in the fields of cultural safety, intercultural health communication and healthcare (Stuart Yiwarr McGrath, Sandawana William Majoni, Michelle Walker, Mandy AhMat, Nicole Lewis, Pirrawayingi Puruntatameri and Rarrtjiwuy Melanie Herdman).

Author attribution

The research contained in this thesis is the outcome of my own investigation unless otherwise acknowledged. For all publications in my thesis, I conceptualised and designed studies with support from, and in collaboration with, my supervisors and co-authors. I led data collection (except for Chapter 3 in which data was collected by Nicole Lewis) and analysis and prepared the first draft of all manuscripts. My supervisors and co-authors provided input prior to journal submission. Contribution details for each publication are described below.

- Chapter 3 is published as: **Kerrigan, V.,** Lewis, N., Cass, A., Hefler, M., & Ralph, A. P. (2020). *"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload*. BMC Medical Education,

2020. 20(1): p. 173. I conceived and designed the study in collaboration with Nicole Lewis (NL) and Anna P Ralph (APR). VK, NL and APR conceived the evaluation. VK conducted the analysis. VK and NL developed the discussion. VK drafted the manuscript with input from APR. All authors contributed to study design, manuscript revisions, read and approved the final manuscript.

- Chapter 4 is published as: **Kerrigan, V.,** McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M., & Ralph, A. P. *From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.* BMC Health Services Research, 2021. **21**(1): p. 548. I conceived the study in collaboration with Sandawana William Majoni (SWM). The study design was a collaboration with all co-authors on both publications: Stuart Yiwarr McGrath (SYM), Sandawana William Majoni (SWM), Michelle Walker (MW), Mandy Ahmat (MA), Marita Hefler (MH), Alan Cass (AC) and Anna P Ralph (APR). VK and SWM conceived the pilot. VK, SYM, SWM, MW, MA, MH, AC and APR contributed to study design. VK, SYM and MA collected data. VK, SYM and MH conducted analysis. VK drafted the manuscript with input from SYM, MH and APR. All authors read and approved the final manuscript.
- Chapter 5 is published as: **Kerrigan, V.,** McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M., & Ralph, A. P. *"The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care*. International Journal for Equity in Health, 2021. 20(1): p. 170. I conceived the study in collaboration with SWM. VK, SYM, SWM, MW, MA, MH, AC and APR contributed to study design. VK, SYM and MA

collected data. VK, SYM and MH conducted analysis. VK drafted the manuscript with input from SYM, MH and APR. All authors read and approved the final manuscript.

- Chapter 8 is published as: **Kerrigan, V.,** McGrath, S. Y., Herdman, R. M., Puruntatameri, P., Lee, B., Cass, A., Ralph, A. P., & Hefler, M. (2022). *"Evaluation of "Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia*. Health Sociology Review., 2022 ('Yuwinbir', a special issue of Health Sociology Review on Indigenous and sociological knowledges: Meeting points for health equity). I conceived the study and design with support from BL, SYM, PP, RMH, MH, AC and APR. I collected data and led analysis with contributions from co-authors. I drafted the manuscript with input from all co-authors who read and approved the final manuscript.

Table 1: Publications

Section	Status	Detail	Journal Impact Factor	Citations (Google scholar)
Chapter Three	Published	**Kerrigan, V.,** Lewis, N., Cass, A., Hefler, M., & Ralph, A. P. (2020). *"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload.* BMC Medical Education, 20(1), 173. https://doi.org/10.1186/s12909-020-02086-5	2.372 (2022)	15
Chapter Four	Published	**Kerrigan, V.,** McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M., & Ralph, A. P. (2021). *From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.* BMC Health Services Research, 21(1), 548. https://doi.org/10.1186/s12913-021-06564-4	2.512 (2022)	4
Chapter Five	Published	**Kerrigan, V.,** McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M., & Ralph, A. P. (2021). *"The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care.* International Journal for Equity in Health, 20(1), 170. https://doi.org/https://doi.org/10.1186/s12939-021-01507-1	2.926 (2022)	1

Chapter Eight	Published	**Kerrigan, V.,** McGrath, S. Y., Herdman, R. M., Puruntatameri, P., Lee, B., Cass, A., Ralph, A. P., & Hefler, M. (2022). *Evaluation of "Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia*. Health Sociology Review. ('Yuwinbir', a special issue of Health Sociology Review on Indigenous and sociological knowledges: Meeting points for health equity).	1.122 (2020)	X
Appendices	Appendix A	**Kerrigan, V.** (2017). Whitefella broadcasting: Why non Indigenous journalists struggle to tell Aboriginal stories in Australia. (Ed.), Journalism Education and Research Association of Australia 2017 Conference, Newcastle.	X	X
	Appendix B	The Communicate Study group. (2020). *Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study.* Medical Journal of Australia, 213(4), 180-181. https://doi.org/10.5694/mja2.50700	7.738 (2020)	5
	Appendix C	Mithen, V., **Kerrigan, V.,** Dhurrkay, G., Morgan, T., Keilor, N., Castillon, C., Hefler, M., & Ralph, A. P. (2021). *Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care.* Health Promotion Journal of Australia, 32(S1), 155-165. https://doi.org/10.1002/hpja.415	1.954 (2022)	4

	Appendix D	**Kerrigan, V.,** Lee, A. M., Ralph, A. P., & Lawton, P. D. (2020). *Stay Strong: Aboriginal leaders deliver COVID-19 health messages.* Health Promotion Journal of Australia, 32 (S1), 203-204. https://doi.org/10.1002/hpja.364	1.954 (2022)	4

References

1. Moreton-Robinson, A., *The white man's burden: Patriarchal white epistemic violence and Aboriginal women's knowledges within the academy.* Australian Feminist Studies, 2011. **26**(70): p. 413-431.
2. Bargallie, D., *Unmasking the Racial Contract: Indigenous voices on racism in the Australian Public Service*. 2020, Canberra, ACT: Aboriginal Studies Press. 256.
3. Taylor, P.S. and D. Habibis, *Widening the gap: White ignorance, race relations and the consequences for Aboriginal people in Australia.* The Australian journal of social issues, 2020. **55**(3): p. 354-371.
4. Kowal, E., *The Politics of the Gap: Indigenous Australians, Liberal Multiculturalism, and the End of the Self-Determination Era.* American anthropologist, 2008. **110**(3): p. 338-3

CHAPTER ONE

Introduction

This chapter introduces the topic under consideration by offering an overview of the frequently vexed relationship between the culture of medicine and clear patient-provider communication. Royal Darwin Hospital (RDH) in the Northern Territory (NT) of Australia is introduced as the location of this intercultural research and I discuss some of the cultural differences between most patients and healthcare providers. The concept of cultural safety, its relationship to communication and the consequences of culturally unsafe communication is outlined. This chapter also provides a review of the literature in relation to policies and documents which pledge to address racism in healthcare. Finally, I provide the thesis aims which includes an overview of how the research project developed and a synopsis of each chapter and appendices.

The culture and consequences of ineffective communication in medicine

Time: 8am, Monday 8th of April 2019. **Location:** Doctors meeting room, Level 7, renal ward, Royal Darwin Hospital, Darwin, Australia
Field note: I am observing Doctor William, a renal consultant, who is participating in my research. In this pre-ward round meeting there are doctors, nurses, allied health professionals and medical students. It's a small room and the multi-disciplinary team is so large some are sitting on the floor. Dr William invites me to introduce myself to the group who have already started discussing patient plans. I

explain I'm a PhD student who is researching how doctors communicate with Aboriginal patients at the hospital. Most people don't react or even acknowledge me. I expect it's because they have bigger concerns including the fact that the hospital is at level 4 (capacity) which means the pressure is on to discharge patients. But there was one reaction which stood out. In the room was an occupational therapist; when I introduced myself to explain I was researching doctors and communication, she laughed loudly. I became very familiar with that reaction over the course of my PhD.

Doctors, especially hospital-based doctors, often struggle to communicate with their patients. [1-7] Hospitals are high stress environments where a doctor's ability to communicate successfully is influenced by practical issues such as the noisy environment, lack of privacy, workforce shortage, shrinking health budgets and, during COVID-19, face masks and personal protection equipment. [6-12] Patient provider communication issues are such a common, seemingly insurmountable, problem it's sometimes considered a laughing matter. This is not to say that doctors want to be poor communicators. Many recognise their limitations and strive to do better as will be documented and explored in this thesis.

Decades of research globally shows that effective communication between patients and healthcare providers is vital to ensure the delivery of effective healthcare; it improves patient health outcomes, consumer engagement and reduces staff burnout and increases staff satisfaction. [1, 2, 9, 13-20] Poor patient-provider communication contributes to a distrust of healthcare providers and services and to patients feeling disrespected, experiencing racism, problems following health plans, poorer health outcomes and has led to death. [1, 21-29]

Despite the evidence of its importance, effective patient-provider communication in medicine can be undervalued as doctors are taught to prioritise the "voice of medicine" which focuses on biomedical problems and places them in a position of power and control over the patient's "voice of the lifeworld". [30, 31] During undergraduate training, doctors learn how to conduct an interaction to solicit biomedical information which paradoxically reduces their ability to communicate as a patient might expect: students "enter medical school with better communication skills than when they leave". [8 p.22] Commonly dismissed as a "soft skill", compared to conducting "hard" clinical medicine, initiatives to improve communication including training and working with interpreters are not prioritised by individuals and the systems in which they work. [2, 19, 32-39]

Australia's NT, the location of this research, is one of the most culturally diverse places in the world and home to the oldest continuous cultures on the planet; the Aboriginal peoples of Australia. In the NT, intercultural communication issues compound the general communication issues within medical culture. The ongoing impact of colonisation and related social and cultural determinants of health contribute to poorer health outcomes for Aboriginal peoples. Life expectancy of Aboriginal peoples from the remote NT is approximately 14 years less than the non-Indigenous population. [40] Aboriginal peoples cope with high burdens of chronic disease such as disproportionate prevalence of rheumatic heart, cardiovascular, lung and end-stage kidney disease and psychological distress. [41] Aboriginal peoples make up 25% of the NT population [42] however approximately 70% of patients at Royal Darwin Hospital (RDH) identify as Aboriginal.[1] English is the language of the

[1] Throughout the thesis statistics relating to Aboriginal peoples in the NT and rates of hospitalisation vary slightly. This is due to statistics being updated over the course of the research period. Statistics cited in this chapter reflect the most recent statistics.

health system [18] but RDH sounds different to other hospitals in Australia. At least 60% of Aboriginal patients speak an Aboriginal language as their first language [43, 44] but only 17% get access to an interpreter. [45]

Most RDH healthcare providers are non-Indigenous; many are from southern parts of Australia or overseas. On arrival at RDH, new staff may experience culture shock as they may be unprepared for the "vastly different medical and cultural environment of the Northern Territory". [17] NT healthcare providers working with high Aboriginal caseloads express a range of emotions from anger to apathy and sadness to laughter when discussing the communication difficulties they experience. Staff demographics align with national statistics which indicate there are increasing numbers of overseas trained doctors working in Australia (33%) and only a small proportion of Aboriginal and Torres Strait islander doctors (0.4%). [46]

Research has found that acute healthcare delivery is not culturally appropriate to Aboriginal peoples and that culturally unsafe care is related to poor communication. [6, 7, 29, 47, 48] Evidence spanning 40 years has shown that culturally unsafe care in Australia has resulted in Aboriginal people's death, absence of informed consent, high rates of self-discharge, amputations without patient permission and patients experiencing racism in healthcare which impacts both mental and physical health. [1, 6, 13, 23, 24, 49] Issues regarding culturally unsafe care and poor communication are also experienced by Asian, Black, Latino, and Indigenous peoples globally who are profiled by health systems built on White norms. [50-53] These issues which stem from colonisation are recognised by the United Nations Declaration on the Rights of Indigenous Peoples which affirms that:

> *….all doctrines, policies and practices based on or advocating superiority of peoples or individuals on the basis of national origin or racial, religious, ethnic or*

> *cultural differences are racist, scientifically false, legally invalid, morally condemnable and socially unjust,* [54 p.2]

Various efforts to improve doctors' communication skills have been implemented globally [55-57] with the Calgary-Cambridge Guide for medical interviews having garnered most traction. [9] The Guide has been adapted and used at both undergraduate and postgraduate levels in the USA, Canada, Europe and to a limited degree in Australia. [58, 59] McKivett et al argue the Calgary-Cambridge Model provides a foundation for improving the clinical interview with Aboriginal peoples [22] whereas Williams et al [60] criticise the Guide which was conceptualised and tested in Western health systems. They argue that intercultural communication issues are "peripheral to the guide" [60 p.41] and therefore it may not be appropriate for cultures which do not follow communication norms constructed in line with Whiteness. [60] For example, some of the recommendations (eye contact and touch) are in direct contrast to communication norms amongst Aboriginal peoples. [61-64] There is a need to explore locally developed solutions to improve the communication skills and cultural competency of doctors who work with high Aboriginal caseloads in northern Australia.

Health communication in Australia

This research builds on intercultural health communication work previously undertaken in the NT [13, 14, 17, 63-67] who have documented barriers to effective health communication across general practice to hospitals. Specifically, this project emerged from research conducted at RDH by Professor Anna Ralph, [17] my primary supervisor who leads the Communicate Study at Menzies School of Health Research. [68] Ralph et al [17] identified three structural barriers to effective intercultural communication at RDH; lack of access to hospital based Aboriginal language interpreters, insufficient cultural awareness training and

the need to employ more Aboriginal health workers at the hospital. The first two barriers are the focus of this thesis. The third barrier was beyond project scope. Whilst it is important to employ more health professionals who identify as Aboriginal to "mitigate the effects of continuing lack of cultural or self-awareness" [69 p.1] among some health professionals, tackling race related inequities should not be the sole domain of those who experience inequities. [70, 71] To allow White Australians to reassign to "Aboriginal people the work White people need to do on themselves" [71 p.357] would only serve to perpetuate "othering" and enlarge the disparities that already exist. Race relations involves everyone. Inspired by Freire's thinking, Came and DaSilva explain the collaboration required:

> *….the descendants of the colonizers and the descendants of the colonized have different tasks to complete but that this should be done in dialogue with each other….* [72 p.120]

Grey literature, including the numerous NT government documents and reports which commit to improving health outcomes of Aboriginal peoples by ensuring healthcare providers can deliver culturally safe care also influenced this project. [73-78] Of specific interest was the description of how racism in healthcare manifests, as outlined in the NT Health Aboriginal Cultural Security Framework 2016-2026:

> *The legacy of colonisation as well as racism and discrimination contribute to poor health outcomes for Aboriginal people. These factors mean that Aboriginal people are less likely to seek out health services when necessary. Negative stereotypes and assumptions about Aboriginal people in Australian culture are also present in our health services, and this can result in people feeling disrespected or not receiving the best care possible.* [79 p.8]

Nationally the Australian government's National Aboriginal and Torres Strait Islander Health Plan 2013-2023 [80] also acknowledges racism in the health system is a major barrier to clients accessing care and a statement of intent from the Australian Health Practitioner Regulation Agency states that Aboriginal and Torres Strait Islander peoples should have access to health services that are "culturally safe and free from racism". [81] The national accreditation body, the Australian Commission on Safety and Quality in Health Care has also identified "Communicating for Safety" as one of the eight National Safety and Quality Health Service Standards. [82] The Commission also states there is a need to create a culturally safe workforce by providing ongoing development opportunities for staff to reflect on their own attitudes and cultural beliefs, to consider power relations and the rights of the patient. [83] Although the vision and policies exist there appears to be a lack of information about how to practically achieve these expressed goals.

Cultural safety in Australia

The cultural safety framework was first articulated in 1989 at gathering of Māori nurses in Aotearoa/New Zealand in response to poor Māori health outcomes and racism. [84, 85] Since then, it has developed and been taught in New Zealand (NZ) universities and implemented in NZ health services, with varying degrees of success. [18, 72] Although cultural safety, has been gaining momentum in Australia in recent years, [82, 84, 86] the concept is still relatively new here. This is apparent in conversations with healthcare providers and executives who use terms such as cultural awareness and cultural safety interchangeably. However, each term has its own goals and values which require an explanation. These three terms will be used throughout this thesis:

- Cultural awareness: is about having an awareness of differences between individuals. [18] Cultural awareness training in North America and Oceania commonly covers five themes: interaction approaches (communication), belief systems, historical matters, discrimination, and organisational issues. This foundational knowledge provides some context to assist healthcare providers better understand inequities. However, the training has been criticised for perpetuating an "us" versus "them" mentality, which can reinforce negative stereotyping. [18, 87-89] The training tends to focus on Aboriginal cultures with little consideration of the broader health service and issues of relating to racism and power. [90] Cultural awareness training is like "going to a museum but then you go home". [18 p.12]
- Cultural competence: considers how individuals and organisations are connected. It is a set of "behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations". [91] The concept was developed in recognition of the cultural and linguistic barriers experienced by patients from immigrant populations and non-English speaking backgrounds when interacting with White health systems. [92] As with cultural awareness, the ethnocentric foundations of cultural competence have been criticised for reinforcing entrenched bias and failing to acknowledge or address issues relating to power and racism. [27]
- Cultural safety: is akin to anti-racism, it is "about the analysis of power and not the customs and habits of anybody". [84 p.181] To that end, cultural safety is relevant to all exchanges between healthcare providers and patients because all interactions in healthcare are power laden. [84] It is about examining prejudice and attitudes of the healthcare providers and the hegemonic systems which have the capacity to

subjugate Aboriginal peoples. By locating individual bias, the power imbalance can be examined, attitudinal and behaviour changes can occur and a new equitable system can be created. [18, 84, 93] Whilst cultural safety can only be determined by patients, it is the responsibility of the healthcare provider to learn and change. [84] This approach avoids problematising Aboriginal peoples.

Organisations such as the Royal Australian College of General Practitioners, the Royal Australasian College of Surgeons and the Australian Indigenous Doctors Association offer one-off online modules or face-to-face single-day cultural safety training to members. [94-96] Despite this, workplace training in Australian health services is still limited. When this research project began (2019), cultural safety training was not offered at RDH or any other NT hospital. Instead, RDH healthcare providers were offered cultural awareness training which was delivered either face to face (full-day or two-hour truncated session) or as an online module. This is despite decades of research which asserts cultural awareness training can have negative consequences. [18, 27, 90, 97, 98] It has been argued that cultural awareness training:

> *….inevitably re-inscribes the power differentials between Indigenous and non-Indigenous Australians, even as it attempts to address them….However, by shifting the focus of training away from trying to teach 'Indigenous culture', toward examining processes of power and identity, a cultural safety framework presents a promising mechanism with which to advance Indigenous cultural training as a tool for Indigenous health.* [99 p.13]

Some argue all forms of cultural education should be discontinued until there is evidence to prove it is necessary. [98] Whilst the international evidence asserts that cultural awareness training can have negative effects, we also note there is limited research in Australia to prove the effectiveness or otherwise of cultural safety interventions. [100] We also know that many NT healthcare providers recognize they have limited knowledge of Aboriginal cultures and are looking for opportunities to learn. Importantly healthcare providers have said in that addition to expanding their knowledge of Aboriginal cultures they also want to critically reflect on individual biases and systemic issues that perpetuate inequitable healthcare delivery. [17, 34]

Cultural safety praxis from cannot be transplanted unmodified from Aotearoa to Australia without considering historical differences, demography, politics and culture. [18, 101] Racism manifests differently according to geographical contexts: [102, 103] it is as Elias et al described as “everywhere different” [104 p.15] therefore to acknowledge and confront racism in NT hospitals nuanced local interventions must be developed in collaboration with Aboriginal peoples. [18, 105]

Thesis aims

The overarching goal of my thesis is to contribute to making healthcare institutions more culturally safe, by upskilling doctors and changing models of care delivery within a tertiary healthcare setting. This cohesive Participatory Action Research (PAR) project comprised a baseline evaluation and two pilot interventions.

The specific aims of my PhD are to:

1. Examine interest in cultural awareness training and identify opportunities for expansion

2. Develop and explore the use of a podcast to deliver clinically relevant cultural education
3. Explore the impact of a new model of working with Aboriginal language interpreters at RDH on doctors, interpreters, and patients
4. Examine the power of "counterstories" to promote critical consciousness amongst hospital-based doctors

The original study design involved two components: a baseline evaluation of cultural awareness training feedback forms from NT healthcare providers (Aim 1) and the creation and evaluation of a podcast to deliver clinically relevant cultural education (Aim 2). During observational data collection to achieve Aim 2, a third aim was developed. While gathering background information from RDH doctors during ward rounds, I observed the difficulties doctors and patients experience when language discordance occurs. After observing those interactions, doctors expressed frustration regarding limited access to Aboriginal language interpreters and imagined the benefits of interpreters embedded in their multi-disciplinary team (MDT). Discussions with the NT Aboriginal Interpreter Service (AIS), RDH and researchers followed, and all agreed that interpreter availability at RDH was a significant problem. The idea to include interpreters in the MDT was conceived and Aim 3 was created.

Hence two interventions (Aim 2 and 3) were piloted which both aimed to counter the *"negative stereotypes and assumptions about Aboriginal people".* [90] The mechanism to counter stereotypes and assumptions was to provide doctors with opportunities to listen to Aboriginal peoples' stories outside of controlled clinical interactions, mainstream media representations of Aboriginal peoples and colonial education systems, which portray Aboriginal peoples as a problem and the White nation as superior. This was the key concept underpinning my approach that is described in Aim 4. As Professors Derek Griffiths and

Chandra Ford said during a 2022 presentation on interventions to mitigate, resist or undo structural racism: statistics and “hard science” are limited, we need to soften hearts with stories so that we can get to their heads. [106]

This premise that stories can counter negative stereotypes which manifest as racism and impede the delivery of equitable was inspired by cultural safety, Critical Race Theory (CRT) and Freirean pedagogy. [84, 93, 107-111] These three decolonising philosophies, which also assert that changes at an individual level can result in institutional change, will be discussed in detail in Chapter 2.

Why I chose to work with doctors is explained in detail in Chapter 2 however one of the reasons was because Nicole Lewis (co-author on Chapter 3), who was employed to deliver cultural awareness training at RDH, reported that doctors tend not to attend cultural awareness training. She explained this was a major problem to be addressed because the hierarchical nature of the hospital means that doctors were often looked to for leadership on the wards, however many lacked even the most basic cultural awareness. [112]

Thesis structure

My thesis consists of four publications and five thesis only chapters. The four chapters which are published journal articles retain each journal’s style, hence the variation in referencing styles within the thesis. As appendices, I have included four related publications and 1 research related output. Chapters and appendices are introduced below.

Chapter 2: methodology and methods

Chapter 2 covers why and how this research was conducted by explaining my methodological approach, the philosophical frameworks and methods used. Firstly, I explain my position as a constructivist which leads to reflections on race, racism and Whiteness. Secondly, I provide

a summary of the three philosophical frameworks (cultural safety, CRT and Freirean pedagogy) which influenced this thesis and how the frameworks fit together. Finally, I provide details on why PAR was chosen as the most suitable method and how it was implemented.

Chapter 3: "How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload.

This chapter was the first paper published as part of my PhD. It provides evidence to justify the two interventions. 596 feedback forms which were completed by cultural awareness training participants between March and October 2018 were analysed. The aim was to assess the perceptions of training to identify strengths and weaknesses and the potential for expansion according to workforce needs. We found participants considered cultural awareness training as a baseline: they want more cultural education focused on intercultural communication, designed and delivered by local people, which is tailored to their professions. A standout feature of this training was the personal stories shared by the Aboriginal trainers. Their personal stories enhanced the curriculum and challenged negative stereotyping of Aboriginal peoples. Importantly, participants recognised the need to explore the impact their own worldviews have on health provision and, requested cultural safety training. We concluded that cultural awareness training is an invaluable entry point. It is crucial workplace training for healthcare providers creates opportunities to address bias and systemic racism through critical self-reflection.

Chapter 4: From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.

Chapter four documents the experiences of Yolŋu and Tiwi patients at RDH when they have consistent access to language interpreters. Yolŋu and Tiwi perspectives on the impact of

consistent access to language interpreters when hospitalised has not been previously documented.

Research globally has found interpreters improve patient experience and outcomes but in the NT interpreters in hospitals are underused by healthcare providers. This pilot tested the impact of consistent access to interpreters from the patient perspective. The pilot also provided an opportunity to document the diversity of Aboriginal languages spoken at RDH, which had not been done before. We found that while English is the operational language of RDH, it is not the language most spoken amongst renal patients. Almost 90% of patients in the renal ward were Aboriginal and nearly 80% spoke one or more of the 15 languages identified in the unit. The most spoken languages were Yolŋu Matha and Tiwi. Patients described feeling "stuck" and disempowered when forced to communicate in English. After receiving access to trusted interpreters who shared their worldviews, patients reported feeling "satisfied" with their care and empowered. Aboriginal language speaking patients who feel culturally safe have better health trajectories which can result in less demand on health services.

Chapter 5: The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care

This chapter is companion paper to chapter 4. It explores the attitudinal and behavioural changes that occurred amongst doctors and Aboriginal language interpreters when they worked together as a team during the interpreter ward round pilot over 4 weeks in 2019. Before the pilot, doctors and interpreters were uncomfortable working together. Frustrated doctors unable to communicate effectively with Aboriginal language speaking patients recognised they lacked knowledge of Aboriginal cultures and communication styles and

criticised hospital systems that prioritized perceived efficiency over interpreter access. The situation at RDH is common globally. Low uptake of interpreters in hospitals is attributed to unavailability of interpreters, that interpreter-mediated communication in healthcare deviates from accepted practice and clinical time constraints. The model piloted in which Aboriginal language interpreters worked side by side with doctors addressed these issues. During the pilot, doctors' knowledge of Aboriginal cultures improved, and doctors adapted their work routines including lengthening the duration of bed side consults beyond 10 minutes. Aboriginal language interpreters who previously felt unwelcome and culturally unsafe within the hospital reported feeling valued as skilled professionals. As interpreters became active participants in the MDT, their health literacy improved allowing them to share power and responsibilities with doctors to ensure patient wellbeing. These beneficial outcomes occurred because doctors changed their behaviour. As a consequence of this model, the power dynamics between doctors and interpreters shifted towards cultural safety. Despite these positive outcomes, resistance to working with interpreters remained amongst some members of the team.

Systemic changes are required to ensure working with interpreters as part of the MDT can be scaled up. Hospital staff require both cultural safety and working with interpreter training and Aboriginal language interpreters require health training and mentoring to ensure they are confident working in the hospital.

Chapter 6: Creating "Ask the Specialist" podcast: why and how?

Recognising the limitations of face-to-face cultural awareness training and opportunities for expansion I developed the podcast: *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare* (hereafter referred to as *Ask the Specialist*). The aim of the chapter

is to explain the philosophy behind the podcast and detail the practical skills required to create *Ask the Specialist.* This will assist anyone who may be interested in adapting the design for other vocations and jurisdictions. To the best of my knowledge, *Ask the Specialist* is the first podcast to be created as a training tool specifically for health professionals who work with Aboriginal peoples in the NT.

The *Ask the Specialist* podcast was created in collaboration with Larrakia and Tiwi Elders and Yolŋu leaders, RDH based doctors, the NT Aboriginal Interpreter Service and researchers. I produced 7 x <18-minute episodes in which doctors ask the *Specialists* (Larrakia, Tiwi and Yolŋu leaders plus a Kriol and Burarra interpreter) questions about working with Aboriginal patients. Specifically, to create the podcast, we were influenced by the Freirean concept of "problem posing education" and CRT's "counterstories".

Chapter 7: Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare podcast

The purpose of this chapter is practical. The website address above links to all podcast episodes which can be accessed via Apple and Google podcasts and Spotify. Additionally, QR codes have been created for each of the seven podcast episodes available via Apple podcasts and Spotify.

Chapter 8: Evaluation of "Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia

After creating *Ask the Specialist* as described in Chapter 6 the podcast was piloted with the same doctors who contributed to its development. To evaluate the podcast, doctors listened to one episode per week over 7 weeks and provided feedback through weekly written reflections and an interview after listening to all 7 episodes.

Doctors reported attitudinal and behavioural changes which indicated the development of critical consciousness. Doctors changed behaviour in relation to building rapport with patients, asking patients questions, working with Aboriginal interpreters, and gaining informed consent. Doctors also reflected on long-held stereotypes and the everyday nature of racism.

The podcast format was rated highly by doctors who appreciated the 7-week program which allowed for cycles of listening, reflection, and action. While the podcast was purposefully local, issues raised had applicability beyond the NT and outside of healthcare. We concluded that cultural education, which addresses the problems doctors face, delivers counterstories from Aboriginal peoples, and encourages critical consciousness can counter racist narratives in healthcare.

Chapter 9: General discussion, recommendations, and future research

This final chapter summarises the problems which inspired this research project and restates my thesis aims which are considered alongside my research findings. I also explore the implications and limitations of my research and outline future research plans. As this was an action orientated research project, I have collated the recommendations from thesis publications and appendices and will provide these to the NT health service. Finally, I have taken this opportunity to reflect on my own position as a White woman who aspires to use stories to counter racism.

Appendices

Appendix A: Whitefella broadcasting: Why non Indigenous journalists struggle to tell Aboriginal stories in Australia.

I have included this paper as an Appendix as it was published prior to enrolling in the PhD program. This peer-reviewed conference paper was my first attempt to critically reflect on my work as a White journalist reporting on Aboriginal stories. I have included this paper because it shows that my interest in storytelling to counter racist narratives began when I was a radio broadcaster. Themes discussed in this paper (communication, culture and power in colonised Australia) are present in this thesis.

Appendix B: Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study.

Research presented here occurred in parallel to my PhD. The Communicate Study team, of which I am a member, implemented a multi-component intervention at RDH comprising employment of an Aboriginal Interpreter Coordinator (a position created by the Top End Health Service [TEHS] in response to advocacy from our team), clinical championing and Working with Interpreter Training. Study activities were quantitatively evaluated. We found a statistically significant increase in interpreter uptake from 12.5% of those in need during the baseline period to 17.5% in the intervention period. The intervention also coincided with a fall in self-discharge rates from 12.0% in April 2018 to 10.1% in March 2019. Self-discharge rates are used as a quantifiable measure of cultural safety ie. if a patient discharges, they are dissatisfied with care. Rates of interpreter use are an indicator of cultural competency: if a healthcare provider works with an Aboriginal language interpreter a patient's cultural safety can improve. Our findings show that health system changes can result in improved interpreter

uptake and a decrease in patient self-discharge rates. This publication supports the assertion in chapters 3, 4, 5, and 8 that to create a culturally safe hospital a suite of interrelated initiatives, supported by relevant stakeholders, are required.

Appendix C: Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care

This research was conducted during my candidature. The study aimed to validate a patient survey designed by the Australian Commission on Quality and Safety in Health care, to audit patient charts for documentation of Aboriginal languages and interpreter use and to document Aboriginal interpreter perspectives on cultural safety at RDH. Data collected augments the in-depth qualitative research presented in this thesis.

We found the survey was problematic, with a mismatch between multiple choice and free text responses. In multiple choice questions (most using a modified 3 option Likert scale), 67% of patients were satisfied with care and 88% indicated hospital staff communicated well. However, respondents who gave positive multiple-choice responses reported in free text comments they felt lonely, unsupported and had experienced racism at RDH. 68 chart audits revealed that primary language spoken by Aboriginal patients was documented by healthcare providers for only 44% of people. Aboriginal interpreters interviewed discussed the benefits of interpreter-mediated communication and the need for service redesign to improve culturally safety for both patients and interpreters at RDH.

We recommended that multiple-choice surveys to assess patient experience be abandoned in this context. Redesigning systems to better suit patient needs must include authentic feedback from Aboriginal patients and interpreters. RDH staff require both cultural awareness

and cultural safety training to improve their knowledge of Aboriginal languages and to address racism.

Appendix D: Stay Strong: Aboriginal leaders deliver COVID-19 health messages.

The COVID-19 pandemic highlighted inequities in healthcare. In Australia, many of the interventions and health promotion campaigns created to slow COVID-19 infection rates were designed to suit White cultural and communication norms. [113, 114] Over the course of the pandemic (2020-2021), in addition to my PhD, I collaborated with NT Aboriginal leaders to develop and deliver two research-based COVID-19 health promotion campaigns. This letter to the editor has been included as it documents the initial health promotion campaign which consisted of five COVID-19 health promotion videos which were developed in March 2020. The PAR project was in response to fears in NT Aboriginal communities about a lack of information in Aboriginal languages regarding the pandemic. The videos, delivered by trusted Aboriginal leaders, provided information about how to stay healthy during the pandemic when also living with underlying health conditions. A link and a QR code to the videos is available in Appendix E.

Appendix E: COVID-19 health promotion videos, 2020/2021

In early 2021 the Australian government began rolling out the COVID-19 vaccine to Aboriginal peoples who were a priority group. This prompted a second research-based health promotion campaign. In collaboration with NT Aboriginal leaders, Aboriginal Community Controlled health services and Aboriginal language centres, I led a team which developed a series of videos to address community concerns regarding vaccines. Commonly asked questions that required answers included: is the vaccine safe? Why do we need a vaccine when COVID is not in our communities? Are we 'guinea pigs'? This PAR project responded to requests for urgent

information that was relevant, accessible, and culturally appropriate. Overall, we produced and distributed 23 COVID-19 related videos in 12 languages: Arrernte, Burarra, Eastern Arrernte, English, Kriol, Kunwinjku, Murrinh-patha, Ngangi'kurunggurr, Tiwi, Warlpiri, Western Kriol and Yolŋu Matha. Qualitative data and social media analytics relating to the 2021 vaccine videos has been gathered and analysis is underway. Videos can be accessed via the website address above or QR codes for individual videos in Appendix E.

References

1. Kerrigan, V., et al., *From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.* BMC Health Services Research, 2021. **21**(1): p. 548.
2. Kerrigan, V., et al., *"The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care.* International Journal for Equity in Health, 2021. **20**(1): p. 170.
3. Amery, R., *Recognising the communication gap in Indigenous health care.* Medical Journal of Australia, 2017. **207**(1): p. 13-15.
4. Kelly, J., et al., *'We get so task orientated at times that we forget the people': staff communication experiences when caring for Aboriginal cardiac patients.* Australian Health Review, 2020. **44**(1): p. 1-6.
5. Benda, N.C., et al., *The active role of interpreters in medical discourse – An observational study in emergency medicine.* Patient education and counseling, 2022. **105**(1): p. 62-73.
6. Jennings, W., C. Bond, and P.S. Hill, *The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication.* Aust J Prim Health, 2018.
7. Askew, D.A., et al., *"I'm outta here!": a qualitative investigation into why Aboriginal and non-Aboriginal people self-discharge from hospital.* BMC Health Serv Res, 2021. **21**(1): p. 907.
8. Kurtz, S.M., J. Draper, and J. Silverman, *Teaching and learning communication skills in medicine*. 2nd ed. ed. 2005, Oxford: Radcliffe Publishing.
9. Silverman, J., S.M. Kurtz, and J. Draper, *Skills for communicating with patients*. Third edition / New and updated edition. ed. 2013, London ;: Radcliffe Publishing.
10. Lee, E., K. Cormier, and A. Sharma, *Face mask use in healthcare settings: effects on communication, cognition, listening effort and strategies for amelioration.* Cognitive Research: Principles and Implications, 2022. **7**(1): p. 2.
11. ABC News, *Surgeries put on hold, double shifts for staff as Darwin hospital overflows*. 4th July 2019.
12. ABC News. *NT Health blowouts review kept under wraps, despite economic crisis*. 2nd April 2019; Available from: https://www.abc.net.au/news/2019-04-02/budget-blowouts-kpmg-review-nt-health-john-langoulant/10958902.
13. Brennan, G., *The need for interpreting and translation services for Australian Aboriginals, with special reference to the Northern Territory : a research report*, ed. S. Australia. Dept. of Aboriginal Affairs. Research. 1979, Canberra]: Canberra : Research Section, Dept. of Aboriginal Affairs.
14. Cass, A., et al., *Sharing True Stories Improving communication between Aboriginal patients and healthcare workers.* Medical Journal of Australia, 2002. **176**(10): p. 466-70.
15. Australian Commission on Safety and Quality in Health Care, *Health Literacy Taking action to improve safety and quality*. 2014: Sydney. p. 1-93.
16. Gardiner, F.W., et al., *Indigenous Australians have a greater prevalence of heart, stroke, and vascular disease, are younger at death, with higher hospitalisation and more aeromedical retrievals from remote regions.* EClinicalMedicine, 2021. **42**: p. 101181.

17. Ralph, A.P., et al., *Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory.* BMC Health Services Research, 2017. **17**(1): p. 733.

18. Taylor, K., *Health care and Indigenous Australians : cultural safety in practice*. Second edition.. ed. Cultural safety in practice, ed. P. Guerin. 2014, South Yarra, Vic.: South Yarra, Vic. : Palgrave Macmillan.

19. Diamond, L.C., et al., *Getting By: Underuse of Interpreters by Resident Physicians.* Journal of General Internal Medicine, 2009. **24**(2): p. 256-262.

20. Álvaro Aranda, C., R.L. Gutiérrez, and S. Li, *Towards a collaborative structure of interpreter-mediated medical consultations: Complementing functions between healthcare interpreters and providers.* Social Science & Medicine, 2021. **269**: p. 113529.

21. Dinku, Y., et al., *Language use is connected to indicators of wellbeing: Evidence from the National Aboriginal and Torres Strait Islander Social Survey 2014-15, Working Paper no.137/2020*. 2020, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

22. McKivett, A., D. Paul, and N. Hudson, *Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners.* Journal of Immigrant and Minority Health, 2018.

23. Allam, L., *Darwin hospital left Aboriginal man to die alone and in agony from surgical injury. Northern Territory coroner issues scathing report detailing multiple failures by Top End health service*, in *The Guardian*. 21st September 2018.

24. NT Coroner Court, *Inquest into the death of Henry George Wilson aka Albert George Wilson [2018] NTLC 022. Findings of Judge Greg Cavanagh*. 2018: Darwin, Northern Territory. p. 1-24.

25. Shankar, M., et al., *Nonmedical Transdisciplinary Perspectives of Black and Racially and Ethnically Diverse Individuals About Antiracism Practices: A Qualitative Study.* JAMA Network Open, 2022. **5**(2): p. e2147835-e2147835.

26. Williams, D.R. and R. Wyatt, *Racial Bias in Health Care and Health: Challenges and Opportunities.* JAMA, 2015. **314**(6): p. 555-556.

27. Berger, J.T. and D.R. Miller, *Health Disparities, Systemic Racism, and Failures of Cultural Competence.* American journal of bioethics, 2021. **21**(9): p. 4-10.

28. Topp, S.M. and J.M. Chipukuma, *A qualitative study of the role of workplace and interpersonal trust in shaping service quality and responsiveness in Zambian primary health centres.* Health policy and planning, 2016. **31**(2): p. 192-204.

29. Mithen, V., et al., *Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care.* Health Promot J Austr, 2021. **32**(S1): p. 155-165.

30. Mishler, E.G., *The discourse of medicine : dialectics of medical interviews*. 1984, Norwood, N.J.: Ablex Pub. Corp.

31. Mishler, E.G., *Patient stories, narratives of resistance and the ethics of humane care: a la recherche du temps perdu.* Health (London, England : 1997), 2005. **9**(4): p. 431-451.

32. Farmer, D.L., *Soft Skills Matter.* JAMA Surgery, 2015. **150**(3): p. 207-207.

33. Abraham, T.H., G.L. Stewart, and S.L. Solimeo, *The importance of soft skills development in a hard data world: learning from interviews with healthcare leaders.* BMC medical education, 2021. **21**(1): p. 147.

34. Kerrigan, V., et al., *"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload.* BMC Medical Education, 2020. **20**(1): p. 173.

35. Gray, B., J. Hilder, and H. Donaldson, *Why do we not use trained interpreters for all patients with limited English proficiency? Is there a place for using family members?* Aust J Prim Health, 2011. **17**(3): p. 240-249.

36. Karliner, L.S., et al., *Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature.* Health Serv Res, 2007. **42**(2): p. 727-754.

37. Hall, W.J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S.H., Coyne-Beasley, T. , *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review.* American Journal of Public Health, 2015. **105**(12).

38. O'Connor, E., et al., *Does improved interpreter uptake reduce self-discharge rates in hospitalised patients? A successful hospital intervention explained.* PLOS ONE, 2021. **16**(10): p. e0257825.

39. Kerrigan, V., et al., *Evaluation of "Ask the Specialist": a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia.* Health Sociology Review., 2022('Yuwinbir', a special issue of Health Sociology Review on Indigenous and sociological knowledges: Meeting points for health equity).

40. Australian Bureau of Statistics. *Aboriginal and Torres Strait Islander life expectancy lowest in remote and very remote areas*. 2019 [cited 2018 2nd December]; Available from: https://www.abs.gov.au/articles/aboriginal-and-torres-strait-islander-life-expectancy-lowest-remote-and-very-remote-areas.

41. Australian Institute of Health and Welfare, *Aboriginal and Torres Strait Islander Health Performance Framework 2020 key health indicators—Northern Territory. Cat. no. IHPF 5*. 2020, AIHW: Canberra.

42. Australian Bureau of Statistics, *Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians (cat. no. 2075.0)*. 2017, ABS Census of Population and Housing, 2016.

43. Northern Territory Government, *NT Aboriginal Health Plan 2021-2031*. 2021, NT Health: Casuarina, NT, Australia.

44. Australian Bureau of Statistics. *Main language spoken at home and English proficiency*. 2018 [cited 2018 29th November]; Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2076.0Main%20Features1012016?opendocument&tabname=Summary&prodno=2076.0&issue=2016&num=&view.

45. Communicate Study Group, *Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study.* Med J Aust, 2020. **213**(4): p. 180-1.

46. Department of Health Australian Government, *Doctors in Focus*. 2018, Commonwealth of Australia: Canberra, Australia.

47. Chong, A., et al., *Improving cultural sensitivity to Indigenous people in Australian hospitals. A continuous quality improvement approach.* Focus on Health Professional Education: a Multi-Disciplinary Journal, 2011. **13**(1): p. 84–97.

48. Skinner, T., et al., *Comparative validation of self-report measures of negative attitudes towards Aboriginal and Torres Strait Islanders.* The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 2013. **13**.

49. McDermott, D.R., *Can we educate out of racism?* Medical journal of Australia, 2012. **197**(1): p. 15-15.

50. Jones, C.P., *Levels of racism: A theoretic framework and a gardener's tale.* Am. J. Public Health, 2000. **90**(8): p. 1212-1215.

51. Chokshi, D.A., M.M.K. Foote, and M.E. Morse, *How to Act Upon Racism—not Race—as a Risk Factor.* JAMA Health Forum, 2022. **3**(2): p. e220548-e220548.

52. Gau, J., et al., *Things we do for no reason™: Routine inclusion of race in the history of present illness.* Journal of Hospital Medicine, 2021. **n/a**(n/a).

53. Came, H. and D. Griffith, *Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis.* Social science & medicine (1982), 2018. **199**: p. 181-188.

54. UN General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples: resolution/adopted by the General Assembly, 2 October 2007, A/RES/61/295*. 2007: Washington, DC, USA. p. 1-18.

55. Yao, M., et al., *The impact of training healthcare professionals' communication skills on the clinical care of diabetes and hypertension: a systematic review and meta-analysis.* BMC family practice, 2021. **22**(1): p. 1-152.

56. Brick, N., *Communication skills training for healthcare professionals working with patients with cancer, their families, and carers.* Clinical journal of oncology nursing, 2012. **16**(6): p. 640-640.

57. Pilnick, A., et al., *Using conversation analysis to inform role play and simulated interaction in communications skills training for healthcare professionals: identifying avenues for further development through a scoping review.* BMC medical education, 2018. **18**(1): p. 267-267.

58. Ammentorp, J., et al., *Upscaling communication skills training – lessons learned from international initiatives.* Patient education and counseling, 2021. **104**(2): p. 352-359.

59. Burt, J., et al., *Assessing communication quality of consultations in primary care: initial reliability of the Global Consultation Rating Scale, based on the Calgary-Cambridge Guide to the Medical Interview.* BMJ Open, 2014. **4**(3): p. e004339.

60. Williams, S., M. Harricharan, and B. Sa, *Nonverbal Communication in a Caribbean Medical School: "Touch Is a Touchy Issue".* Teaching and learning in medicine, 2013. **25**(1): p. 39-46.

61. Lee, B., *Healing from the Dilly Bag: Holistic healing for your body, soul and spirit*. 2013: Xlibris AU

62. Burarrwanga, L., et al., *Song spirals : sharing women's wisdom of Country through songlines*. Songspirals, ed. L. Burarrwana, et al. 2019: ALLEN & UNWIN.

63. Lowell, A., *Communication and Cultural Knowledge in Aboriginal Health Care. A review of two subprograms of the Cooperative Research Centre for Aboriginal and Tropical Health's Indigenous Health and Education Research program*. 1998, Cooperative Research Centre for Aboriginal and Tropical Health: Casuarina, NT.

64. Trudgen, R.I., *Why warriors lie down & die : towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact : djambatj mala*. Djambatj mala. 2000, Darwin: Darwin : Aboriginal Resource & Development Services Inc.

65. Anderson, K., et al., *"All they said was my kidneys were dead": Indigenous Australian patients' understanding of their chronic kidney disease.* The Medical Journal of Australia, 2008. **189**: p. 499-503.

66. Eckermann, A.-K., *Binan Goonj: bridging cultures in Aboriginal health*. 3rd ed. 2010, Sydney: Churchill Livingstone.

67. Lowell, A., et al., *Health literacy communication and cultural competence towards an integrated approach in Indigenous health care*. 2014, Northern Territory Department of Health.

68. Menzies School of Health Research. *The Communicate study (Stages 1 and 2)*. 2018; Available from: https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/The_communicate_study_stages_1_and_2/.

69. Topp, S.M., et al., *Unique knowledge, unique skills, unique role: Aboriginal and Torres Strait Islander Health Workers in Queensland, Australia.* BMJ Global Health, 2021. **6**(7): p. e006028.

70. DiAngelo, R. and M.E. Dyson, *White Fragility: Why It's So Hard for White People to Talk about Racism*. 2018, Boston: Beacon Press.

71. Taylor, P.S. and D. Habibis, *Widening the gap: White ignorance, race relations and the consequences for Aboriginal people in Australia.* The Australian journal of social issues, 2020. **55**(3): p. 354-371.

72. Came, H.A. and S. da Silva, *Building political competencies for the transformation of racism in Aotearoa.* Kōtuitui: New Zealand Journal of Social Sciences Online, 2011. **6**(1-2): p. 113-123.

73. Northern Territory Department of Health, *2016-17 Annual Report*. 2017, Northern Territory Government: Darwin, NT. p. 1-269.

74. Northern Territory Government, *Northern Territory Health Strategic Plan 2014-2017* 16 November 2014: Darwin, Northern Territory,.

75. Northern Territory Government and Top End Health Service, *Improving TEHS Culture. Organisational Culture Assessment. Summary Report.* August 2016: Darwin, NT. p. 1-19.

76. Northern Territory Department of Health, *NT Health Aboriginal Cultural Security Policy*. 2016: Darwin, NT. p. 1-8.

77. Northern Territory Government, *Department of Health Annual Report 2019-2020*. 2020, Department of Health: Darwin, Australia.

78. Northern Territory Government, *Department of Health Annual Report 2020-2021*. 2021: Darwin, Australia.

79. Northern Territory Department of Health, *NT Health Aboriginal Cultural Security Framework 2016-2026*. 2016: Darwin, NT. p. 1-40.

80. Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. 2013.

81. Australian Health Practitioner Regulation Agency, *National Scheme Aboriginal and Torres Strait Islander Health Strategy - Statement of Intent*. 2018.

82. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. Second Edition. Overview*. 28 November 2017: Sydney, NSW.

83. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. User Guide for Aboriginal and Torres Strait Islander Health*. 2017: Sydney, NSW.

84. Ramsden, I.M., *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. 2002, Victoria University of Wellington: Wellington, New Zealand. p. 211.

85. Wepa, D., *An Exploration of the Experiences of Cultural Safety Educators in New Zealand: An Action Research Approach.* Journal of transcultural nursing, 2003. **14**(4): p. 339-348.

86. Watego, C., D. Singh, and A. Macoun, *Partnership for Justice in Health: Scoping paper on race, racism and the Australian health system.* . 2021, The Lowitja Institute: Melbourne.

87. Byrne, A. and A. Tanesini, *Instilling new habits: addressing implicit bias in healthcare professionals.* Adv Health Sci Educ Theory Pract, 2015. **20**(5): p. 1255-62.

88. Doutrich, D., et al., *Cultural Safety in New Zealand and the United States:Looking at a Way Forward Together.* Journal of Transcultural Nursing, 2012. **23**(2): p. 143-150.

89. Phillips, G., *Aboriginal Health, Cultural Safety & Medical Education*. 19 August 2017, ABSTARR Consulting: Presented to the Aboriginal Health Council of South Australia General Practice Forum.

90. Downing, R., E. Kowal, and Y. Paradies, *Indigenous cultural training for health workers in Australia.* International Journal for Quality on Health Care, 2011. **23**(3): p. 247-257.

91. Cross, T., et al., *Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed.* , in *Child and Adolescent Service System Program Technical Assistance Center*. 1989, Georgetown University Child Development Center: Washington, DC.

92. Truong, M., Paradies, Y., and Priest, N., *Interventions to improve cultural competency in healthcare: a systematic review of reviews.* BMC Health Services Research, 2014. **14**(99): p. 1-17.

93. Curtis, E., et al., *Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition.* International Journal for Equity in Health, 2019. **18**(1): p. 174.

94. Royal Australasian College of Surgeons, *Royal Australasian College of Surgeons, Reconciliation Action Plan, May 2020-2022*. 2020: Melbourne p. 24.

95. Royal Australian College of General Practitioners, *Cultural awareness education and cultural safety training*. n/a: Melbourne, Australia.

96. The Australian Indigenous Doctors' Association. *Cultural Safety Training*. 2022; Available from: https://aida.org.au/cultural-safety-program/what-is-cultural-safety/.

97. Byrne, A. and A. Tanesini, *Instilling new habits: addressing implicit bias in healthcare professionals.* Advances in Health Sciences Education: Theory Practice, 2015. **20**(5): p. 1255-62.

98. Shepherd, S.M., *Cultural awareness workshops: limitations and practical consequences.(Report).* BMC Medical Education, 2019. **19**(1).

99. Downing, R. and E. Kowal, *A postcolonial analysis of Indigenous cultural awareness training for health workers.* Health Sociology Review, 2011. **20**(1): p. 5-15.

100. Lock, M., et al., *Absence of rigorous evidence undermines cultural safety reforms.* Australian Journal of Rural Health, 2020. **28**(1): p. 4-5.

101. Australian Association of Gerontology: Aboriginal and Torres Strait Islander Ageing Advisory Group. *Delivering better care for older Aboriginal and Maori peoples: An introduction to cultural safety*. May 29, 2018; Available from: https://www.youtube.com/watch?v=tXnSCtu0_hQ&feature=youtu.be.

102. Essed, P., *Understanding Everyday Racism : An Interdisciplinary Theory*. 1991, Thousand Oaks, UNITED STATES: SAGE Publications.

103. Kidd, J., H. Came, and T. McCreanor, *Using vignettes about racism from health practice in Aotearoa to generate anti-racism interventions.* Health & Social Care in the Community, 2022. **n/a**(n/a).

104. Elias, A., F. Mansouri, and Y. Paradies, *Countering racism: Challenges and progress in anti-racism efforts*, in *Racism in Australia Today*. 2021, Springer Singapore: Singapore. p. 319-351.

105. Bainbridge, R., et al., *Cultural competency in the delivery of health services for Indigenous people*, in *Closing the gap clearinghouse Issues paper*. 2015, Australian Institute of Health and Welfare and Australian Institute of Family Studies: Canberra. p. 1-44.

106. Kerrigan, V. *To defeat racism we need to soften peoples hearts to get to their heads*. Twitter [Tweet]. 2022 27th March 2020.

107. Bell, L.A., *Telling Tales: What stories can teach us about racism.* Race, ethnicity and education, 2003. **6**(1): p. 3-28.

108. Tichavakunda, A.A., *An Overdue Theoretical Discourse: Pierre Bourdieu's Theory of Practice and Critical Race Theory in Education.* Educational studies (Ames), 2019. **55**(6): p. 651-666.

109. Delgado, R., J. Stefancic, and A. Harris, *Critical Race Theory (Third Edition): An Introduction*. Third edition. ed. 2017, New York: New York University Press.

110. Freire, P., *Pedagogy of the oppressed*. 30th Anniversary Edition ed. 2005 (1970), New York: The Continuum International Publishing Group.

111. DasGupta, S., et al., *Medical Education for Social Justice: Paulo Freire Revisited.* The Journal of medical humanities, 2006. **27**(4): p. 245-251.

112. Kerrigan, V., *Journal note*. 26th June 2018.

113. Kerrigan, V., et al., *Stay Strong: Aboriginal leaders deliver COVID-19 health messages.* Health Promotion Journal of Australia, 2020. **32**(S1): p. 203-204.

114. Crooks, K., D. Casey, and J.S. Ward, *First Nations peoples leading the way in COVID-19 pandemic planning, response and management.* Medical journal of Australia, 2020. **213**(4): p. 151-152.e1.

CHAPTER TWO

Research design

This chapter describes my methodological approach, the philosophical framework and the methods used to conduct this project. Firstly, I explain what it means to be a constructivist. This leads to a discussion regarding the construction of race, racism, and Whiteness. Three philosophical frameworks influenced and guided this project: cultural safety, CRT and Freirean pedagogy. Each framework is explained and then how these frameworks are combined and underpin the research. Finally, the chapter covers the methods used in this PAR project.

Methodology

This qualitative study followed a constructivist paradigm as defined by Guba and Lincoln who contend that reality is socially constructed and that there are "multiple realities" associated with different groups. [1-3] Constructivism “recognizes the existence of power relations” and that those who hold positions of power can determine which version of reality is considered the norm from which all others are judged. [4 p.12] Guba and Lincoln explain that social constructions are not fixed but are alterable through interactions with others. [2] When individuals interact with those who have constructed a different reality, and critically reflect on their own constructions of reality, new knowledge and new shared realities can be co-created. A constructivist approach gives power back to Aboriginal peoples by co-constructing relationships which privileges Aboriginal perspectives.[5, 6] For these reasons, constructivism underpins the theoretical framework of this thesis.

The construction of race and racism

Race, like gender, is socially constructed. [7, 8] Racism is more than individual acts of hate, stereotyping or discrimination. [9] It is a system of power that upholds the coloniser's culture. [7, 10, 11] Gilmore defined racism as ''the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death.'' [12 p.247] As Ford [13] says this definition brings into sharp focus that structural racism kills.

Racism is a system of advantage for White people and a system of disadvantage for Indigenous peoples. [14, 15] It is embodied in attitudes, beliefs, behaviours, laws, norms and practices and can be defined as a social system in which some individuals experience societal advantages which gives them the capacity to exert power over others based on socially constructed categories of 'race'. [14, 16] The concept of "race" was constructed during the so-called "Enlightenment" period when intellectuals of the 16th and 17th century created a hierarchy of human classifications based on phenotypes placing White people at the top. [17-19] The concept was constructed by the state to "control the population", [20 p.64] to justify racial violence and colonisation. [21] These notions of race have been used by medical practitioners to devalue and degrade those who were classified as non-European. [13]

Power is a distinct dimension of racism. Racist policies and practices attempt to maintain control over a racial group. [22] Hage continues: racism is more than just representing people in a stereotypical fashion or locking people into their ethnic identity, people who experience racism are subjugated. Everyone can "entertain prejudiced fantasies about a variety of 'others', it is the power to subject these 'others' to your fantasies that constitutes the social problem" referred to as racism. [22 p.34]

Racism occurs at differing levels: in this thesis I am interested in interpersonal, systemic and institutional racism. Interpersonal racism occurs between individuals and is illustrated by prejudicial attitudes and practices which can be both overt and subtle, intentional and unintentional. In her seminal "Gardeners Tale" article, Jones [23] articulated five ways interpersonal racism can manifest. To relate Jones' work to this research, I have listed the five manifestations identified and provided specific examples relating to hospital-based healthcare. Jones detailed that interpersonal racism can manifest as 1) lack of respect (failure to communicate options, failure to identify patient's language), 2) suspicion (questioning the legitimacy of patients speaking their first language, expecting the patient will not take medication), 3) devaluation (surprise at patients health literacy, assuming the patient will not understand), 4) scapegoating (the patient is "non-compliant", the patient doesn't care about their health) and 5) dehumanization (referring to patients as a disease, excluding family from decision making). Interpersonal racism can also manifest as inaction when action is required. [24] This has been referred to as dysconscious racism [25] which is discussed in Chapter 5. "Dysconscious racism is a form of racism that tacitly accepts dominant White norms and privileges." [25 p.135] Dysconscious individuals lack the critical consciousness required to recognise injustice.

Institutional and systemic racism are often used interchangeably with the latter appearing more commonly in Australian literature. [21] The National Aboriginal and Torres Strait Islander health plan 2013-2023 defined systemic racism as the failure of the "system to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin'." Similarly institutionalised racism is defined as:

> *…differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need.* [23 p.1212]

Racism mutates like a virus. It is dynamic and changes according to political, geographic, economic and social circumstances. [24, 26] While the instability of racism means it is challenging to define across different locations it also means it can be modified. Globally, as a result of anti- racism efforts, there has been a decline in overt manifestations of racism over the last five decades.[27] World leaders including US President Joe Biden, have introduced laws to address the "unbearable human costs of systemic racism". [28] In Australia, as described above, overt demonstrations of racism are discouraged through policies and sometimes outlawed, but that has not removed the "attitudes, behaviours and underlying institutional structures" [27 p.333] that perpetuate racism in practice. [21] During my 4-year candidature I have been told by numerous leaders across the NT health sector not to say or write the word "racism" because: 1) it makes White people uncomfortable and 2) they deny racism exists in healthcare. As explained by Bonilla Silva and others this "colour blind racism", which denies the existence of racism, can be used to justify inaction in the face of inequity. [7, 29] Resistance to discussing racism also exists because White people who hold positions of power within mainstream institutions lack racial literacy: most don't understand what racism is and how it manifests daily. [26, 30]

Health care attracts humanitarians. [31] It is fair to assume that most healthcare providers believe they are anti-racist, that they are beyond the "crass prejudicial views about racial minority groups". [29 p.1359] However medicine has a long history of racism:

> *"Hippocrates thought Asiatics were feeble, Down associated trisomy 21 with a perceived inferior Mongoloid race, and in the infamous Tuskegee study, black men were denied an available cure for syphilis."* [31 p.765]

Whilst some of these overtly racist ideas have been debunked, individuals who outwardly express anti racist ideas may have internalised racist beliefs. [32, 33] The inevitability of racialised thinking needs to be accepted: "non-racism is virtually unattainable".[34] Admitting racism exists is not about trying to shame, anger or make individuals feel guilty. Rather it is about understanding the assumptions and attitudes we carry and being able to take responsibility, and if necessary change behaviour, to improve health outcomes. [34]

In colonised countries such as Australia and Aotearoa, White people are beneficiaries of racism. [15] As a White Australian researcher, I recognise that the constructed reality from which I operate has been shaped by Whiteness. Therefore, following Lincoln and Guba's [1] recommendation that qualitative researchers should articulate their values and explain the reality from which the research occurs I share a little of my background.

Researcher reflexivity on being White

I am a 7th generation Australian settler with Anglo Celtic heritage. On my father's side, Christopher Kerrigan a stone mason, arrived in Australia as a free settler from Ireland on the 11th February 1840 on a ship called The Crescent. After arriving in Sydney, he eventually settled 170 kilometres north on the lands of the Wonnarua people (today known as Maitland, NSW), where many of my family still reside. My ancestors share history with the Wonnarua

and surrounding nations. My family has no record of whether the history was predominantly violent or peaceful, however considering colonisation we can assume there was conflict. I am a white skinned, middle aged, English speaking, healthy, heteroromantic, cisgender female who is tertiary educated, with a mortgage, a car, a blemish free legal history, a passport, a fridge full of food, a cat, the capacity to take on the role of the oppressor and a desire to be an effective ally who disrupts racism. Accepting I am "White" does not mean I am proud of it; quite the opposite, the term makes me feel uncomfortable and to that end it serves its purpose: it reminds me that I have unearned privileges that result from my socially constructed race and I should use my "insider" status, [7, 22, 35] as a White person working in White institutions created mainly by White men, to challenge racism.

The term "White" stems from the work of W.E.B. Du Bois [36 p.45] who facetiously wrote that Whiteness means "the ownership of the earth forever and ever, Amen!". As Du Bois alluded to, Whiteness is about having power in society: it represents "normality, dominance and control". [35 p.9] Bargaille [26 p.19] defined Whiteness in Australia "as a system of power relations that privileges non-Indigenous peoples over Indigenous Australian peoples". Whiteness is not only about the physical body "but also about discourses and practices, ontology and epistemology". [37 p.289] Therefore White includes non-Anglo people who follow the norms and values associated with Australian culture which has its roots in British colonisation. [22, 38] For people who are racially marginalised, becoming White may require diluting values, beliefs and behaviours to become "racially innocuous". [39 p.143] Embracing Whiteness can also be the result of internalized racism.[23] Creating a new "intersectional identity", [39 p.152] which abides by White values means people who may have been marginalised by the dominating culture can experience the benefits associated with White

privilege: access to education, healthcare, support from the law, community services, employment opportunities and so on. [22, 35, 38]

Over the course of my candidature the term "White", imperative to any discussion involving race and racism, has created discomfort amongst everyone from some of my supervisors to research participants to Aboriginal collaborators. As "Whiteness" is usually invisible, particularly to White people, this uneasiness is not uncommon. [7, 22, 35] I identify as White because, just as some people have been racially categorised for centuries, the label also places me in a socially constructed racial category and acknowledges my ways of being and knowing are constructed and not held by all. I see value in identifying as White because the label problematises me:

> *…thinking of ourself as 'white', as the whiteness problematic forces you to do, means you are trying to understand how you as an individual are ensnared in the social relationships of oppressed and oppressor.* [35 p.7]

The relationship between the "oppressed and oppressor" started to become clear to me towards the end of my 20-year career as a radio broadcaster with the Australian Broadcasting Corporation (ABC). Before I moved into research, I worked at ABC Darwin for a decade as the "Drive" presenter (4-6pm Monday to Friday). It was here in the NT's Top End I began to realise there may be some truth to the ABC's unfortunate epithet: the Anglo Broadcasting Corporation. [40] At ABC Darwin, I realised that as a White journalist I was constructing and perpetuating the racist narratives sustained by mainstream Australian media outlets which have routinely defamed and silenced Aboriginal peoples. [20, 40-43] The constant stream of negative stories which portray "dysfunction corruption, neglect and sexual abuse" [20 p.68] elicit White virtue which is used by colonisers to justify superiority. During the late 1880s the

Bulletin magazine regularly featured cartoons which portrayed Aboriginal peoples as drunk and destitute. [20] Australian history has been told through "the eyes of the colonisers" who have misrepresented Aboriginal values and cultures and silenced Aboriginal voices. [44 p.5] As I began to understand my "Whiteness" and the privilege I am afforded due to my affiliation with dominant Australian culture my interest in critically examining communication, power and culture developed.

Whiteness in Australian healthcare The thesis scope does not permit an in-depth examination of the history of Whiteness and healthcare. However, the connection is important to consider because the site of this research is RDH, the main tertiary referral hospital in the NT, which operates according to norms established by the White Australian healthcare system. There are two aspects of interest here: 1) health and medical practice in Australia which is embedded in Whiteness has been used as an apparatus of colonial control, [45-47] and 2) a White view of health differs to Aboriginal views on health. [48]

The shared history of Western medicine and colonisation contributes to Aboriginal peoples feeling unsafe and disrespected when seeking healthcare today. [49, 50] This has been recognised by the Australian Commission on Safety and Quality in Health Care:

> *The health system in the past included segregated wards and service entrances, deliberately different (substandard) care, forced removal of newborn babies from mothers who were considered 'not competent' or not able to provide the 'right upbringing', and removal of children from home while parents were sick in hospital and failure to return these children to their parents' care.* [46]

Official policies to segregate Aboriginal patients in hospitals across the NT were implemented until at least 1979 when the so called "Native Ward" at Katherine District Hospital, 3 hours

south of Darwin, closed. [51] Official or unofficial segregated wards in NT hospitals may have continued beyond that time however evidence to support that supposition have not been identified. These practices were based on ideas of White superiority which were enshrined in the White Australia Policy (1901-1973). The White Australia Policy was not a single piece of legislation but an accumulation of laws and practices (including the practice of medicine) that aimed to create a White nation. [22, 26, 35, 37, 47] Bashford and Mayes provide evidence that the practice of medicine in the tropical north of Australia, where this research was conducted, actively promoted scientific racism. At the start of the 20th century, the purpose of medicine in the Australia's north was to support the "life of the white man" [47 p.254] who wanted to colonise and control the area. Medicine in Australia's north thus participated in building a White Australia which has bred a "racist nationalist culture". [47 p.256]

In Australian hospitals today, doctors conform to the institutionalised norms established by health systems which were developed during the White Australia Policy. [21, 37, 47] Experiences of racism through history have a cumulative effect [24, 52] on the collective psyche of both Aboriginal and White peoples. For Aboriginal peoples, when history intersects with other forms of ongoing oppression supported by systemically racist institutions healthcare providers and services are not trusted. [46] Past practices can be used by White healthcare providers to justify actions today. A 2016 report which examined the organisational culture of Top End Health Service (TEHS) stated that addressing bias amongst staff "will be a critical challenge for TEHS in its further work". [53 p.15]

Western medicine has had an enormous positive impact on disease management however it is based on White theories of illness and modes of treatment. [54-56] A White view of health is individual-centric and largely biomedical: "an illness is always explained with one or more

physical malfunctions". [57 p.76] These indicators tend to ignore the social and cultural context of people's lives. [48, 57, 58] An Indigenous approach to good health includes being connected to family, culture and country as well as intangible life experiences such as feeling a sense of belonging and purpose. [48, 55, 59] Many healthcare users have a different worldview to the ideas which underpin the delivery of healthcare in Australian hospitals that operate according to White biomedical norms. [48, 49]

Consequently, Aboriginal peoples may lack confidence with services to deliver care which respects their cultural values and priorities, and healthcare providers struggle to deliver services within White institutions which do not cater for the needs of Aboriginal peoples. [60, 61] These issues are not unique to Australia. Whiteness is embedded in institutions across the colonised countries of Canada, Aotearoa and the United States and individuals who do not identify with Whiteness do not receive the same quality of healthcare afforded to White people. [23, 32, 62-66]

Philosophical framework

My approach to conducting this research was influenced by three decolonising philosophies: cultural safety, [62] Critical Race Theory (CRT) [8] and Freirean pedagogy. [67] Initially I was interested in alternatives to cultural awareness training, which led me to cultural safety. As I read more about the philosophy behind cultural safety, particularly work by Curtis et al, [68] two ideas solidified in my mind: 1) this was about addressing racism which 2) requires hegemonic individuals to develop critical consciousness. This led me to Brazilian philosopher Paulo Freire who named and explained critical consciousness and also to CRT which acknowledges that racism occurs every day. Cultural safety, CRT and Freirean philosophy focus on redressing the power imbalance between the hegemony and marginalised peoples

by encouraging perspective taking amongst the hegemony through dialogue. Each philosophy will be explained individually before the commonalities are drawn together in relation to this research.

Cultural safety

As described in Chapter 1, cultural safety was conceived by Māori nurses in 1989. Scholar and nurse Irihapeti Ramsden then detailed the social justice framework in her 2002 thesis which is grounded in critical theory. [62] Cultural safety can be used as a research methodology and it can be practically applied in healthcare.

As a methodology, cultural safety can be used to decolonise the research space. The aim of culturally safe research is to provide evidence which is beneficial to Aboriginal peoples. [69-71] It requires researchers to be critically conscious which includes: 1) reflecting on their own cultural reality (as I have done above) which can impact how research is conducted, 2) understanding the social and political circumstances which lead to marginalised peoples being marginalised and 3) designing research projects which do not favour western epistemologies over Aboriginal epistemologies. As a White researcher, inspired by the critical focus cultural safety places on me and my colonising ancestors, I have reflected and continue to reflect on my privilege and power:

> *Undertaking a continual process of self-reflection enables the identification of the researcher's worldviews, epistemologies, and the power (among other things) that may adversely impact upon the research process.* [69 p.73]

Reflection resulted in action which included working with Aboriginal health professionals and researchers who contributed to all stages of the research process.

Underpinning a culturally safe research project are the "3 P's": partnership, participation, and protection.[70] A culturally safe researcher works in partnership by developing authentic relationships with collaborators who are partners in the research, not just participants. [70, 71] A culturally safe environment is one in which "Indigenous people do not feel like the subject of research but instead feel they are a contributor". [71 p.49] Participation refers to collaboration from project inception through to dissemination of findings. Protection ensures Aboriginal peoples are not portrayed as a problem to be researched. Protection also refers to respecting Aboriginal knowledges and protocols: not everyone has a right to Aboriginal knowledge, and when collecting or analysing data researchers must respect protocols such as avoidance relationships. Whether research practices are culturally safe or not is decided by collaborators and partners, not by the researcher.

Cultural safety applies throughout the participatory action cycle, as detailed below. The practical application of cultural safety in healthcare practice is twofold. Firstly, to deliver culturally safe care those belonging to the colonising culture are required to critically reflect on their assumptions, values, and bias so that a redistribution of power from healthcare providers to patients may occur. [55, 62, 68] Through self-reflection, individuals develop their critical consciousness which enables them to recognise the structural factors (historical, political, social and economic) that perpetuate inequity. [55, 62, 68]

> *Embodying critical consciousness requires a willingness to challenge one's own position of power and privilege*. [72 p.17]

The importance of developing and employing critical consciousness to counter racist ideas and policies is also advocated by Critical Race theorists and Freirean practitioners. Secondly, cultural safety involves ensuring communication is effective, respectful and free from

stereotypical thinking which manifests as racism. A cultural safety approach to communication places the onus on the healthcare provider to reflect on their own learnt communication practices and adapt their communication style to ensure patients do not feel demeaned. [62, 73, 74] When a healthcare provider changes how they communicate with Aboriginal peoples, the clinical consult can become a culturally safe interaction where power is shared between patient and provider. [73]

Critical Race Theory (CRT)

CRT is a transdisciplinary philosophy used to identify, understand and challenge racism. [8, 75] CRT originated in legal studies in the U.S.A and is grounded in social justice. [8] CRT scholars accept that race is socially constructed through thoughts, dialogue and relations and that racism is "ordinary not aberrational". [8] CRT offers a new paradigm to health providers who wish to "investigate the root causes of health disparities" [13 p.1] by encouraging healthcare providers to develop their critical consciousness. This helps to equalise the power imbalance between patients and providers.

Identifying power dynamics and eliminating power differentials is key to CRT. [8] The main way CRT practitioners challenge power is by placing a critical lens on knowledge production processes which they do through counter storytelling. [8, 13] CRT activists work to construct a more equitable society by centering the experiential knowledge of the "outsider"; this challenges the hegemonic narrative created by the "in-group". [76-78] The lived experience of the "outsider" is referred to as "counterstories".

> *To center in the margins is to shift a discourse's starting point from a majority group's perspective, which is the usual approach, to that of the marginalized group or groups.* [13 p.S31]

In countries such as Australia and the United States, the colonizer is considered the "in-group" and they have historically had the power to tell stories which have placed "whites on top and browns and blacks at the bottom". [79] This was my experience as a White radio broadcaster employed by ABC Radio [40] and a practice I aim to overturn with this research project. The discourse which currently frames Aboriginal people as deficient is a barrier to improving health outcomes. [80] Research in Australia has found when healthcare providers are exposed to Aboriginal peoples' stories which encourages perspective taking, critical thinking relating to White privilege occurs. [81-83] The idea of counterstories directly influenced the creation of the *Ask the Specialist* podcast.

Freirean pedagogy

The concept of critical consciousness was developed in the 1970s by educator and philosopher Paulo Freire who deliberated how to decolonise the education system in Brazil. In his seminal work, *Pedagogy of the Oppressed*, [67] Freire argued that education is politicised and controlled by the hegemony (colonisers) who use schools to reproduce the status quo. [67, 84] Reproduction occurs through "banking education" in which students are deposited with the myths oppressors wish to foster to maintain their superiority and power. To counter this Freire proposed a decolonising approach which he called "problem posing education". It involves three phases:

> *…(a) identify and name the social problem, (b) analyze the causes of the social problem, and (c) find solutions to the social problem.* [85 p.69]

Problem posing education involves praxis: an iterative process of awareness, reflection and action, stimulated by dialogue between seemingly opposing parties, which leads to critical

consciousness. Freire believed that dialoguing is an "act of creation" [67 p.89] which leads to a view of "total reality" that considers all perspectives not just those of the oppressor. [67 p.108] Asking questions regarding how reality is constructed through dialogue encourages critical thinking which leads to the development of critical consciousness:

> *If people are not aware of inequity and do not act to constantly resist oppressive norms and ways of being, then the result is residual inequity in perpetuity. If inequity is likened to a disease or poison, then CC* (critical consciousness) *has been deemed the antidote to inequity and the prescription needed to break the cycle.* [86 p.1]

Freire argued that oppressed peoples need to develop critical consciousness. The limitation here is that the onus for addressing societal inequities is placed onto those who have limited power. Jemal argued Freire's focus suggests that "oppression is a problem for the oppressed to solve". [86 p.15] However what is required is a collaboration between the oppressed and the oppressor. [86-88] Privileged individuals must also develop critical consciousness because they have "greater access to resources and power and can operate as allies". [86 p.16] This is in line with cultural safety which requires the healthcare providers to consider their power. It is the responsibility of the "in-group" to work with the "out-group" to deliver equitable health care in White institutions.

Fostering critical consciousness amongst healthcare providers has received limited attention in healthcare, [72, 89-91] however as the social determinants of health are increasingly recognized as key contributors to health disparities there has been a move away from "targeting individual behaviors and investing resources on specialized care of disease" towards addressing the contextual barriers to health. [88 p.1] When healthcare providers

have critical consciousness they have the capacity to address the social determinants of health, “the root causes of health inequities”. [88]

> *Ostensibly the goal of linking CC and health is to understand inequities in health and ultimately take action to improve health outcomes and reduce health inequities.* [88 p.2]

Commonalities of cultural safety, CRT and Freirean pedagogy

These philosophies, which augment each other, offer an intellectually robust approach to inform the development of a decolonised health workforce in the NT. Cultural safety, CRT and Freirean pedagogy are linked by: 1) a critical focus on the hegemony or colonisers; 2) foregrounding race and racism; 3) a commitment to social justice and community based participatory approaches; 4) the assertion that dialogue between the oppressor and oppressed peoples (also referred to as in-group and out-groups) is paramount to creating societal change; and 5) the understanding that individuals who develop critical consciousness are capable of identifying power dynamics and creating a more equitable society.[8, 13, 62, 67, 68, 85] Further discussion on how these philosophies shaped research design and findings have been incorporated into the published journal articles which are included as chapters 3, 4, 5 and 8.

Methods

My aim here is to provide information relevant to the overall project. I will explain why PAR was chosen as a suitable method, provide more details on the study site, explain who I worked with and detail how literature was reviewed and incorporated.

Participatory Action Research

The purpose of Participatory Action Research (PAR) is to enable action which leads to the creation of a more equitable society. [92-96] PAR is a transformative framework which aligns with constructivism and the philosophies outlined above: it encourages questioning how knowledge is created and who has the power to create knowledge. As with CRT, cultural safety and Freirean pedagogy, PAR projects value the experiential knowledge and lived experience of marginalised peoples. PAR draws heavily on Freire's definition of critical consciousness: when researchers and participants engage in dialogue of a nonhierarchical nature cycles of awareness, reflection and action can transform the world. [67, 93, 96, 97] To implement a PAR project, the imagined barrier between researchers and participants disappears; instead people work together as equal collaborators to identify and address areas requiring change. [92, 98] This model reduces the possibility of objectifying people or misrepresenting knowledge and experiences which has historically occurred in research with Indigenous populations worldwide. [97, 99]

> *At its heart is collective, self-reflective inquiry that researchers and participants undertake, so they can understand and improve upon the practices in which they participate and the situations in which they find themselves. The reflective process is directly linked to action, influenced by understanding of history, culture, and the local context and embedded social relationships.* [92 p.854]

PAR is increasingly used in health research with Indigenous communities in Australia and internationally. [63, 100-103] PAR compliments an Indigenous research paradigm, both approaches require participants to establish relationships of trust. [44, 104] Establishing relationships of reciprocity allows the participant-researcher duality to move into a space

where parties are equal and can become co-learners. [104] Addressing power differentials is expected of PAR researchers who work to eliminate the hierarchy between the researcher and the researched. PAR projects work against deficit approaches which have perpetuated the superiority of Whiteness. Trust when conducting research with Aboriginal communities in Australia is vital as research has been connected with colonization, experimentation and exploitation of Aboriginal peoples. [44, 99, 103, 104]

Trust between PAR researchers and White participants is also required for a project which aims to explore stereotypes and racism. Indigenous health can be an "emotionally charged zone". [82 p.34] In gathering data from doctors it was vital to create a space for doctors to "feel safe enough to open up" so they can tap into feelings, and beliefs that may be confronting. [82 p.34] This emotional discomfort, which can be felt by both the researcher and the participant, in relation to race and identity are an essential part of transformation. [82, 105-107]

Finally, PAR was chosen because PAR projects are about collaboration and real-world action. PAR was used in a Danish hospital to work with healthcare providers, patients, families and researchers to develop communication training which encourages shared decision making between patient and provider. [108] Similar to the Danish project, in this research it was recognised that if the interventions piloted produced positive outcomes, plans for scale-up would require support from frontline healthcare providers, healthcare leaders and community members. Table 2 provides a breakdown of the specific methods used in each publication which are presented as chapters 3, 4, 5 and 8.

Recognising that long term engagement across the community is required to create change during my candidature I delivered presentations and workshops to: five conferences, five

symposia, eight NT health committees and staff events, seven university courses, two health organisations and one Aboriginal Community Controlled Health Organization (see Table 3 and 4). Additionally, the *Ask the Specialist* podcast generated media attention and received three awards (Table 5 and 6). I personally received two awards for my research which again raised the profile of this body of work (Table 6).

Table 2: Methods per publication

Publication	**Methods**
Chapter 3: "How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload.	Quantitative: teaching domains were ranked using a Likert scale on training evaluation forms. The mean score each domain was calculated, as was the overall score for the course. Qualitative: Free text comments were analysed using the Framework Method which drew on a phenomenological approach. Kirkpatrick's evaluation model was used to interpret results.
Chapter 4: From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital	Qualitative: Inductive narrative analysis, guided by critical theory and Aboriginal knowledges.
Chapter 5: "The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care	Qualitative: Inductive narrative analysis was guided by critical theory
Chapter 8: Evaluation of "Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia	Qualitative: guided by critical theory, inductive narrative analysis was initially applied. After, codes were deductively grouped according to Kirkpatrick's training evaluation framework.

Study site

Research was conducted on the unceded lands of the Larrakia people known as Darwin, the capital of the NT. The origins of Darwin began with a permanent white settlement in 1869. Since then, the Larrakia have fought to maintain their sovereignty and culture in the face of ongoing oppression and dispossession. An example of this includes work being undertaken by Larrakia Elder, my supervisor, Aunty Bilawara Lee and others to revive the Larrakia language. Today around 2000 people identify as Larrakia. [109]

Darwin has a population of approximately 136,000 people of which 20% identify as Aboriginal.[110] In Australia's northern most city, race relations are a "matter of everyday experience and discussion". [111 p.359] An official breakdown of how many Aboriginal nations reside in Darwin today does not exist however Darwin is the regional centre for many Aboriginal peoples from across the north of Australia spanning Western Australia, the NT and Queensland. Aboriginal peoples are commonly forced to relocate from their own communities to Darwin to receive lifesaving healthcare.

The two pilot interventions were conducted at RDH: a 360-bed facility managed by the NT government's Top End Health Service (TEHS). In addition to RDH, TEHS manages three other hospitals across the region (Palmerston, Katherine and Gove) and 57 remote clinics. Over 2020-2021 period, TEHS employed 5079 full time equivalent staff, of whom 530 (10%) identified as Aboriginal and 1303 (27%) did not speak English as their first language. [112] The NT Health annual report [112] does not provide a breakdown of how many Aboriginal staff work as doctors, however we assume statistics are similar to national numbers which reveal just 0.4% of doctors identify as Aboriginal. [113] The number of staff who do not speak English

as a first language does not include how many staff members speak an Aboriginal language or what Aboriginal languages are spoken by staff.

TEHS provides over 100,000 episodes of inpatient care annually. Aboriginal peoples make up 70% of hospitalisations and 89% of remote clinic presentations. [114] Across the NT 60% of Aboriginal peoples speak an Aboriginal language as their first language. Whilst most of the 250 languages spoken across the continent at the time of colonisation are now extinct, 14 languages are still considered "relatively strong" (ie. the language is spoken fluently by all age groups) and 12 of those languges are spoken in the NT.[115] The number of Aboriginal languages in the NT is relevant because language is central to identity, culture and wellbeing [116] and the vitality and diversity of Aboriginal languages still spoken is just one obvious example of the strength and resilience of Aboriginal peoples in the NT. The NT Aboriginal Interpreter Service (AIS) has interpreters employed to cover nearly 50 languages.

Aboriginal co-researchers

As per PAR, I worked closely with Aboriginal health professionals, interpreters, researchers, community leaders and Elders as co-researchers. Each person has been acknowledged for their work in the publications presented in chapters 3, 4, 5 and 8. Whilst this research was only possible because of each individual, I feel it is particularly important to credit my co-researcher Stuart Yiwarr McGrath: an Aboriginal Health Practitioner (AHP) who was studying to be a registered nurse. Stuart is from the Gumatj clan of the Yolŋu nation: Djambarrpuyŋu (Yolŋu Matha dialect) is his first language. Stuart and I were successful in securing an Indigenous Development and Training Award through an NHMRC funded initiative referred to as HOT NORTH. This award covered Stuart's employment costs for the first 18 months of data collection and analysis. Stuart's subsequent employment was paid through a Menzies

small grant I was awarded. When we started working together Stuart had no previous experience in research, but his personal background and professional healthcare experience meant his skills were vital to the success of this project. Over the life of the project Stuart developed his research skills and subsequently has been invited to collaborate on various other research and health projects across the country. Four years later, we continue our collaboration.

Recruiting participants

PAR projects emerge from issues identified in the community and people who participate in PAR projects often have a vested interest in the issues being explored. In this project, participants were co-researchers who contributed to study design, implementation, and evaluation. [117] This model was ideal for the topic under consideration: when researching racism in healthcare it is sensible to collaborate with allies, "those who stand in solidarity with people targeted by racism", [118] as it reduces resistance to the concepts which challenge the status quo. To address racism in healthcare, allies are required to use their influence to encourage institutional changes. [119 p.107]

As discussed, PAR projects are about relationships. Having lived in Darwin for almost a decade before the project began, I had friendships and working relationships with Aboriginal leaders across the Top End. One very important contact from my days as an ABC broadcaster was Larrakia Elder Aunty Bilawara Lee who became one of my PhD supervisors and a Specialist in the podcast. Details about the other podcast Specialists and how they were invited to work on the project are in Chapter 6. Other Elders, Aboriginal health professionals and interpreters who participated in the project were invited through personal networks or employed by NT Health or the NT AIS.

As I had no practical experience working in a hospital, I had to build relationships with NT health staff. The first six months of my candidature I focused on familiarising myself with the hospital workplace culture. This included shadowing Yolŋu researcher Galathi Dhurrkay (co-author on Appendix C) who was surveying patients regarding their hospital experience; connecting with staff working in cultural safety related fields (cultural awareness trainers and interpreter support staff); attending relevant TEHS training sessions including RDH Grand Rounds and Surgical Grand Rounds; meeting with executives and delivering presentations to relevant committees. I also attended both the two hour and full day ACAP delivered to RDH staff. As a result, I met some of the people who eventually became participant/co-researchers and also developed a sense of RDH culture.

Considering doctors, nurses and allied health professionals have their own sub-cultures within the hospital, a decision needed to be made about which sub-culture to work with. As mentioned in Chapter 1, cultural awareness trainer Nicole Lewis reported that very few doctors attend training and she was keen to see doctors engaged. [120] Also, most previous work on cultural safety in health care focused on nurses [74, 121-124]: working with doctors on cultural safety was an identified gap. Additionally, two of my PhD supervisors (Ralph and Cass) were doctors: their connections were important. Finally, I chose to work with doctors because: 1) the doctor patient relationship is at the very heart of communication in healthcare; [125] 2) doctors have the capacity to be transformational leaders; [126] 3) doctors display leadership in the hierarchical hospital where they have the opportunity to influence executive and policy makers. [126]

Literature review

While my thesis does not contain a "literature review" chapter, evidence of previous research and grey literature is incorporated into each chapter as part of the overall narrative presented in the thesis. At the start of my candidature, I conducted a preliminary literature scan which refined the topic under consideration, provided baseline information, and was drawn on to inform the literature incorporated into each chapter. To conduct the literature scan search terms included: 'Aboriginal', 'anti-racism', 'Australia', 'communication', 'critical race theory', 'critical consciousness', 'cultural awareness', 'cultural competency', 'cultural safety', 'doctors', 'health', 'hospital', 'medical', 'racism', 'storytelling', 'podcast' and 'training' in various combinations. Databases searched included PubMed, Scopus, Medline, Indigenous HealthInfoNet and others. Some literature was obtained using a snowballing technique from references in published papers. A manual web search was conducted to find grey literature including policy documents to ensure alignment with government and organisational policies. Papers reporting on cultural education training in countries which did not have a similar history of colonisation to Australia were excluded. There were no restrictions on dates.

During my candidature I kept up to date with research developments and policy changes and continually added to my literature library through professional and personal networks, journal subscriptions, educational institutions, social justice and healthcare organisations and other relevant stakeholders. Social media was also a source of information particularly Instagram where race scholars in America were very active.

Figure 1 First Nations Languages and Health Communication Symposium 2021

L-R: Vicki Kerrigan and Stuart Yiwarr McGrath

Figure 2 East Arnhem Health Partnership symposium 2021

Rarrtjiwuy Melanie Herdman (centre) leading an impromptu weaving class, Gulkula, NT

Table 3: Conference presentations related to thesis

Date	Conference/meeting	Details	Type
4-5 Nov 2021	HOT North Annual Scientific Symposium, Darwin, 2021.	**Kerrigan V**. and McGrath SY. *Ask the Specialist podcast Plus.*	Oral (invited)
8-10 Sept 2021	International Forum on Quality and Safety in Healthcare, Australasia 2021	**Kerrigan V,** McGrath, SY, Lee B, Nethercott B, Puruntatameri P, Herdman RM, Ralph AP. *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare. A cultural education podcast*	Poster (abstract accepted)
22-23 June 2021	East Arnhem Health Partnership symposium, Gulkula, NT, Australia 2021	**Kerrigan V** and Herdman RM. *Ask the Specialist: stories to inspire better healthcare. A cultural education podcast*	Oral (invited)
9-11 June 2021	International Forum on Quality and Safety in Healthcare, Europe 2021	**Kerrigan V,** McGrath, SY, Lee B, Nethercott B, Puruntatameri P, Herdman RM, Ralph AP. *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare. A cultural education podcast.*	Poster (abstract accepted)
12-13 May 2021	First Nations Languages and Health Communication Symposium, Darwin Australia 2021	**Kerrigan V,** Burrunali J, McGrath SY & Davies J. *Addressing COVID-19 vaccine fears with NT Aboriginal leaders and languages*	Panel discussion (invited)
12-13 May 2021	First Nations Languages and Health Communication Symposium, Darwin Australia 2021	**Kerrigan V** and McGrath SY. *From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters at RDH*,	Oral (abstract accepted)
21 Nov 2019	Indigenous languages and Health Communication Symposium, Darwin, November 2019	**Kerrigan V.** and McGrath SY. *The 'Communicate' study: developing cultural training for doctors*.	Oral (invited)
21 Nov 2019	Indigenous languages and Health Communication Symposium, Darwin, 2019	**Kerrigan V.,** Majoni SW and Ahmat M. *RDH Aboriginal Interpreter Ward Round pilot: an AIS, TEHS and Menzies collaboration*	Panel discussion (invited)
12-13 Aug 2019	HOT North Annual Scientific Symposium, Darwin, 2019	**Kerrigan V**. "*The 'Communicate' study: developing cultural training for doctors at RDH,*	Oral (invited)

26-28 June 2019	17th International Conference on Communication, Medicine and Ethics, University of South Australia, 2019	**Kerrigan V.** *The role of communication in determining health care safety, quality and equity for Indigenous Australians: Podcasts to promote patient stories and address provider held unconscious bias.*	Oral (abstract accepted)
18-20 June 2019	Lowitja Institute, International Indigenous Health Conference, Darwin June 2019	**Kerrigan V** and Daly S. *Aboriginal patients and non-Indigenous doctors developing culturally safe communication at Royal Darwin Hospital.*	Oral (abstract accepted)
10-12 Sept 2018	International Forum on Quality and Safety in Healthcare, Australia, 2018	**Kerrigan V.,** Dhurrkay, G., Castillon, C., Alexander, D., Cass, A., Lowell, A., Ralph, A. *The 'Communicate' Study: Improving communication with hospitalised Aboriginal patients to ensure quality and safety in healthcare.*	Poster (abstract accepted)

Table 4: Community and stakeholder engagement related to thesis

Date	Where	Topic	Type
14/3/22	Aboriginal Health Committee, Top End Health Service	**Kerrigan V.** *The Communicate study*	Presentation
30/9/21	Clinical Governance and Risk Management unit, University of New South Wales	**Kerrigan V.** *Ask the Specialist. A cultural education podcast about communication and power*	Guest lecture
15/9/21	Medical science unit, Charles Darwin University	**Kerrigan V.** *The Communicate study*	Guest lecture
21/7/21	The Society of Hospital Pharmacists of Australia.	**Kerrigan V.** *Ask the Specialist. A cultural education podcast about communication and power*	Workshop presentation
7/5/21	Indigenous health unit, Master of Public Health Charles Darwin University	**Kerrigan V** and Herdman RM. *The Communicate study*	Guest lecture
9/11/20	1st Yr Medical students, Flinders Medical School	**Kerrigan V.** *The Communicate study*	Guest lecture
27/8/20	Optometry students, Transition to clinical practice, Deakin University	**Kerrigan V.** *The Communicate study*	Guest lecture
6/11/20	Heart Foundation (NT)	**Kerrigan V.** *Ask the Specialist podcast*	Workshop presentation
12/10/20	Grand Rounds, Top End Health Service	**Kerrigan V** and Ralph AP. *The Communicate study*	Presentation
19/8/20	Bachelor of Clinical Sciences. Charles Darwin University	**Kerrigan V.** *The Communicate study*	Guest lecture
18/5/20	Indigenous health unit, Master of Public Health, Charles Darwin University	**Kerrigan V.** *The Communicate study*	Guest lecture
14/5/20	Medical Advisory Committee, Top End Health Service	**Kerrigan V.** *Ask the Specialist podcast*	Presentation

11/5/20	Aboriginal Health Committee, Top End Health Service	**Kerrigan V.** *Ask the Specialist podcast*	Presentation
11/5/20	National Safety and Quality Health Service Standard 6 Committee, Top End Health Service.	**Kerrigan V.** *Ask the Specialist podcast*	Presentation
19/3/20	Aboriginal and Torres Strait Islander Workforce Advisory Group, Top End Health Service	**Kerrigan V.** *Ask the Specialist podcast*	Presentation
14/2/20	Miwatj Health Aboriginal Corporation	**Kerrigan V** and McGrath SY. *Communicate study research findings: practical application*	Workshop presentation
7/11/19	Remote Medical Practitioner workshop, Top End Health Service	**Kerrigan V** and McGrath SY. *The Communicate study*	Workshop presentation
13/3/19	National Safety and Quality Health Service Standard 2 Committee, Top End Health Service	**Kerrigan V.** *Ask the Specialist podcast*	Presentation

Table 5: Media coverage related to thesis

Date	Where	Topic
13/12/21	ABC Darwin	Ask the Specialist podcast awarded an NT Human Rights Award (the Fitzgerald Social Change Award). Interview with Vicki Kerrigan
1/2/21	The Health Advocate: Australian Healthcare & Hospitals Association	*"Ask the Specialist: a cultural education podcast".* https://issuu.com/aushealthcare/docs/the_health_advocate_-_february_2021/s/11717195
4/12/20	Australian Nursing and Midwifery Journal	*"Podcast delivers specialist cultural advice on Aboriginal and Torres Strait Islander healthcare".* https://anmj.org.au/podcast-delivers-specialist-cultural-advice-on-aboriginal-and-torres-strait-islander-healthcare/
24/11/20	ABC Darwin	Ask the Specialist podcast awarded silver medal for Smartest Podcast at the Australian Podcast Awards. Interview with Vicki Kerrigan
5/8/20	Territory FM	Ask the Specialist podcast launch. Interview with Vicki Kerrigan
4/8/20	CDU E News	*"Podcasts for Top End doctors go global"* https://www.cdu.edu.au/enews/stories/ask-the-specialist
21/7/20	ABC Darwin	Racism at Royal Darwin Hospital. Interview with Aunty Bilawara Lee
19/7/20	ABC news online	*"Ask the Specialist's podcast experts address health racism at Royal Darwin Hospital".* https://www.abc.net.au/news/2020-07-19/ask-the-specialist-podcast-menzies-health-racism-darwin-hospital/12467382
2/7/20	ABC Darwin	Ask the Specialists podcast launch. Interview with Vicki Kerrigan
2/7/20	TEABBA	Ask the Specialists podcast launch. Interview with Vicki Kerrigan and Rarrtjiwuy Melanie Herdman

Table 6: Awards during candidature

Award	Awardee
NT Human Rights Award: the Fitzgerald Social Change Award, 2021	Ask the Specialist podcast
Australian and New Zealand Communication Conference, Grant Noble Award for Best Postgraduate Abstract, 2021	Vicki Kerrigan
CSL Florey Next Generation Award, 2020	Vicki Kerrigan
Awards Australia, Health and Wellbeing Award, 2020	Ask the Specialist podcast
Australian Podcast Awards (2020): • Smartest podcast: Ask the Specialist (silver medal) • Best Indigenous podcast: Ask the Specialist (finalist)	Ask the Specialist podcast

Figure 3 Awards Australia, Health and Wellbeing Award 2020

L-R: Pirrawayingi Puruntatameri, Anna Ralph, Stuart Yiwarr McGrath, Aunty Bilawara Lee, Bernadette Nethercott, Rarrtjiwuy Melanie Herdman and Vicki Kerrigan

References

1. Guba, E.G. and Y.S. Lincoln, *Fourth generation evaluation*. 1989, Newbury Park, Calif: Sage Publications.
2. Guba, E.G. and Y.S. Lincoln, *Competing paradigms in qualitative research (Chapter 6)*. Handbook of qualitative research. Norman K. Denzin, Yvonna S. Lincoln, editors. 1994, Thousand Oaks : Sage Publications, c1994: Denzin, Norman K. ; Lincoln, Yvonna S. editors.
3. Lincoln, Y.S., *The constructivist credo*, ed. E.G. Guba. 2013, Walnut Creek, Calif.: Walnut Creek, Calif. : Left Coast Press, Inc.
4. Garneau, A.B. and J. Pepin, *Cultural Competence: A Constructivist Definition.* Journal of Transcultural Nursing, 2015. **26**(1): p. 9-15.
5. Duthie, D., J. King, and J. Mays, *Raising awareness of Australian Aboriginal peoples reality: Embedding Aboriginal knowledge in social work education through the use of field experiences.* The International Education Journal: Comparative Perspectives, 2013. **12**: p. 197-212.
6. Stewart, S., *Family Counselling as Decolonization: Exploring an Indigenous Social-Constructivist Approach in Clinical Practice.* First peoples child & family review, 2019. **14**(1): p. 43.
7. DiAngelo, R. and M.E. Dyson, *White Fragility: Why It's So Hard for White People to Talk about Racism*. 2018, Boston: Beacon Press.
8. Delgado, R., J. Stefancic, and A. Harris, *Critical Race Theory (Third Edition): An Introduction*. Third edition. ed. 2017, New York: New York University Press.
9. McIntosh, P., *White privilege: Unpacking the invisible knapsack*, in *Peace and Freedom, July/August*. 1989: Philadelphia, PA: Women's International League for Peace and Freedom. p. 10-12.
10. Paradies, Y., et al., *Racism as a Determinant of Health: A Systematic Review and Meta-Analysis.* PLOS ONE, 2015. **10**(9): p. e0138511.
11. Chadha, N., et al., *Toward the Abolition of Biological Race in Medicine*. 2020, UC Berkeley: Othering & Belonging Institute.
12. Gilmore, R.W., *Golden gulag prisons, surplus, crisis, and opposition in globalizing California*. American Crossroads ; v.21. 2007, Berkeley: University of California Press.
13. Ford, C.L. and C.O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis.* American Journal of Public Health, 2010. **100**(S1): p. S30-S35.
14. Paradies, Y.C., *Defining, conceptualizing and characterizing racism in health research.* Critical public health, 2006. **16**(2): p. 143-157.
15. Came, H.A. and S. da Silva, *Building political competencies for the transformation of racism in Aotearoa.* Kōtuitui: New Zealand Journal of Social Sciences Online, 2011. **6**(1-2): p. 113-123.
16. Boynton-Jarrett, R., A. Raj, and D.J. Inwards-Breland, *Structural integrity: Recognizing, measuring, and addressing systemic racism and its health impacts.* EClinicalMedicine, 2021. **36**: p. 100921.
17. Turda, M. and M.S. Quine, *Historicizing race*. 2018, London ;: Bloomsbury Academic.
18. Jablonski, N.G., *Skin color and race.* American Journal of Physical Anthropology, 2021. **175**(2): p. 437-447.
19. Eze, E.C., *Race and the enlightenment : a reader*. 2009, Malden, Mass: Blackwell.
20. Moreton-Robinson, A., *Imagining the Good Indigenous Citizen: Race War and the Pathology of Patriarchal White Sovereignty.* Cultural Studies Review, 2009. **15**(2): p. 61-79.
21. Watego, C., D. Singh, and A. Macoun, *Partnership for Justice in Health: Scoping paper on race, racism and the Australian health system.* . 2021, The Lowitja Institute: Melbourne.
22. Hage, G., *White nation : fantasies of white supremacy in a multicultural society / by Ghassan Hage*. 1998, Sydney: Pluto Press.

23. Jones, C.P., *Levels of racism: A theoretic framework and a gardener's tale.* Am. J. Public Health, 2000. **90**(8): p. 1212-1215.
24. Kidd, J., H. Came, and T. McCreanor, *Using vignettes about racism from health practice in Aotearoa to generate anti-racism interventions.* Health & Social Care in the Community, 2022. **n/a**(n/a).
25. King, J.E., *Dysconscious Racism: Ideology, Identity, and the Miseducation of Teachers.* The Journal of Negro education, 1991. **60**(2): p. 133-146.
26. Bargallie, D., *Unmasking the Racial Contract: Indigenous voices on racism in the Australian Public Service*. 2020, Canberra, ACT: Aboriginal Studies Press. 256.
27. Elias, A., F. Mansouri, and Y. Paradies, *Countering racism: Challenges and progress in anti-racism efforts*, in *Racism in Australia Today*. 2021, Springer Singapore: Singapore. p. 319-351.
28. The White House. *Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. January 20 2021; Available from: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/.
29. Bonilla-Silva, E., *The Structure of Racism in Color-Blind, "Post-Racial" America.* The American behavioral scientist (Beverly Hills), 2015. **59**(11): p. 1358-1376.
30. Lentin, A., *Why Race Still Matters*. 2020, Cambridge, UK; Medford, MA: Polity Press.
31. The Lancet, *Institutionalised racism in health care.* The Lancet, 1999. **353**(9155): p. 765.
32. Byrne, A. and A. Tanesini, *Instilling new habits: addressing implicit bias in healthcare professionals.* Advances in Health Sciences Education: Theory Practice, 2015. **20**(5): p. 1255-62.
33. Cohan, D., *Racist Like Me - A call to Self-Reflection and Action for White Physicians*. February 28, 2019: The New England Journal of Medicine. p. 805-807.
34. Paradies, Y., H. Franklin, and E. Kowal, *Development of the Reflexive Antiracism Scale – Indigenous.* Equality, Diversity and Inclusion: An International Journal, 2013. **32**(4): p. 348-373.
35. Garner, S., *Whiteness: an introduction*. Whiteness. 2007, Milton Park, Abingdon, Oxon ;: Routledge.
36. Du Bois, W.E.B., *The Souls of White Folk*, in *Monthly Review*. 2003. p. 44+.
37. Mayes, C., *White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare.* Journal of Australian studies, 2020. **44**(3): p. 287-302.
38. Kowal, E., *The Politics of the Gap: Indigenous Australians, Liberal Multiculturalism, and the End of the Self-Determination Era.* American anthropologist, 2008. **110**(3): p. 338-348.
39. Liu, W.M., et al., *Racial Trauma, Microaggressions, and Becoming Racially Innocuous: The Role of Acculturation and White Supremacist Ideology.* The American psychologist, 2019. **74**(1): p. 143-155.
40. Kerrigan, V. *Whitefella broadcasting: Why non Indigenous journalists struggle to tell Aboriginal stories in Australia*. in *Journalism Education and Research Association of Australia 2017 Conference*. 2017. Newcastle: The Journalism Education and Research Association of Australia Incorporated (JERAA Inc).
41. McCallum, K., *The Media and Indigenous policy: how news media reporting and meditatized practice impact on Indigenous policy - a preliminary report*. 2012, Journalism & Communication Studies, Faculty of Arts & Design, University of Canberra: Canberra.
42. Stoneham, M.J., J. Goodman, and M. Daube, *The Portrayal of Indigenous Health in Selected Australian Media.* International Indigenous Policy Journal, 2014. **5**(1).
43. Burarrwanga, L., et al., *Song spirals : sharing women's wisdom of Country through songlines*. Songspirals, ed. L. Burarrwana, et al. 2019: ALLEN & UNWIN.

44. Laycock, A., et al., *Researching Indigenous health: a practical guide for researchers*. 2011, Melbourne: The Lowitja Institute.
45. *Slice of LIME Seminar 9.3: 'Outing' Unconcious Bias - Dr Chelsea Bond*. 3rd September 2018, LIME Network.
46. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. User Guide for Aboriginal and Torres Strait Islander Health*. 2017: Sydney, NSW.
47. Bashford, A., *'Is White Australia possible?' Race, colonialism and tropical medicine.* Ethnic and racial studies, 2000. **23**(2): p. 248-271.
48. Garvey, G., et al., *The Fabric of Aboriginal and Torres Strait Islander Wellbeing: A Conceptual Model.* International journal of environmental research and public health, 2021. **18**.
49. McCalman, J., C. Jongen, and R. Bainbridge, *Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature.* International Journal for Equity in Health, 2017. **16**(1): p. 78.
50. Byrne, A. and A. Tanesini, *Instilling new habits: addressing implicit bias in healthcare professionals.* Adv Health Sci Educ Theory Pract, 2015. **20**(5): p. 1255-62.
51. Ascott, J., *A Brief History of Katherine Hospital 1934-1994*. n.d., On behalf of the Katherine Hospital Management Board to commemorate the 60th Anniversary of the establishment of Katherine Hospital.
52. Crenshaw, K., *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color.* Stanford law review, 1991. **43**(6): p. 1241-1299.
53. Northern Territory Government and Top End Health Service, *Improving TEHS Culture. Organisational Culture Assessment. Summary Report.* August 2016: Darwin, NT. p. 1-19.
54. Reid, J., *Body, land and spirit : health and healing in Aboriginal society*. 1984, St. Lucia, Qld.: St. Lucia, Qld. : University of Queensland Press.
55. Taylor, K., *Health care and Indigenous Australians : cultural safety in practice*. Second edition.. ed. Cultural safety in practice, ed. P. Guerin. 2014, South Yarra, Vic.: South Yarra, Vic. : Palgrave Macmillan.
56. Eckermann, A.-K., *Binan Goonj: bridging cultures in Aboriginal health*. 3rd ed. 2010, Sydney: Churchill Livingstone.
57. Rocca, E. and R.L. Anjum, *Complexity, Reductionism and the Biomedical Model*, in *Rethinking Causality, Complexity and Evidence for the Unique Patient: A CauseHealth Resource for Healthcare Professionals and the Clinical Encounter*, R.L. Anjum, S. Copeland, and E. Rocca, Editors. 2020, Springer International Publishing: Cham. p. 75-94.
58. Butler, T.L., et al., *Aboriginal and Torres Strait Islander people's domains of wellbeing: A comprehensive literature review.* Social Science & Medicine, 2019. **233**: p. 138-157.
59. Boyden, S., *The Biology of Civilisation: Understanding Human Culture as a Force in Nature*. 2004, Sydney: UNSW Press.
60. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. Overview: Guide to better care for Aboriginal and Torres Strait Islander communities*. 2016.
61. Chong, A., et al., *Improving cultural sensitivity to Indigenous people in Australian hospitals. A continuous quality improvement approach.* Focus on Health Professional Education: a Multi-Disciplinary Journal, 2011. **13**(1): p. 84–97.
62. Ramsden, I.M., *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. 2002, Victoria University of Wellington: Wellington, New Zealand. p. 211.
63. Jull, J., et al., *Shared decision making with Aboriginal women facing health decisions* AlterNative: An International Journal of Indigenous Peoples, 2015. **11**(4): p. 401-416.
64. Miller, D.R. and J.T. Berger, *Ethics and Society: Physician Assisted Suicide and White Ethnocentrism.* Journal of pain and symptom management, 2021. **62**(3): p. e1-e2.

65. Paradies, Y., *Colonisation, racism and indigenous health.* Journal of Population Research, 2016. **33**(1): p. 83-96.
66. Heke, D., et al., *Exploring anti-racism within the context of human resource management in the health sector in Aotearoa.* International Journal of Critical Indigenous Studies, 2021. **14**(2): p. 114-132.
67. Freire, P., *Pedagogy of the oppressed*. 30th Anniversary Edition ed. 2005 (1970), New York: The Continuum International Publishing Group.
68. Curtis, E., et al., *Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition.* International Journal for Equity in Health, 2019. **18**(1): p. 174.
69. Wilson, D. and S. Neville, *Culturally safe research with vulnerable populations.* Contemporary Nurse, 2009. **33**(1): p. 69-79.
70. Wilson, D., *Culturally Safe Research with Vulnerable Populations (Māori)*, in *Handbook of Research Methods in Health Social Sciences*, P. Liamputtong, Editor. 2019, Springer Singapore: Singapore. p. 1525-1542.
71. Heckenberg, S., *Cultural safety: A model and method that reflects us, respects us and represents us.* Journal of Australian Indigenous Issues,, 2020. **23**(3-4): p. 48-66.
72. Halman, M., L. Baker, and S. Ng, *Using critical consciousness to inform health professions education : A literature review.* Perspectives on medical education, 2017. **6**(1): p. 12-20.
73. Jennings, W., C. Bond, and P.S. Hill, *The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication.* Aust J Prim Health, 2018.
74. Papps, E. and I. Ramsden, *Cultural Safety in Nursing: the New Zealand Experience.* International Journal for Quality in Health Care, 1996. **8**(5): p. 491-497.
75. Ford, C.L. and C.O. Airhihenbuwa, *Commentary: Just What is Critical Race Theory and What's it Doing in a Progressive Field like Public Health?* Ethnicity & disease, 2018. **28**(Suppl 1): p. 223-230.
76. Solorzano, D.G., *Critical race theory, race and gender microaggressions, and the experience of Chicana and Chicano scholars.* International Journal of Qualitative Studies in Education, 1998. **11**(1): p. 121-136.
77. Yosso, T.J., *Whose culture has capital? A critical race theory discussion of community cultural wealth.* Race, ethnicity and education, 2005. **8**(1): p. 69-91.
78. Essed, P., *Understanding Everyday Racism : An Interdisciplinary Theory*. 1991, Thousand Oaks, UNITED STATES: SAGE Publications.
79. Delgado, R., *Storytelling for Oppositionists and Others: A Plea for Narrative.* Michigan law review, 1989. **87**(8): p. 2411-2441.
80. Fogarty, W., et al., *Deficit discourse and strengths-based approaches: changing the narrative of Aboriginal and Torres Strait Islander Health and Wellbeing*. 2018, The Lowitja Institute: Melbourne.
81. Grogan, J., D. Hollinsworth, and J. Carter, *Using videoed stories to convey Indigenous 'Voices' in Indigenous Studies.* The Australian journal of indigenous education, 2019. **50**(1): p. 38-46.
82. Sjorberg, D. and D. McDermott, *The deconstruction exercise: An assessment tool for enhancing critical thinking in cultural safety education.* International Journal of Critical Indigenous Studies, 2016. **9**(1): p. 28-48.
83. Wain, T., et al., *Engaging Australian Aboriginal narratives to challenge attitudes and create empathy in health care: a methodological perspective.* BMC Med Educ, 2016. **16**: p. 156.
84. Shor, I., *EDUCATION IS POLITICS: PAULO FREIRE'S CRITICAL PEDAGOGY*, in *Paulo Freire. A Critical Encounter*, P. Leonard and P. McLaren, Editors. 1993, Routledge. Taylor and Francis Group: London and New York. p. 25-38.

85. Smith-Maddox, R. and D.G. Solórzano, *Using Critical Race Theory, Paulo Freire's Problem-Posing Method, and Case Study Research to Confront Race and Racism in Education.* Qualitative Inquiry, 2002. **8**(1): p. 66-84.
86. Jemal, A., *Critical Consciousness: A Critique and Critical Analysis of the Literature.* The Urban review, 2017. **49**(4): p. 602-626.
87. Thomas, A.J., et al., *Assessing Critical Consciousness in Youth and Young Adults.* Journal of research on adolescence, 2014. **24**(3): p. 485-496.
88. Windsor, L.C., et al., *Linking critical consciousness and health: The utility of the critical reflection about social determinants of health scale (CR_SDH).* SSM - population health, 2022. **17**: p. 101034-101034.
89. DasGupta, S., et al., *Medical Education for Social Justice: Paulo Freire Revisited.* The Journal of medical humanities, 2006. **27**(4): p. 245-251.
90. Braun, L., *Theorizing Race and Racism: Preliminary Reflections on the Medical Curriculum.* American journal of law & medicine, 2017. **43**(2-3): p. 239-256.
91. Kumagai, A.K. and M.L. Lypson, *Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education.* Academic Medicine, 2009. **84**(6): p. 782-787.
92. Baum, F., C. MacDougall, and D. Smith, *Participatory action research.* Journal of Epidemiology & Community Health, 2006. **60**(10): p. 854.
93. Hall, B., *Research, commitment and action: The role of participatory research.* International Review of Education, 1985. **30**(3): p. 289-299.
94. Kemmis, S., R. McTaggert, and R. Nixon, *The Action Research Planner: Doing Critical Participatory Action Research*. 2014, New York: Springer.
95. Creswell, J.W., *Qualitative inquiry & research design : choosing among five approaches*. Fourth edition.. ed. Qualitative inquiry and research design, ed. C.N. Poth. 2018: Los Angeles SAGE.
96. Glassman, M. and G. Erdem, *Participatory action research and its meanings: Vivencia, praxis, conscientization.* Adult education quarterly, 2014. **64**(3): p. 206-221.
97. Baum, F.E., *Power and glory: applying participatory action research in public health.* Gaceta sanitaria, 2016. **30**(6): p. 405-407.
98. Daniels, K., et al., *Fair publication of qualitative research in health systems: A call by health policy and systems researchers.* International journal for equity in health, 2016. **15**(1): p. 98-98.
99. Smith, L.T., *Decolonizing methodologies: research and indigenous peoples*. Second edition. ed, ed. C. Proquest Ebook. 2012, London, New York: Zed Books: distributed in the USA exclusively by Palgrave Macmillan.
100. Haynes, E., et al., *Community-based participatory action research on rheumatic heart disease in an Australian Aboriginal homeland: Evaluation of the 'On track watch' project.* Evaluation and Program Planning, 2019. **74**: p. 38-53.
101. Zemits, B., et al., *Moving Beyond "Health Education": Participatory Filmmaking for Cross-Cultural Health Communication.* Health Commun, 2015. **30**(12): p. 1213-22.
102. Kerrigan, V., et al., *A community-based program to reduce acute rheumatic fever and rheumatic heart disease in northern Australia.* BMC Health Services Research, 2021. **21**(1): p. 1127.
103. Cochran, P.A.L., et al., *'Indigenous Ways of Knowing: Implications for Participatory Research and Community',.* American Journal Of Public Health, 2008. **98**(1): p. 22-27.
104. Wilson, S., *Research is ceremony: Indigenous research methods*. 2008, Black Point, Nova Scotia: Fernwood.
105. Constance-Huggins, M., *Intersection of race, gender, and nationality in teaching about race and racism.* Reflective Practice, 2018. **19**(1): p. 81-88.
106. Belfiore, M.N., et al., *Teaching Note-Exploring Podcast-Facilitated Course Work on Racism.* Journal of social work education, 2021. **57**(1): p. 173-180.

107. Bond, C.J., G.K. Spurling, and D.A. Askew, *A different kind of treatment.* Med J Aust, 2014. **201**(1): p. 10-10.
108. Ammentorp, J., et al., *How participatory action research changed our view of the challenges of shared decision-making training.* Patient Education and Counseling, 2018. **101**(4): p. 639-646.
109. Larrakia Nation. *The Larrakia People*. 2022 12th November 2021]; Available from: http://larrakia.com/about/the-larrakia-people/.
110. Australian Bureau of Statistics, *Census of Population and Housing - Counts of Aboriginal and Torres Strait Islander Australians (cat. no. 2075.0)*. 2017, ABS Census of Population and Housing, 2016.
111. Taylor, P.S. and D. Habibis, *Widening the gap: White ignorance, race relations and the consequences for Aboriginal people in Australia.* The Australian journal of social issues, 2020. **55**(3): p. 354-371.
112. Northern Territory Government, *Department of Health Annual Report 2020-2021*. 2021: Darwin, Australia.
113. Department of Health Australian Government, *Doctors in Focus*. 2018, Commonwealth of Australia: Canberra, Australia.
114. Northern Territory Government, *NT Aboriginal Health Plan 2021-2031*. 2021, NT Health: Casuarina, NT, Australia.
115. Australian Institute of Aboriginal Torres Strait Islander Studies, A.N.U., *National Indigenous languages report*. 2020, Government of Australia.
116. Dinku, Y., et al., *Language use is connected to indicators of wellbeing: Evidence from the National Aboriginal and Torres Strait Islander Social Survey 2014-15, Working Paper no.137/2020*. 2020, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.
117. Canlas, I.P. and M. Karpudewan, *Blending the Principles of Participatory Action Research Approach and Elements of Grounded Theory in a Disaster Risk Reduction Education Case Study.* International Journal of Qualitative Methods, 2020. **19**: p. 1609406920958964.
118. Came, H. and D. Griffith, *Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis.* Social science & medicine (1982), 2018. **199**: p. 181-188.
119. Came, H., et al., *From Gorse to Ngahere: An Emerging Allegory for Decolonising the New Zealand Health System.* The New Zealand Medical Journal, 2020. **133**(1524).
120. Kerrigan, V., *Journal note*. 26th June 2018.
121. Browne, A.J., et al., *Cultural safety and the challenges of translating critically oriented knowledge in practice.* Nursing Philosophy, 2009. **10**(3): p. 167-179.
122. Hart-Wasekeesikaw, F., *Cultural competence and cultural safety in nursing education. A framework for First Nations, Inuit and Métis Nursing*. 2009, Aboriginal Nurses Association of Canada: Ottawa, Canada.
123. Mortensen, A., *CULTURAL SAFETY: DOES THE THEORY WORK IN PRACTICE FOR CULTURALLY AND LINGUISTICALLY DIVERSE GROUPS?* Nursing Praxis in New Zealand, 2010. **26**(3): p. 6-16.
124. Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, *The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework. An adaptation of and complementary document to the 2014 Aboriginal and Torres Strait Islander Health Curriculum Framework*. May, 2017, CATSINaM: Canberra.
125. Cushing, A., *History of the Doctor-Patient Relationship*, in *Clinical communication in medicine*, J. Brown, et al., Editors. 2016, John Wiley & Sons Inc. : Chichester, West Sussex. Ames, Iowa.
126. Gabel, S., *Power, leadership and transformation: the doctor's potential for influence.* Medical Education, 2012. **46**(12): p. 1152-1160.

CHAPTER THREE

"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload

Publication: Kerrigan V, Lewis N, Cass A, Hefler M, Ralph AP. "How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload. BMC medical education. 2020 Dec;20(1):1-1.

Kerrigan et al. BMC Medical Education (2020) 20:173
https://doi.org/10.1186/s12909-020-02086-5

BMC Medical Education

RESEARCH ARTICLE Open Access

"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload

Vicki Kerrigan[1*], Nicole Lewis[2], Alan Cass[1], Marita Hefler[1] and Anna P. Ralph[1,3]

Abstract

Background: Aboriginal cultural awareness training aims to build a culturally responsive workforce, however research has found the training has limited impact on the health professional's ability to provide culturally safe care. This study examined cultural awareness training feedback from healthcare professionals working with high Aboriginal patient caseloads in the Top End of the Northern Territory of Australia. The aim of the research was to assess the perception of training and the potential for expansion to better meet workforce needs.

Methods: Audit and qualitative thematic analysis of cultural awareness training evaluation forms completed by course participants between March and October 2018. Course participants ranked seven teaching domains using five-point Likert scales (maximum summary score 35 points) and provided free-text feedback. Data were analysed using the Framework Method and assessed against Kirkpatrick's training evaluation model. Cultural safety and decolonising philosophies shaped the approach.

Results: 621 participants attended 27 ACAP sessions during the study period. Evaluation forms were completed by 596 (96%). The mean overall assessment score provided was 34/35 points (standard deviation 1.0, range 31-35) indicating high levels of participant satisfaction. Analysis of 683 free text comments found participants wanted more cultural education, designed and delivered by local people, which provides an opportunity to consciously explore both Aboriginal and non-Aboriginal cultures (including self-reflection). Regarding the expansion of cultural education, four major areas requiring specific attention were identified: communication, kinship, history and professional relevance. A strength of this training was the authentic personal stories shared by local Aboriginal cultural educators, reflecting community experiences and attitudes. Criticism of the current model included that too much information was delivered in one day.

(Continued on next page)

* Correspondence: vicki.kerrigan@menzies.edu.au
[1]Menzies School of Health Research, Charles Darwin University, PO Box 41096, Casuarina, Northern Territory 0811, Australia
Full list of author information is available at the end of the article

(Continued from previous page)
Conclusions: Healthcare providers found cultural awareness training to be an invaluable entry point. Cultural education which elevates the Aboriginal health user's experience and provides health professionals with an opportunity for critical self-reflection and practical solutions for common cross-cultural clinical encounters may improve the delivery of culturally safe care. We conclude that revised models of cultural education should be developed, tested and evaluated. This requires institutional support, and recognition that cultural education can contribute to addressing systemic racism.

Keywords: Aboriginal, Indigenous, cultural awareness, cultural safety, unconscious bias, hospital training

Background

Research from the colonised countries of Canada, Australia, New Zealand and the United States has found when Indigenous peoples access healthcare services they do not receive equal treatment [1–5]. Historically, health and medical practice in Australia was used as a tool of colonial control and the impact of a colonial history resulting in intergenerational trauma has been identified as a driver of Indigenous poor health [5–7]. In Australia, Aboriginal and Torres Strait Islander people access hospital services at 1.3 times the rate of other Australians and are admitted with a much greater burden of disease [8]. High mortality rates as a result of chronic disease, trauma and suicide have led to an unrelenting cycle of "sorry business" [9, 10]. "Sorry business" broadly refers to the cultural practices, including funerals, around death. Mainstream health services, operating according to biomedical norms and western concepts of wellbeing fail to deliver care which respects the cultural values and priorities of Aboriginal and Torres Strait Islander peoples [8, 11, 12]. Adverse consequences including death and absence of informed consent have been documented as a result of failures to deliver culturally safe care in Australian hospitals [13–17].

Regarding terminology, in reference to the First Nations people of Australia, Aboriginal or Aboriginal and Torres Strait Islander will be used. In discussing these issues, we acknowledge that Aboriginal and Torres Strait Islander peoples are "not culturally homogenous" [18] rather there is a myriad of distinct cultural groups with unique languages, knowledge systems and beliefs. However, as Behrendt states [18], Aboriginal and Torres Strait Islander peoples share a history of government dispossession and genocide which has influenced the collective psyche. For example, the government sanctioned forced removal of children from their families between 1910 and 1970, known as the "Stolen Generations", continues to adversely impact on Aboriginal and Torres Strait Islander peoples [19].

The northernmost 'Top End' of Australia's Northern Territory (NT), a remote sparsely populated and geographically large jurisdiction, offers a unique test case to explore the health professionals experience of cultural awareness training. Aboriginal people in the NT comprise 30% of the population, the highest proportion of any Australian state or territory [20]. The lifespan of people from remote parts of the NT is approximately 14 years less than the non-Indigenous population [21]. English is the language of the health system [22] however 60% of Aboriginal people in the NT speak one of the 100 Aboriginal languages spoken in the NT as their first language [23, 24]. At Royal Darwin Hospital (RDH), in the capital of the NT, 54% of patients identify as Aboriginal and most healthcare providers identify as non-Indigenous. Often they are from southern parts of Australia or overseas; 30% of Australia's medical practitioners are trained overseas, the majority being from India, England and New Zealand. On commencing work in the NT, new staff may experience culture shock, or even "a sense of 'hopelessness", as they are often unprepared for the unique medical and complex cultural environment [22, 25]. To assist in this regard, healthcare providers are offered Aboriginal cultural awareness training. However, a previous study at RDH found staff appreciated cultural awareness training but were dissatisfied with its scope which failed to address racism (unconscious and institutional) [25].

The theories behind cultural education have been extensively explored by scholars [26] however there is a paucity of Australian-specific evidence regarding the practical educational strategies which are effective in improving quality of care for Aboriginal and Torres Strait Islander Australians [22, 27, 28]. There are some who argue that all forms of cross-cultural education should be discontinued until there is evidence it is necessary [26]. However, the lack of evidence may be attributable to the difficulties associated with connecting the impact of training to improvement in service due to the range of variables that determine patient outcomes. The infancy of this field is also apparent through the lack of consensus around terminology [3, 6, 29]. Terms such as cultural awareness, cultural competence and cultural safety (to name a few) have been used interchangeably. However, each are slightly different and some scholars argue these terms exist along a cultural continuum, indicated by the order above [2, 22, 27, 30], with cultural awareness at the beginning. For necessary context, a brief overview of terms is outlined. Cultural awareness training aims to educate non Aboriginal people about

aspects of Aboriginal beliefs and practices however cultural awareness training can reinforce negative stereotyping [1, 26, 31]; it has been likened to "going to a museum but then you go home" [22]. Cultural competence is more than awareness, it focuses on the capacity of the health system to integrate culture into the delivery of health services [29]. Cultural competency interventions have been found to improve client/practitioner relationships which consequently increased health service access [32]. In contrast to cultural awareness and competency, cultural safety is more challenging as it requires critical examination of the self and the broader health system [29]. While some argue cultural safety is part of a continuum of learning (awareness, then competence, then safety) we subscribe to the idea that cultural safety actually requires a "paradigm shift" [33]. Cultural safety is embedded in critical theory and social justice concepts, it requires hegemonic individuals and organisations to self-reflect and critique the power structures which contribute to maintaining health inequities [6, 34]. Overall scholars agree that further research is required to explore the impact of cultural education on clinical practice and racially-based healthcare disparities [32]. In the meantime, cultural awareness training continues to be developed and delivered by health organisations.

This research is embedded in the 'Communicate' study [35]. We are working with Aboriginal health service users, Aboriginal interpreters and medical professionals to explore options to address the intercultural communication barriers between health providers and Aboriginal patients in the Top End. Poor patient-provider communication adversely impacts on the delivery of equitable care [6] and has been identified as one of the most common ways clients experience racism in the health setting [36]. Communication is shaped by unconscious ideas which can be difficult to acknowledge and control, including stereotypes and negative attitudes which contribute to racial/ethnic disparities [37]. A contributing factor to negative stereotyping is a lack of cultural knowledge. Research from North America, Australia and New Zealand found that well intentioned cultural awareness training, focusing on Aboriginal cultures with little consideration of the broader health service and dominant culture, does little to address the health inequities experienced by racial and ethnic minorities [26–28, 31]. Assessing the impact of cultural awareness training on patient outcomes is difficult to track. For this reason, the aim of this research was to assess the health care professionals' (clinical and non-clinical) perceptions of cultural awareness training after attendance, to identify strengths and weaknesses and the potential for expansion according to workforce needs. To the best of our knowledge this is the first time such research has been undertaken in this jurisdiction.

Methods

Study setting and context

In the tropical far north of Australia, the Top End Health Service (TEHS) manages three hospitals: RDH, Katherine and Gove Hospital, and 57 remote health clinics. TEHS provides over 100,000 episodes of inpatient care annually and employs approximately 4260 full time equivalent staff [38]. During the study period, TEHS offered a one-day (7 hours), face-to-face Aboriginal Cultural Awareness Program (ACAP) which was delivered by one trainer from the NT Department of Health. The trainer (second author) NL resides in Darwin and her family come from Gurindji country or what is now referred to as the Victoria River area of the NT. When NL was unavailable, the course was delivered by another experienced cultural educator (a member of the Muran clan) with family connections through north western Arnhem Land and Kakadu in the NT. A TEHS Key Performance Indicator states 100% of staff must have participated in cultural awareness training before June 2017 [39]. By September 2018, approximately 30% of staff had completed the training [40]. Cultural awareness training became mandatory for all new staff in 2018 [41] however existing staff do not have protected time, away from existing duties, to attend training during work hours.

In addition to the full day ACAP, some TEHS employees deliver cultural education including an abridged two-hour ACAP session [39]. This paper only reports on the evaluation of the full day face to face ACAP training.

Design

Our research is shaped by the philosophical underpinnings of cultural safety which recognises that the onus for change resides with hegemonic individuals and institutions [2]. Healthcare providers, who critically reflect on the culture of the health care system, and their position within the system, are well placed to advocate for change from the inside [22]. This aligns with the philosophical approach of community development practitioners who theorise that for sustainable positive change to occur the institutions and values, which perpetuate entrenched inequalities, must change [42]. The research was also influenced by decolonising principles [43, 44]: NL's (second author) lived experience as an Aboriginal health care user, a patient escort and a cultural educator, contributed to the data collection, analysis and discussion.

One day face-to-face ACAP sessions were delivered between March and October 2018. The ACAP covers

the five workshop themes commonly canvassed in cultural awareness workshops in North America and Oceania: interaction approaches (communication), belief systems, historical matters, discrimination and organisational issues [26]. Training priorities are guided by the lived experience of cultural educators, the Ottawa Charter for Health Promotion [45] and various NT government reports including the NT Department of Health Strategic Plan which aims to "improve Aboriginal health outcomes" and "build a highly skilled and culturally responsive workforce" [46] to meet community needs.

Data and analyses

A mixed methods approach was used to collect and analyse data. Anonymous evaluation forms were completed by participants at the conclusion of each training session. Feedback was entered into an excel spreadsheet by NL for analysis and the de-identified data collated for each training session was provided to the auditor (VK) for analysis.

Quantitative data

Using a five-point Likert scale, participants ranked the quality of training in five key domains: introduction to culture; introduction to language, communication and working with interpreters; introduction to kinship system; concept of Aboriginal well-being; and Indigenous history. A final score out of 35 was generated. The mean score (out of a maximum 5 points) assigned for each of the seven topic areas was calculated, as was the overall summary score for the course (out of a maximum 35 points).

Qualitative data

Qualitative (free-text) options were included in the form to allow participants to provide feedback including suggested topics for future training. The Framework Method, commonly used in health research and well suited to the thematic analysis of data sets which cover similar issues [47], was used to analyse data. Initial coding using NVIVO 12 software was conducted by VK. Themes were refined through an iterative process with VK, NL, MH and AR. As the Framework Method can be applied to various methodological approaches we also drew on phenomenological methods to code "significant statements" [48]. Statements are presented as direct quotes to ensure participant experience is accurately portrayed.

Finally, Kirkpatrick's training evaluation model [49] was chosen as the appropriate explanatory framework to assess and interpret results in the discussion. Kirkpatrick's model evaluates training across four levels: 1) learner reactions; 2) learning; 3) on the job behavior change and; 4) observable organisational results [50].

Results

Participation

Six hundred twenty-one TEHS staff from Darwin, Katherine and Gove attended 27 ACAP sessions from March to October 2018. Demographic details such as age/gender/ethnicity/professional discipline were not collected on evaluation forms however some participants shared such information in free text comments. Participants included: experienced health professionals plus new recruits; Indigenous and non-Indigenous healthcare providers from Darwin, other regions of Australia and international healthcare graduates.

Ranking of teaching domains

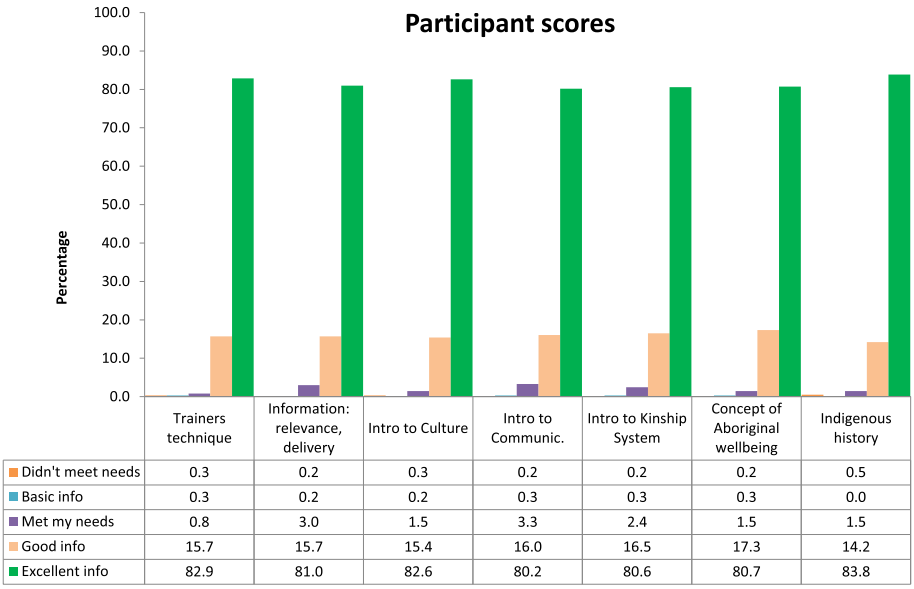
Five hundred ninety-six evaluation forms were collected (completion rate 96.0%). The mean overall assessment score provided by participants for the 27 ACAP sessions was 34 points (standard deviation 1.0, range 31-35). Scores across the seven individual topic areas were all high (Figure 1) which revealed the training provided good to excellent information across all topics. Considering the high numerical scores with largely consistent responses across all domains, the authors decided to concentrate analysis on the free text which provided a richer and more diverse data source.

Thematic analyses

Six hundred eighty-three free text comments which varied in length from single word answers to a 74-word paragraph were analysed. An evaluation of learner reactions revealed participants were satisfied with the ACAP describing the course as *"vitally important"* and stating training should be mandatory for NT government employees. One participant had "*completed over 100 hours [of] cultural training*" and stated that "*this was the first strengths-based presentation"*. Presenters were praised for their engaged and *"passionate*" approach with one participant exclaiming: *"this is the best ACAP I have attended in 44 years working in the health system"*. Teaching resources including PowerPoint presentations and videos were valued. The following quotes indicate participants from different cultural backgrounds acknowledged lessons learned:

> *"A very interesting day of learning Aboriginal culture. Even for an Indigenous person my eyes have been opened to so much I did not know."* – Participant feedback

> *"So helpful. I am a kiwi, relatively ignorant- I feel more informed but astounded this is the circumstances in Australia."* – Participant feedback



	Trainers technique	Information: relevance, delivery	Intro to Culture	Intro to Communic.	Intro to Kinship System	Concept of Aboriginal wellbeing	Indigenous history
Didn't meet needs	0.3	0.2	0.3	0.2	0.2	0.2	0.5
Basic info	0.3	0.2	0.2	0.3	0.3	0.3	0.0
Met my needs	0.8	3.0	1.5	3.3	2.4	1.5	1.5
Good info	15.7	15.7	15.4	16.0	16.5	17.3	14.2
Excellent info	82.9	81.0	82.6	80.2	80.6	80.7	83.8

Fig. 1 Participant rating of Aboriginal Cultural Awareness Program training day

Only one comment stated the training was extraneous: *"waste of my time and hospital resources"*. Other complaints referred to lack of tea and coffee making facilities and training logistics including course duration and location.

The three key findings were: 1) participants expressed a desire for more cultural education; 2) designed and delivered by local people; 3) which provides an opportunity to consciously explore both Aboriginal and non-Aboriginal cultures (including self-reflection). As the request to expand cultural education was multifaceted, we identified four major areas requiring specific attention: communication, kinship, history and professional relevance.

More cultural education*: "How can I do more?"* Learning about and understanding Aboriginal culture was recognised as *"a continual learning process for staff"*. Many participants stated too much information was delivered in one day and requested the training be expanded to avoid feeling overwhelmed, and to create opportunities for discussion and self-reflection. Suggestions included delivering the training over two days, follow-up training every three to six months, and online modules to refresh learning, including videos which portray common clinical scenarios.

> *"For a person who comes from the south*, this education needs to be more in depth to ensure that I/we are better culturally* (sic) *and ensure that nurses like me can serve the community in the best way at all times of care."* – Participant feedback (*south refers to southern Australian states, where the proportion of Aboriginal and Torres Strait Islander people is lower and the cultural context different).

The four areas requiring further training will be explored below:

Communication: Intercultural communication training was identified as the greatest area of need. More in-depth training on working with Aboriginal interpreters was requested, as well as practical advice on how to communicate, verbally and non-verbally, in the clinical setting if an interpreter was unavailable.

> *"Communication methods, socially acceptable behaviours, more understanding of cultural norms that can affect clinical practice e.g. male and female interaction rules."* – Participant feedback

Participants were also interested in learning key phrases or greetings from commonly spoken Aboriginal languages in the region. At Gove District Hospital, where patients mostly speak Yolŋu Matha, staff requested lessons in relevant dialects. Participants valued new knowledge around how commonly used terms in medicine may be misinterpreted. For example, the word "deadly" is often used by Aboriginal peoples to mean fantastic, not fatal.

Kinship: An overview of the Aboriginal kinship system was appreciated with some participants stating the lessons learned can be applied to clinical work. However due to the complexity of kinship, many found information was *"overwhelming"* and *"difficult to follow"*. A stand-alone course on the structure and responsibilities

of social relationships was requested so healthcare providers can better understand *"why we must do things"* when working with Aboriginal patients.

History: The importance of understanding the history of colonised Australia was recognised and more information about the Stolen Generations was requested. Teachings on history were considered vital by those indicating they had recently arrived in Australia and also Australian-born health professionals.

> *"Indigenous history: quite confronting, we don't learn about this in school"* –Participant feedback

Relevant to health profession: Some non-clinical staff suggested training could be reduced to a half day, or less, for non-clinicians. Health professionals with patient contact requested service specific information. How to gain informed consent, including identifying the appropriate guardian for a child, was repeatedly mentioned as an area of concern. Practical advice on how to verify the identity of patients unaware of their date of birth was also requested. Clinicians sought more training applicable to their specialties: emergency department, palliative care, midwifery, drug and alcohol, renal, mental health and paediatrics.

> *"I would love to learn more about Aboriginal and Torres Strait Island culture if there was also a specific discipline presentation, for example 'Cultural Awareness for Aboriginal and Torres Strait Islanders in Maternity'"* – Participant feedback

Designed and delivered by local people: *"Great use of personal stories"* An abundance of appreciative feedback related to the personal stories and *"real life anecdotes"* shared by trainers. The personal stories elevated the *"Aboriginal person's experience"* creating an opportunity for participants to empathise and thereby relate learnings to clinical work.

> *"Enjoyed* (trainer's name) *personal stories related to their experiences as an Aboriginal person navigating the 'western' system."* – Participant feedback

Local information relating to the NT was new information for many. Site specific information about working with, and the pressures faced by, Aboriginal Liaison Officers (ALO) and Aboriginal Health Practitioners (AHP) in the Top End was also beneficial.

> *"Didn't realise strain load on ALOs and AHPs within the hospital system"* – Participant feedback

Culture: *"Would be great to meet some local Elders to share local issues"* A desire to learn more about the diversity of Aboriginal communities through interactions with Elders and emerging leaders was also expressed. The need for more education about Aboriginal concepts of wellbeing and cultural practices, including the use of bush medicine and traditional healers and how that may intersect with hospital care, was a recognised knowledge gap. Participants expressed a desire to know more about men's and women's business; sorry business protocols; ceremonies; tribal law and payback. Participants reasoned that if health professionals had a better understanding of cultural obligations, they may be able to reduce the number of patients who "take their own leave" from hospital.

> *"Sorry business protocols - Relevant to patients taking their own leave* [from] *hospital."* – Participant feedback

Cultural safety training to address unconscious bias and institutional racism was also requested. Participants noted the need to reflect on their own cultural background, privilege and power:

> *"A session about our own concept of culture i.e. we have 'culture' and this affects our response to other cultures."* -Participant feedback

Discussion

This study builds on previous research identifying the need to improve cultural awareness training [25, 51] because health professionals need "to have a degree of knowledge and understanding of other cultures" [6]. As a result of low ACAP attendance, assumptions exist that healthcare providers do not value the training but we found those who attend recognise cultural awareness is an important foundation. The discussion will be divided into two parts. Firstly, Kirkpatrick's evaluation model will be used as a framework to interpret findings, and secondly, options to expand cultural education will be explored.

ACAP evaluated according to Kirkpatrick's model

Level 1: Reaction

Most participants enjoyed the training as indicated by the high numerical scores displayed in Figure 1 and the free text comments outlined. We assert a major contributor to the positive feedback was due to the trainer's enhancing the set curriculum with personal stories as users of the health service and active members of the local community. We recognize this as a strength of the training, discussed in more detail below.

Level 2: Learning

Learning about the historical determinants of health relating to Aboriginal peoples in the Northern Territory and Australia was a revelation to both Australian and overseas educated participants. Participants appreciated knowledge which related to the clinical setting: insights into how the kinship system may impact patient care and learning Aboriginal English [52] terms such as "deadly" was valued. Top End specific information about the role of ALO's and AHP's who juggle cultural obligations alongside incompatible expectations of non-Indigenous colleagues often in the face of discrimination, lack of professional support and chronic illness [53, 54] was considered valuable.

Level 3: On the job behaviour change

Due to the nature of the evaluation it was impossible to assess if the ACAP resulted in behavior change however from the data we can surmise that health professionals aspire to transfer learnings to the workplace especially if training is expanded.

Level 4: Observable organisational results

The authors determined evaluating level 4 is beyond the scope of this data. Kirkpatrick states, it is "difficult, if not impossible" to evaluate the impact of training on an organisation due to an inability to separate the variables which could be attributed to training or other factors [49]. Researchers working on the aforementioned 'Communicate' study [35] are undertaking projects which may address outstanding questions regarding the impact of cultural education on service delivery, staff turnover and operational costs.

Expanding cultural education for workforce needs

Aligning with previous research [55], participants recognised that insufficient cultural education is a barrier to providing culturally appropriate care. Disrespectful communication coupled with institutionalised racism and collective past experience, can result in an individual or family being unwilling to engage with a system they don't trust [39]. ACAP participants want more cultural education, designed and delivered by local people, which provides an opportunity to learn about Aboriginal cultures and critically explore the interface with non-Aboriginal cultures. Specific topics, which should be expanded to meet workforce needs were: communication, kinship and history. Participants were also adamant that training should be tailored to professions. The communication style of health professionals has previously been described as "an apparatus of colonisation" used to control Indigenous peoples [56]. Conversely, good interpersonal communication contributes to improved health outcomes, consumer engagement and adherence [51, 57]. Participants recognised that learning key phrases in local Aboriginal languages was an important component of building patient-provider rapport and may create a gateway to levelling out the power differential. Participants requested more in-depth information about kinship; however, this may be difficult for cultural educators because specific knowledge must be shared by "traditional knowledge holders" from the various Aboriginal nations [58]. However, understanding that kinship relationships impact on how Aboriginal people navigate the health system is crucial [59]. McBain-Rigg and Veitch assert that for some Aboriginal patients, health issues are framed in relation to family and community connections and the importance of personal relationships extends to encounters with health professionals. Patient- provider relationships based on trust and respect are a necessary part of good healthcare; yet for the health professional, trained to focus on task-based issues, this approach is an anomaly [59, 60]. This cultural difference needs to be understood by the health professional if they are to deliver culturally safe patient centred care. It is crucial health professionals, both Australian and overseas born, reflect on the history of colonisation to better understand the circumstances which lead to individuals requiring their service [22]. The impact of the 'Stolen Generation', for example, contributes to the ongoing impairment of the health and wellbeing of Aboriginal and Torres Strait Islander peoples [53]. Cultural safety advocates for the demystification of colonial history [2]. Finally, it was clear that a one size fits all approach to cultural awareness training should be reconsidered. Shepherd [26] argues training does little to assist the medical professional to practically address the "nuances typical of a cross cultural encounter" in the clinical setting. Recognising the complexities of the dynamic hospital environment, ACAP participants requested cultural education tailored to roles; doctors, nurses and allied health professionals need knowledge and skills specific to their clinical tasks [3]. Cultural education which inspires non-clinical staff to critically think about the structures in which they work is also imperative: service planners and policy makers have the power to create systems which support the delivery of culturally safe care.

The future of cultural education in the Top End

The concept of culture is central to cultural education [61]. Many healthcare users have a different worldview to the western biomedical approach which underpins mainstream healthcare delivery [32]. An awareness of differing worldviews [62, 63] and the ability to self-reflect on one's own culture and the broader culture of the healthcare system is required by the culturally safe health professional [64]. Training needs to expand

beyond the superficial "museum approach" [26] towards cultural safety which creates opportunities for health professionals to reflect on interpersonal power differences between provider and patient and also the policies and systems which contribute to inequities in health care [6]. Concordant with Curtis et al [6], this research revealed that health professionals recognise cultural competency does not have an endpoint but instead employees should be engaged repeatedly [65] as is the case with mandatory training including annual fire safety and biennial hand hygiene training. The 'one-shot' cultural awareness classroom-based training is unlikely to influence behaviour in clinical contexts as health professionals are better able to form new habits in situ through continuous practice [1]. In the high-pressure hospital environment, clinicians are "acutely aware of the constraints these environments have on skills gleaned from short professional development exercises" [26]. A communication training intervention delivered in a European hospital found doctors were able to quickly apply lessons learned and as a result, patient-centered care improved [66].

TEHS is working to rectify low attendance rates by exploring ways to redesign the delivery of cultural awareness training. In 2018, RDH made the full day face to face ACAP mandatory for all new staff [41]. Whilst upfront orientation prior to commencing work in a new location is vital, we contend if culturally safe patient-centered care is to be delivered, ongoing opportunities are required to address questions arising from clinical experiences. For example, after attending ACAP, experienced Top End health professionals expressed a desire to learn more about the social and cultural obligations of Aboriginal patients, including "sorry business" protocols. Greater understanding of such obligations and protocols may contribute to reduced self-discharge rates. Patients who discharge against medical advice (DAMA) from NT hospitals is a substantial problem and adverse outcomes include suspension of medical treatment, health costs to individuals, negative impacts on staff morale and high system costs [67]. Aboriginal patients are more likely to take their own leave from hospitals and this is viewed "as an indirect measure of cultural safety" as it indicates the extent to which hospitals are responsive to the needs of Aboriginal patients [68]. Further research is required to explore if a redeveloped cultural education package could improve cultural safety and reduce DAMA rates. This research may go some way to addressing Kirkpatrick's elusive level 4: observable organisational results.

We acknowledge employment of more health professionals who identify as Aboriginal would improve the delivery of culturally safe healthcare. There are 100,000 medical practitioners registered in Australia and 0.5% identify as Aboriginal or Torres Strait Islander [69]. It would be unfair to place the burden of improving health outcomes on Aboriginal health professionals alone [11, 22]. We believe it is the responsibility of the majority of the workforce to examine and adapt their practices to improve health outcomes of Aboriginal people [22]. The Australian healthcare workforce is dominated by non-Indigenous Australians and relies on overseas trained professionals [22]; 31.5% of medical practitioners gained qualifications overseas and from that cohort India were the largest group, followed by England and New Zealand [69]. Health professionals, Australian and internationally trained, who have had limited relations with Aboriginal people may bring preconceived stereotypes, often shaped by negative media reports, to their roles [30]. Negative stereotyping of Aboriginal patients has been identified by the NT Health Department as a contributor to "people feeling disrespected or not receiving the best care possible" [70]. The well-intentioned cultural awareness training commonly delivered in Australian hospitals can reinforce negative stereotypes [1, 31] as it may perpetuate "othering" of Aboriginal people. Instead, stereotypes associated with minorities (unconscious bias) may be addressed by providing counter stereotypical stimuli such as increasing opportunities for positive experiences [1] or engaging Aboriginal leaders to share "authentic stories with strong messages about the health needs of Aboriginal people" [71]. In this ACAP, the possibility of 'othering' was diminished by the Aboriginal trainer's emotive and relatable stories which expanded the set curriculum. The personal stories exposed differing ontologies and created an opportunity for the healthcare provider to examine their beliefs, position of power and the impact these may have on others [2]. In spite of funding constraints [72], opportunities to employ more cultural educators and to collaborate with Aboriginal Elders to document and share stories with staff to counter racialised assumptions and stimulate self-reflection should be explored. Regular reflexive learning circles in which health providers share experiences to troubleshoot common intercultural scenarios may be a worthwhile consideration. In a non-judgmental setting, with cultural educators as facilitators, actionable strategies coupled with personalised feedback regarding bias may result in attitude and behaviour change [65]. Research is required to evaluate cost savings that could be achieved by investing in cultural education to support the development of a culturally safe workforce.

Accommodating cultural education into the busy clinical schedule of healthcare providers, working in an under resourced health service, requires organisational flexibility and commitment. Options worthy of consideration include protected (paid) time during clinical placements or development of engaging after-hours opportunities. Incorporating cultural education into work hours signals it is valued by the organisation [61] and is not a symbolic

tick-box exercise [26]. It could also address the need for observable organisational results as noted by Kirkpatrick's Level 4 [49] including increasing attendance rates. Institutions which do not prioritise staff attendance at cultural education may be accused of institutional racism, whereas a culturally safe organization is committed to ensuring staff attend training [6]. Podcasts are recognised as useful tools in medical education as the flexible format can deliver "high yield information in a short time" [73, 74]. In contrast to video or online training, podcasts can easily be integrated into busy schedules. Considering the reliance on online training modules, it is relevant to note that audio has been found to be more effective than text based learning [75].

A potential limitation of this study is selection bias; those who attend a whole day ACAP may be more interested in cultural awareness than peers who do not attend. The auditor did not have access to the original evaluation forms; transcribing errors may have occurred between paper forms and the electronic database. However, data entry was completed by an NT Health Department employee experienced in data entry, so the risk of systematic error is low. We also recognise the findings of this project may not be generalisable to other health jurisdictions due to different social, cultural and historical contexts. We deliver this research with a cautionary note: whilst we have revealed opportunities to redevelop cultural training according to workforce needs, in order to meet community priorities all cultural education must be developed in consultation with Aboriginal educators and community leaders.

Conclusion

Cultural awareness training is a phenomenon, which continues to be developed and delivered by health organisations despite the extensive academic critiques. Our research found the ACAP delivered to Top End healthcare providers is an invaluable entry point revealing important information which stimulates further enquiry. We assert a key reason participants valued this training was because of the authentic personal stories shared by local Aboriginal educators. Healthcare providers require ongoing cultural education, localised to the region where they are working, which can be applied to the clinical environment. It is crucial the education creates opportunities to address unconscious bias and institutional racism through critical self-reflection. A suite of initiatives, including engaging relevant cultural education, are required to improve the delivery of culturally safe care for Aboriginal and Torres Strait Islander healthcare users. Further research is required to examine cost effective ways to expand cultural education which addresses the needs of staff, the organization, the patient and their family.

Abbreaviations

ALO: Aboriginal Liaison Officer; AHP: Aboriginal Health Practitioner; ACAP: Aboriginal Cultural Awareness Program; DAMA: Discharge Against Medical Advice; NT: Northern Territory; RDH: Royal Darwin Hospital; TEHS: Top End Health Service

Acknowledgements

The authors would like to thank the (second, unnamed) cultural awareness trainer and all workshop participants. We also thank Katarina Hamberg from Umeå University and anonymous reviewers for their constructive comments and suggestions.

Authors' contributions

VK, NL and AR conceived the evaluation. VK conducted the analysis. VK and NL developed the discussion. VK drafted the manuscript with input from AR. All authors, VK, NL, AC, MH and AR contributed to study design, manuscript revisions, read and approved the final transcript.

Funding

Vicki Kerrigan is supported by an Australian Government Research Training Program Scholarship and Improving Health Outcomes in the Tropical North: A multidisciplinary collaboration (HOT NORTH)', grant identification number 1131932. Anna P Ralph is supported by an NHMRC fellowship 1142011. Funders had no role in the design of the study, collection, analysis, and interpretation of data and in writing the manuscript.

Availability of data and materials

The data that support the findings of this study are the property of the Northern Territory Department of Health; restrictions apply to the availability of these data, which were used under license for the current study. Data are however available from the authors upon reasonable request and with permission of NT Department of Health.

Ethics approval and consent to participate

Approval was provided by the NT Department of Health and Menzies School of Health Research Ethics Committee *(HREC-2017-3007)*. The need for participant consent was waived since forms were deidentified and audited retrospectively.

Consent for publication

Not applicable

Competing interests

At the time of writing, Nicole Lewis was employed as the Aboriginal Cultural Awareness Coordinator by the Northern Territory Department of Health. Alan Cass was a Board Director for Top End Health Service from 2015 until June 2017. No competing interests were declared by other authors.

Author details

[1]Menzies School of Health Research, Charles Darwin University, PO Box 41096, Casuarina, Northern Territory 0811, Australia. [2]Department of Health, Northern Territory Government, GPO Box 2391, Darwin, NT 0801, Australia. [3]Royal Darwin Hospital, Darwin, Northern Territory 0811, Australia.

Received: 7 February 2020 Accepted: 21 May 2020
Published online: 29 May 2020

References

1. Byrne A, Tanesini A. Instilling new habits: addressing implicit bias in healthcare professionals. Adv Health Sci Educ Theory Pract. 2015;20(5):1255–62.
2. Ramsden IM. Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu. Wellington: Victoria University of Wellington; 2002.
3. Paradies Y, Truong M, Priest N. A systematic review of the extent and measurement of healthcare provider racism. J Gen Intern Med. 2014;29(2):364–87.
4. Jull J, Giles A, Boyer Y, Lodge M, Stacey D. Shared decision making with Aboriginal women facing health decisions AlterNative: An International Journal of Indigenous Peoples. 2015;11(4):401-416.
5. Paradies Y. Colonisation, racism and indigenous health. J Popul Res. 2016;33(1):83–96.

6. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health. 2019;18(1):174.
7. Bond C. Slice of LIME Seminar 9.3: 'Outing' Unconcious Bias LIME Network; 3rd September; 2018.
8. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: Overview: Guide to better care for Aboriginal and Torres Strait Islander communities; 2016.
9. Toussaint S. Climate Change, Global Warming and Too Much Sorry Business. Australian J Anthropol. 2008;19(1):84–8.
10. Carlson B, Frazer R. "It's like Going to a Cemetery and Lighting a Candle": Aboriginal Australians, Sorry Business and social media. AlterNative: An International Journal of Indigenous Peoples. 2015;11(3):211-224.
11. Chong A, Renhard R, Wilson G, Willis J, Clarke A. Improving cultural sensitivity to Indigenous people in Australian hospitals. A continuous quality improvement approach. Focus Health Prof Educ. 2011;13(1):84–97.
12. Skinner T, Blick J, Coffin J, Dudgeon P, Forrest S, Morrison D. Comparative validation of self-report measures of negative attitudes towards Aboriginal and Torres Strait Islanders. Int Electron J Rural Remote Health Res Educ Pract Policy. 2013;13:1–9.
13. NT Coroner Court. Inquest into the death of Kristelle Ruby Mulladad aka Oliver [2010] NTMC 64. In: Findings of Mr Greg Cavanagh: Alice Springs; 2010.
14. NT Coroner Court. Inquest into the death of Henry George Wilson aka Albert George Wilson [2018] NTLC 022. In: Findings of Judge Greg Cavanagh: Darwin, Northern Territory; 2018.
15. Mitchell A, Lowell A, Ralph A. Report on the Patient Educator service at Royal Darwin Hospital, 2001-2009: insights into inter-cultural communication in healthcare: Research gate; 2016.
16. ABC News. Low use of Indigenous interpreters at Royal Darwin Hospital putting patients at risk, researchers say 20th July 2019 [Available from: https://www.abc.net.au/news/2019-07-20/indigenous-language-interpreters-hospital-patients-at-risk/11326876.
17. Lowell A, Maypilama E, Yikaniwuy S, Rrapa E, Williams R, Dunn S. "Hiding the story": Indigenous consumer concerns about communication related to chronic disease in one remote region of Australia. Int J Speech Lang Pathol. 2012;14(3):200–8.
18. Behrendt L. Cultural Conflict in Colonial Legal Systems: An Australian Perspective. In: Bell C, editor. Intercultural Dispute Resolution in Aboriginal Contexts. Vancouver: UBC Press; 2004. p. 116–27.
19. Common Ground. The Stolen Generations: Common Ground First Nations; 2020 [Available from: https://www.commonground.org.au/learn/the-stolen-generations.
20. Australian Bureau of Statistics. Estimates of Aboriginal and Torres Strait Islander Australians 2018 [Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001.
21. Australian Bureau of Statistics. Aboriginal and Torres Strait Islander life expectancy lowest in remote and very remote areas 2019 [Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3302.0.55.003~2015-2017~Media%20Release~Life%20expectancy%20lowest%20in%20remote%20and%20very%20remote%20areas%20(Media%20Release)~15.
22. Taylor K. In: Guerin P, editor. Health care and Indigenous Australians : cultural safety in practice. 2nd ed. South Yarra, Vic.: South Yarra, Vic: Palgrave Macmillan; 2014.
23. Australian Bureau of Statistics. Main language spoken at home and English proficiency 2018 [Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2076.0Main%20Features1012016?opendocument&tabname=Summary&prodno=2076.0&issue=2016&num=&view.
24. Northern Territory Government. Aboriginal languages in NT 2018 [Available from: https://nt.gov.au/community/interpreting-and-translating-services/aboriginal-interpreter-service/aboriginal-languages-in-nt.
25. Ralph AP, Lowell A, Murphy J, Dias T, Butler D, Spain B, et al. Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory. BMC Health Serv Res. 2017;17(1):733.
26. Shepherd SM. Cultural awareness workshops: limitations and practical consequences.(Report). BMC Med Educ. 2019;19(1).
27. Bainbridge R, McCalman J, Clifford A, Tsey K. Cultural competency in the delivery of health services for Indigenous people. Canberra: Australian Institute of Health and Welfare and Australian Institute of Family Studies; 2015.
28. Downing R, Kowal E, Paradies Y. Indigenous cultural training for health workers in Australia. Int J Qual Health Care. 2011;23(3):247–57.
29. Jongen C, McCalman J, Bainbridge R, Clifford A. Cultural Competence in Health. A review of the Evidence: Springer; 2018.
30. Coffin J. Rising to the Challenge in Aboriginal Health by Creating Cultural Security. Aboriginal Isl Health Worker J. 2007;31(3):22–4.
31. Doutrich D, Arcus K, Dekker L, Spuck J, Pollock-Robinson C. Cultural Safety in New Zealand and the United States:Looking at a Way Forward Together. J Transcult Nurs. 2012;23(2):143–50.
32. McCalman J, Jongen C, Bainbridge R. Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. Int J Equity Health. 2017;16(1):1–19.
33. Brascoupé S, Waters CM. Cultural Safety Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness. J Aborig Health. 2009;5(2):6–41.
34. Curtis E. Slice of LIME 12.2: LIME Connection VIII - Why Cultural Safety rather than Cultural Competency is Required to Achieve Health Equity Christchurch, New Zealand: University of Otago; 26 February 2020.
35. Menzies School of Health Research. The Communicate study (Stages 1 and 2) 2018 [Available from: https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/The_communicate_study_stages_1_and_2/.
36. Jennings W, Bond C, Hill PS. The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication. Aust J Prim Health. 2018.
37. Hall WJ, Chapman MV, Lee KM, Merino YM, Thomas TW, Payne BK, Eng E, Day SH, Coyne-Beasley T. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Am J Public Health. 2015;105(12).
38. Northern Territory Government. Candidate Information Pack, Chief Operating Officer, Top End Health Service. In: Hardy Group, editor. Darwin, Northern Territory. 2018.
39. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: User Guide for Aboriginal and Torres Strait Islander Health; 2017.
40. Daly S. A/Consumer and Cultural Consultant RDH, Top End Health Service. In: Kerrigan V, editor. Text message regarding ACAP completion numbers; 2018.
41. Williams J, Haste M, Williams M, Kangaharan N. Improving Aboriginal and Torres Strait Islander Patient Care: Royal Darwin Hospital – Coronary Care Unit. In: Reducing Discharge Against Medical Advice. Lighthouse Hospital Project National Forum. Melbourne: National Heart Foundation of Australia; 2019.
42. Kenny S. Developing Communities for the Future. 4th ed. Sydney: Cengage Learning; 2011.
43. Flood A. Understanding phenomenology. Nurs Res (through 2013). 2010;17(2):7–15.
44. Smith LT. Decolonizing methodologies: research and indigenous peoples. Second edition. ed. Proquest Ebook C, editor. London: Zed Books: distributed in the USA exclusively by Palgrave Macmillan; 2012.
45. World Health Organisation. Ottawa Charter for Health Promotion: First International Conference on Health Promotion: Ottawa; 1986.
46. Northern Territory Government. Northern Territory Health Strategic Plan 2014-2017 Darwin, Northern Territory, 2014.
47. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Methodol. 2013;13(1):117.
48. Creswell JW. In: Poth CN, editor. Qualitative inquiry & research design : choosing among five approaches. 4th ed. Los Angeles: SAGE; 2018.
49. Kirkpatrick D. Great Ideas Revisited. Techniques for Evaluating Training Programs. Revisiting Kirkpatrick's Four-Level Model. Training and Development. 1996;50(1):54.
50. Shelton S, Alliger G. Who's afraid of Level 4 evaluation? A practical approach. Train Dev. 1993;47(6):43.
51. Cass A, Lowell A, Christie M, Snelling PL, Flack M, Marrnganyin B, et al. Sharing True Stories Improving communication between Aboriginal patients and healthcare workers. Med J Aust. 2002;176(10):466–70.
52. Eades D. Aboriginal ways of using English: Canberra Aboriginal Studies Press; 2013.
53. Conway J, Tsourtos G, Lawn S. The barriers and facilitators that indigenous health workers experience in their workplace and communities in providing self-management support: a multiple case study. BMC Health Serv Res. 2017;17(1):319.
54. Topp SM, Edelman A, Taylor S. "We are everything to everyone": a systematic review of factors influencing the accountability relationships of

Aboriginal and Torres Strait Islander health workers (AHWs) in the Australian health system. Int J Equity Health. 2018;17(1):67.
55. Liaw ST, Hasan I, Wade V, Canalese R, Kelaher M, Lau P, et al. Improving cultural respect to improve Aboriginal health in general practice: A multi-methods and multi-perspective pragmatic study. Australian Fam Physician. 2015;44(6):387–92.
56. Eckermann A-K, Goonj B. Bridging cultures in Aboriginal health. 3rd ed. Sydney: Churchill Livingstone; 2010.
57. Australian Commission on Safety and Quality in Health Care. Health Literacy Taking action to improve safety and quality: Sydney; 2014.
58. Riley L, Howard-Wagner D, Mooney J. Kinship Online: Engaging "Cultural Praxis" in a Teaching and Learning Framework for Cultural Competence. Australian J Indigenous Educ. 2015;44(1):70.
59. McBain-Rigg KE, Veitch C. Cultural barriers to health care for Aboriginal and Torres Strait Islanders in Mount Isa. Australian J Rural Health. 2011;19(2):70–4.
60. Kelly J, Dowling A, McBride K, Keech W, Brown A. 'We get so task orientated at times that we forget the people': staff communication experiences when caring for Aboriginal cardiac patients. Australian Health Rev. 2020;44(1):1–6.
61. Parmenter J, Trigger D. Aboriginal cultural awareness training for mine employees: Good intentions, complicated outcomes. Extractive Ind Soc. 2018;5(2):363–70.
62. Lincoln YS, Guba EG. Paradigmatic controversies, contradictions, and emerging confluences. In: Denzin NK, Lincoln YS, editors. Handbook of qualitative research. 2nd ed. Thousand Oaks: Sage; 2000. p. 163–88.
63. Guba EG, Lincoln YS. Competing paradigms in qualitative research. In: Lincoln NKDYS, editor. Handbook of qualitative research. Thousand Oaks: Sage; 1994. p. 105–17.
64. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res. 2014;14(99):1–17.
65. Chang EH, Milkman KL, Gromet DM, Rebele RW, Massey C, Duckworth AL, et al. The mixed effects of online diversity training. Proc Natl Acad Sci. 2019; 116(16):7778–83.
66. Maatouk-Burmann B, Ringel N, Spang J, Weiss C, Moltner A, Riemann U, et al. Improving patient-centered communication: Results of a randomized controlled trial. Patient Educ Couns. 2016;99(1):117–24.
67. Henry B, Dunbar T, Barclay L, Thompson R. Self-discharge against medical advice from Northern Territory Hospitals. In: Prevalence rates, experiences and suggestions, economic implications and recommended strategies for improvement. A report prepared for the Department of Health and Community Services. Charles Darwin University and the Cooperative Research Centre for Aboriginal Health; 2007.
68. Australian Institute of Health and Welfare. Cultural safety in health care: monitoring framework. Canberra: AIHW; 2019.
69. Australian Institute of Health and Welfare. Medical practitioners workforce 2015 2016 [Available from: https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015/contents/who-are-medical-practitioners.
70. Northern Territory Department of Health. NT Health Aboriginal Cultural Security Framework 2016-2026. Darwin; 2016. p. 1–40.
71. Northern Territory Government, Top End Health Service. Improving TEHS Culture. Organisational Culture Assessment. Darwin: Summary Report; 2016.
72. ABC News. NT Health blowouts review kept under wraps, despite economic crisis 2019 [Available from: https://www.abc.net.au/news/2019-04-02/budget-blowouts-kpmg-review-nt-health-john-langoulant/10958902.
73. Prakash SS, Muthuraman N, Anand R. Short-duration podcasts as a supplementary learning tool: Perceptions of medical students and impact on assessment performance. BMC Med Educ. 2017;17(1):1–14.
74. Scott KM, Nerminathan A, Alexander S, Phelps M, Harrison A. Using Mobile Devices for Learning in Clinical Settings: A Mixed-Methods Study of Medical Student, Physician and Patient Perspectives. Br J Educ Technol. 2017;48(1): 176–90.
75. Catherine S-B, Karen MS, Lucy T, Giuseppe C, Steve C. The value of using short-format podcasts to enhance learning and teaching. Res Learn Technol. 2009;17(3).

Publisher's Note

CHAPTER FOUR

From “stuck” to satisfied: Aboriginal people’s experience of culturally safe care with interpreters in a northern territory hospital

Publication: Kerrigan V, McGrath SY, Majoni SW, Walker M, Ahmat M, Lee B, Cass A, Hefler M, Ralph AP. From “stuck” to satisfied: Aboriginal people’s experience of culturally safe care with interpreters in a Northern Territory hospital. BMC Health Services Research. 2021 Dec;21(1):1-3.

BMC Health Services Research

RESEARCH ARTICLE Open Access

From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital

Vicki Kerrigan[1*], Stuart Yiwarr McGrath[1], Sandawana William Majoni[1,2,3], Michelle Walker[4], Mandy Ahmat[4], Bilawara Lee[5], Alan Cass[1], Marita Hefler[1] and Anna P. Ralph[1,2]

Abstract

Background: Globally, interpreters are underused by health providers in hospitals, despite 40 years of evidence documenting benefits to both patients and providers. At Royal Darwin Hospital, in Australia's Northern Territory, 60-90% of patients are Aboriginal, and 60% speak an Aboriginal language, but only approximately 17% access an interpreter. Recognising this system failure, the NT Aboriginal Interpreter Service and Royal Darwin Hospital piloted a new model with interpreters embedded in a renal team during medical ward rounds for 4 weeks in 2019.

Methods: This research was embedded in a larger Participatory Action Research study examining cultural safety and communication at Royal Darwin Hospital. Six Aboriginal language speaking patients (five Yolŋu and one Tiwi), three non-Indigenous doctors and five Aboriginal interpreter staff were purposefully sampled. Data sources included participant interviews conducted in either the patient's language or English, researcher field notes from shadowing doctors, doctors' reflective journals, interpreter job logs and patient language lists. Inductive narrative analysis, guided by critical theory and Aboriginal knowledges, was conducted.

Results: The hospital experience of Yolŋu and Tiwi participants was transformed through consistent access to interpreters who enabled patients to express their clinical and non-clinical needs. Aboriginal language-speaking patients experienced a transformation to culturally safe care. After initially reporting feeling "stuck" and disempowered when forced to communicate in English, participants reported feeling satisfied with their care and empowered by consistent access to the trusted interpreters, who shared their culture and worldviews. Interpreters also enabled providers to listen to concerns and priorities expressed by patients, which resulted in holistic care to address social determinants of health. This improved patient trajectories and reduced self-discharge rates.

Conclusions: A culturally unsafe system which restricted people's ability to receive equitable healthcare in their first language was overturned by embedding interpreters in a renal medical team. This research is the first to demonstrate the importance of consistent interpreter use for providing culturally safe care for Aboriginal patients in Australia.

Keywords: Cultural safety, Patient, Health, Aboriginal, Interpreters, Communication

* Correspondence: vicki.kerrigan@menzies.edu.au
[1]Menzies School of Health Research, Charles Darwin University, PO Box 41096, Casuarina, Northern Territory 0811, Australia
Full list of author information is available at the end of the article

Introduction

Language is more than a communication tool; it is a pivotal aspect of culture which supports and strengthens Aboriginal and Torres Strait Islander people's health and wellbeing [1–4]. Paradoxically, Aboriginal language speakers in Australia who have stronger social capital from speaking their first language often have restricted engagement with, and limited access to, English speaking health services resulting in poorer health outcomes [5]. Australia's Northern Territory (NT) is one of the most linguistically diverse jurisdictions in the world [6]. Around 60% of the Aboriginal population speak one, or more, of dozens of Aboriginal languages as their first language [1, 6, 7]. The life expectancy of Aboriginal peoples in the NT is the lowest in Australia, around 15 years less than non-Indigenous people [8]. The prevalence of chronic diseases is also disproportionately high [9]. Research has found interpreters in health care improve patient outcomes [10], but in the NT interpreters are profoundly underused [11–13]. This is despite the formation of the NT Aboriginal Interpreter Service (AIS) in 2000 and literature spanning 40 years explaining the benefits of interpreters in healthcare. A 1979 federal government report stated "there is a desperate need" for interpreter services in NT hospitals, describing interpreters as a vital link in the communication chain between the "two nations" [14]. Unfortunately, since then culturally unsafe communication has continued contributing to growing suspicion and fear of health services, absence of informed consent and death [15–17]. Poor patient provider communication is also one of the most common ways patients experience racism [18–20]. Our previous research has found upwards of 50% of Aboriginal patients at Royal Darwin Hospital (RDH) would benefit from an interpreter, however currently an estimated 17% of patients get access [11]. Work to improve interpreter uptake at RDH, where most patients identify as Aboriginal, is underway however there remains considerable scope for improvement [11, 13].

This paper reports on a new model of Aboriginal interpreter use piloted at RDH in 2019. At the time of the pilot, RDH did not directly employ Aboriginal interpreters. Instead, depending on interpreter availability, the NT AIS provided one Aboriginal language interpreter to work at the hospital for 4 h every weekday morning. The 'rostered hospital interpreter' was not attached to a team or division but instead waited to be paged by a health provider [12]. These interpreters were underused and felt undervalued [12]. Additionally, Aboriginal interpreters could be booked with 24-48 h' notice. However, because NT AIS interpreters worked across a range of settings including legal and community services they were often unavailable to work in the hospital when required. Recognising these problems, the NT AIS and RDH piloted a model in which Aboriginal interpreters were embedded in a medical team for 4 weeks. This guaranteed interpreters were consistently available face-to-face every weekday during the morning medical ward round in which critical medical decision-making moments occur. The model provided an opportunity to explore the impact of Aboriginal interpreters in the hospital on the delivery of culturally safe care. Proponents of cultural safety argue patient outcomes will improve when health systems no longer diminish and demean an individual's cultural identity [21–27]. However in Australia, there is a dearth of evidence to demonstrate that culturally safe communication practices results in better patient outcomes [27, 28].

The aim of this paper is to present Aboriginal language speaking patient experiences and perspectives of hospital care when access to interpreter-mediated communication is consistent. The patient perspective provides a means to assess cultural safety, which by definition is determined by recipients of care [21]. Patient narratives are presented alongside stories from Aboriginal interpreters who share patients worldview and insights from non-Indigenous doctors regarding hegemonic thinking and systems. An in-depth examination of provider perspectives on the model will be presented separately (manuscript underway). The value of the approach presented here will inform the redesign of systems currently being explored by participating health and interpreter services.

Methods

Study design

This pilot study on Aboriginal interpreter-meditated communication at RDH is embedded in a larger Participatory Action Research (PAR) [29–31] project exploring the barriers and enablers to culturally safe communication at RDH [11, 12, 32, 33]. This PAR project entailed researchers and participants collaborating through a cycle of action and reflection to identify and address areas requiring transformation [29–31]. The theoretical framework was influenced by cultural safety [21] and critical race theory [34] which draws on Habermas' approach to critical theory [35, 36]. The framework avoids problematizing Aboriginal peoples [37] and promotes "counterstories" [34, 38] which challenge and displace the narratives and beliefs that maintain inequities in colonised Australia.

Researcher reflexivity

The lead author VK is an Australian born White researcher of Anglo-Celtic heritage; English is her first language. Reflecting on her White privilege [39–42] and capacity to assume what hooks refers to as the colonising role of the "privileged interpreter-cultural overseer"

[43], VK uses PAR to facilitate the collective production of knowledge [29] to prioritise subjugated voices and challenge the status quo [34]. The second author SYM is a Gumatj man from the Yolŋu nation; Djambarrpuyŋu, a dialect of Yolŋu Matha, is his first language. SYM is an Aboriginal Health Practitioner and researcher. Through the moral bonds of kinship which are expressed as responsibilities and obligations [44] SYM was related to Yolŋu participants.

Study setting

This pilot was a collaboration between Menzies School of Health Research, Top End Health Service (TEHS) and the NT AIS. TEHS manages RDH: a 360-bed tertiary referral hospital in the NT capital city, Darwin, on Larrakia country. The study was conducted in the RDH renal unit where approximately 90% of patients identify as Aboriginal. It was chosen due to the high percentage of Aboriginal patients and support from nephrologists. Due to unreliable language documentation at RDH [12, 45] the prevalence of Aboriginal languages spoken by renal patients was unknown. However, Djambarrpuyŋu, a dialect of Yolŋu Matha, is the most commonly spoken Aboriginal language in the region, with more than 4200 speakers from north-east Arnhem Land in the NT [1, 46]. For this reason, the NT AIS initially supplied a Yolŋu Matha interpreter to work alongside doctors. A Tiwi interpreter was also added after assessing the patient cohort. This supplemented the NT AIS on-demand interpreter service available at RDH as described above.

Participant sampling

A purposeful sampling strategy was used to identify key informants who, as per PAR, had a vested interest in the area of study and could provide "information rich cases" which exemplified dysfunction and exposed opportunities for change [29, 30, 47, 48]. Also consistent with PAR, some participants were researchers. Aboriginal patients were eligible if they spoke an Aboriginal language as their first language, were hospitalised for a minimum 5-day period and able to consent to participate. Doctors, interpreters and interpreter support staff were sampled based on their commitment to study aims and availability (work roster).

Data collection

Data sources for this study included interviews with patients, doctors and interpreters, researcher field notes, reflective journals by doctors, interpreter job logs and patient language lists. Semi-structured conversations with Yolŋu patients were conducted in Yolŋu Matha either by Yolŋu researcher SYM or by VK with an interpreter. Both SYM and the interpreters had perspectives on communication and health which aligned with those of patients [49] and relationships of accountability with patients through kinship [44]. These relationships ensured data was collected in a culturally safe manner [50]. Conversations were recorded at the hospital in the patients' preferred locations, either at the beside or in a private room. Patients were thanked for their participation with a hospital café voucher. Doctors and NT AIS staff were interviewed before and after the pilot at a location of their choice by VK in English. Doctors' journals and researcher field notes [47] documented participant experiences who consented to be observed only. Additionally, journals and notes were explored for contradictions and consistencies between patient, doctor and interpreter perspectives and used as a prompt for interviews.

With no reliable mechanism to document Aboriginal languages spoken by RDH patients [12, 45], participating doctors or NT AIS staff asked each patient: "what language do you speak at home?". This was recorded on patient lists and shared with VK who entered de-identified data into an excel spreadsheet. To document the frequency of patient-interpreter-provider interaction, each interaction was logged by interpreters on the paper-based interpreter job log sheet. Handwritten data were double entered into an electronic database (Microsoft Excel v2011), by VK and a project officer then cross checked by VK for accuracy.

Data analysis

Aligning with PAR's transformative goals [51], a critical theory [36] lens guided analysis which was undertaken by SYM and VK. Interviews recorded in English were transcribed verbatim. Patient conversations recorded in Yolŋu Matha were interpreted into English by SYM. Throughout translation, SYM reviewed and shared contextual explanations, referred to as "cultural intuition" [52], which gave further insights into Yolŋu worldviews regarding health. Using NVIVO12, VK conducted inductive narrative analysis [53] of English transcripts to identify key turning points in patient trajectories of care. These turning points, refined through discussion with co-authors, were reconstructed into a consolidated patient journey which drew on patient, health provider, interpreter and researcher data. Consistent with critical race theory, this process revealed "counterstories" [34] which formed the basis of the findings. Pseudonyms were assigned for participants except for the specialist doctor (co-author SWM: Dr. William) and the NT AIS trainer (co-author MA: Mandy) who, as per PAR methods [30], were both researcher and the researched, and are both identified in accordance with their wishes.

Ethical considerations

Pseudonyms derived from White first names have been used for the interpreters and patients who used their

White names during interactions with health providers. We acknowledge the use of such pseudonyms risks perpetuating White cultural dominance however, following advice from Aboriginal researchers, Yolŋu or Tiwi pseudonyms have not been used as it risks compromising the cultural integrity of skin names which indicate a person's bloodline and kinship obligations [54]. The term White is capitalised in line with Whiteness studies stemming from the sociological work of W.E.B Du Bois [55]. White does not refer to skin colour but instead refers to a social category which describes those who "participate in the racialized societal structure that positions them as "White" and accordingly grants them the privileges associated with the dominant Australian culture." [56] Regarding terminology, the nation or language group of Aboriginal participants will be used. Otherwise, the term Aboriginal, which refers to the original occupants of mainland Australia, will be used. Approval to conduct the study was provided by the Northern Territory Department of Health and Menzies School of Health Research Ethics Committee.

Findings

The interpreter ward round pilot occurred in the RDH renal department in 2019 during two periods: 14th to 27th of August (10 days) and 25th November to 3rd December (7 days). Differences in duration was due to NT AIS resourcing issues. Seventeen interviews were conducted before and after the pilot. Shadowing of doctors by VK and SYM occurred between the hours of 8 am to 2 pm for a total of 29 h across 7 non-consecutive days, during which 20 patient interactions with interpreters were observed. In the RDH renal ward during the pilot 84% of patients identified as Aboriginal, of whom 78% spoke one or more Aboriginal languages. Fifteen Aboriginal languages, of which 13 were from the NT, were counted: the most spoken languages were Yolŋu Matha and Tiwi. Other languages documented were: Kunwinjku, Anindilyakwa, Kriol, Burarra, Murrinh-Patha and Ngan'gikurunggurr, Warlpiri, Maung, Wurlaki, Ngarinyin (Western Australia), Garawa, Yumplatok (Torres Strait Creole, Queensland) and Ngaringman.

Six patients participated. Yolŋu patients Patricia, Linda and Sally consented to be interviewed. Yolŋu man Paul and Tiwi man Owen consented to observations only. Yolŋu Elder Matthew, identified as a key informant, was interviewed three times and interpreter mediated healthcare interactions with Matthew were observed on 5 of the 7 days of shadowing doctors. SYM interviewed Matthew twice (2 months apart) during the 2019 pilot. As per PAR, a third conversation with Matthew occurred 18 months after the pilot to verify findings. The conversation, conducted by VK with a Yolŋu Matha interpreter, also allowed Matthew to add further details to his story. Yolŋu and Tiwi patient stories either support, or add to, Matthew's perspectives and experiences. Additionally, three non-Indigenous doctors and five NT AIS employees all identifying as Aboriginal participated. Data were collected from two Yolŋu Matha interpreters, two Tiwi interpreters and an interpreter trainer. Doctor and NT AIS staff perspectives on the impact of the pilot are shared to locate the patient experience within the hegemonic institution. Consolidated patient journeys are presented below, which show key turning points in the patients experience due to regular access to interpreters.

We found consistent availability of face-to-face interpreters during medical ward rounds when critical patient care decisions were made positively shifted the patients' experiences towards culturally safe care. Aboriginal language speaking patients who felt frustrated and misunderstood when forced to communicate in English reported feeling empowered and satisfied with the care they received with interpreters present.

The frustrated and misunderstood patient

Without consistent interpreter mediated communication which allowed for clear two-way patient-provider communication, treatments were inflicted on frustrated, distressed and misunderstood patients. Some patients signed surgical consent forms without understanding what they were consenting to. We also found patients who experienced communication problems would self-discharge from hospital, exercising the limited power they had.

Yolŋu Elder Matthew had been a patient at RDH intermittently over 5 years. His home community was in north east Arnhem Land, 650 km away from the hospital. He had been in the English-speaking hospital system for so many years Matthew worried he was losing his language. Matthew was primarily under the care of the renal team but also being treated by other specialists for comorbidities. When health providers explained the reasons for his hospitalisation in English he said:

> *"I was finding it hard when it was just me talking. Finding it really complicated and I would think to myself, 'Oh who's going to help me?'."* – Matthew, Yolŋu Matha speaker.

Without an interpreter, Matthew wondered why doctors did not use plain English: *"I sometimes wonder to myself, are there simpler words they can use so maybe I can understand?"*. He explained he understood about 50% of what English speaking health providers say:

> Matthew: *Half of it I don't understand and then a little bit, I understand it a bit.*
>
> SYM: *So when the interpreters came in, what did you think about that?*

Matthew: *It's really nice…It really helps when Yolŋu are here and we both understand each other, and I understand. Sometimes I get confused and think 'How am I going to talk?' Really, I don't know what to say.*

SYM: *Do you get angry alone?*

Matthew: *Yeah, I get angry when I don't understand and sometimes, I think about praying and I pray to God about it because I'm so frustrated.*

Across the hospital, Matthew had a reputation as *"very abusive"* and *"very aggressive"*. It was argued *"that he understood English very well"* and he *"was being deliberately obstructive"* (Dr William, journal, 14/8/2019). Dr. Sean first met Matthew 4 years ago when he was *"very funny and witty"* but *"now he's on dialysis, he's pretty much bedbound. If he stands and walks, he's in a lot of pain and he's had recurrent infections."* Over 5 years, Matthew underwent a series of major procedures, only partially understanding what was being done to him. Numerous surgeries were performed, including to enable his body to connect to a dialysis machine and to address comorbidities. One day before the pilot began, Matthew had surgery again. Dr. Sean worried whilst Matthew would nod in agreement when consent was requested in English, the display of gratuitous concurrence was just *"to get people to go away"*. Dr. Jack has seen other Aboriginal language speakers also undergo surgery without full comprehension of the procedure which was explained without an interpreter. He described it as *"unacceptable"*:

> *"….and it's not as if this is something benign. This is putting someone on a* (dialysis) *machine for the rest of their life and performing surgery to create access for that machine without explaining to them why…. and the same thing happens across the board. It happens in oncology. You give people…poison, toxic chemotherapy without really ascertaining as to whether they understand the risks and/or benefits."* - Dr Jack

Interpreters also reported patients have attempted to withdraw written consent after the interpreter explained what the patient been signed:

> *"when the doctor's talking to them, they agree to everything and once I get there I ask them, 'Do you know why you're signing this form?' And they go, 'No'. That's why it's a bit difficult and I'm like, 'You just signed a form for the doctors to take you to theatre'. And they're like, 'What? No, I don't want to do that. Can you just rip the paper up?'."* – Carly, Yolŋu Matha interpreter

Another example of how patients were misunderstood pertains to the label "frequent flyer", which was given by staff to individuals who are frequently readmitted to hospital. Tiwi speaking patient Owen was one such patient. When health providers communicated with Owen in English, he would be discharged from hospital without the right supports in place to ensure he remained well. Owen was homeless and struggled with an alcohol addiction, but his circumstances were not well understood by the treating team. At times he would re-present to RDH so unwell he was admitted to the intensive care unit (ICU):

> *"So he* [Owen] *would come in very short of breath and go into ICU. We'd start dialysis. He gets dialysis. He gets better. He's discharged. He does the same. Until we did that ward round* [with interpreters]*"* – Dr William

Our findings also indicated that distressed misunderstood patients would self-discharge from hospital. Self-discharge results in prematurely stopping, or limiting, the medical treatment underway. Three reasons were identified as to why patients may self-discharge. Firstly, patients have responsibilities outside the hospital requiring attention. Linda had also been labelled a "frequent flyer". With an interpreter present, she revealed that as the primary carer in her family, she needed to leave hospital to help her family address pressing legal and housing issues. Why Linda self-discharged had not previously been explored by doctors, which Dr. Jack believes is *"racist because we don't explore why they want to walk out"*. Secondly, hospital priorities and procedures which shift across the organisation numerous times a day were not explained to the patient. Yolŋu patients Matthew and Linda were often frustrated after being told planned surgery was cancelled. Yolŋu Matha interpreter Carly said Linda was thinking about discharging herself because her surgery was repeatedly delayed:

> *"She was saying that she was getting tired…*(they) *keep changing the times for her operation…she was ready to go home. But lucky I was there to explain to her all the stuff. Like, 'There's probably somebody in before you that's got a worse condition than you'… She was like 'Maybe that's why they keep changing the times and not seeing me because there's somebody else in front of me'."* - Carly, Yolŋu Matha interpreter

Finally, frustrated misunderstood patients self-discharge because they felt uncomfortable or even persecuted. Dr. Jack said patients leave because the hospital is

notoriously cold "*or it might be that they overheard someone saying that they smelled or they're dirty*".

None of the patients had requested an interpreter. Yolŋu patient Sally explained she had not requested an interpreter before despite a) having seen them on the wards at Gove hospital and b) stating she would prefer to communicate in Yolŋu Matha because doctors *"use too many big words and the interpreter helps me understand"*. Visibility of interpreters at RDH was low and many patients were unaware interpreters can assist at no cost to them. NT AIS trainer Mandy said the patient will not ask for an interpreter as *"they're in a foreign place"*, potentially in pain, missing family and disempowered: "*They don't understand that that's their basic right to request the interpreter"*.

Diminishing Aboriginal cultures and disempowering patients

In mid-2019 Matthew was admitted to RDH to treat a recurring leg infection. Six weeks into this 21-week admission, on Day 1 of the pilot, Matthew saw an interpreter for the first time. Matthew said before the pilot he did not have access to an interpreter in the hospital: *"there was nobody* (referring to interpreters) *…It was complicated, and I didn't understand."* He later added*: "I was very upset at that time"*. Yolŋu speaker Sally shared a similar story: she had been receiving treatment at RDH and Gove Hospital for over 2 years and said the first time she experienced interpreter-mediated communication in either Top End hospital was when interpreter Carly appeared with the renal team during the pilot.

Three reasons were identified for why Matthew had not been provided with an interpreter previously. Firstly, his Yolŋu surname which would have identified him as a Yolŋu speaker to interpreters was not on the hospital record. Matthew was registered at the hospital with his White and Yolŋu first names as his first and surname. On the first day of the pilot, Yolŋu interpreter Carly followed standard practice to identify Yolŋu Matha speakers: she studied the patient list for Yolŋu surnames. As languages were not methodically documented, interpreters assessed language needs based on surnames which link individuals to language groups. Carly identified two Yolŋu Matha speakers but Matthew's incorrectly registered name meant he was not identified. Another patient was also missed this way. Matthew and the other patient were identified as Yolŋu Matha speakers in a second process of language identification undertaken during the pilot whereby Dr. Sean asked each patient directly what language(s) they spoke at home. Secondly, the ad hoc hospital system which relied on a health provider placing a magnetic removable 'interpreter' sign above the patient's bed was not actioned for Matthew. During the pilot, if an 'interpreter' magnet was seen above a patient bed it was rare the name of the patient's language was appropriately documented accompanying the sign. Five months after Matthew was admitted, and after his language needs had been clearly determined, there was still no language information above his bed, although there was a generic interpreter sign (VK field notes 26/11/19). Carly suggested if Aboriginal languages were visible on the ward, knowledge may improve:

> *"I noticed that they don't have, like, the language sign on top of their beds so maybe that's why it was hard for doctors to find out where they came from and what language they speak."* – Carly, Yolŋu Matha interpreter

The final reason as to why language discordance was not considered in relation to Matthew was because health providers assessed Matthew's English as adequate.

> *"At the start they didn't get me an interpreter because they assessed my English and they said it was understandable. But when they got into the concepts of what had happened to my leg and what the treatment was, that's when it got complicated and I didn't fully understand"* – Matthew, Yolŋu Matha speaker

The same determination regarding English proficiency was made about Tiwi speaking patient Owen and Yolŋu Elder Patricia. Patricia said doctors assumed she was happy speaking English because she had previously worked as a lecturer at a Darwin college. Patricia explained, "*English is her second language*" and Yolŋu Matha is her "*normal language*". During one bedside consult, Patricia declined an interpreter. From this single interaction, health providers extrapolated Patricia did not want an interpreter for any consult. The following day she explained to researcher SYM in Yolŋu Matha she was in pain the previous day and didn't want to talk to anyone. She made it clear her preference was to speak in her first language with an interpreter present:

> *"First language is important to us, it's like growing up as a child into that language. That Yolŋu Matha it's very important our language. We were born with it, we live with it, we prefer it."* – Patricia, Yolŋu Matha speaker

Patricia suggested the reason why Aboriginal interpreters are not commonly accessed by hospital staff is because staff lack cultural competency. Both Matthew and Patricia said RDH staff require training to improve knowledge of Aboriginal cultures and the importance of

speaking first languages: *"I want someone to deliver an awareness course here. In Yolŋu Rom."* Researcher SYM explained that Patricia used Yolŋu in this case to refer to all Aboriginal peoples and Rom means "law" or "culture". Patricia said Aboriginal and non-Aboriginal peoples should work together to deliver cultural education so both perspectives are understood.

Building relationships of trust

When patients can communicate in their first language, they no longer feel frustrated or misunderstood. On Day 1 of the pilot, in the pre-ward round meeting, the renal team were warned about Matthew who had been tagged the "*angry man*" by hospital staff. He was the first patient on the list and so became the first to experience this new model of care. A large pack of providers (four doctors, the interpreter, the interpreter trainer, nurse in charge, two allied health team members and researcher VK) gathered around the "*angry man's*" bed to see how he would react to the presence of an interpreter. Matthew was attached to the dialysis machine, the hospital-issued white blanket pulled up over his head. Patients commonly do this to get some privacy, block the fluorescent lights or to keep warm in the heavily air-conditioned hospital. With Carly interpreting, Dr. William introduced the assembled pack and told Matthew that today he can speak in his language. Matthew pulled the blanket down to reveal his face. What happened next was described by NT AISNT AIS trainer Mandy as "*mind blowing …as soon as he heard Carly's voice in language, you know everything opened up".*

During this initial interpreter-mediated bedside consult Matthew was able to comprehensively describe the pain he had been experiencing which resulted in doctors changing his medication. With an interpreter he also explained why he had a history of missing dialysis appointments at the hospital. Matthew said he had limited support at home and struggled to walk which meant he sometimes missed the hospital bus pick-up service to transport him for treatment. He told doctors he wanted to live in a supportive environment "*where I don't get sick again."* Dr. William said: "*We wouldn't have picked that up without language."* Although, the revelations were disputed by some staff who argued what Matthew said in English was more reliable than what was said in Yolŋu Matha through an interpreter. Dr. Sean journaled that disbelief may stem from some of his colleagues feeling like they had failed the patient:

> *"Patients were able to tell us their true story for the first time after many months or years of work by professionals in the department, it is understandable that there is frustration that any work done by these professionals has been in vain."* – Dr Sean, journal 15/8/19

The benefits of interpreter mediated communication for Yolŋu and Tiwi patients went beyond language interpretation. Reflecting on that first interaction with Yolŋu interpreter Carly, Matthew used the Yolŋu word *"latju"* (nice) to describe the experience. He said having another Yolŋu person present made him feel at ease: *"that was nice because Yolŋu were helping Yolŋu, really helping me."* Matthew explained there is inherent trust between interpreters and patients who share a language because they are related:

> *"The trust is massive…I feel when they come here* (interpreters), *I feel really good not only because I'm related to them, but I feel like the flow of the conversation is going faster. We are all understanding each other…. It's just a good feeling when it's flowing and everyone understands."* - Matthew, Yolŋu Matha speaker

Dr. William said *"just having someone from the same community"* shifts the power imbalance between patient and provider. Doctors hoped that by working alongside trusted interpreters the patients who feared hospital would feel safer:

> "*You know, getting Linda on-side. That we're not these terrible people and this is not the scary place where all her family members have gone to die."* – Dr Sean

Yolŋu patient Sally said when she first meets an interpreter, she establishes her kinship relationship with them; this ensures both are clear on the responsibilities of their relationship which may include avoidance. Yolŋu Elder Patricia explained that because Yolŋu patients and interpreters share culture and beliefs, they can explain the unspoken subtext of the spoken words:

> *"Like, this Balanda* [non-Aboriginal] *person doesn't understand what this Yolŋu person is saying. So that's why the Yolŋu has to be there to explain it to you. To make better communication with the Balanda people."* - Patricia, Yolŋu Matha speaker

Yolŋu Matha interpreter Carly relayed an interaction, which did not occur during the pilot but during her prior experience as an interpreter, which showed how patient perspectives are understood by interpreters. During a consent discussion with a Yolŋu-speaking patient, Carly interpreted the risk of blood loss and the

possibility of a blood transfusion. The patient was resistant to a blood transfusion because according to his ontology blood should not be transferred from one person to another:

> *"Us Yolŋu people we don't want to take other people's blood and put it in our body, it's just wrong because sometimes when you do that, like, you could have somebody's family member going into you and what if that person had someone that was very close to him or her that passed away that was hanging around you and then you getting that in you, it would be hard."* - Carly, Yolŋu Matha interpreter

Sharing the patient's worldview, Carly was able to explain to the doctors the patient's perspective. With this new information the treating team realised they needed to give the patient more time and information to consider all options.

Proactive confident patients

Consistent access to interpreters meant Tiwi and Yolŋu patients were able to question the treatment offered, exercise choice and make decisions based on their priorities. Matthew's power increased:

> *"Yes I was more forceful with my treatment and making decisions and also I had more choices ….I was more forceful, making decisions based on things I wanted."* - Matthew, Yolŋu Matha speaker

Two days after first experiencing the benefits of interpreter-mediated communication Matthew requested more information with an interpreter about his recurring infection. With Carly interpreting for Dr. Sean, a nuanced discussion regarding the complexities of infections, antibiotics and efficacy of antibiotic treatment occurred. Afterwards, Matthew said he was relieved because he finally understood his situation. He said: *"I could hear clearly."*

As Matthew's understanding of his health condition grew, he also became more confident communicating in English when interpreters were not available. On one occasion without an interpreter, he explored the option of moving to Sydney for treatment to be closer to his Sydney-based son, however *"the doctors said there is the same medication down there and here".* Satisfied with the discussion and information provided, Matthew decided to remain in Darwin. Dr. William journaled (14/8/19) that with interpreters embedded in medical teams, patients became *"proactive partners"* instead of passive recipients of care unable to scrutinize the effectiveness of treatments.

Another example of increasing patient autonomy occurred in a family meeting. Yolŋu patient Paul had end stage kidney disease. He was faced with the life-or-death decision to start dialysis. Paul needed to speak with his family, most of whom were 580 km away in north east Arnhem Land. A video link was organised for Paul with his wife and children in Darwin to connect with family, who gathered at the remote community clinic. Unlike most family meetings where the clinical team controls the space, in this case Paul and his family were in control. Dr. Jack journaled on the 26/11/19: *"it was quite extraordinary. It was nothing like I'd seen before because we weren't involved".* The medical team faded into the background with the interpreter positioning herself behind Dr. William's left shoulder. Interpreter Joanna was like an earpiece interpreter at the United Nations. For 25 min, one by one each person stood in front of the camera and spoke directly to Paul: they all encouraged him to try dialysis. Joanna whispered into Dr. Williams ear without interrupting the family's conversation in Yolŋu Matha. Paul in his wheelchair listened to everyone, he said very little. After the meeting in which doctors encouraged Paul to try dialysis with a view to receiving a kidney transplant, Paul had 3 dialysis sessions and then decided not to continue. He wanted to go home to pass away. As Dr. Jack journaled (26/11/19) the benefit of interpreters "*wasn't in explaining the medical details but the ability to listen to Paul's concerns".*

Satisfied patients

Matthew received access to a Yolŋu Matha interpreter 11 times across 17 days. On some days Matthew saw an interpreter twice if attention was required from other members of the multidisciplinary team. Two months after first having access to an interpreter Matthew reported he felt much more supported: *"Yeah heaps of them are helping me".* He added interpreters not only helped him understand; importantly they helped the health providers understand his perspective and priorities. Matthew said with interpreters, communication works both ways: *"None of us are stuck or confused."* Being able to communicate in his first language, Matthew was able to express his needs beyond the acute conditions he was being treated for. This resulted in addressing the social determinants Matthew articulated in the initial interpreter mediated consult. He received occupational therapy to improve movement, housing assistance and also a change to his hospital diet. Considering Matthew was hospitalized for nearly 5 months, food was a significant part of his hospital experience: *"I wasn't eating the hospital food. I would just buy food from the* (hospital) *cafe."* Matthew was a saltwater man, from a remote island community where fish was an important part of his diet. With an interpreter present he requested

fish once a week via the hospital dietician. Carly shared her conversation with Matthew:

> *"(*He said) *'I just want to be home and have fish and something I feel comfortable eating'….and then he asked me like, 'Why hasn't this happened before? I was here for how long? And nobody spoke to me about my food but I'm happy that you came'."*– Carly, Yolŋu Matha interpreter

Interpreter Joanna explained for Matthew, who is hundreds of kilometres away from his family, just being able to communicate in his first language *"cheers him up instead of trying to speak English"*. Staff attitudes towards Matthew changed. Dr. Sean said: *"once Matthew knew what was happening to his body, he suddenly was no longer this 'angry man' that everyone talked about"*. Dr. William reported Matthew's trajectory changed:

> *"Now Matthew he's done very, very well. He's been discharged. He's living in some accommodation of his choice because that was one of the things which we didn't understand but he explained it through the interpreter. He completed his courses of antibiotics which he would have missed some if he hadn't, if things hadn't been explained to him. He didn't understand why he was taking the antibiotics. So that was a huge change in his life."* – Dr William

During the pilot, doctors noticed patients who were previously referred to as "frequent flyers" were now attending dialysis regularly and therefore not being readmitted through the emergency department. After the purpose of dialysis was explained to Tiwi speaker Owen, and he was also able to explain his personal circumstances, he was discharged into an alcohol rehabilitation program and began attending dialysis regularly. After Yolŋu patient Linda, who was stuck in a pattern of self-discharge and readmission, voiced the legal and housing issues her family faced, the treating team arranged for support staff from relevant external services to attend the hospital with an interpreter to solve the problems. Linda said she valued having an interpreter to assist in solving the non-clinical issues which were affecting her ability to engage with clinical care. Linda stayed in hospital for 9 days after her priorities were addressed. Participating doctors asserted a simple cost analyses would show regular interpreter use will save money on admissions:

> *"So for Owen and Linda, if spending $100 on an interpreter every day even prevents one $20,000 ICU admission, I think it's worth it."* - Dr Sean

At the end of the pilot, doctors reported Yolŋu and Tiwi patient projected health outcomes improved. Dr. Sean said: *"we've completely changed trajectories of illness and probably will save lives based on this project."* All patients preferred to speak their first language in the hospital. Matthew said before interpreters became involved in his care he was *"stuck"* but after consistent interpreter-mediated communication with staff he is *"satisfied"*. Yolŋu Elder Patricia wants to see the model of embedded interpreters in medical teams permanently: "*Balanda doctor and Yolŋu interpreter all the time. I need to see that happen."*

Discussion

To our knowledge, this is the first study to qualitatively document the Aboriginal language speaking patient experience of culturally safe care in an Australian hospital. Cultural safety advocates for changing systems, and attitudes, which enables a transfer of power from service provider to health care consumer [21]. We found Tiwi and Yolŋu hospitalised patients who were frustrated and misunderstood became empowered after receiving consistent access to interpreters. Aboriginal interpreters who shared patient worldviews acted as cultural brokers, bridging the gap between western medicine and Indigenous knowledges [3, 13, 14] as well as provided linguistic interpretation. Changing hospital systems to ensure access to Aboriginal language interpreters, albeit for only 4 weeks, also changed patient health trajectories. Our findings contribute to research which asserts Aboriginal patients want Aboriginal providers involved in their care [57] and that language is a vital expression of cultural identity with demonstrated benefits for health outcomes [1, 2, 4, 5].

Yolŋu and Tiwi patients were gladdened by the presence of Aboriginal interpreters who were seen as a trusted ally. Interactions with health services for Aboriginal peoples are shaped by experiences of racism and powerlessness [58]. When engaging with mainstream services, many Aboriginal peoples anticipate racism regardless of whether they have been discriminated against [59]. We found Aboriginal interpreters, related through kinship to patients, provided a shortcut to developing trust with the patient. Aboriginal language interpreters came to work at RDH with a bank of social capital [60] stemming from kinship relationships which have high standards of "responsibility, with special attention to relationships of care, reciprocity, and consent, among others." [44] As Tiwi and Yolŋu patients had trusting relationships with interpreters, the impersonal nature of the large ward round with rapid fire clinically focused questions [61] changed. The usually intimidating interaction with a large medical pack standing over a patient's bed, shifted to a style more akin to "the reciprocal

nature of yarning" [37], in which patients developed a comprehensive understanding of care which enabled them to communicate in English when an interpreter was not available. Patients were strengthened by kinship, shared knowledge and adherence to cultural protocols: this is a culturally safe service.

When patients speak their own language, they can exert control in an environment where they may otherwise feel disempowered. With interpreters present, patients were able to verbalise their priorities which included food. Food provides emotional as well as nutritional sustenance [21] and unappetising food adds to the discomfort of the hospital experience [12]. For other patients, expressing priorities meant social determinants affecting their capacity to engage with healthcare were addressed. This led to a reported drop in readmission rates and self-discharge. In the hospital, self-discharge is often the only form of resistance a patient can utilise against a culturally unsafe service, therefore self-discharge rates can be used as an indirect measure of cultural safety [27].

Consistent interpreter mediated communication meant that Yolŋu and Tiwi patients developed a more comprehensive understanding of their condition and hospital processes. In primary health care, the use of English with Aboriginal language speaking patients has been found to be inadequate as it failed to communicate "often lifesaving information to clients" [62]. Our research found the same evidenced by patients who, before the pilot, had a history of repeated admissions to the ICU. Unable to communicate in their first language, patients were disengaged from their care, and medical outcomes were suboptimal [13], and lives were at risk. However, with interpreters working alongside doctors over several days, patients were better able to consider the information delivered and question their treatment. Patients also felt empowered after hospital processes were clearly explained by a trusted source. When a patient's surgery is repeatedly cancelled, that can be interpreted as disrespect and even discrimination. Understanding their clinical condition, and hospital systems, empowered patients to lead decision-making, including going against medical advice in favour of spending time on country with family before passing away.

Culturally respectful communication is a key component of delivering culturally safe care [21, 26, 63]. Before interpreters were embedded into the renal team, provider communication with Aboriginal language speaking patients could be described as ranging from pragmatic to hostile, as indicated by patients being labelled "*angry*". When miscommunication occurred, the patient was blamed and consequently labelled non-compliant or non-communicative. Similarly, the labelling of patients as "frequent flyers" triggered another negative stereotype that Aboriginal patients were not interested in maintaining their own health [26]. These labels assisted in socialising other staff into expecting Aboriginal patients to be difficult: such attitudes support individual and institutional racism. We found once health providers took responsibility for communication by changing systems, the perception of the non-compliant angry patient was overturned and the so-called "frequent flyers" stop representing to hospital. Our research shows that when health providers invest time listening to and communicate with patients, rather than speaking about patients, health outcomes improve. Further research into the perception that time spent with patients is costly is required to ensure health providers are not engaging in "false economies" [26].

Whilst English is the operational language of TEHS, it is not the language most spoken amongst renal patients. Almost 90% of patients were Aboriginal and nearly 80% spoke one or more of the 15 languages identified in the unit. A culturally safe service is actively mindful and respectful towards Indigenous cultures, strengths and differences [27]. To that end, we recommend the following changes to hospital processes and systems to ensure cultural determinants of health are addressed. Firstly, health providers make incorrect assessments about the need for an interpreter, a finding supported by previous work in this setting [64]. The NT AIS asserts that the main purpose of the interpreter is to allow the health providers to speak the patient's language. This approach removes the need to judge the patient's English proficiency because it is the language proficiency of the health providers which should be judged. If the health provider does not speak the patient's language fluently, an interpreter is recommended. This is culturally safe, person-centred care. Secondly, language documentation must be addressed immediately. Previous research found that language was documented for only 44% of Aboriginal patients and in some cases, languages were identified as "Aboriginal" or "local" language reflecting the lack of importance staff place on information [12]. Additionally, there were seven separate RDH administrative and clinical forms which provided space to document patient language [12]. Of those seven forms, one of the most used forms, the patient list was not included. The patient list was used by doctors and the multidisciplinary team from the start of their shift, and consistently throughout the day in the process of care delivery. We recommend language be documented on the patient list alongside name and date of birth. This would ensure language discordance is considered at the same time as clinical discussions and it would also improve familiarity of Aboriginal languages in the NT. Thirdly, poor language documentation may be due to the low level of awareness of Aboriginal

languages in the NT. Both cultural competency and cultural safety training should be regularly undertaken to improve awareness of local Aboriginal cultures, cater for the high turnover of staff and to show that the institution values culturally safe communication [33]. Clinical competencies, technical expertise and theoretical knowledge prioritised by institutions are only part of delivering comprehensive care [65]. Finally, we recommend that patients should be registered with healthcare facilities using their correct names, not their colonised names. Names give people an inalienable connection to country and kin [59] hence interpreters can assess language needs based on a patient's surname. The format of Australian legal documents often forces name changes to conform with White norms which is a form of assimilation [59].

Limitations

Findings may under-represent the prevalence and diversity of Aboriginal language speakers during the pilot for two reasons: patient language details were undocumented on one day of the study and Yolŋu Matha and Kriol were each counted as single languages during data collection. Yolŋu Matha and Kriol are umbrella terms for a collection of mutually comprehensible dialects and languages. We also recognise that reporting on a small sample size does not technically permit broad generalizations. However, logical generalizations can be made from the evidence produced [40] which is representational of other Aboriginal language speaking patients in the same setting. Hospitals can improve the quality of care by exploring and understanding the patient's insider perspective revealed through key informants [66].

Conclusion

The United Nations Declaration on the Rights of Indigenous Peoples, adopted by the Australian government in 2009, has enshrined the right for individuals to "understand and be understood" in their first language and if not, the state must ensure "the provision of interpretation" [67]. It is clear from our findings the state has failed to provide services to Aboriginal language speakers requiring hospital care in the Top End of the NT. Changing systems to facilitate easy access to Aboriginal language interpreters in the hospital addressed an institutionally racist system [68]. Implementation of a model of care comprising Aboriginal interpreters embedded in medical ward rounds achieved transformative change in patient experience. Patients described that the frustrations of hospitalisation, characterised by misunderstandings and distress regarding their diagnoses, treatment options and hospital systems, were overcome when an interpreter was included in the multidisciplinary team. Clear communication in first language averted premature discharges and allowed patients to make decisions according to their priorities. An enabling health system which places interpreters at the coal face of care delivery was shown to be essential for the provision of culturally safe care. Health care delivered in the absence of this approach – as experienced by the participating patients before the study - was unsafe and ineffective.

Abbreviations

ICE: Intensive Care Unit; NT: Northern Territory; NT AIS: Northern Territory Aboriginal Interpreter Service; PAR: Participatory Action Research; RDH: Royal Darwin Hospital; TEHS: Top End Health Service

Acknowledgements

The authors would like to thank: TEHS, the RDH Division of Medicine, RDH renal department staff, Dr. Maddison Hall, Curtis Roman from the NT AIS and NT AIS staff. We also thank Menzies School of Health Research project officer Vincent Mithen for contributing to data cleaning.

Authors' contributions

VK and SWM conceived the pilot. VK, SYM, SWM, MW, MA, MH, AC and APR contributed to study design. VK, SYM and MA collected data. VK, SYM and MH conducted analysis. VK drafted the manuscript with input from SYM, MH and APR. All authors read and approved the final transcript.

Funding

Vicki Kerrigan is supported by an Australian Government Research Training Program Scholarship and Improving Health Outcomes in the Tropical North: A multidisciplinary collaboration (HOT NORTH)', (NHMRC GNT1131932). Stuart Yiwarr McGrath was supported by HOT NORTH Indigenous Development and Training Award (NHMRC GNT 113193). Anna P Ralph is supported by an NHMRC fellowship 1142011. A funding contribution to undertake data collection was provided by the Menzies School of Health Research Grants Scheme. The NT AIS provided interpreters and the trainer in kind.

Availability of data and materials

Data collected and analysed during the current study are not publicly available due privacy issues and ethical considerations. Data may be available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Approval to conduct the study was provided by the Northern Territory Department of Health and Menzies School of Health Research Ethics Committee (HREC-2017-3007 and HREC-2019-3295). The study conducted is in accordance with the Declaration of Helsinki guidelines.

Consent for publication

Informed written consent was obtained from all the participants.

Competing interests

At time of writing, Sandawana William Majoni and Anna P Ralph were employed by Top End Health Service. Michelle Walker and Mandy Ahmat were employed by the NT Aboriginal Interpreter Service. Alan Cass was a Board Director for Top End Health Service from 2015 until June 2017. Bilawara Lee was a member of the TEHS Health Advisory Group and a member of the NT Health Ministers Advisory Committee. No competing interests were declared by other authors.

Author details

[1]Menzies School of Health Research, Charles Darwin University, PO Box 41096, Casuarina, Northern Territory 0811, Australia. [2]Royal Darwin Hospital, Darwin, Northern Territory 0811, Australia. [3]Flinders University, Northern Territory Medical Program, Darwin, Northern Australia 0815, Australia. [4]Aboriginal Interpreter Service, Northern Territory Government, GPO Box 4396, Darwin, Northern Territory 0801, Australia. [5]Charles Darwin University, PO Box 41096, Casuarina, NT 0811, Australia.

Received: 16 March 2021 Accepted: 17 May 2021
Published online: 04 June 2021

References

1. Australian Institute of Aboriginal Torres Strait Islander Studies ANU. National Indigenous languages report. Canberra: Government of Australia; 2020.
2. SCRGSP (Steering Committee for the Review of Government Service Provision). Overcoming indigenous disadvantage: key indicators 2020. Canberra: Productivity Commission; 2020.
3. Finlay S, Armstrong K. Indigenous languages must play a role in tackling noncommunicable diseases. BMJ Opin. 2019. Available from: https://blogs.bmj.com/bmj/2019/08/13/summer-finlay-and-kate-armstrong-indigenous-languages-must-play-a-role-in-tackling-noncommunicable-diseases/.
4. Salmon M, Doery K, Dance P, Chapman J, Gilbert R, Williams R, et al. Defining the indefinable: descriptors of Aboriginal and Torres Strait islander peoples' cultures and their links to health and wellbeing, Aboriginal and Torres Strait islander health team. Canberra: Research School of Population Health, The Australian National University; 2019.
5. Dinku Y, Markham F, Venn D, Angelo D, Simpson J, O'Shannessy C, et al. language use is connected to indicators of wellbeing: evidence from the national aboriginal and torres strait islander social survey 2014-15, working paper no.137/2020. Canberra: Centre for Aboriginal Economic Policy Research, Australian National University; 2020.
6. Northern Territory Government. Aboriginal languages in NT. 2018 Available from: https://nt.gov.au/community/interpreting-and-translating-services/aboriginal-interpreter-service/aboriginal-languages-in-nt.
7. Australian Bureau of Statistics. Main language spoken at home and English proficiency 2018 Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2076.0Main%20Features1012016?opendocument&tabname=Summary&prodno=2076.0&issue=2016&num=&view.
8. Commonwealth of Australia, Department of the Prime Minister and Cabinet. Closing the Gap Report 2020. Canberra: Australian Government; 2020.
9. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2020 key health indicators—Northern Territory. Cat. no. IHPF 5. Canberra: AIHW; 2020.
10. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical Care for Patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007;42(2):727–54.
11. The Communicate Study group. Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study. Med J Aust. 2020;213(4):180–1.
12. Mithen V, Kerrigan V, Dhurrkay G, Morgan T, Keilor N, Castillon C, et al. Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care. Health Promot J Aust. 2021;32(S1):155–65.
13. Amery R. Recognising the communication gap in indigenous health care. Med J Aust. 2017;207(1):13–5.
14. Brennan G. In: Australia Dept. of Aboriginal Affairs Research S, editor. The need for interpreting and translation services for Australian Aboriginals, with special reference to the Northern Territory: a research report. Canberra: Research Section, Dept. of Aboriginal Affairs; 1979.
15. Mitchell A, Lowell A, Ralph A. Report on the patient educator service at Royal Darwin Hospital, 2001-2009: insights into inter-cultural communication in healthcare. Darwin: Research gate; 2016.
16. Allam L. Darwin hospital left Aboriginal man to die alone and in agony from surgical injury. Northern Territory coroner issues scathing report detailing multiple failures by Top End health service. Australia: The Guardian; 2018.
17. ABC News. Low use of Indigenous interpreters at Royal Darwin Hospital putting patients at risk, researchers say 2019 Available from: https://www.abc.net.au/news/2019-07-20/indigenous-language-interpreters-hospital-patients-at-risk/11326876.
18. Chong A, Renhard R, Wilson G, Willis J, Clarke A. Improving cultural sensitivity to indigenous people in Australian hospitals. A continuous quality improvement approach. Focus Health Prof Educ. 2011;13(1):84–97.
19. Skinner T, Blick J, Coffin J, Dudgeon P, Forrest S, Morrison D. Comparative validation of self-report measures of negative attitudes towards Aboriginal and Torres Strait islanders. Int Electr J Rural Remote Health Res Educ Pract Policy. 2013;13:1–9.
20. Kelaher MA, Ferdinand AS, Paradies Y. Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Med J Aust. 2014;201(1):44–7.
21. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu. Wellington: Victoria University of Wellington; 2002.
22. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health. 2019;18(1):174.
23. Australian Government. National Aboriginal and Torres Strait islander health plan 2013-2023. 2013.
24. Australian Health Practitioner Regulation Agency. The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025. 2020.
25. Laverty M, McDermott DR, Calma T. Embedding cultural safety in Australia's main health care standards. Med J Aust. 2017;207(1):15–6.
26. Taylor K. In: Guerin P, editor. Health care and Indigenous Australians: cultural safety in practice. 2nd ed. South Yarra: Palgrave Macmillan; 2014.
27. Australian Institute of Health and Welfare. Cultural safety in health care: monitoring framework. Canberra: AIHW; 2019.
28. Lock M, Burmeister O, McMillan F, Whiteford G. Absence of rigorous evidence undermines cultural safety reforms. Aust J Rural Health. 2020;28(1):4–5.
29. Hall B. Research, commitment and action: the role of participatory research. Int Rev Educ. 1985;30(3):289–99.
30. Baum F, MacDougall C, Smith D. Participatory action research. J Epidemiol Community Health. 2006;60(10):854.
31. Kemmis S, McTaggert R, Nixon R. The action research planner: doing critical participatory action research. New York: Springer; 2014.
32. Menzies School of Health Research. The Communicate study (Stages 1 and 2). 2018 Available from: https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/The_communicate_study_stages_1_and_2/.
33. Kerrigan V, Lewis N, Cass A, Hefler M, Ralph AP. "How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload. BMC Med Educ. 2020;20(1):173.
34. Delgado R. In: Harris A, Stefancic J, editors. Critical Race Theory (Third Edition): An Introduction. 3rd ed. New York: New York University Press; 2017.
35. Habermas J. The philosophical discourse of modernity: twelve lectures. Cambridge: Polity in association with Basil Blackwell; 1987.
36. Bronner SE. Of critical theory and its theorists. 2nd ed. New York: Routledge; 2002.
37. Jennings W, Bond C, Hill PS. The power of talk and power in talk: a systematic review of indigenous narratives of culturally safe healthcare communication. Aust J Prim Health. 2018;24:109–15.
38. Delgado R. Storytelling for oppositionists and others: a Plea for narrative. Michigan Law Rev. 1989;87(8):2411–41.
39. Moreton-Robinson A. Talkin' up to the white woman: Aboriginal women and feminism. St Lucia: University of Queensland Press; 2000.
40. Schön D. Educating the reflective practitioner: toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass; 1987.
41. DiAngelo R, Dyson ME. White fragility: why It's so hard for white people to talk about racism. Boston: Beacon Press; 2018.
42. McIntosh P. White privilege: Unpacking the invisible knapsack. Peace and Freedom. Philadelphia: Women's International League for Peace and Freedom; 1989. p. 10–2.
43. hooks b. Yearning: race, gender, and cultural politics. New York: Routledge, Taylor & Francis Group; 2015.
44. Whyte K. Against crisis epistemology. Routledge Handbook of Critical Indigenous Studies. B. Hokowhitu, A. Moreton-Robinson, L. Tuhiwai-Smith, C. Andersen and S. Larkin. Routledge: International Handbooks; 2021. p. 52-64.
45. Ralph AP, Lowell A, Murphy J, Dias T, Butler D, Spain B, et al. Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory. BMC Health Serv Res. 2017;17(1):733.
46. Australian Bureau of Statistics. Census of Population and Housing: Characteristics of Aboriginal and Torres Strait Islander Australians, 2016. 19th February 2018. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/census-population-and-housing-characteristics-aboriginal-and-torres-strait-islander-australians/latest-release.
47. Patton MQ. In: Patton MQ, editor. Qualitative evaluation and research methods. 2nd ed. Newbury Park: Sage Publications; 1990.
48. Canlas IP, Karpudewan M. Blending the principles of participatory action research approach and elements of grounded theory in a disaster risk reduction education case study. Int J Qual Methods. 2020;19:1609406920958964.

49. Lowell A. Communication and cultural knowledge in Aboriginal health care. In: A review of two subprograms of the cooperative research Centre for Aboriginal and Tropical Health's indigenous health and education research program. Casuarina: Cooperative Research Centre for Aboriginal and Tropical Health; 1998.
50. Williams R. Cultural safety — what does it mean for our work practice? Aust N Z J Public Health. 1999;23(2):213–4.
51. Glassman M, Erdem G. Participatory action research and its meanings: Vivencia, praxis, conscientization. Adult Educ Q. 2014;64(3):206–21.
52. Bernal DD. Using a Chicana feminist epistemology in educational research. Harv Educ Rev. 1998;68(4):555–81.
53. Clandinin DJ. Handbook of narrative inquiry mapping a methodology. Thousand Oacks: SAGE; 2007.
54. The University of Sydney. Aboriginal Kinship Presentation: Skin Names. 2014.
55. Du Bois WEB. The Souls of White Folk. Monthly Review. 2003 2003/11//:44+.
56. Kowal E. The politics of the gap: indigenous Australians, Liberal multiculturalism, and the end of the self-determination era. Am Anthropol. 2008;110(3):338–48.
57. Taylor EV, Lyford M, Parsons L, Mason T, Sabesan S, Thompson SC. "We're very much part of the team here": A culture of respect for Indigenous health workforce transforms Indigenous health care. PLOS ONE. 2020;15(9): e0239207.
58. Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One. 2015;10(9):e0138511.
59. Bargallie D. Unmasking the racial contract: indigenous voices on racism in the Australian public service. Canberra: ACT, Aboriginal Studies Press; 2020. p. 256.
60. Mathie A, Cunningham G. From clients to citizens: asset-based community development as a strategy for community-driven development. Dev Pract. 2003;13(5):474–86.
61. Mishler EG. The discourse of medicine : dialectics of medical interviews. Norwood: Ablex Pub. Corp.; 1984.
62. Mitchell AG, Belton S, Johnston V, Gondarra W, Ralph AP. "That heart sickness": young Aboriginal People's understanding of rheumatic fever. Med Anthropol. 2018;38:1–14.
63. De Souza R. Cultural safety: On healing the health system through partnership; 2019.
64. Cass A, Lowell A, Christie M, Snelling PL, Flack M, Marrnganyin B, et al. Sharing true stories improving communication between Aboriginal patients and healthcare workers. Med J Aust. 2002;176(10):466–70.
65. Pannick S, Archer S, Long SJ, Husson F, Athanasiou T, Sevdalis N. What matters to medical ward patients, and do we measure it? A qualitative comparison of patient priorities and current practice in quality measurement, on UK NHS medical wards. BMJ Open. 2019;9(3):e024058.
66. Goodyear L. Qualitative inquiry in evaluation : from theory to practice. First edition. Ed: San Francisco. California: Jossey-Bass; 2014.
67. UN General Assembly. United Nations declaration on the rights of indigenous peoples: resolution/adopted by the general assembly, 2 October 2007, A/RES/61/295. 2007.
68. The Lancet. Institutionalised racism in health care. Lancet. 1999;353(9155): 765.

Publisher's Note

CHAPTER FIVE

"The talking bit of medicine, that's the most important bit": doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care.

Publication: Kerrigan V, McGrath SY, Majoni SW, Walker M, Ahmat M, Lee B, Cass A, Hefler M, Ralph AP. "The talking bit of medicine, that's the most important bit": doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care. International Journal for Equity in Health. 2021 Dec;20(1):1-5.

International Journal for Equity in Health

RESEARCH Open Access

"The talking bit of medicine, that's the most important bit": doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care

Vicki Kerrigan[1*], Stuart Yiwarr McGrath[1], Sandawana William Majoni[1,2,3], Michelle Walker[4], Mandy Ahmat[4], Bilawara Lee[5], Alan Cass[1], Marita Hefler[1] and Anna P. Ralph[1,2]

Abstract

Background: In hospitals globally, patient centred communication is difficult to practice, and interpreters are underused. Low uptake of interpreters is commonly attributed to limited interpreter availability, time constraints and that interpreter-medicated communication in healthcare is an aberration. In Australia's Northern Territory at Royal Darwin Hospital, it is estimated around 50% of Aboriginal patients would benefit from an interpreter, yet approximately 17% get access. Recognising this contributes to a culturally unsafe system, Royal Darwin Hospital and the NT Aboriginal Interpreter Service embedded interpreters in a renal team during medical ward rounds for 4 weeks in 2019. This paper explores the attitudinal and behavioural changes that occurred amongst non-Indigenous doctors and Aboriginal language interpreters during the pilot.

Methods: This pilot was part of a larger Participatory Action Research study examining strategies to achieve culturally safe communication at Royal Darwin Hospital. Two Yolŋu and two Tiwi language interpreters were embedded in a team of renal doctors. Data sources included interviews with doctors, interpreters, and an interpreter trainer; reflective journals by doctors; and researcher field notes. Inductive thematic analysis, guided by critical theory, was conducted.

Results: Before the pilot, frustrated doctors unable to communicate effectively with Aboriginal language speaking patients acknowledged their personal limitations and criticised hospital systems that prioritized perceived efficiency over interpreter access. During the pilot, knowledge of Aboriginal cultures improved and doctors adapted their work routines including lengthening the duration of bed side consults. Furthermore, attitudes towards culturally safe communication in the hospital changed: doctors recognised the limitations of clinically focussed communication and began prioritising patient needs and interpreters who previously felt unwelcome within the hospital reported feeling valued as skilled professionals. Despite these benefits, resistance to interpreter use remained amongst some members of the multi-disciplinary team.

* Correspondence: vicki.kerrigan@menzies.edu.au
[1]Menzies School of Health Research, Charles Darwin University, PO Box 41096, Casuarina, Darwin, NT 0811, Australia
Full list of author information is available at the end of the article

Conclusions: Embedding Aboriginal interpreters in a hospital renal team which services predominantly Aboriginal peoples resulted in the delivery of culturally competent care. By working with interpreters, non-Indigenous doctors were prompted to reflect on their attitudes which deepened their critical consciousness resulting in behaviour change. Scale up of learnings from this pilot to broader implementation in the health service is the current focus of ongoing implementation research.

Keywords: Cultural safety, Health, Racism, Communication, Aboriginal, Interpreters, Healthcare communication

Introduction

Effective communication between doctors and patients is a determinant of patient outcomes, and vital for the delivery of culturally safe care [1–5]. In Australian hospitals, language discordance for patients who speak English as a second language is common. Interpreter mediated healthcare has been shown to improve clinical outcomes and contribute to higher patient satisfaction [5–8], however professional interpreters in healthcare are underused globally [6, 8–10].

This is particularly concerning in the Northern Territory (NT) of Australia where Aboriginal peoples experience an extremely high burden of disease and 60% speak an Aboriginal language as their first language [11]. The NT is the heartland of Aboriginal languages in Australia. Of the 14 languages identified nationally as "relatively strong", 12 are in the NT [12, 13]. In the Top End of the NT, between 60 and 90% of patients presenting to hospitals and clinics are Aboriginal. Life expectancy of Aboriginal peoples in the NT is the lowest in Australia (66 years for males and 69 years for females) [14] and the prevalence of rheumatic heart, cardiovascular, lung and end-stage kidney disease and psychological distress are disproportionately high [15]. Ineffective health communication in the NT has resulted in death [16, 17]; absence of informed consent, unnecessary elongated hospital stays; discharge against medical advice and distrust of healthcare providers [5, 18–20]. Research has also found one of the most common ways patients experience racism is through poor communication [16, 21–23]. Intercultural communication challenges are also a stressor for healthcare providers who can "experience a sense of hopelessness" [24] when language discordance occurs. However when providers work effectively with interpreters the quality of medical care improves [6]; this includes a reduction in unnecessary diagnostic tests [25] and duration of hospitalisation stays [26]. Interpreter-mediated communication between patient and provider also means miscommunication is "much less likely" [6] which results in reducing the prospect of medical errors attributable to communication issues.

At the NT's largest hospital, Royal Darwin Hospital (RDH), it is estimated around 50% of patients would benefit from an interpreter, yet only approximately 17% get access [27], despite face to face and telephone interpreting services being available. The underuse of interpreters in healthcare is commonly blamed on limited interpreter availability, healthcare provider time constraints and the perception that use of interpreters in healthcare is an anomaly [6, 7]. However, even when interpreters are readily available, doctors tend to communicate without an interpreter, utilising the physician centred style of communication which focuses on gathering clinical data and limits opportunities for shared decision making and person-centred care [7]. To overcome these constraints and attempt to normalise the presence of Aboriginal language interpreters, we conducted a pilot study which embedded Yolngu Matha and Tiwi interpreters in a team of renal doctors at RDH. The Yolngu and Tiwi patient experience of the pilot study has been previously reported [5]. We found by embedding Aboriginal language interpreters in the renal team, the power dynamics between doctors and Aboriginal clients changed. With consistent access to interpreter mediated communication patients determined the care they received was culturally safe. Before the pilot, with limited or no interpreter access, patients described feeling "stuck" and disempowered when forced to communicate in English. After receiving access to trusted interpreters who shared patients' worldviews, patients said they felt empowered and "satisfied" with their care [5].

Jennings et al. [4] argued by changing how healthcare providers speak with Aboriginal clients, "we can alter the power dynamics and cultural safety of health consultations". Cultural safety places the onus for change on providers and institutions to reflect on their own culture and acknowledge the "biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics" which impede the delivery of equitable care [28]. To deliver culturally safe care, healthcare providers and the institutions in which they work, also need to be culturally competent. Culturally competency requires an ongoing commitment to respect and respond to cultural diversity [29] thereby creating the opportunity to deliver culturally safe care. Both cultural competency and cultural safety avoids problematizing Aboriginal peoples by focusing on creating individual and systemic change through critical reflection [3, 4, 28, 30, 31]. The aim of this paper is to document the process of self-reflection, and subsequent changes, undertaken by RDH doctors

and Aboriginal language interpreters who worked side by side during the 4-week pilot study.

Methods

Study design

This pilot study which embedded Aboriginal language interpreters in a RDH renal medical team is part of a larger Participatory Action Research (PAR) [32–34] project in which participants and researchers collaborated to address barriers to culturally safe communication at RDH. During data collection for the larger PAR project [27, 35–37] co-author SWM, and other doctors, expressed frustration regarding limited access to Aboriginal language interpreters at RDH and imagined the benefits of interpreters embedded in the multi-disciplinary team (MDT). Discussions with the NT Aboriginal Interpreter Service (AIS), RDH and researchers followed, and all agreed to pilot and evaluate the idea. The projects' conceptual framework was influenced by cultural safety [3] and critical race theory [38] which both draw on Habermas' approach to critical theory [39, 40]. Of particular relevance is Habermas position that communication can be used to address power structures which create and maintain inequities [39, 40].

Researcher reflexivity

The lead author VK is an English speaking Australian born White researcher [41]. The second author SYM is a Gumatj man from the Yolŋu nation in north east Arnhem Land in the NT. SYM is bilingual: he speaks Djambarrpuyŋu, a dialect of Yolŋu Matha and English. Reflecting on the propensity of White researchers to perpetuate a "politic of domination" [42], the PAR project was designed collaboratively with Aboriginal researchers, interpreters, community leaders and healthcare providers who shared a commitment to social justice. As per PAR, this approach ensured the research addressed local priorities and findings could be translated into practice [32, 34].

Study context

RDH is a 360-bed facility managed by the NT government's Top End Health Service (TEHS), on Larrakia country in the capital of the NT. The pilot study was conducted at the inpatient renal unit where 84% of patients identified as Aboriginal [5]. Whilst English is the operational language of RDH, it is not the language most spoken amongst renal patients: 78% of Aboriginal renal patients spoke one or more of the 15 Aboriginal languages identified [5]. The most spoken languages were Yolŋu Matha and Tiwi, followed by Kunwinkju, Anindilyakwa and Kriol [5]. At the time of the pilot, Aboriginal language interpreters for RDH were provided by the NT AIS via a bookings system. The NT AIS is funded by the NT government which provides qualified interpreters to both government and non-government agencies including health, legal and community service organisations. Depending on interpreter availability, the NT AIS also provided one interpreter to RDH every weekday morning for 4 hours. The study was divided into two 2-week periods to align with specialist SWM's roster. The NT AIS initially agreed to supply one Yolŋu Matha interpreter to work with the renal team led by SWM during morning ward rounds when important clinical decisions were made. The decision to focus on Yolŋu Matha was based on both the predominance of Yolŋu languages and pragmatism: the NT AIS employed experienced Yolŋu Matha interpreters and researcher SYM spoke the dialect Djambarrpuyŋu as his first language. After further assessing the language needs of the patient cohort, Tiwi interpreters were also employed. Two of the strongest Aboriginal languages are Tiwi (> 2000 speakers) and Djambarrpuyŋu, a dialect of Yolŋu Matha (> 4000 speakers). Yolŋu Matha is a group of mutually comprehensible languages of the Yolŋu people from North-East NT [12].

Participants

Consistent with PAR [32, 43], doctors and NT AIS staff were purposively sampled based on their work roster, anticipated capacity to contribute to "the development of knowledge" [44] and commitment to the aims of the pilot. All participants provided written consent to participate. As per PAR, some doctors and NT AIS staff had roles as both co-researchers and participants. Doctors were only eligible to participate if they had worked in the Top End for more than 12 months and planned to remain in the region for 12 months or more. This selection criteria had a dual purpose: it meant doctors could reflect on their practice pre-pilot, report changes and consolidate learnings and be a potential catalyst for systemic change. We acknowledge doctors have the capacity to be transformational leaders in their teams and amongst hospital executive and policy makers [45].

Data collection

Data sources included semi-structured interviews conducted by VK in English, field notes which documented patient-interpreter-provider interactions and doctors journals. Pre pilot, lengthy interviews provided an opportunity for doctors and NT AIS staff to reflect on their own behaviour and the systems they work in. During the pilot, to gain a deeper understanding of attitudes and behaviour, VK and SYM shadowed doctors during ward rounds, staff meetings and breaks and doctors wrote journal entries for each day they worked on the pilot.

Data analysis

A critical theory [40] lens which examined power relations and explored multiple realities considering social,

political and cultural context shaped analysis. Interviews were transcribed verbatim. Inductive narrative analysis [46] of interview transcripts, doctors' journals, and researcher field notes was conducted using NVivo12. First round analysis entailed coding transcripts, journals and field notes separately. The second round of analysis merged the separate codes to identify turning points and "transformative emotional growth experiences" [47] for both doctors and interpreters. Co-authors then iteratively refined findings guided by the literature and drawing on both personal and professional experiences. For reporting purposes, participants were given a choice of using a pseudonym or their own name: co-researchers and participants SWM (Dr William) and the NT AIS trainer MA (Mandy) are identified in the paper according to their wishes.

Ethical considerations

Regarding terminology, the language group, or associated nation, of Aboriginal participants will be used. Otherwise, the term Aboriginal, which refers to the original occupants of mainland Australia, will be used. The term White is capitalised in line with Whiteness studies. White refers to a social category which describes individuals who participate in "racialized societal structure that positions them as "White" and accordingly grants them the privileges associated with the dominant Australian culture." [41] Approval to conduct the study was provided by the Northern Territory Department of Health and Menzies School of Health Research Ethics Committee.

Results

The pilot occurred in the RDH renal department over two periods in 2019: 14th to 27th of August (10 days) and 25th November to 3rd December (7 days). Period 2 was shorter due to NT AIS resourcing issues. Twelve interviews were conducted, comprising baseline and follow up interviews with three doctors, the two Yolŋu Matha interpreters and an interpreter trainer. The Tiwi interpreters consented to be observed only. The renal team and interpreters were shadowed by VK, and SYM when appropriate, during medical ward rounds which occurred between the hours of 8 am to 2 pm for a total of 29 h across 7 non-consecutive days. Twenty-one patient-interpreter-provider interactions were observed (15 Yolŋu Matha, 5 Tiwi, 1 Ngan'gikurunggurr).

Three male doctors from the RDH renal team participated. Dr. William was a specialist nephrologist, who had worked in the Top End for a decade. He was trained in Zimbabwe and the United Kingdom. From the Shona tribe in Zimbabwe, he spoke two African languages (Shona and Ndebele) and English. Dr. Sean was a medical registrar who had worked in Darwin for 12 months. He completed his medical training in Northern Ireland where he was born. He grew up speaking Gaelic and said he viewed the world through an *"Irish Catholic lens"*. Dr. Jack was an Australian trained medical registrar who had worked in the Top End for 4 years. He described his background as Anglo Celtic conservative, Christian and privileged. He was a monolingual English speaker. Dr. William participated in period 1 and 2. Due to the nature of their work roster, Dr. Sean participated in period 1 and Dr. Jack in period 2. Observations of the multidisciplinary renal team (other doctors, nurses, allied health) were documented by VK and will be presented anonymously.

Two Yolŋu Matha interpreters, two Tiwi interpreters and an interpreter trainer participated. All interpreters were employed by the NT AIS on a casual basis. Period 1 Yolŋu interpreter Carly worked previously as an Aboriginal Health Practitioner and subsequently as an interpreter for over 12 months. Period 2 Yolŋu interpreter Joanna recommenced work at the NT AIS 1 week before period 2 started. Joanna had a long professional history, including as a nationally accredited interpreter, and more recently holding managerial positions in mainstream institutions. The period 1 Tiwi interpreter was employed 2 days before starting work on the pilot. The period 2 Tiwi interpreter had been employed on a casual basis by the NT AIS for more than 12 months. During the pilot, interpreters were supported by NT AIS trainer Mandy. Mandy was born in Darwin; she has Aboriginal and Torres Strait Islander heritage with connections to the Nyikina and Ngalakgan peoples and Badu Island. Mandy's primary role was to support interpreters, although as her knowledge of the hospital developed she also supported doctors and patients by booking extra Aboriginal interpreters as required. This will be discussed in more detail below. Participant details are also presented in Table 1.

To document any potential transformation amongst hospital-based healthcare providers, findings will be presented as a timeline: pre pilot, the pilot and post-pilot

Pre-pilot: individual and institutional issues

Before the pilot, doctors and interpreters reflected on hospital culture regarding communication and working with interpreters at RDH. Participants discussed attitudes and systems which bolster the idea that culturally safe communication is not a key component of running the hospital and also explored the barriers to consistently working with interpreters at RDH.

Hospital culture

Doctors reported that, patient centred communication is not prioritised due to the way hospital processes are implemented. Dr. Jack journaled about the dominant

Table 1 Interpreter ward round pilot participants

	Period 1	Data collected	Period 2	Data collected
AIS staff				
Yolŋu Interpreter	Carly: AHP; interpreter at NT AIS for > 12 months	Interviews; observation	Joanna: experienced interpreter; former manager at a government department; interpreter at NT AIS for 1 week	Interviews; observation
Tiwi Interpreter	Name withheld: interpreter at NT AIS for 2 days	observation	Name withheld: interpreter at NT AIS for > 12 months	observation
Interpreter trainer	Mandy: NT AIS trainer for four years. Aboriginal and Torres Strait Islander heritage: connections to the Nyikina and Ngalakgan peoples and Badu Island.	Interviews; observation	Mandy also participated in period 2	
Doctors				
Specialist	William: born Zimbabwe; multilingual; Top End > 10 yrs	Interviews; observation, journal	William also participated in period 2	
Registrars	Sean: born Northern Ireland; multilingual; Top End > 2 yrs	Interviews; observation, journal	Jack: born Australia; monolingual; Top End > 4 yrs	Interviews; observation, journal
Members of the Multi-disciplinary team (MDT)	Unnamed doctors, nurses, allied health professionals	Observation	Unnamed doctors, nurses, allied health professionals	Observation
Patients (reported in Kerrigan et al [5])				
Aboriginal	51 Aboriginal patients; 40 Aboriginal language speakers.	Observation	39 Aboriginal patients; 30 Aboriginal language speakers.	Observation
Non-Aboriginal	4 non-Indigenous patients. 4 patients unknown heritage.		5 non-Indigenous patients. 4 patients unknown heritage.	

attitude which concerned him: "*we are here to 'do' medicine, not the soft stuff*". As communication is not prioritised, the responsibility for effective communication is left with the patient. A theme which consistently arose in interviews, journals and observations was that health providers justify communicating without an interpreter because a) they have determined the patient speaks "good English" and b) the patient did not request an interpreter. When communication goes awry, the patient is blamed and often labelled "non-compliant". Dr. William admitted when he started working in the NT, his preconceived ideas impacted his approach to patients:

> *"I had this view, which is actually a very skewed view, which a lot of health care professionals bring here with them from down south or from overseas, that Aboriginal people are non-compliant; they don't listen"* – Dr William

The Top End has a high level of transient health staff. According to Dr. Jack, some come to Darwin for *"a short time or a good time*" to undertake training and others were "*tired"* long term staff, resistant to change. Many overseas trained health providers arrive in the Top End unfamiliar with Aboriginal cultures and the impact of colonisation. After starting work at RDH Dr. Sean, who migrated from Northern Ireland, said he was *"absolutely distraught at seeing people my age or younger on dialysis or dead or incredibly sick"*. As immigrants to Australia, both Dr. Sean and Dr. William acknowledged their own cultural background influenced their decision making. Dr. William saw similarities between the culture of Zimbabwe and Aboriginal cultures: respect for Elders, caring for the environment, concept of time and the impact of westernisation. But he said not all healthcare providers have the capacity to reflect and empathise with the patient. He provided the following example regarding speaking English:

> *"I put myself in the patient's position as I was when I was learning English and imagining a doctor speaking to me in English at that stage. I wouldn't have understood anything they were saying … .and a lot of our doctors here are immigrants or they've come to Australia, so we should understand better."* - Dr William

The hospital often operates above capacity, resulting in pressure to process, treat and discharge patients quickly. Dr. Jack understood the benefits of interpreter-mediated communication but explained he doesn't use interpreters because the hospital's priority is "*staffing*

and budgets and chaos and patient numbers in bed block". Dr. Jack said it's *"like the patients aren't even there".* Exemplifying the pressure frontline care providers contend with, during the pilot, Dr. William received a page from hospital executive: "experiencing extreme bed pressure" (VK field notes 26/11/19). The pressure was on to discharge existing patients to vacate beds. Accelerated discharge and associated poor communication can lead to subsequent unplanned readmission. This cycle of discharge and readmission due to poor communication contributed to negative perceptions of Aboriginal patients who were labelled *"frequent flyers".* Dr. Jack said that patients who are readmitted frequently are perceived as a *"chore"* and "*an inconvenience in your day".* Doctors explained that stereotyping of patients results in "othering" of Aboriginal peoples in the hospital, as in the wider community:

> *"there's a lot of talk of 'them' and 'they' … and all the stereotypes associated with that, and rarely do the two mix except in our eyes in healthcare and in the courts … . particularly in a place like Darwin, it's pretty much segregation still".* - Dr Jack

Social segregation means interactions between non-Aboriginal and Aboriginal peoples are commonly limited to the hospital and the justice system which resulted in biased views, as lamented by Dr. Jack describing the system he works within:

> *"I guess we see them – 'them' again, here I go again but – patients as perpetrators or they're deviant, or they're victims, really. I guess in other settings, in more community-based settings, you see more patients and you can see a broader spectrum of community lives."* – Dr Jack

Difficulty accessing interpreters

Attitudes contributed to interpreter uptake and availability. Pre-pilot, accessing interpreters in the hospital was described by Dr. William as "*extremely difficult".* Three main reasons were identified to explain this. Firstly, there is a small pool of Aboriginal interpreters in the NT. Having worked in other Australian hospitals which serviced migrant non-English speaking populations, Dr. Jack said accessing interpreters via a telephone hotline was easy compared to accessing Aboriginal interpreters. Dr. Sean shared his experience of trying to book a Burarra interpreter over 10 days for a chronically ill patient with cancer. Unable to book an interpreter and facing pressure from the hospital to discharge the patient, the team's specialist decided to deliver the diagnosis in English. The complex conversation required an explanation of the patients swollen stomach. Dr. Sean said *"because of the swollen belly and the actions that were being demonstrated"* the patient thought she was pregnant. Doctors discovered this through a conversation with the patient's family. An interpreter was subsequently able to be accessed to explain the patient was not pregnant but in fact had cancer.

Secondly, there is a perception amongst hospital staff that using Aboriginal interpreters is unnecessary, disrupts workflow and is a waste of scarce resources. The disposition of hospital staff was noted by interpreters who reported feeling unwelcome. Interpreter Joanna described doctors as "*intimidating*" and "*just like police*". Many interpreters chose not to take hospital jobs because they had a bad experience or had heard from colleagues the hospital was an unpleasant place to work:

> *"most of the interpreters don't like coming back here because I think they find the staff rude or something, that they don't speak to them".* - Carly, Yolŋu Matha interpreter

Thirdly, Aboriginal interpreters themselves deal with a large burden of illness. One interpreter was treated in the Emergency Department twice during a 5-day period around work commitments. Another interpreter's grandmother was an RDH inpatient and every day after her shift, she cared for her grandmother:

> *"working with the pilot was hard for me because my grandmother was in hospital and I just kept getting calls from her because my mum was away at* [an East Arnhem community] *for a funeral. So my brother and I had to rotate around for her but my brother was also sick so it was just me."* – Carly, Yolŋu Matha interpreter

Funerals are prominent in the lives of Aboriginal interpreters. Mandy explained Period 2 was delayed because a Yolŋu leader died which meant six Yolŋu interpreters were *"all out on sorry business".* "Sorry business" broadly refers to funerals and associated cultural practices.

The pilot: changing systems, developing knowledge and challenging attitudes

To integrate interpreters into medical teams during ward rounds, doctors adapted their work routines which resulted in improved knowledge of Aboriginal cultures, improved interpreter health literacy and an attitudinal shift amongst both doctors and interpreters.

Changing the work routine

Four areas of change were noticed: 1) doctors adapted their training schedule, 2) patient language needs were included in clinical conversations, 3) the duration of

bedside consults lengthened and 4) the use of Aboriginal language interpreters, beyond Tiwi and Yolŋu Matha, increased.

Firstly, to ensure doctors had some knowledge of how best to work with Aboriginal interpreters, and knowledge of NT Aboriginal languages, the NT AIS offered a one-hour training session before both pilot periods to the renal doctors. Team leader, Dr. William said he had to *"squeeze in"* the working with interpreter training sessions amongst the heavy clinical training load. However, after attending sessions in period 1 and 2, he determined the training was invaluable and should be mandated. Dr. Sean journaled (19/8/19) the training reminded doctors to avoid medical jargon, use plain English and to communicate concisely: "*There are many who recite an essay before allowing the interpreter to speak*".

Secondly, patient language needs were discussed during pre-ward round meetings when clinical plans were developed. This was an immediate change which was observed on Day 1 of period 1. Language requirements were known because the day before the pilot began, following researchers request, Dr. Sean asked each patient what language they spoke at home. With interpreters and researchers present in the pre-ward round meeting, doctors reviewed treatment plans and for the first time each patient's language was discussed. Researcher VK observed the following. The registrar Dr. Sean briefed the team: he introduced each patient by name, language spoken and then discussed their condition. The first patient was from Borroloola, the specialist Dr. William said: *"Do you know I cover Borroloola, but I don't know what language they speak."* Next was a patient from Groote Eylandt who spoke Anindilyakwa. Dr. William said: *"I didn't know there was a language like that."* The language needs of a Tiwi patient were discussed, and Dr. William revealed he was unaware there were two Tiwi languages: modern and traditional. He asked NT AIS trainer Mandy to explain the difference between them. Dr. William appeared to be exposing his lack of knowledge as a learning opportunity in front of his junior staff (VK field notes 14/8/19). Over 10 days, this new pattern of discussing patients was standardised. Dr. Sean said this led to a shift in care as patients were considered in terms of *"Who they are, rather than what they are"*.

Another obvious consequence of embedded interpreters was the length of bedside consults with Yolŋu and Tiwi patients increased from 5 to 10 min to 40 min to 1 h. Drs William, Sean and Jack deemed this necessary to make up for years of miscommunication. Dr. Sean said*: "things take longer when you're actually speaking to your patients"*. Dr. Jack said spending time communicating in the patient's first language resulted in better time management overall: *"you spend less time chasing your tail, miscommunicating about something over and over again"*. Ward rounds which previously finished before midday were now continuing until mid-afternoon, meaning paperwork was not completed in a timely manner. Dr. Sean said a lengthy ward round should not be blamed on interpreters but on the doctors, who were learning how to work in a culturally safe system. However, the lengthy interpreter-mediated consults caused some disharmony amongst the renal team who noticed other language speakers were neglected. This caused an argument amongst doctors concerned that Tiwi and Yolŋu patients were receiving preferential treatment:

> *"it's frustrating that patients who don't speak Tiwi or Yolŋu Matha are being neglected but for now I'm enjoying that we have a preferential option for Yolŋu and Tiwi people. Compared to the usual preferential option for non-Aboriginal people found in the Royal Darwin Hospital."* - Dr Sean, journal 20/8/19

Finally, despite the perceived preferential treatment for Yolŋu and Tiwi patients, access to other Aboriginal language interpreters also improved because of the presence of the NT AIS trainer Mandy. During the pilot it was unclear who, amongst health staff, had responsibility to identify patient language needs or book interpreters. Mandy noticed this and took on the role of booking interpreters for the renal team. Dr. Jack appreciated Mandy's initiative which meant interpreters were often available within an hour. Dr. William said having someone who was responsible to book interpreters embedded in the medical team meant *"family meetings which would have taken a week, were done on the same day."* It was not possible to track all additional interpreter bookings generated by Mandy however VK observed on just 1 day (26/11/19) Mandy arranged for 3 extra interpreters for patients who spoke Ngaringman, Murrinh-Patha and Ngan'gikurunggurr.

Developing knowledge

As outlined above, healthcare provider knowledge of Aboriginal languages spoken in the north of Australia was poor. During period 2, amongst a group of 6 doctors (plus 3 medical students) none knew that Yolŋu Matha referred to a group of dialects which includes Djambarrpuyŋu and Gupapuyngu (VK field notes 25/11/19). Dr. Jack said the lack of knowledge *"speaks to the emphasis that we place on the importance of our Aboriginal patients"*. However, during the pilot, knowledge of dialects and languages spoken in the NT increased amongst doctors with some learning a few phrases. At the bedside of a hospitalised Yolŋu Elder, Dr. William asked Yolŋu Matha interpreter Carly to teach his team the Yolŋu Matha words for 'good', 'no good' and 'goodbye'.

Interpreters were pleased with this and explained that learning words or phrases showed respect to the patient.

By working closely with interpreters, doctors observed culturally appropriate ways of communicating. For example, in family meetings which included an interpreter, Dr. Jack said he learnt about the importance of listening and remaining silent during interactions to allow patients to consider information. He also learnt that Aboriginal patients make decisions not as individuals but from a collective standpoint considering family, community, culture and medical advice:

> "*The presence of an interpreter allowed an understanding of the negotiation processes of health decision making which are so far from our own. We typically view our patients as rational individuals making decisions solely based on the evidence provided without significant influence of a wider range of factors. A dispassionate health consumer, who will always act in self-interest. I think we overestimate our importance and the seemingly irrefutable strength of our recommendations … ..we need to give space and time to our patients and their families to go through processes that I cannot begin to comprehend."* – Dr Jack, journal 26/11/19

Dr. Sean believed the pilot was a seminal experience for him and others, especially junior doctors and medical students who were still developing their skills. During Period 1, a medical student from the UK said he learnt more from working alongside the Yolŋu Matha and Tiwi interpreter over 10 days than he did from previous cultural awareness courses.

Just as doctors benefited from in situ learning, so too did interpreters. Pre ward round meetings were an opportunity for doctors to explain procedures to interpreters which would then be explained to the patient. VK observed a registrar explaining to interpreter Carly the medical procedure referred to as a "tap". Dr. Sean said his and Carly's professional relationship strengthened across 10 days and they developed an efficient communication style. He is confident that with the right support and training all interpreters and doctors can experience the same:

> *"She was able to pre-empt things. She's heard me explain this thing ten times, she can actually just crack on. She knows what she's talking about, and she knows what I want to say.* – Dr Sean

Challenging attitudes

A mix of attitudes towards communicating with patients in their first language and working with interpreters was exposed. After just 1 day of working with embedded interpreters, Dr. William realised the "*gravity*" of communication: *"I've been communicating with people for years who really didn't understand what we were saying to them."* With interpreters present, Dr. William felt more confident he was delivering culturally competent care. Dr. Sean provided the following example of communicating with and without an interpreter with the same patient:

> *"Speaking to a patient in their language allowed us to explain why she's sick and what we can do for them. They, for maybe the first time, were consented for their procedure in their first language. However, while consented in their first language, doing the procedure at 2pm without an interpreter was very challenging. The requirement to give painful needles to take away the pain of later needles wasn't something I was able to communicate to this patient in English, their 3rd or 4th language. It was traumatic for everyone involved."* - Dr Sean, journal 15/8/19

This situation was stressful for the patient and the health providers, so the decision was made to delay the procedure. One week later with the interpreter present the required procedure was completed:

> *"Last Thursday, we had a frightened panicked patient, today the use of an interpreter during the procedure allowed me to explain the scans, the needles and what would happen next in the person's first language. It went well."* - Dr Sean, journal 22/8/19

Some doctors working on the periphery of the pilot noticed the benefits of working with interpreters and questioned the effectiveness of their own communication. A senior renal registrar started asking her patients if they knew why they were on dialysis. To her surprise, she discovered most patients did not know. She then rectified the situation by booking appropriate interpreters to explain to the patients their condition. Dr. Sean hoped the pilot contributed towards valuing communication in the hospital:

> "*The talking bit of medicine - that's the most important bit of medicine … we have million dollar machines that do fancy scans, most of the diagnoses we make are based on talking to someone"* - Dr Sean

Not all health staff welcomed the pilot experience. During period 1, although the doctor group was enthusiastic, some allied healthcare providers feared embedding interpreters would stymie their capacity to deliver care. Dr. William journaled (14/8/19) MDT members requested a meeting: "*two of the members who called me*

privately to their offices thought it was unnecessary and was going to undermine their work. I was not sure how and they could not explain how." During period 1, doctors and NT AIS staff observed these attitudes and expressed concern some staff appeared to have prioritised themselves over patient needs. Three months later when period 2 commenced, doctors who participated in period 1 had been replaced by a new cohort. On Day 1 of period 2 the new group appeared disinterested in working with interpreters; one team member, who was in favour of the pilot, described the pre ward round MDT meeting, with interpreters present, as a "*shitshow*". Dr. Jack journaled the same allied health staff who discreetly expressed concern in period 1 now openly displayed contempt: "*Morning handover was rushed, chaotic and very tense, with a degree of hostility between members of the MDT* (multi-disciplinary team) *family."* After the meeting, doctors divided into two teams to undertake their ward rounds and the Yolŋu Matha interpreter joined one team. Dr. Jack overheard a junior doctor ask the interns:

> *"'Are you coming with us or are you going to join the parade?' It highlighted the perception among some staff that it is not an integral or even important part of our practice to be able to communicate with our patients. It is viewed as a quaint exercise that has no real impact."* – Dr Jack, journal 25/11/19

Despite some resistance, after working collaboratively with doctors, the pilot interpreters reported feeling like valued members of the MDT. Period 1 interpreter Carly said: *"We went from strangers, to friends, to family"*. Period 2's Yolngu interpreter Joanna, who had previously described doctors as intimidating like police, said working alongside Dr. William made her feel valued: *"I felt like I was his shadow"*. Embedded in the medical team with a clearly defined role, Joanna said she felt culturally safe.

> *"We were all just one colour. That's how I felt. I didn't really see a black or white in the room at all, and there was a lot of different races in there. African, there was a few Asians, non-Indigenous, Yolŋu … It was like we were all the same colour in there."*- Joanna, Yolŋu Matha interpreter

After working across both periods 1 and 2, NT AIS trainer Mandy confirmed interpreters were "*feeling much more valued and comfortable with medical staff*" but said further work was required to improve relations to ensure sustainable change. Mandy was also concerned the negative attitudes previously felt by Aboriginal interpreters were also experienced by Aboriginal patients. Mandy thought health staff lacked an awareness of patient needs beyond the biomedical and appeared insensitive and unkind to Aboriginal peoples*: "I could just feel body language"*. Mandy was hesitant to label the attitudes as racist, fearing patients may experience a backlash:

> *"Racism is a very big word, and maybe it's their ignorance and not understanding Aboriginal people's ways … and not taking into account that they've got to come from community, leave their country behind and family … to get their treatment.* - Mandy, NT AIS trainer

By participating in the pilot Dr. Jack said he and his colleagues started to talk about patients "*in their own humanity"* which challenged racist stereotypes and changed attitudes:

> *"You're using interpreters and you have an actual meaningful discussion with someone … it gets you to understand who they are, and I think understanding their wishes is mandatory. I think that if we're seeing patients without actually understanding what they want and whether they consent to something, that's criminal."* – Dr Jack

Communicating with patients in their first language builds trust between patient and provider which is required to deliver culturally safe health care. Yolŋu Matha interpreter Carly said without effective communication "*nothing works*". She continued: "*communication is the life of any relationship"*.

Post-pilot: opportunities and barriers to sustainable change

Systemic change is required to ensure the positive changes experienced by individuals during the pilot can be experienced more widely. Doctors and interpreters believed the pilot showed how medicine should be delivered in the NT. Reflecting on his experience Dr. Sean declared:

> *"English is not the language of the Royal Darwin Hospital … There's many languages that are the language of the Royal Darwin Hospital, and it was quite nice for two weeks to be efficient and be able to be a doctor in a hospital where I don't speak the language."* – Dr Sean

To ensure the model is sustainable, the following opportunities and barriers need to be considered. Firstly, more cultural education is required. Secondly the lack of trained Aboriginal language interpreters needs to be addressed. Thirdly policies are required to ensure sustainable change.

Cultural education

During the pilot Dr. William, wanting to praise the interpreter, said *"I don't need cultural awareness training, I just need an interpreter."* (VK field notes 14/9/19) However Mandy explained intercultural communication requires more than an interpreter because *"even when an interpreter's there, that white person, the English speaker, can say something wrong."* Incidents were related in which patients were offended by attitude and tone. In one situation, a patient told Mandy that a healthcare provider was "*too pushy*". Mandy feared staff would resist cultural training which was confirmed by Dr. Jack who journaled (25/11/19) "*the resistance is palpable in eyerolls and groans*". He explored the idea further in an interview saying that cultural education was seen as *"an imposition that's in the way of getting on with our business"* but then also suggested TEHS should mandate all staff learn a language indigenous to the NT:

> *"Maybe they should just say, 'Oh, if you haven't learned an Aboriginal language in your first five years of being here, then we're not going to renew your contract'."* – Dr Jack

More trained interpreters

A lack of trained interpreters is a barrier to implementing sustainable change. For example, Kunwinkju was the third most spoken language on the renal ward during the pilot however there was only one Kunwinjku interpreter in Darwin employed by the NT AIS and they were working for the justice system. Doctors suggested it may be beneficial to employ interpreters directly at the hospital to ensure access and to build a cohort of health interpreters. Some interpreters felt under-prepared working in the health setting because the NT AIS was unable to deliver consistent health training to interpreters over the last 5 years. NT AIS trainer Mandy was concerned the hospital did not have appropriate systems and cultural knowledge to safely employ and support Aboriginal interpreters directly. Instead, she hoped the two organisations could develop training together to ensure interpreters became familiar with health terminology and familiar with hospital processes. Until more interpreters are trained and employed, Joanna suggested RDH patient lists could be emailed to the NT AIS each afternoon so staff could identify language needs based on patient last names and book interpreters for the following day:

> *"It's just a matter of an email, and boom, boom, boom – Mandy's really good at picking up someone out of nowhere. Get the list to the bookings team: this is the patients. They can identify the most needed at that time and then send them out."*- Joanna, Yolŋu Matha interpreter

Policies

Finally, policies are required to counter resistance and to ensure changes are not dependant on frontline individuals. Across the pilot, doctors led by the specialist Dr. William were communicating respectfully and effectively with patients but when Dr. William completed his rostered 2 weeks as leader, communication changed. Dr. Sean described another specialist's style of communication as follows: "*the boss's style of practicing medicine, is standing at the end of the bed with his arms folded shouting for a few minutes and walking on."* Dr. Jack believed it will take a "*momentous effort*" to see the model embedded in the hospital and Mandy feared change will only occur after the institution or individuals face penalties:

> *"not until something drastic happens and they've got a compensation claim put in, or a coroner's report...It's a lot cheaper to get an interpreter than to go on your merry way and think that everyone understands good English."*- Mandy, NT AIS trainer

Participating doctors and interpreters would like the model of embedded interpreters in the renal team to continue. They also agreed there is scope to adapt the model for other divisions within the hospital. Dr. Sean proposed an idea that he said would *"fly in the face of medical tradition".* He suggested that RDH medical teams be arranged to work with language groups which would allow healthcare providers, interpreters, and patients to develop relationships.

> *"And surgery would work slightly differently because of the demands of surgery, but I think on a general medicine team, you could... general medicine East Arnhem, general medicine the Daly region … But you have interpreters 8:00 to 4:00, Monday to Friday, who then get to know the doctors, get to know the patients, get to know how the team works".* – Dr Sean

Discussion

This paper documents hospital-based healthcare providers and interpreter attitudes towards working together at RDH and the changes which occurred after interpreters were embedded in a renal team over 4 weeks. The analysis reveals benefits and challenges for all involved. Benefits for doctors included improved knowledge of Aboriginal languages and communication styles and increased confidence in working with interpreters. Collaborating consistently with interpreters

resulted in doctors feeling more culturally competent when working with Aboriginal language speaking patients. During the pilot, interpreters shifted from feeling unwelcome and undervalued [37] to respected co-healthcare professionals and valuable allies; an approach supported by previous research [48]. Additionally, interpreter's health literacy improved, and they became active participants in the MDT sharing power and responsibilities with doctors to ensure patient wellbeing. This model of working "with" not "next to" [48] clinicians contrasts with guidelines which present interpreters and healthcare providers as separate. These beneficial outcomes occurred because doctors changed their behaviour which allowed interpreters to surpass the "invisible role as mere linguistic conduits" [48]. Our research found, culturally competent healthcare providers, who collaborate with Aboriginal language interpreters, have the potential to deliver culturally safe care [5]. Aboriginal language speaking patients who feel culturally safe have better health trajectories which can result in less demand on health services [5]. This is referred to as "interest convergence" [49]. Critical race theorists argue when the interests of the "the dominant group, namely White people" converge with those experiencing discrimination, change is more likely to occur [50].

The discussion will now turn to challenges identified by primarily focusing on the attitudes and behaviour of healthcare providers. It is vital to understand the healthcare providers experience because cultural safety places the onus for change on the healthcare provider and the hegemonic institutions [3, 28]. Through understanding healthcare provider perspectives insights are gained into how health systems reproduce inequitable health outcomes [51].

Before the pilot, doctors' attempts to communicate with patients in their first language were thwarted by perceived hospital priorities. Participating doctors were frustrated and disheartened by their inability to work with Aboriginal language interpreters but attempts to engage interpreters were often impeded by time pressures. Aligning with US research, we found doctors made decisions "about interpreter use by weighing the perceived value of communication in clinical decision making against their own time constraints" [7]. We also found patients who did not converse may be preferred by some providers who aimed for efficient ward rounds. Doctors are taught to control a bedside consult by using a "medical voice" to manage content and duration of the conversation [52]. While important for obtaining required aspects of the medical history, this communication style has been described as "an apparatus of colonisation" used to control Indigenous peoples [53]. During the pilot, doctors changed their communication style to work collaboratively with interpreters thereby testing the conviction that spending time communicating with a patient was inefficient and ineffectual. With interpreters present, the duration of bed side consults extended from 10 min to in some cases 1 hour. Doctors were genuinely listening to patients, which built trust between patient and provider, thereby rehumanising the patient and reducing the power differential [5]. Previous research has asserted investing time communicating with Aboriginal language speaking patients in their first language will have "immense payoffs over the long term." [54] Our research found after having consistent access to Yolngu Matha and Tiwi interpreters patients felt culturally safe, health trajectories improved and there was a reduction in so called "frequent flyer" patients re-presenting to hospital [5]. As reported here, we also found when doctors invested time in culturally safe communication practices, they were more satisfied with the culturally competent care they were delivering.

Doctors' attempts to work with interpreters were also stalled by unconscious and overt individual bias. Research suggests that about 75% of Australians have unconscious bias against Aboriginal and Torres Strait Islander peoples [55]. As RDH is a microcosm of broader society, negative perceptions found outside the hospital can be replicated inside the hospital. Furthermore, hospital based health professionals who work long hours in stressful environments where decisions need to be made quickly are more prone to making decisions based on unconscious bias [56]. It is also vital to recognise that medicine has a history of systemic racism [57, 58]. Systemic racism has been defined as the failure of the "system to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin' [59]. In Australian hospitals historically, Aboriginal patients were segregated and treated in separate wards. At one Top End hospital, the so called "Native Ward" only closed in 1979 [60]. This is in living memory of both long-term health providers and patients. Whilst overt segregation policies no longer exist in Australia, the insidious convention continues to manifest in the colonised nation as described above by doctors. By increasing the number of Aboriginal professionals in the hospital ie. interpreters, the internalized ideologies of non-Indigenous healthcare providers that Aboriginal peoples were deviants, perpetrators or victims was challenged by counter knowledge [47] offered by NT AIS staff. These opportunities assisted in correcting the skewed perception of Aboriginal peoples and lead to some healthcare providers, experiencing what King [47] has referred to as "transformative emotional growth experiences". Participating doctors who supported this new model of working with interpreters had a level of "critical consciousness" [61, 62] which enabled them to reflect on their own "assumptions, biases, and values" and

the institutions in which they work [61]. As a result of their critical consciousness they tested a new way of working with interpreters which required a change in their behaviour to improve health service delivery [55, 63]. Whilst it may be challenging for the anti-racist healthcare provider to accept bias, racialised thinking is virtually inevitable [63, 64] and when accepted, opportunities for change occur as observed in this pilot.

Another challenge which impeded interpreter mediated communication was the hospital culture. RDH staff were socialised into an institution which diminished Aboriginal cultures, as displayed by poor patient language documentation [37], low attendance rates at cultural awareness training [36], low uptake of Aboriginal interpreters [27], and low levels of staff knowledge of Aboriginal languages. Low uptake of Aboriginal interpreters has been blamed on supply issues. However, as we observed even when interpreters were readily available resistance continued. It has been argued this occurs because Aboriginal peoples are expected to assimilate into English speaking Australia [65]. This assertion is supported by evidence which states interpreters of migrant languages are more common than Aboriginal language interpreters in the Australian health care system [24]. Regarding cultural education, before the pilot, approximately 30% of TEHS staff had attended cultural awareness training [36]. Low attendance could imply staff disinterest, but research found TEHS staff wanted more cultural education and in fact low attendance was more likely attributable to the organisational decision to offer cultural education outside of paid work hours [36]. This has since changed [66]. During the pilot, we found further evidence that cultural education is valued by TEHS staff. Cultural education in the form of 'working with interpreter training' was delivered as a part of medical training curricula. Initially doctors appeared unconvinced of the value of the training as indicated by the admission it was "squeezed in". However, after experiencing 'working with interpreter training' which included information on Aboriginal languages spoken in the NT, doctors were convinced the training was invaluable, stating it should be mandated. There are two major benefits to incorporating cultural education into the clinical training curricula. Firstly, when training is delivered during the clinician's workday, it indicates to staff that the organisation values cultural competency as much as clinical competencies [36]. Secondly, attendees can quickly translate learnings into practice thereby testing out and normalising behaviour change [67].

The pilot also identified patterns of ingrained behaviour requiring institutional attention to ensure the delivery of culturally safe care. Firstly, responsibility for booking interpreters should be delegated to identified staff members in each MDT. If patient languages were methodically documented and information provided daily to the NT AIS, the service may be able to prepare casual staff for work the following day. Secondly, we identified two common justifications as to why interpreters were not utilised. Staff assert interpreters are not required because the patient speaks "good English". The judgment is made based on conversational English not by using a validated assessment tool [5]. Once the assertion is made it is taken as fact, and rarely questioned by colleagues. The habit of judging a patient's English proficiency must be overturned. It is the language proficiency of the provider that requires assessment [5]. If the provider does not speak the patient's language, an interpreter is required. This is culturally safe patient centred care. The concept is now promoted amongst TEHS staff, but work is still required to educate staff on the necessary paradigm shift. Considering the cultural and language diversity amongst TEHS staff, about 22% speak English as a second language [68], it could be assumed the value of communicating in first language would be appreciated as indicated by Dr. William. However, healthcare providers appeared to accept the hegemonic Australian culture, the culture of medicine and hospitals over their own understanding of the importance of communicating in first languages. The acceptance of White institutionalised norms, by some healthcare providers, revealed a lack of critical consciousness [62] which has been called dysconscious racism [47]. Dysconsciousness is an uncritical habit of mind that justifies inequity by accepting the status quo [47]. Dysconcious racism risks patient safety [69]. Staff also commonly state patients do not require an interpreter because they did not request one. This assertion ignores that all exchanges between healthcare providers and patients are "power laden" in favour of the provider [3, 4]. This idea was explained by Aboriginal linguist Gloria Brennan in a 1979 Australian government commissioned report on the need for Aboriginal languages interpreters in hospitals: *"It is generally assumed that the more powerful of the two parties will get his message across."* [70] Healthcare providers control both clinical treatment and communication. Just as a patient is not expected to request a nephrologist or a nurse, they should not be expected to request an interpreter. We acknowledge these justifications may have developed in reaction to a history of unsatisfactory experiences in which interpreters were unavailable. However, these approaches create a self-perpetuating cycle of staff dissatisfaction, and both statements contribute to a culturally unsafe service. The assertions dissociate Aboriginal peoples from their culture and deny Aboriginal peoples the right to speak their language, as deemed a human right by the NT Ombudsmen [71] and set out by the United Nations Declaration on the Rights of Indigenous Peoples [72]. These patterns of behaviour can be

addressed through better training as described above and updated hospital policies which could be disseminated to staff through an internal marketing campaign.

As per critical theory, we purposefully focussed our discussion on issues the institution can address as hospitals are regarded as being considerably resistant to change [73]. However, our research also revealed issues requiring attention from the NT AIS. Future models must consider how best to support, develop and retain the Aboriginal interpreter workforce [71]. Regarding support, Aboriginal interpreters often face the same social and cultural determinants of health which lead to their family members being hospitalised as patients. As we saw during the pilot, one interpreter required treatment from the Emergency Department twice during a 5-day work period and another had a family member hospitalised during the pilot study. Employers must understand and adapt to the personal circumstances, family and cultural obligations interpreters juggle alongside the expectations of non-Indigenous colleagues who work within "'Western' models of clinical governance and management" [74]. Regarding development, there is a small pool of trained Aboriginal interpreters overall and even fewer trained in health communication. NT AIS interpreters require health training to ensure they are equipped, and confident, to work in the clinical setting. As suggested by Mandy from the NT AIS, this training could be developed as a collaboration between the NT AIS and the NT Department of Health. In terms of retention, the small number of trained interpreters may be associated with employment conditions. All interpreters involved in the pilot were employed casually by the NT AIS. Casual employees face irregular and potentially insufficient work hours, resulting in fluctuations in earnings and are also much less likely than permanent employees to have access to on-the-job training [75].

In the 18 months since this pilot study was undertaken, the hospital has funded employment of up to four part-time interpreters, in addition to contracting interpreters from the NT AIS. It is a positive change which will require sustained education of the hospital staff regarding the delivery of culturally safe care and careful mentoring and support for the interpreters. In consultation with researchers, TEHS has also developed, and adopted, new training modules including the Ask the Specialist podcast [76] which promotes the importance of culturally competent communication with and without Aboriginal interpreters.

A methodological strength of the study was the in-depth qualitative research which revealed dysfunction and the potential for change to redress inadequate systems [77]. We acknowledge this specific model of embedding interpreters in a medical team during morning ward rounds may not be suitable for other hospital departments such as the Emergency Department. However, our findings reveal that barriers to interpreter use stretch beyond the pragmatic issue of interpreter availability and deployment. As suggested, work is required to address the individual and systemic racism which diminishes Aboriginal cultures in health care. We also acknowledge each healthcare provider subgroup lacked gender diversity however this arose from the pragmatic approach which reflected consent processes and staffing at the time.

Conclusion

This model of Aboriginal interpreter-mediated communication to improve the delivery of culturally competent care provides a viable alternative to the current unsatisfactory approach. Systemic changes are required to ensure the benefits of collaborating with interpreters during the pilot are sustained and scaled up. Continued education of hospital staff about the delivery of culturally safe care, together with mentoring and support for interpreters to ensure a culturally safe workplace should be prioritised. We have provided qualitative evidence regarding the value of culturally competent and interpreter mediated communication in hospital, paving the way for work to examine short term and intermediate cost and health benefits. We contend that investment in culturally safe communication is likely to rival investment in other aspects of healthcare such as expensive diagnostic machines.

Abbreviations

AHP: Aboriginal Health Practitioner; MDT: Multi-Disciplinary Team; NT: Northern Territory; NT AIS: Northern Territory Aboriginal Interpreter Service; PAR: Participatory Action Research; RDH: Royal Darwin Hospital; TEHS: Top End Health Service

Acknowledgements

The authors would like to thank: TEHS, the RDH Division of Medicine, RDH renal department staff, Dr Maddison Hall from RDH, Curtis Roman from the NT AIS and NT AIS staff.

Authors' contributions

VK and SWM conceived the pilot. VK, SYM, SWM, MW, MA, MH, AC and APR contributed to study design. VK, SYM and MA collected data. VK, SYM and MH conducted analysis. VK drafted the manuscript with input from SYM, MH and APR. All authors read and approved the final transcript.

Funding

Vicki Kerrigan is supported by an Australian Government Research Training Program Scholarship and Improving Health Outcomes in the Tropical North: A multidisciplinary collaboration (HOT NORTH)', (NHMRC GNT1131932). Stuart Yiwarr McGrath was supported by HOT NORTH Indigenous Development and Training Award (NHMRC GNT 113193). Anna P Ralph is supported by an NHMRC fellowship 1142011. Funding to undertake data collection was provided by the Menzies School of Health Research Grants Scheme. The NT AIS provided interpreters and the interpreter trainer in kind.

Availability of data and materials

Data from the study are not publicly available due to ethical considerations. Data may be available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Approval to conduct the study was provided by the Northern Territory Department of Health and Menzies School of Health Research Ethics Committee (HREC-2017-3007 and HREC-2019-3295). The study conducted is in accordance with the Declaration of Helsinki guidelines.

Consent for publication

Consent was given by all participants.

Competing interests

At time of writing, Sandawana William Majoni and Anna P Ralph were employed by Top End Health Service. Michelle Walker and Mandy Ahmat were employed by the NT Aboriginal Interpreter Service. Alan Cass was a Board Director for Top End Health Service from 2015 until June 2017. Bilawara Lee was a member of the TEHS Health Advisory Group and a member of the NT Health Ministers Advisory Committee. No competing interests were declared by other authors.

Author details

[1]Menzies School of Health Research, Charles Darwin University, PO Box 41096, Casuarina, Darwin, NT 0811, Australia. [2]Royal Darwin Hospital, Darwin, NT 0811, Australia. [3]Flinders University, Northern Territory Medical Program, Darwin, NT 0815, Australia. [4]Aboriginal Interpreter Service, Northern Territory Government, GPO Box 4396, Darwin, NT 0801, Australia. [5]Charles Darwin University, PO Box 41096, Casuarina, Darwin, NT 0811, Australia.

Received: 27 May 2021 Accepted: 8 July 2021
Published online: 23 July 2021

References

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. In: Overview. 2nd ed. Sydney: NSW; 2017.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. In: User Guide for Aboriginal and Torres Strait Islander Health. Sydney: NSW; 2017.
3. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu. Wellington: Victoria University of Wellington; 2002.
4. Jennings W, Bond C, Hill PS. The power of talk and power in talk: a systematic review of indigenous narratives of culturally safe healthcare communication. Aust J Prim Health. 2018;24(2):109–15. https://doi.org/10.1071/PY17082.
5. Kerrigan V, McGrath SY, Majoni SW, Walker M, Ahmat M, Lee B, et al. From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital. BMC Health Serv Res. 2021; 21(1):548. https://doi.org/10.1186/s12913-021-06564-4.
6. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical Care for Patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007;42(2):727–54. https://doi.org/10.1111/j.1475-6773.2006.00629.x.
7. Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A. Getting by: underuse of interpreters by resident physicians. J Gen Intern Med. 2009; 24(2):256–62. https://doi.org/10.1007/s11606-008-0875-7.
8. Estrada RD. An analysis of interpreter-mediated healthcare interactions. University of South Carolina - Columbia: ProQuest Dissertations Publishing; 2014.
9. Gray B, Hilder J, Donaldson H. Why do we not use trained interpreters for all patients with limited English proficiency? Is there a place for using family members? Aust J Prim Health. 2011;17(3):240–9. https://doi.org/10.1071/PY10075.
10. Blay N, Ioannou S, Seremetkoska M, Morris J, Holters G, Thomas V, et al. Healthcare interpreter utilisation: analysis of health administrative data. BMC Health Serv Res. 2018;18(1):348. https://doi.org/10.1186/s12913-018-3135-5.
11. Northern Territory Government. Aboriginal languages in NT 2018. Available from: https://nt.gov.au/community/interpreting-and-translating-services/aboriginal-interpreter-service/aboriginal-languages-in-nt.
12. Australian Institute of Aboriginal Torres Strait Islander Studies ANU. National Indigenous languages report. Canberra: Government of Australia; 2020.
13. Australian Bureau of Statistics. Census of Population and Housing: Characteristics of Aboriginal and Torres Strait Islander Australians, 2016. Available from: https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/census-population-and-housing-characteristics-aboriginal-and-torres-strait-islander-australians/latest-release.
14. Commonwealth of Australia, Department of the Prime Minister and Cabinet. Closing the Gap Report 2020. Canberra: Australian Government; 2020.
15. Australian Institute of Health and Welfare. Medical practitioners workforce 2015. Available from: https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015/contents/who-are-medical-practitioners.
16. NT Coroner Court. Inquest into the death of Henry George Wilson aka Albert George Wilson [2018] NTLC 022. Darwin: Findings of Judge Greg Cavanagh; 2018.
17. NT Coroner Court. Inquest into the death of Kristelle Ruby Mulladad aka Oliver [2010] NTMC 64. Alice Springs: Findings of Mr Greg Cavanagh; 2010.
18. Mitchell A, Lowell A, Ralph A. Report on the patient educator service at Royal Darwin Hospital, 2001–2009: insights into inter-cultural communication in healthcare. Darwin: Research gate; 2016.
19. Henry B, Dunbar T, Barclay L, Thompson R. Self-discharge against medical advice from Northern Territory Hospitals. In: Prevalence rates, experiences and suggestions, economic implications and recommended strategies for improvement. Darwin: A report prepared for the Department of Health and Community Services: Charles Darwin University and the Cooperative Research Centre for Aboriginal Health; 2007.
20. Lowell A, Maypilama E, Yikaniwuy S, Rrapa E, Williams R, Dunn S. "hiding the story": indigenous consumer concerns about communication related to chronic disease in one remote region of Australia. Int J Speech Lang Pathol. 2012;14(3):200–8. https://doi.org/10.3109/17549507.2012.663791.
21. Chong A, Renhard R, Wilson G, Willis J, Clarke A. Improving cultural sensitivity to indigenous people in Australian hospitals. A continuous quality improvement approach. Focus Health Prof Educ. 2011;13(1):84–97.
22. Skinner T, Blick J, Coffin J, Dudgeon P, Forrest S, Morrison D. Comparative validation of self-report measures of negative attitudes towards Aboriginal and Torres Strait islanders. Int Electr J Rural Remote Health Res Educ Pract Policy. 2013;13:1–9.
23. Kelaher MA, Ferdinand AS, Paradies Y. Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Med J Aust. 2014;201(1):44–7. https://doi.org/10.5694/mja13.10503.
24. Taylor K. In: Guerin P, editor. Health care and Indigenous Australians : cultural safety in practice. 2nd ed. South Yarra: Palgrave Macmillan; 2014.
25. White J, Plompen T, Osadnik C, Tao L, Micallef E, Haines T. The experience of interpreter access and language discordant clinical encounters in Australian health care: a mixed methods exploration. Int J Equity Health. 2018;17(1):151. https://doi.org/10.1186/s12939-018-0865-2.
26. Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. J Gen Intern Med. 2012;27(10):1294–9. https://doi.org/10.1007/s11606-012-2041-5.
27. The Communicate Study group. Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study. Med J Aust. 2020;213(4):180–1. https://doi.org/10.5694/mja2.50700.
28. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health. 2019;18(1):174. https://doi.org/10.1186/s12939-019-1082-3.
29. Cross T, Bazron B, Dennis K, Isaacs M. Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed. Washington, DC: Georgetown University Child Development Center; 1989.
30. Doutrich D, Arcus K, Dekker L, Spuck J, Pollock-Robinson C. Cultural safety in New Zealand and the United States:looking at a way forward together. J Transcult Nurs. 2012;23(2):143–50. https://doi.org/10.1177/1043659611433873.
31. Fredericks B, Bargallie D. An indigenous Australian cultural competence course: talking culture, race and power. In: Frawley J, Russell G, Sherwood J, editors. Cultural competence and the higher education sector: Australian perspectives, policies and practice. Singapore: Springer Singapore; 2020. p. 295–308. https://doi.org/10.1007/978-981-15-5362-2_16.
32. Hall B. Research, commitment and action: the role of participatory research. Int Rev Educ. 1985;30(3):289–99. https://doi.org/10.1007/BF00597906.
33. Baum F, MacDougall C, Smith D. Participatory action research. J Epidemiol Community Health. 2006;60(10):854–7. https://doi.org/10.1136/jech.2004.028662.

34. Kemmis S, McTaggert R, Nixon R. The action research planner: doing critical participatory action research. New York: Springer; 2014. https://doi.org/10.1007/978-981-4560-67-2.
35. Menzies School of Health Research. The Communicate study (Stages 1 and 2) 2018. Available from: https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/The_communicate_study_stages_1_and_2/.
36. Kerrigan V, Lewis N, Cass A, Hefler M, Ralph AP. "How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload. BMC Med Educ. 2020;20(1):173.
37. Mithen V, Kerrigan V, Dhurrkay G, Morgan T, Keilor N, Castillon C, et al. Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care. Health Promot J Austr. 2021;32(S1):155–65. https://doi.org/10.1002/hpja.415.
38. Delgado R. In: Harris A, Stefancic J, editors. Critical race theory (third edition): an introduction. 3rd ed. New York: New York University Press; 2017. https://doi.org/10.2307/j.ctt1ggjjn3.
39. Habermas J. The philosophical discourse of modernity: twelve lectures. Cambridge: Cambridge: Polity in association with Basil Blackwell; 1987.
40. Bronner SE. Of critical theory and its theorists. 2nd ed. New York: Routledge; 2002.
41. Kowal E. The politics of the gap: indigenous Australians, Liberal multiculturalism, and the end of the self-determination era. Am Anthropol. 2008;110(3):338–48. https://doi.org/10.1111/j.1548-1433.2008.00043.x.
42. Hooks B. Yearning: race, gender, and cultural politics. New York: Routledge, Taylor & Francis Group; 2015.
43. Canlas IP, Karpudewan M. Blending the principles of participatory action research approach and elements of grounded theory in a disaster risk reduction education case study. Int J Qual Methods. 2020;19:1609406920958964.
44. Patton MQ. In: Patton MQ, editor. Qualitative evaluation and research methods. 2nd ed. Newbury Park: Sage Publications; 1990.
45. Gabel S. Power, leadership and transformation: the doctor's potential for influence. Med Educ. 2012;46(12):1152–60. https://doi.org/10.1111/medu.12036.
46. Clandinin DJ. Handbook of narrative inquiry mapping a methodology: thousand oaks, Calif. London: SAGE; 2007. https://doi.org/10.4135/9781452226552.
47. King JE. Dysconscious racism: ideology, identity, and the Miseducation of teachers. J Negro Educ. 1991;60(2):133–46. https://doi.org/10.2307/2295605.
48. Álvaro Aranda C, Gutiérrez RL, Li S. Towards a collaborative structure of interpreter-mediated medical consultations: complementing functions between healthcare interpreters and providers. Soc Sci Med. 2021;269:113529. https://doi.org/10.1016/j.socscimed.2020.113529.
49. Bell D. Silent covenants: Brown v. In: Board of Education and the unfulfilled hopes for racial reform. New York: Oxford University Press; 2020.
50. Rea Preston L. 'I'm gonna use this White face!': missteps of becoming a 'race'-cognizant White scholar. White Educat. 2019;4(2):146–61.
51. Smedley BD. In: Smedley BD, Stith AY, Nelson AR, editors. Unequal treatment confronting racial and ethnic disparities in health care. Washington, D.C.: National Academy Press; 2003.
52. Mishler EG. The discourse of medicine : dialectics of medical interviews. Norwood: Ablex Pub. Corp.; 1984.
53. Eckermann A-K. Binan Goonj: bridging cultures in Aboriginal health. 3rd ed. Sydney: Churchill Livingstone; 2010.
54. Amery R. Recognising the communication gap in indigenous health care. Med J Aust. 2017;207(1):13–5. https://doi.org/10.5694/mja17.00042.
55. Shirodkar SV. Bias against indigenous Australians: implicit association test results for Australia [online]. J Austr Indigen Issues. 2019;22(3–4):3–34.
56. Byrne A, Tanesini A. Instilling new habits: addressing implicit bias in healthcare professionals. Adv Health Sci Educ Theory Pract. 2015;20(5):1255–62. https://doi.org/10.1007/s10459-015-9600-6.
57. The Lancet. Institutionalised racism in health care. Lancet. 1999;353(9155):765. https://doi.org/10.1016/S0140-6736(99)00039-2.
58. Chadha N, Lim B, Kane M, Rowland B. Toward the abolition of biological race in medicine. UC Berkeley: Othering & Belonging Institute; 2020.
59. Australian Government. National Aboriginal and Torres Strait islander health plan 2013–2023. 2013.
60. Ascott J. A brief history of Katherine Hospital 1934–1994: on behalf of the Katherine Hospital management board to commemorate the 60th anniversary of the establishment of Katherine Hospital; n.d.
61. Kumagai AK, Lypson ML. Beyond cultural competence: critical consciousness, social justice, and multicultural education. Acad Med. 2009;84(6):782–7. https://doi.org/10.1097/ACM.0b013e3181a42398.
62. Freire P. Pedagogy of the oppressed. New York: New York Herder and Herder; 1970.
63. Paradies Y, Franklin H, Kowal E. Development of the reflexive antiracism scale – indigenous. Equal Divers Inclusion. 2013;32(4):348–73. https://doi.org/10.1108/EDI-03-2012-0017.
64. DiAngelo R, Dyson ME. White fragility: why It's so hard for White people to talk about racism. Boston: Beacon Press; 2018.
65. Trudgen RI. Why warriors lie down & die: towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact: djambatj mala. Darwin: Aboriginal Resource & Development Services Inc; 2000.
66. Williams J, Haste M, Williams M, Kangaharan N. Improving Aboriginal and Torres Strait Islander Patient Care: Royal Darwin Hospital – Coronary Care Unit. In: Reducing Discharge Against Medical Advice. Lighthouse Hospital Project National Forum. Melbourne: National Heart Foundation of Australia; 2019.
67. Maatouk-Burmann B, Ringel N, Spang J, Weiss C, Moltner A, Riemann U, et al. Improving patient-centered communication: results of a randomized controlled trial. Patient Educ Couns. 2016;99(1):117–24. https://doi.org/10.1016/j.pec.2015.08.012.
68. Northern Territory Department of Health. 2016–17 Annual Report. Darwin: Northern Territory Government; 2017. p. 1–269.
69. Wilson E, Chen AHM, Grumbach K, Wang F, Fernandez A. Effects of limited English proficiency and physician language on health care comprehension. J Gen Intern Med. 2005;20(9):800–6. https://doi.org/10.1111/j.1525-1497.2005.0174.x.
70. Brennan G. In: Australia Dept of Aboriginal Affairs Research S, editor. The need for interpreting and translation services for Australian Aboriginals, with special reference to the Northern Territory: a research report. Canberra: Research Section, Dept. of Aboriginal Affairs; 1979.
71. Ombudsman NT. Report. Strangers in their own land. In: Use of Aboriginal Interpreters by NT public authorities; 2018.
72. UN General Assembly. United Nations declaration on the rights of indigenous peoples: resolution/adopted by the general assembly. 2007. 2 October 2007, A/RES/61/295
73. Bourke CJ, Marrie H, Marrie A. Transforming institutional racism at an Australian hospital. Aust Health Rev. 2019;43(6):611–8. https://doi.org/10.1071/AH18062.
74. Topp SM, Edelman A, Taylor S. "We are everything to everyone": a systematic review of factors influencing the accountability relationships of Aboriginal and Torres Strait Islander health workers (AHWs) in the Australian health system. Int J Equity Health. 2018;17(1):67.
75. Gilfillan G. Characteristics and use of casual employees in Australia, Research Paper Series, 2017–18 Parliament of Australia; 2018. Contract No.: 7th March.
76. Kerrigan V, McGrath SY, Lee B, Puruntatameri P, Herdman RM. Ask the specialist: Larrakia, Tiwi and Yolngu stories to inspire better healthcare. Darwin: Menzies School of Health Research; 2020. Podcast
77. Goodyear L. Qualitative inquiry in evaluation: from theory to practice. 1st ed. San Francisco: Jossey-Bass; 2014.

Publisher's Note

CHAPTER SIX

Creating the Ask the Specialist podcast: why and how?

Chapters 3 to 5 [1-3] have provided evidence that NT healthcare providers, and specifically doctors at RDH, want more training which enables them to deliver culturally safe care. In chapter 4, Yolŋu and Tiwi patients said their hospital experience changed when they received culturally safe care and Yolŋu Elder Patricia specifically requested that healthcare providers need more training in how best to work with Aboriginal peoples. In chapter 5, staff from the NT AIS also recognised staff lacked cultural competency and suggested healthcare providers require more comprehensive training. Appendix C [4] also support arguments presented in thesis chapters.

Considering these findings, we developed a training package titled *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare* [5] for RDH. The aim of the training package was to encourage the development of critical consciousness amongst healthcare providers. This is the personal development work individuals, and the collective, are required to do to address racism in healthcare. [6] The training package consisted of a podcast (7 episodes) which was designed to be the catalyst for one hour face to face weekly discussion groups to be held over 7 weeks during clinical placements. However due to the COVID-19 pandemic, which restricted gatherings and increased healthcare provider workloads, we were unable to pilot the discussion groups in 2020. Nonetheless we were able to produce and pilot the podcast which has been widely accessed.

This chapter will explain the philosophy behind the *Ask the Specialist* podcast and the practical skills required to create the 7-episode podcast. The aim is to assist those outside this context to imagine how this intervention could be adapted for other jurisdictions.

Background

As previously discussed, most staff at RDH are non-Indigenous, many are from southern Australian states or overseas trained. Additionally, staff turnover at RDH is high, many work at the hospital for 3 to 12 months to fulfill clinical training requirements; healthcare providers have limited knowledge of Aboriginal cultures in the NT and have been educated by a White medical curriculum which reinforces racial stereotyping and perpetuates health inequities. [1-3, 7-10] Commonly medical exam questions provide a patient's racial or ethnic identity, and students are taught to note a person's race during oral presentations or in written chart notes suggesting that observable traits are relevant to diagnosis. [7, 11-13] Given that race is a socio-political construct [14] and there is "no rigorous scientific evidence to support using race or culture as a surrogate for genetic or heritage information" [13 p.550] this tradition of medicine stereotypes patients which contributes to culturally unsafe care. Considering NT demographics, the medical curriculum of colonized countries, and consequences of culturally unsafe care as outlined in chapter 1 to 5, workplace training is required to assist healthcare providers deliver culturally safe care.

In the NT, new staff are offered one-day face to face cultural awareness training which aims to build a culturally responsive workforce. [1] As outlined in chapter 3, an evaluation of 596 cultural awareness training feedback forms from health staff found that whilst attendees valued learning about Aboriginal cultures, which compensated for knowledge gaps, they wanted on-going training which focused on improving intercultural communication in the hospital. [1] Staff also requested opportunities to reflect on their own culture (bias and stereotypes) and how that affects interactions with peoples from other cultures. Additionally, attendees enjoyed and benefited from listening to Aboriginal educators who shared personal

stories. [1] Our research also found one-off face-to-face training was criticised by time-poor healthcare providers who had no protected time away from clinical duties to attend training, thereby missing out. [1] Our ongoing research in this space also revealed that staff reported that online and face to face training was considered an institutional tick-box exercise; a disruption to clinical duties; and was generally met with “eyerolls and groans”. [3]

Staff attitudes and lack of protected time away from clinical duties results in low attendance. In September 2018 it was estimated that only 30% of staff attended some form of cultural awareness training. [1] A limitation of this statistic which was supplied directly to me by an RDH cultural awareness trainer is there was no breakdown between online and face to face course completions. During the COVID-19 pandemic (2020-2021), the one-day face to face training was suspended for long periods and instead staff were encouraged to complete a two hour online introductory course which satisfied accreditation requirements. [15, 16] According to the NT health 2020-2021 annual report, when NT health employed 8056 full time staff, there were 1601 online course completions and 842 face to face one day course completions. Assuming each course completion represents one full time staff member, the estimated proportion of staff completing the online module would be calculated as 20% (1601/8056) and the proportion completing face-to-face training, 10% (842/8056).

A new mode of delivering cultural education which incorporates teaching about Aboriginal cultures and provides opportunities to examine communication, power and racism was required. [1, 13, 17] As McDermott [18 p.15] eloquently stated: “Becoming a thinking, culturally safe practitioner is also the prerequisite for emerging as a clinically safe one”.

Podcast project design

The podcast approach was guided by critical race theory (CRT) and Freire's theories on transformative education [14, 19] which were described in chapter 2. Both philosophical frameworks attempt to disrupt deep-rooted colonising ideologies which manifest as racism and oppression. [20]

> *In essence, CRT and Freirean pedagogy are forms of resistance to oppressive social relationships….Both frameworks recognize that the experiential knowledge of people of color is critical to understanding and analyzing issues pertaining to race and racism.* [20 pp.70-71]

The podcast challenges oppressive relationships, in this case the power imbalance between patient and provider, by centering the experiences of Larrakia, Tiwi and Yolŋu peoples (known as the *Specialists*) in relation to healthcare. Stories are a "bridge between individual experience and systematic social patterns". [21 p.4] Elevating experiential knowledge of marginalized peoples facilitates critique and analysis of institutional policies. [22]

Specifically, to create the podcast, I was influenced by the Freirean concept of "problem posing education" [19] and CRT's "counterstories. [14, 23] The concepts will be briefly explained. Freire [19] argued educators traditionally have deposited information into students to maintain the status quo which he called "banking education". The remit of banking education is to perpetuate White Eurocentric ways of thinking.[24] To decolonise the system and students thinking, Freire argued for "problem posing education". Banking education conceals "certain facts which explain the way human beings exist in the world; problem posing education sets itself the task of demythologizing." [19 p.83] Taking inspiration from problem posing education this training package strives to demythologise Larrakia, Tiwi

and Yolŋu approaches to healthcare by elevating subjugated voices and encouraging critical thinking. This pedagogical approach which encourages questioning contrasts with the didactic banking model of education which dominates the medical curriculum. [25-27] Whilst "problem-based learning", which is related to problem posing education, has been incorporated into the medical curriculum in recent times, [25-27] previous cultural safety training programs have struggled to encourage critical reflection amongst medical students because students describe themselves as "concrete thinkers" and expect a "shopping list" of solutions. [18] However depositing instructions will not disassemble the "planks of belief" that perpetuate culturally unsafe care. [18 p.15] To address racism in healthcare, individuals must think critically about society in order to identify the root cause of problems, develop solutions and act to change. [19, 20, 27-29] Dasgupta et al argue that if problem posing education was commonplace in medical training, healthcare providers would be acculturated into a style of communicating which encourages dialogue, thereby equalising the power imbalance between patient and provider. Training healthcare providers in this way has the potential to improve the delivery of culturally safe care:

> *Creating a non-hierarchical learning environment in which trainees are encouraged to critique, question and challenge teachers models for trainees the creation of a similar clinical environment, where patients are encouraged to raise questions and speak frankly to their doctors about their concerns.* [27 p.249]

Encouraging healthcare providers to question themselves, and the system they work in can create an opening for counterstories to be heard. CRT scholars use counterstories to challenge the deficit narrative relating to marginalized peoples. [23, 30] Counterstories reveal perspectives which may have been previously silenced through banking education. This is vital

in healthcare because despite commitments to patient-centered care mainstream medicine has a "deeply problematic" relationship with marginalized peoples who are viewed "at best as passive recipients of philanthropically-informed care or at worst as morally culpable for poor health". [25 pp.252-253] We found similar attitudes among NT healthcare providers who expect Aboriginal patients to be "non-compliant; they don't listen". [3 p.5] These negative narratives found in medicine are supported by the wider socio-political landscape, fostered by negative media reports, which stereotype Aboriginal peoples as the problem.[31-34] However just as stories can reinforce negative beliefs, stories also have the power to expose racism and destroy oppressive ideologies.[14, 21] Counterstories build a "common culture of shared understandings" [30 p.2414] by opening "new windows into reality, showing us there are possibilities for life other than the ones we live." [30 p.2412] These "new windows" can reveal what Mishler [35] referred to as the "voice of the lifeworld" which is commonly ignored in the clinical setting in preference to the "voice of medicine". Listening to the "voice of the lifeworld", personal stories of Aboriginal patients, is key to understanding that Aboriginal peoples perceive health and sickness differently to Western biomedical constructs. [36, 37]

Podcast title

Inherent in the title, *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare*, is problem posing education and counterstories. Firstly, the title promises questions will be asked and answers provided by marginalised voices who are referred to as *the Specialists*. Secondly, *Ask the Specialist* is a common phrase used to refer to specialists within a White healthcare system. The title interferes with the "history of Whiteness and white supremacy in medicine" [25 p.252] by recognising that Larrakia, Tiwi and Yolŋu ways of thinking about the world are "authentic sources of human knowledge". [38 p.184] Thirdly, we

chose not to use the term “Aboriginal” which is a category that only exists because of colonisation. [39] Instead the distinct nations, which existed pre-colonisation, of individuals involved were used: Larrakia, Tiwi and Yolŋu. This does not mean the experiences shared exclude other Aboriginal and Torres Strait Islander peoples. In fact, the stories may mirror experiences of Aboriginal and Torres Strait Islander peoples across Australia as there is a common history of trauma and dispossession which has influenced the collective psyche. [40] Finally, *stories to inspire better healthcare* was crafted to indicate the training was intended to inspire action to improve healthcare delivery rather than be didactic.

Why a podcast?

Podcasts are digital audio files which are distributed via the internet and listened to on demand via smartphones or computers. Originally an extension of radio and beholden to news cycles and editorial restrictions, many podcasters have developed a deinstitutionalized form of broadcasting where an alternative discourse to mainstream narratives can be published. [41, 42] Now fashionable in medical education, podcasts have become the most popular form of supplementary education preferred over textbooks, journals and Google. [43, 44] In recent years, podcasts discussing emergency medicine, paediatrics, ophthalmology and obstetrics and gynaecology have been produced. [43, 45-47] Podcasts are also popular amongst social justice scholars such as Brené Brown [48, 49] and Critical Race scholars including Ibram X Kendi [50] who use the medium to stimulate conversations exploring theoretical and philosophical ideas. Despite the medium’s popularity, we found only one example where a podcast was used as a catalyst to teach cultural competency and encourage critical reflection; [51] a pre-existing podcast about historic and systemic racism in the US was incorporated into a course on racism for undergraduate social work students. To the best of

our knowledge, *Ask the Specialist* is the first podcast to be created specifically as a catalyst for training healthcare providers in Australia.

The podcast format was also chosen because, for time poor healthcare providers, its flexibility delivers high yield information in a short time. [52, 53] A key benefit of podcasts is the ability to listen on-demand while undertaking activities such as commuting or exercising, making them more readily able to be integrated into busy schedules. [43] Multi-tasking whilst listening could suggest the podcast listener is inattentive, allowing content to wash over them like listening to "low-demand" radio. [41 p.12] However, it has been argued that podcast listeners partake in "intentional listening": listeners are invested in the content before they press play because they actively chose to seek out content and listen. [41, 54]

Another benefit of a podcast is that it is "perfectly placed to explore lived, personal experiences". [55 p.24] The NT experiences high staff turnover and relies on fly-in/fly-out locums whose experiences of Aboriginal peoples may be limited to stereotypes perpetuated by mainstream media. [3, 31] Healthcare providers may have limited opportunities to engage personally with Aboriginal peoples outside of treating them as patients. [8, 56] Podcasts engender "a sense of hyper-intimacy, where listeners feel deeply engaged" by the stories they listen to, usually alone with headphones. [41 p.14] When personal stories are shared through the intimate podcast medium, familiarity and empathy is generated between storyteller and listener. [55] Generating empathy between parties, a goal of anti-racism training, Freirean pedagogy and CRT can inspire those who hold power to challenge the ideas and systems which create inequity. [14, 19, 57]

Importantly, a podcast can encourage the development of a community to discuss the issues which have been considered too hard, too soft or part of the "hidden curriculum" which

continues to devalue the social and cultural determinants of health. [27, 58] A podcast can do more than just deliver information:

> *Perhaps it may help combat some of the more 'wicked' problems facing medicine today…..podcasts have the potential to make explicit and positively influence the 'hidden curriculum', which at times can be toxic and perpetuate moral injury. Producers of podcast content can serve as role models for curiosity, camaraderie, and professional satisfaction for novice learners. Social learning theory asserts that individuals learn by observing others[12]; in the case of podcasts, listening to others may not only disseminate medical knowledge but engage in critical thinking and sharing cultural competencies*. [43 p.2177]

Finally, I had 20 years' experience as an ABC radio broadcaster so I had both the technical, creative and critical skills to create a podcast like this. As outlined in chapter 2 and appendix A, I had also spent many years critically reflecting on my contribution as a White journalist to the racist narrative perpetuated by mainstream media. [31] These reflections motivated me to research communication between White Australians and Aboriginal peoples in the NT which led to this PhD.

Podcast contributors

There were 16 doctors, 4 Specialists and 2 podcast hosts. A mix of snowball and purposeful sampling [59] was used to invite doctors and potential Specialists who were identified through personal and professional networks. Podcast hosts were decided upon based on pragmatic and philosophical considerations which will be explained below.

Doctors Potential participant doctors were provided with information about the study, and written, informed consent to participate in interviews, observation of clinical practice, and participation in podcast piloting and feedback, was sought. 16 doctors represented the diversity of the hospital workforce: 9 White Australian, 2 Aboriginal (Yolŋu and Wiradjuri), 1 Irish, 1 American, 1 Indian-Malaysian, 1 Zimbabwean and 1 English (UK). Doctors worked in general medicine, nephrology, oncology, paediatrics, and surgery across the four Top End hospitals: RDH, Palmerston, Katherine and Gove. Experience ranged from interns to consultants with more than 40 years' experience. Doctors were unnamed in the podcast. Anonymity for doctors ensured they could reflect on issues without fear of reprisal upon questioning medical culture or hospital processes.

The Specialists Leaders in their communities, The Specialists, were all accomplished storytellers, educators and health professionals who also had experience as patients, or carers to patients, within the hospital system. Positioning Elders and leaders as teachers in the curriculum to reinforce the value of those knowledges has been used in other teaching programs to address racism and White privilege [8] The Specialists' identities are public to ensure knowledge shared is attributable to individuals thereby maintaining sovereignty over ideas. Additionally, by listening to the same named individuals across multiple episodes [60] healthcare providers had the opportunity to develop a relationship with *Specialists*. Relationships of trust can be established through podcasts which can lead to "transformative empathy." [61 p.81] As the podcast was created on Larrakia country, Aunty Bilawara Lee, a senior Elder of the Larrakia Nation was the first person invited to participate. Aunty Bilawara has more than 50 years' experience in education, health and the community sector and authored *Healing from the Dilly Bag* [37] which offers information on Aboriginal concepts of

health and wellbeing. Additionally, Tiwi and Yolŋu leaders were invited as representatives of two of the largest Aboriginal nations in the Top End. Aunty Bilawara had previously worked with, and recommended, Pirrawayingi Puruntatameri, a Tiwi Elder. Pirrawayingi's name translates to "someone who represents his people". He has 40 years' experience working in health, education, justice and the community sector. He is bilingual: Tiwi and English. Rarrtjiwuy Melanie Herdman is a Gälpu women from the Yolŋu nation. Her work spans the health, environmental, political and research sectors and was encompassed in the Yolŋu phrase: Rrambaŋi djäma (working together). Rarrtjiwuy is bilingual: Dhaŋu (Yolŋu Matha dialect) and English. Rarrtjiwuy and I had previously worked together on other research projects. Considering low rates of interpreter uptake within NT health [62, 63] an Aboriginal interpreter, Bernadette Nethercott also shared knowledge in one podcast episode. Bernadette's involvement was facilitated through existing collaborations with the NT Aboriginal Interpreter Service. Bernadette is trilingual: Burarra, Kriol and English. If Specialists were not employed by a collaborating stakeholder, individuals were offered a casual employment contract with Menzies School of Health Research or a $50 voucher for every hour they worked on podcast production, based on their preference.

Podcast hosts The podcast was hosted by me and Stuart Yiwarr McGrath who was employed on a casual contract as a researcher. Stuart is a Gumatj man from the Yolŋu nation; an Aboriginal Health Practitioner, a student of nursing and researcher. He is bilingual: Djambarrpuyŋu (Yolŋu Matha dialect) and English. Stuart had no previous experience in podcasting but is a confident, witty, articulate communicator. The combination of a White female with a Yolŋu male aligns with the literature which asserts that racism is best cotaught by educators who represent racial and gender differences. [64] This model overturns the assumption that tackling race, and related social justice issues, is only for oppressed peoples: "racism is a relationship in which both groups are involved". [65 p.64]

Figure 4 Recording Ask the Specialist

Stuart Yiwarr McGrath, September 2019, Darwin, Australia

Producing podcast content

I led podcast production by combining the collaborative principles of PAR with my professional experience as a radio broadcaster. Episodes were developed as per documentary feature practices in which producers strive to "ethically, truthfully and skilfully capture and record a version of actuality". [66 p.117] A documentary feature centres real-life stories which are arranged to create a narrative that provides new insights into the world. [66-68] This approach is perfect for showcasing counterstories from the Specialists. Audio was recorded on a H6 Zoom recorder and edited on Audacity and Protools. This work demonstrates a way of co-designing cultural education with Aboriginal educators that is grounded in problems identified by the end user ie. doctors. Podcast production involved five key steps: identify problems, source counterstories, edit episodes, review podcast pre-distribution, and distribute the podcast. These steps, displayed in Figure 6, will be explained in detail.

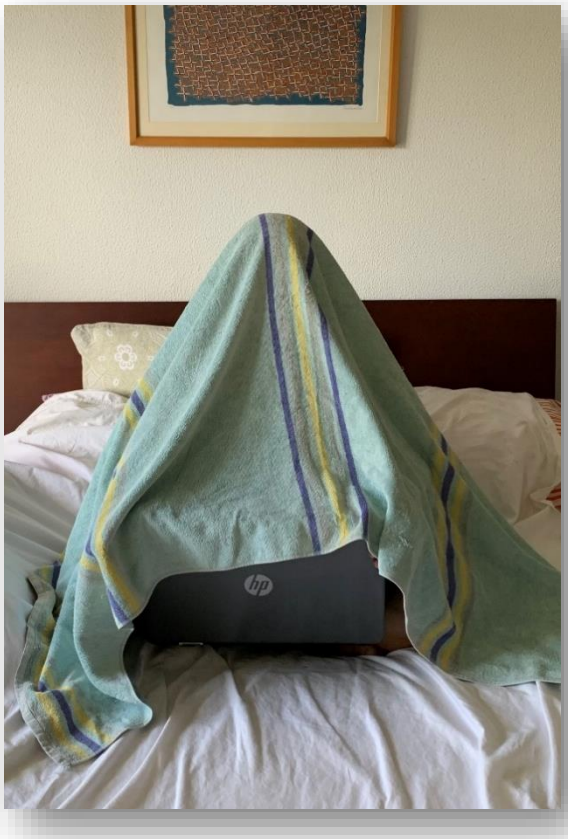


Figure 5 Recording podcast voice overs

Vicki Kerrigan in her makeshift voice recording booth under a towel on a bed surrounded by pillows, October 2019, Darwin

Figure 6 Podcast production

Identify problems

All doctors were interviewed by me and some were observed (pre-interview) working at RDH by Stuart and I (Table 6.1). Observational field notes and literature shaped the doctors interview guide. Observations were particularly important for me, given I have no experience as a healthcare provider. I conducted the doctors' interviews because doctors were often available at short notice and as the full time PhD student leading the project, I was able to meet doctors at random times. Additionally, it was recognised that White people often feel more comfortable discussing issues relating to race with other White people. [64] The semi-structured interviews with doctors had two interrelated goals: 1) to provide doctors with opportunities to reflect on medical and hospital culture without fear of retribution or judgement and 2) to generate podcast content. The first goal was shaped by the Freirean idea

of problem posing education which encourages individuals to identify their own knowledge gaps, thereby developing the critical consciousness required to instigate change. The second goal included inviting doctors to articulate a "burning question" in relation to working with Aboriginal patients and families. To prepare for this, approximately 48 hours before being interviewed I sent a text message to doctors encouraging them to compose their "burning question". These in-depth interviews generated a lot of data relating to racism in healthcare. Data not relevant to podcast production has been isolated and will be analysed separately as part of my post-doctoral research.

To identify the problems and issues to be addressed by Specialists, doctors' interviews were transcribed verbatim. Narrative analysis [69] was conducted using NVivo12. Narrative analysis simultaneously "keeps stories intact" [70 p.443] and repackages stories in a framework that makes sense to the audience. [71] This approach suited podcast production requirements.

Following analysis, an interview guide for Specialists was created. The interview guide included direct quotes and frequently asked questions, inductively derived from the doctor's interview data which was analysed by Stuart and I. Questions were grouped into six topics: building patient rapport, communication, consent, hospital experience, different worldviews and power. It also became apparent these six topics could become six podcast episodes. See Table 2.

Source counterstories

Semi structured interviews with the Specialists were led by Stuart with support from me (Table 6.1). I conducted one Specialist interview with the Aboriginal interpreter Bernadette Nethercott because Stuart was unavailable. Stuart yarned [72] with Specialists about the issues raised by doctors. Yarning allowed for stories to be shared without direct questioning

catering for the sociolinguistic norms of many Aboriginal people. [56, 73] The Specialists received a copy of doctors' questions before yarns were recorded so they could be prepare; this also helped maintain a culturally safe space. Yarns with Specialists were recorded separately. This allowed for each to share perspectives without being influenced by others.

The recorded yarns with each Specialist were transcribed verbatim for record keeping. However, transcriptions were not used to conduct analysis, instead I listened to the conversations Stuart and the Specialists shared. Voice recordings are legitimate qualitative data and should be considered more than just a precursor to transcription which silences accents, laughter, pauses, agitation, reactions such as audible gasps and so on. [74] As an ex-radio broadcaster I understood transcriptions remove emotions from the stories which, in the case of the Specialists stories, were imbued with perspective and feeling. Transcriptions dematerialise voices to a series of words, which can be useful when anonymity is required (as per doctor's interviews) however listening to the voice of marginalised peoples has emancipatory potential. [74] To identify the counterstories to be used in the podcast, I listened for revelatory insights that had the potential to trigger a reaction in the listener. This is an example of where my broadcasting expertise and academic methods merge. In research terms, I was employing narrative analysis which strives to locate "epiphanies". [75 p.198] As insights were identified, including contrasting advice, they were edited into single files (referred to in radio as "Grabs" ranging in duration from 15 secs to 90 secs) and saved with titles relating to problems identified by doctors. This created a collection of counterstories which could be edited together to answer doctors' questions.

Table 7 Podcast production data

Date	Format	Amount of data collected
1st April - 21st June 2019.	Observations: 10* (of 16) doctors	TOTAL: 60 hours and 30 minutes. Observed interactions with 78 patients, 46 identified as Aboriginal.
10th October 2018 – 11th July 2019	Interviews: 16 (of 16) doctors	TOTAL: 25 hours and 20 minutes. Duration range: 1 hr 32 secs to 2 hrs 32 minutes
24th July 2019 - 3rd September 2019	Interviews: 4 Specialists	TOTAL: 4 hours and 41 minutes Duration range: 22 minutes 12 secs to 1hr 53 mins
*Only 10 (of 16) doctors were observed. This occurred because: 1) planned observational arrangements could not proceed due to clinical care priorities and 2) some junior doctors were hesitant to be observed concerned supervisors would not approve.		

During analysis it became obvious the six episodes initially conceptualised were insufficient. Responding to the Specialists stories three changes were made. Firstly, an additional episode was added, “Communicating with interpreters and your patient”. Secondly, the order of episodes was reorganised to assist with building a narrative arc across the seven episodes. Initial episodes provided practical tips, subsequent episodes built on the practical concepts by introducing more complex ideas associated with deeper philosophical concepts and the final episode discussed cultural knowledge. Episode 7 on different worldviews titled “Perspectives on health and wellbeing” was deliberately last as the content of this episode focused on learning about, as Ramsden put it, the exotic other. This was to ensure the “othering” that is prominent in cultural awareness training is not the initial point of

engagement with the listener but comes after listeners have been invited to consider their own culture and bias. Finally, topics were renamed to clarify content. Seven podcasts were now planned: get to know your patient, communicating with your patient, communicating with interpreters and patient, patient centred care, informed consent, cultural safety and perspectives on health and wellbeing (Table 6.2).

Table 8 Podcast draft episodes

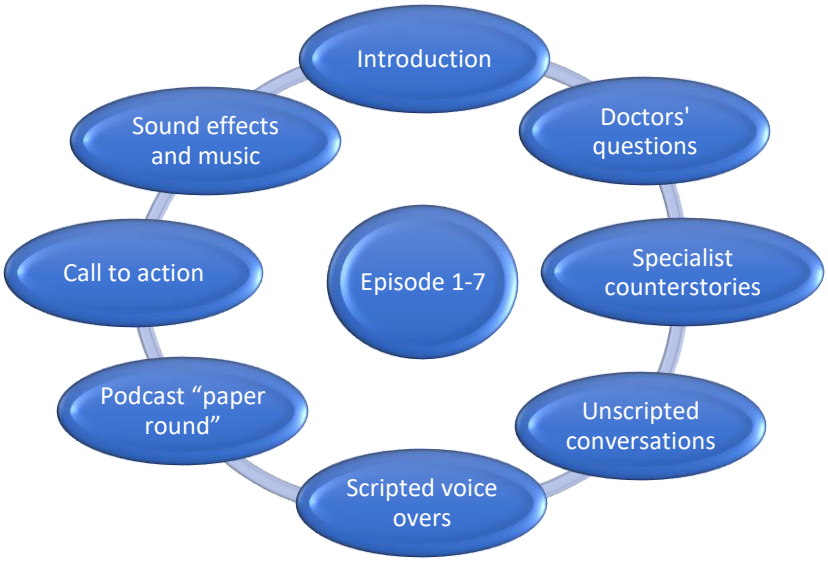
Draft episodes	
Draft 1: Post doctor interview analysis	**Draft 2: Post doctor & Specialist interview analysis**
Episode 1	
Building patient rapport	**Get to know your patient**
Episode 2	
Communication	**Communicating with your patient**
Episode 3	
N/A	**Communicating with interpreters and your patient**
Episode 4	
Consent	**Patient Centred Care**
Episode 5	
Hospital Experience	**Informed Consent**
Episode 6	
Different worldviews	**Cultural Safety**
Episode 7	
Power	**Perspectives on health and wellbeing**

Edit podcast

The most time consuming element of podcasting is editing. [76] It requires high level technical skills, well-developed editorial judgement, and creativity. For the documentary maker "characters-the voices-that convey the deepest emotional truth" are pivotal. [77 p.195] As per documentary practice, "intriguing interviews" from the characters come before scripts are written. [78 p.162] Therefore, each episode of *Ask the Specialist* was developed around

the Specialists' stories. References to current events were removed to ensure the podcast had a lifespan beyond the time of production. [54] This is an advantageous argument to make to health services who struggle with ever shrinking budgets. Each episode featured up to 6 speakers and consisted of eight main elements: the *Ask the Specialist* introduction, doctors' questions, *Specialists* counterstories, unscripted conversations between Stuart and I, scripted voice overs, a summary of key points referred to as the "podcast paper round", a "call to action" at the end of each episode, sound effects and music. Elements were edited together to ensure the tone of the podcast was "uncomfortable but comfortable enough" [18 p.15] to not alienate listeners. The aim was to keep episodes less than 20 minutes: the duration equated with typical car commute times in Darwin where doctors lived. Figure 7 is a diagram of the eight non-linear elements in each episode. Each episode contains every element however there was no standard order. Based on editorial expertise, I decided how the elements were combined in each episode.

Figure 7: Non-linear episodic elements



Podcast introduction Named the podcast, explained the purpose and each Specialist introduced themselves. The voice over was recorded by Hamish Robertson, who was employed to complete technical post-production (details below). A royalty free music track, *Cold Funk* by Kevin McLeod was sourced from the website: www.filmmusic.io. The guitar-based track was jaunty and confident, chosen to create a positive energising vibe.

Box 1: Podcast introduction

Episode 1-7	Voice over: *Ask the Specialist. A podcast where doctors from Royal Darwin Hospital ask a team of specialists to answer the questions they have about working with Aboriginal patients.* Specialists: GRAB[2]: *My name is Bilawara Lee. Bilawara means the red-tailed black cockatoo. I'm an Elder of the Larrakia Nation.* GRAB: *My name is Pirrawayingi Puruntantameri, a Tiwi Elder.* GRAB: *And my name is Rarrtjiwuy Melanie Herdman and I am from Arnhem land.* Voice over: *The Specialists are Larrakia, Tiwi and Yolŋu leaders who have all had personal experiences in hospital in the Northern Territory of Australia.*

Doctors' questions The problem posing philosophy was easily implemented as a Q and A format which became the backbone of each episode. Doctors' questions were recorded by Richard Margetson, a voice over artist, to ensure the identity of doctors was concealed. I recorded sound effects of RDH wards and edited audio to ensure no individual voice was identifiable. These were mixed under doctors' questions, as background, to evoke the idea questions were asked in the hospital.

[2] GRAB: refers to a short piece of recorded audio, a key quote or significant statement, which is taken from a longer interview.

The Specialists' counterstories Specialist responses were edited together from the collection of counterstories previously compiled. No additional sound effects or music were mixed under the stories to ensure the focus of listeners was solely on each Specialist's voice. An example of how stories were combined with doctors' questions appears in Box 6.2.

Box 2: Combining questions and counterstories

Episode 2: Communicating with your patient Time: 3'24" - 5'15"	Doctor question: *How best can we communicate with them? I don't know their language. I've maybe learned one or two words…..What is the best way we can communicate with them? Is it through interpreters?* Pirrawayingi: *Interpreters can help but they may not be available on occasions. So you know, there's no reason why, like they do at CDU for example, a Yolŋu language or something language can be taught to these practitioners for them to learn.* Stuart: *In the hospital?* Pirrawayingi: *In the hospital.* Bilawara: *Speak slowly. Don't use big words or acronyms. Tone, volume. Yeah, a lot of our people have otitis media but still, clearly, simply.* Mel: *use pictures, online, google, medical books, skeletons, and heart models and all of those things to use because, the other thing is, we are visual people. So, if you can draw pictures then that's gonna make your job easier.* Bilawara: *Knowing one or two words is good, you know a greeting, a goodbye. First thing to learn about Larrakia language is "Mamak": see you later. I mean if a person walks in and you say hello to them in their language, they're gonna be like "Oh!" and the next time I go see the doctor, it'd be like, "I like you 'cause you learnt a little bit of my language".* Stuart: *I mean it's not like we as Aboriginal patients are expecting you to learn the whole language.* Bilawara: *God no.* Stuart: *You know, that's the notion with some health professionals like "Oh god, I gotta learn a whole different language?". Nah, just say a few words. That's it. It puts the clinical environment at ease.*

Unscripted conversations After the doctors' questions and Specialists' answers were edited together as a rough draft, Stuart and I listened to the edited conversations and recorded our responses. Such unscripted conversations have been referred to in the podcasting literature as "chumcasting": podcast hosts "riff off each other chatting in a casual and rambunctious manner around a theme". [67 p.70] These conversations, sometimes funny, added a degree of informality which is a technique commonly used in podcasts to avoid monotony, highlight key points and expand on ideas. [79, 80] Additionally, the conversation creates an additional narrative strand in which the listener feels included in a private conversation between hosts. [67] Hospital café sound effects (cups chinking, sugar sachets scrunching, background chatter, footsteps), sourced from the BBC online sound effects library, were mixed under the unscripted conversations to further evoke a casual conversation atmosphere. At times we shared stories from our own lives. An example is shared in Box 6.3.

Box 3: Unscripted conversations

Episode 3: Communicating with interpreters your patient Time: 10'44" – 11'43"	Vicki: *There was a story that a doctor told me, that idea of "discharging against medical advice". Lots of people are really worried about that: when patients discharge themselves. And this doctor said: "how can you say that people are discharging against medical advice if they don't actually understand the medical advice?"* Stuart: *Yeah, yeah. That's a good point eh. You know, in my experience working in the clinic a lot of the patients are deemed "non-complaint" and I'm like, "This person doesn't really understand what's wrong with them". You know there was one cancer patient who was just really really pissed off and they just said "Oh he's just angry all the time. He doesn't want to engage with the healthcare". That's the only body language they got. But really, he didn't know what was happening to his body. So it was a language barrier so I had to work with him, for like, two months to build that bridge to build that relationship between the doctors and him.*

Scripted voice overs I recorded minimal scripted voice overs to support listener engagement with the story. These scripts were written after the skeleton of each episode, which consisted of doctors' questions, Specialists' counterstories and unscripted conversations between Stuart and I, were edited together. Scripts linked audio by providing background information on the Specialists; summaries of relevant research; and "signposts" [81] which are used in podcasts to reset content and "locate the audience within the audio". [80 p.55] An example of the three styles of scripted voice over links appears in Box 6.4.

Box 4: Scripted voice overs

1) Background info on Specialists	
Episode 6: Recognising and addressing racism Time: 10'16"- 10'59"	Script: *Aunty Bilawara talking big picture stuff. Aunty Bilawara Lee is an Elder of the Larrakia Nation. She's a member of the Cubillo family. She's the eldest of 15 children, she's got 9 brothers and 5 sisters. She's a communicator, a healer and so obviously a teacher. She spent most of her life working in health and education. She sits on many committees and boards in the sector and currently she's the Larrakia Elder in Residence at Charles Darwin University and if that's not enough she's also working on reviving the Larrakia language.*
2) Summaries of relevant research	
Episode 2: Communicating with your patient Time: 00"- 36"	Script: *An interesting study was done in UK hospitals in 2019. They looked at what makes a ward a good ward, and they found that there's a big gap between what health professionals and patients think is important. The most important thing to patients was good communication and staff attitudes but according to the health professional hand hygiene and infection control was top of the list. I'm not saying communication is more important than hygiene…it's just interesting to be reminded that patients prioritise different things to you, the health professional.*
3) "Signposts"	
Episode 4: Patient Centred Care Time: 4'50" – 5'04"	Script: *I'm Vicki, here with my co-host Stuart. Stuart is an Aboriginal Health Practitioner, so he works with patients all the time. We're*

	talking about giving patients power, which is important, so they actually engage with their care.

Podcast "paper round" The podcast "paper round" was named after a daily activity conducted by hospital-based doctors. A paper round is where a treating team work through a paper list of patients to summarise each patient's condition(s) and discuss what to do next. Similarly, the podcast paper round, which I voiced, summarised key points and discussed what was next. Summarising content is a pedagogic strategy, used in other educational podcasts, which enhances learning.[80] Paper round scripts were written after episodes were drafted and repeated key audio grabs from the Specialists. To encourage listeners to engage with the next episode, what's referred to in radio broadcasting as, a "forward promote" was crafted. A forward promote is a short grab from the next episode to entice the listener to keep listening (Box 6.5).

Box 5: Podcast "paper round" and the "forward promote"

Episode 1: Get to know your patient Time: 13'37"-15'05"	Script: *But now at the end of our first podcast, about the importance of getting to know your patient, let's go over what we know. In fact, let's call this little summary, the podcast "paper round":* • *Getting to know your patient is part of delivering good health care. You want your patient to trust you and you want to trust your patient.* ○ Bilawara GRAB: *"Taking time at the beginning is critical in best healthcare."* • *Share a little bit about who you are.* • *Learn a few phrases in local Aboriginal languages.* • *Ask your patient how they would like you to refer to them. Mr, Mrs, Uncle or Aunty. Or maybe they would like you to use their Aboriginal name, not their English name.* • *Try to avoid direct questions.*

	• *Give your patient power.*
	  ○ Stuart GRAB: *that's why I usually say, you know, "You're the boss you're your body. What do you want to do?"*
	• *One of the most commonly asked questions: is it ok to make eye contact?*
	  ○ Rarrtjiwuy GRAB: *Sometimes yes and sometimes no.*
	• *But try not to sit face to face, instead sit side by side with your patient.*
	Next time on Ask the Specialist:
	  ○ Pirrawayingi GRAB: *There are opportunities to make communication better for Indigenous people.*
	We'll answer your questions about how you can better communicate with your patients.

Call to action To inspire the Freirean and CRT concept that dialogue can lead to action, [14, 19] a call to action was delivered at the end of each episode. Listeners were asked to reflect on the stories and to consider their behaviour. As per cultural safety,[82] the call to action places the onus for the change onto the healthcare provider. The music track used in the introduction, *Cold Funk* by Kevin McLeod, was mixed under the call to action (Box 6.6).

Box 6: Call to Action

Episode 1-7	Script: *Thank you to Aunty Bilawara Lee, Pirrawayingi Puruntatameri, Rarrtjiwuy Melanie Herdman, and Stuart Yiwarr McGrath for sharing their knowledge and personal experiences. I'm Vicki Kerrigan, we hope you've learnt some stuff you can try at work, but we also hope you've been inspired: to reflect on who you are and how you work. Because while it's helpful and completely fascinating to learn about Aboriginal cultures, if we're sincere about wanting to improve health outcomes for everyone we need to critically think about our culture and how we can change, not just as individuals but also take a look at the institutions we've created to suit how we think the world should operate.*

Sound effects and music A podcast is more than a series of voices: it is a rich soundscape, layered with sound effects and music chosen to build and enhance connection with the target audience. [83] As explained above, music was used sparingly: mixed under the introduction and reprised for the call to action at the end of each episode. In addition to the sound effects described above, we also incorporated local Darwin sounds: birds tweeting, cars driving, and bicycle wheels spinning (recorded by me) to locate the podcast in the tropical city. Sound effects and music were used for three reasons: as segues to indicate a change in conversation tone or content; to evoke images in the listener's mind; and to offer the listener a moment to pause and consider what they had heard.

Post-production After I edited together the eight elements of each episode, technical post-production was completed by contracted sound engineer Hamish Robertson. Uncompressed audio files from Audacity were shared with Hamish who completed post-production in ProTools. Post-production tasks included: refine mix of sound effects and music with voices and remove audio issues that interfered with sound quality. A sample of production notes (1st December 2019) from approximately 2'00" (of 15'55") from Episode 1 appears in Box 6.7.

Box 7: Post-production notes

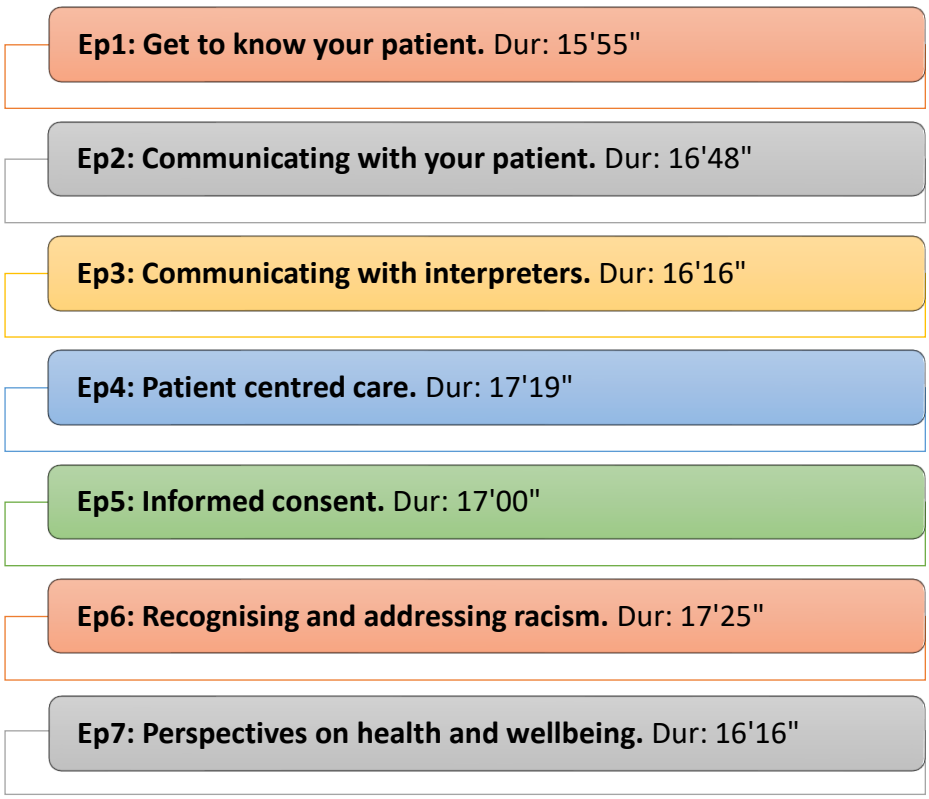
Episode 1	1'34": Mix "hospital café" SFX*. Before Stuart intros himself bring up hospital café SFX to indicate change of setting. Leave the "hello testing testing" and the mic scratch (which you can see I put in as an SFX) before Stuart intro's himself. This may need more space around it. Not sure? 2'05": remove bump if you can 2'10": remove bump if you can Leave my ums and ahs when I intro myself. Meant to sound conversational.

	2’36”: I recorded the voice over in two parts and I can hear the difference in the recording. Can you fix it so it sounds all the same? Script: “now I’m doing this. (recording changes) I’m working on a phd…) 2’54”: Richard’s intro is really loud. Fix levels please. 2’59: Fade out hospital café and fade into RDH SFX. Fix levels of SFX. 3’23”: Fade out RDH SFX approx. 3’23”
*SFX: sound effects	

Review podcast pre-distribution

Seven episodes each less than 18-minutes were created. Episodes were reviewed, and approved, by the Specialists before the podcast series was distributed to doctors as part of the research pilot. This was vital to ensure Specialists stories were not misrepresented or “whitewashed” by me, the White person who led podcast production. Following feedback, two changes occurred. Episode 7 was edited to remove the use of the Yolŋu words for sorcerer and healer. This was done at the request of the Yolŋu contributors. Secondly, the title of episode 6 changed from *Cultural Safety* to *Recognising and addressing racism*. This occurred for two reasons. The term cultural safety is commonly confused with terms such as cultural awareness and cultural competency even though cultural safety is about anti-racism. [82] By removing the title *Cultural Safety* we removed the need to engage in academic debates around the definitions. Secondly, despite the plethora of policies and government documents which name racism as a determinant of health, it is rare to hear healthcare providers or healthcare executives openly talk about racism. Whilst working in Indigenous health is an “emotionally charged zone” and just the word racism can trigger a backlash, [84] McDermott [18 p.15] argues discussing and analysing racism in healthcare is “not an optional extra” if the goal of improving Aboriginal health outcomes is to be achieved.

Table 9 Ask the Specialist final episodes



Distribute podcast

There were two stages to podcast distribution.

Stage 1: the pilot

Before public distribution, the podcast was piloted with the same doctors who consented to be interviewed/observed before the podcast was created. Over seven weeks (29 January 2020 -11 March 2020), one episode per week was shared with doctors via a link to a password protected podcast host site (Storyboard). Recognising podcasts are not "intrinsically learning tools" but have the potential to be a catalyst for reflective learning [85 p.133] doctors were asked to provide weekly feedback on each episode which was guided by a list of feedback prompts. As per cultural safety practice [86] this encouraged doctors to engage in a cycle of reflection, action and change over seven weeks. Additionally weekly reflections constituted data which was analysed alongside the final feedback interviews

conducted after all 7 episodes were listened to. Findings generated from the pilot were published in the special issue of the Health Sociology Review: Yuwinbir This Way!. [87] The evaluation found that, after listening to the podcast, doctors reported attitudinal and behavioural changes which led to increasing the amount of time with patients to develop trust, more frequently working with Aboriginal language interpreters and improving consent processes. The podcast format was rated highly by doctors who also appreciated the 7-week program which allowed for cycles of listening, reflection, and action. Whilst the podcast was designed to be deliberately local and specific to the individuals and cultures represented, universal truths applicable beyond the NT and outside of healthcare were apparent to listeners. One doctor said: "this is the training that is required…This project will change the healthcare professional-patient communication landscape." [87 p.7]

Stage 2: public release

Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare [5] podcast was publicly released in June 2020 through Apple and Google podcasts and Spotify. 18 months after the podcast was released (January 2021) the podcast had reached 20,000 downloads. Listeners were mainly in Australia but also across the world including America, Brazil, China, Hong Kong, Israel, Aotearoa, Sweden, Saudi Arabia, Turkey and the UK.

Indicating the significance of this work to the NT, the podcast was officially launched at NT Government House by Her Honour the Honourable Vicki O'Halloran AO, Administrator of the Northern Territory on Monday, 29 June 2020. Additionally, the Specialists and I hosted a lunchtime event at RDH on the 30th of June 2020 to promote the podcast directly to healthcare providers.

Dissemination and distribution of the final product was supported by a press release which was emailed to relevant nationwide organisations and individuals. This resulted in considerable media attention (Table 2.4). Presentations were also delivered to RDH grand rounds, NT health executive committees and other relevant stakeholders. Consequently, the series was endorsed by the Aboriginal Medical Services of the NT, Australian Indigenous Doctors Association, Australian Indigenous HealthInfoNet, Charles Darwin University, the Centre for Healthcare Knowledge and Innovation, the College of Intensive Care Medicine Of Australia and New Zealand, Deakin University, Indigenous Allied Health Australia, the Leaders in Indigenous Medical Education (LIME) Network, Miwatj Aboriginal Health Corporation, NT General Practice Education, Northern Territory Public Health Network, Public Health Association of Australia, Royal Australasian College of Physicians, Royal Australasian College of Surgeons, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Royal Australasian College of Surgeons, and NT Health. After listening to the podcast, the NT Anti-Discrimination Commissioner Sally Sievers tweeted that Ask the Specialist has “the potential to save lives and address systemic racism”.

The podcast has received three awards (Table 2.5): 1) the Health and Wellbeing Award at the NT Community Achievement Awards 2020; 2) Silver at the 2020 Australian Podcast Awards for the Smartest Podcast and 3) The Fitzgerald Social Change Award at the 2021 NT Human Rights Awards. The Specialists have also been recognised for their incredible contributions to social justice in our community: Aunty Bilawara Lee and Pirrawayingi Puruntatameri were named Female and Male Elders of the Year at the 2021 NAIDOC Awards and Stuart Yiwarr McGrath was named 2021 NT Young Australian of the Year.

What's next

This project is embedded in the Communicate Study at Menzies School of Health Research led by my primary supervisor Professor Anna Ralph. The Communicate study has been funded by the National Health and Medical Research Council for 5 years (2022-2027) to identify and implement options to improve cultural safety at four NT hospitals. Our project will scale up the *Ask the Specialist* training package plus increase availability of Aboriginal language interpreters and Aboriginal health practitioners at RDH, Palmerston, Gove and Katherine hospital. We are also working with Flinders Medical School to tailor the *Ask the Specialist* package to be delivered to final year medical students as they prepare to transition into their profession as the next generation of NT Healthcare providers.

Figure 8 Ask the Specialist launch, NT Government House, 2020.

L-R: Vicki Kerrigan, Stuart Yiwarr McGrath, the NT Administrator, Her Honour the Honourable Vicki O'Halloran AO, Aunty Bilawara Lee, NT Health Minister Natasha Fyles, Rarrtjiwuy Melanie Herdman, Alan Cass, Anna Ralph and Marita Hefler. Absent: Pirrawayingi Puruntatameri and Bernadette Nethercott.

References

1. Kerrigan, V., et al., *"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload.* BMC Medical Education, 2020. **20**(1): p. 173.
2. Kerrigan, V., et al., *From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.* BMC Health Services Research, 2021. **21**(1): p. 548.
3. Kerrigan, V., et al., *"The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care.* International Journal for Equity in Health, 2021. **20**(1): p. 170.
4. Mithen, V., et al., *Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care.* Health Promot J Austr, 2021. **32**(S1): p. 155-165.
5. Kerrigan, V., et al., *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare.*, V. Kerrigan and S.Y. McGrath, Editors. 2020, Menzies School of Health Research: Darwin.
6. Heke, D., et al., *Exploring anti-racism within the context of human resource management in the health sector in Aotearoa.* International Journal of Critical Indigenous Studies, 2021. **14**(2): p. 114-132.
7. Brett, A.S. and C.W. Goodman, *First Impressions — Should We Include Race or Ethnicity at the Beginning of Clinical Case Presentations?* New England Journal of Medicine, 2021. **385**(27): p. 2497-2499.
8. Leaders in Indigenous Medical Education Network, *LIME Good Practice Case Studies: Volume Five 2019*. 2019, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne: Melbourne.
9. Ly, A. and L. Crowshoe, *'Stereotypes are reality': addressing stereotyping in Canadian Aboriginal medical education.* Medical education, 2015. **49**(6): p. 612-622.
10. Chadha, N., et al., *Toward the Abolition of Biological Race in Medicine*. 2020, UC Berkeley: Othering & Belonging Institute.
11. Acquaviva, K.D. and M. Mintz, *Perspective: are we teaching racial profiling? The dangers of subjective determinations of race and ethnicity in case presentations.* Acad Med, 2010. **85**(4): p. 702-5.
12. Gau, J., et al., *Things we do for no reason™: Routine inclusion of race in the history of present illness.* Journal of Hospital Medicine, 2021. **n/a**(n/a).
13. Krishnan, A., et al., *Addressing Race, Culture, and Structural Inequality in Medical Education: A Guide for Revising Teaching Cases.* Acad Med, 2019. **94**(4): p. 550-555.
14. Delgado, R., J. Stefancic, and A. Harris, *Critical Race Theory (Third Edition): An Introduction*. Third edition. ed. 2017, New York: New York University Press.
15. Northern Territory Government, *Department of Health Annual Report 2019-2020*. 2020, Department of Health: Darwin, Australia.
16. Northern Territory Government, *Department of Health Annual Report 2020-2021*. 2021: Darwin, Australia.
17. Berger, J.T. and D.R. Miller, *Health Disparities, Systemic Racism, and Failures of Cultural Competence.* American journal of bioethics, 2021. **21**(9): p. 4-10.
18. McDermott, D.R., *Can we educate out of racism?* Medical journal of Australia, 2012. **197**(1): p. 15-15.
19. Freire, P., *Pedagogy of the oppressed*. 30th Anniversary Edition ed. 2005 (1970), New York: The Continuum International Publishing Group.

20. Smith-Maddox, R. and D.G. Solórzano, *Using Critical Race Theory, Paulo Freire's Problem-Posing Method, and Case Study Research to Confront Race and Racism in Education.* Qualitative Inquiry, 2002. **8**(1): p. 66-84.
21. Bell, L.A., *Telling Tales: What stories can teach us about racism.* Race, ethnicity and education, 2003. **6**(1): p. 3-28.
22. Tichavakunda, A.A., *An Overdue Theoretical Discourse: Pierre Bourdieu's Theory of Practice and Critical Race Theory in Education.* Educational studies (Ames), 2019. **55**(6): p. 651-666.
23. Solórzano, D.G. and T.J. Yosso, *Critical Race Methodology: Counter-Storytelling as an Analytical Framework for Education Research.* Qualitative inquiry, 2016. **8**(1): p. 23-44.
24. Lentin, A., *Why Race Still Matters*. 2020, Cambridge, UK; Medford, MA: Polity Press.
25. Braun, L., *Theorizing Race and Racism: Preliminary Reflections on the Medical Curriculum.* American journal of law & medicine, 2017. **43**(2-3): p. 239-256.
26. Cianciolo, A.T. and G. Regehr, *Learning Theory and Educational Intervention: Producing Meaningful Evidence of Impact Through Layered Analysis.* Academic Medicine, 2019. **94**(6).
27. DasGupta, S., et al., *Medical Education for Social Justice: Paulo Freire Revisited.* The Journal of medical humanities, 2006. **27**(4): p. 245-251.
28. Minkler, M. and K. Cox, *Creating Critical Consciousness in Health: Applications of Freire's Philosophy and Methods to the Health Care Setting.* International Journal of Health Services, 1980. **10**(2): p. 311-322.
29. Came, H. and D. Griffith, *Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis.* Social science & medicine (1982), 2018. **199**: p. 181-188.
30. Delgado, R., *Storytelling for Oppositionists and Others: A Plea for Narrative.* Michigan law review, 1989. **87**(8): p. 2411-2441.
31. Kerrigan, V. *Whitefella broadcasting: Why non Indigenous journalists struggle to tell Aboriginal stories in Australia*. in *Journalism Education and Research Association of Australia 2017 Conference*. 2017. Newcastle: The Journalism Education and Research Association of Australia Incorporated (JERAA Inc).
32. Stoneham, M.J., J. Goodman, and M. Daube, *The Portrayal of Indigenous Health in Selected Australian Media.* International Indigenous Policy Journal, 2014. **5**(1).
33. Watego, C., D. Singh, and A. Macoun, *Partnership for Justice in Health: Scoping paper on race, racism and the Australian health system.* . 2021, The Lowitja Institute: Melbourne.
34. Moreton-Robinson, A., *Imagining the Good Indigenous Citizen: Race War and the Pathology of Patriarchal White Sovereignty.* Cultural Studies Review, 2009. **15**(2): p. 61-79.
35. Mishler, E.G., *The discourse of medicine : dialectics of medical interviews*. 1984, Norwood, N.J.: Ablex Pub. Corp.
36. Garvey, G., et al., *The Fabric of Aboriginal and Torres Strait Islander Wellbeing: A Conceptual Model.* International journal of environmental research and public health, 2021. **18**.
37. Lee, B., *Healing from the Dilly Bag: Holistic healing for your body, soul and spirit*. 2013: Xlibris AU
38. Turner, D., *On the politics of Indigenous translation: Listening to Indigenous peoples in and on their own terms* in *Routledge Handbook of Critical Indigenous Studies.* , Hokowhitu B., et al., Editors. 2021, Routledge International Handbooks: : London. p. 175-188.
39. Brigg, M., *Registers of Relationality for Knowing Indigenous-Settler Politics.* , in *Questioning Indigenous-Settler Relations. Indigenous-Settler Relations in Australia and the World*, S. Maddison and S. Nakata, Editors. 2020, Springer: Singapore.
40. Behrendt, L., *Cultural Conflict in Colonial Legal Systems: An Australian Perspective*, in *Intercultural Dispute Resolution in Aboriginal Contexts,*, C. Bell, Editor. 2004, UBC Press: Vancouver. p. 116-127.
41. Berry, R., *Podcasting: Considering the evolution of the medium and its association with the word 'radio'.* Radio Journal, 2016. **14**(1): p. 7-22.

42. Berry, R., *Radio, music, podcasts – BBC Sounds: Public service radio and podcasts in a platform world.* Radio journal, 2020. **18**(1): p. 63-78.
43. Berk, J., et al., *Medical Education Podcasts: Where We Are and Questions Unanswered.* Journal of General Internal Medicine, 2020. **35**(7): p. 2176-2178.
44. Mallin, M., et al., *A Survey of the Current Utilization of Asynchronous Education Among Emergency Medicine Residents in the United States.* Academic Medicine, 2014. **89**(4): p. 598-601.
45. Little, A., et al., *Podcasting in Medicine: A Review of the Current Content by Specialty.* Cureus, 2020. **12**(1): p. e6726-e6726.
46. Milligan, K.J., et al., *Creation of a Student-Run Medical Education Podcast: Tutorial.* JMIR Med Educ, 2021. **7**(3): p. e29157.
47. Young, B., et al., *Eyes for Ears—A Medical Education Podcast Feasibility Study.* Journal of surgical education, 2021. **78**(1): p. 342-345.
48. Brown, B., *Dare to Lead* B. Brown, Editor. 2022: Spotify.
49. Brown, B., *Unlocking Us*, B. Brown, Editor. 2022: Spotify.
50. Kendi, I.X., *Be Antiracist*, I.X. Kendi, Editor. 2022, Pushkin Industries: Apple podcasts.
51. Belfiore, M.N., et al., *Teaching Note-Exploring Podcast-Facilitated Course Work on Racism.* Journal of social work education, 2021. **57**(1): p. 173-180.
52. Prakash, S.S., N. Muthuraman, and R. Anand, *Short-duration podcasts as a supplementary learning tool: Perceptions of medical students and impact on assessment performance.* BMC Medical Education, 2017. **17**(1): p. 1-14.
53. Wittich, C.M., et al., *E-learning in graduate medical education: survey of residency program directors.* BMC Medical Education, 2017. **17**.
54. Lindgren, M., *'This Australian life': The Americanisation of radio storytelling in Australia.* Australian journalism review : AJR, 2014. **36**(2): p. 63-75.
55. Lindgren, M., *Personal narrative journalism and podcasting.* Radio Journal, 2016. **14**(1): p. 23-41.
56. Wain, T., et al., *Engaging Australian Aboriginal narratives to challenge attitudes and create empathy in health care: a methodological perspective.* BMC Med Educ, 2016. **16**: p. 156.
57. Elias, A., F. Mansouri, and Y. Paradies, *Countering racism: Challenges and progress in anti-racism efforts*, in *Racism in Australia Today*. 2021, Springer Singapore: Singapore. p. 319-351.
58. Lehmann, L.S., L.S. Sulmasy, and S. Desai, *Hidden Curricula, Ethics, and Professionalism: Optimizing Clinical Learning Environments in Becoming and Being a Physician: A Position Paper of the American College of Physicians.* Ann Intern Med, 2018. **168**(7): p. 506-508.
59. Patton, M.Q., *Qualitative evaluation and research methods*. 2nd ed.. ed, ed. M.Q. Patton. 1990, Newbury Park, Calif.: Newbury Park, Calif. : Sage Publications.
60. Lindgren, M., *Intimacy and Emotions in Podcast Journalism: A Study of Award-Winning Australian and British Podcasts.* Journalism Practice, 2021: p. 1-16.
61. Spinelli, M. and L. Dann, *Podcasting: The Audio Media Revolution.* . 2019, London: Bloomsbury Academic.
62. The Communicate Study group, *Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study.* Medical Journal of Australia, 2020. **213**(4): p. 180-181.
63. Ralph, A.P., et al., *Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory.* BMC Health Services Research, 2017. **17**(1): p. 733.
64. Constance-Huggins, M., *Intersection of race, gender, and nationality in teaching about race and racism.* Reflective Practice, 2018. **19**(1): p. 81-88.
65. DiAngelo, R. and M.E. Dyson, *White Fragility: Why It's So Hard for White People to Talk about Racism*. 2018, Boston: Beacon Press.

66. Kerrigan, S. and P. McIntyre, *The 'creative treatment of actuality': Rationalizing and reconceptualizing the notion of creativity for documentary practice.* Journal of media practice, 2010. **11**(2): p. 111-130.
67. McHugh, S., *How podcasting is changing the audio storytelling genre.* Radio Journal, 2016. **14**(1): p. 65-82.
68. Grierson, J., *Grierson on documentary / edited and compiled by Forsyth Hardy*, ed. F. Hardy. 1966, London: Faber.
69. Clandinin, D.J., *Handbook of narrative inquiry mapping a methodology*. 2007: Thousand Oaks, Calif., London: SAGE.
70. Griffin, A. and V. May, *Narrative Analysis and Phenomenoloigical Analysis*, in *Researching Society and Culture*, C. Seale, Editor. 2012, Sage: London.
71. Liamputtong, P., *Qualitative research methods*. 4th ed.. ed. 2013, South Melbourne: South Melbourne : Oxford University Press.
72. Bessarab., D. and B. Ng'andu., *Yarning and Yarning as a Legitimate Method in Indigenous Research.* International Journal of Critical Indigenous Studies, 2010. **3**(1).
73. Lin, I., C. Green, and D. Bessarab, *'Yarn with me': applying clinical yarning to improve clinician-patient communication in Aboriginal health care.* Aust J Prim Health, 2016. **22**(5): p. 377-382.
74. Gallagher, M., *Voice audio methods.* Qualitative research : QR, 2020. **20**(4): p. 449-464.
75. Creswell, J.W., *Qualitative inquiry & research design : choosing among five approaches*. Fourth edition.. ed. Qualitative inquiry and research design, ed. C.N. Poth. 2018: Los Angeles SAGE.
76. Berk, J., M. Watto, and P. Williams, *Twelve tips for creating a medical education podcast.* Medical Teacher, 2020. **42**(11): p. 1221-1227.
77. Tolan, S., *The Voice and the Place*, in *Reality Radio, second edition: Telling true stories in sound*, J. Biewen and A. Dilworth, Editors. 2017, University of North Carolina Press.
78. Dmae, R., *Finding the Poetry*, in *Reality Radio, second edition: Telling true stories in sound*, J. Biewen and A. Dilworth, Editors. 2017, The University of North Carolina Press. p. 154.
79. Fothergill, J., *Podcasts and online learning*, in *Podcasting for learning in universities*, G. Salmon and P. Edrisingha, Editors. 2008, Open University Press: Maidenhead. p. 80-91.
80. Kidd, W., *Utilising podcasts for learning and teaching: a review and ways forward for e-Learning cultures.* Management in education, 2012. **26**(2): p. 52-57.
81. Drew, C., *Edutaining audio: an exploration of education podcast design possibilities.* Educational Media International, 2017. **54**(1): p. 48-62.
82. Ramsden, I.M., *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. 2002, Victoria University of Wellington: Wellington, New Zealand. p. 211.
83. Kerrigan, S., et al., *Podcasting as a Creative Practice and the Spirit of Radio: Local Histories of Maitland.* Journal of Radio & Audio Media, 2021: p. 1-20.
84. Sjorberg, D. and D. McDermott, *The deconstruction exercise: An assessment tool for enhancing critical thinking in cultural safety education.* International Journal of Critical Indigenous Studies, 2016. **9**(1): p. 28-48.
85. Ng'ambi, D., *Podcasts for reflective learning*, in *Podcasting for Learning in Universities*, G. Salmon and P. Edririsingha, Editors. 2008, Open University Press: Maidenhead, Berkshire, England. p. 132-145.
86. Wilson, A., *Addressing Uncomfortable Issues: Reflexivity as a Tool for Culturally Safe Practice in Aboriginal and Torres Strait Islander Health.* Australian Journal of Indigenous Education, 2014. **43**(2): p. 218-230.
87. Kerrigan, V., et al., *Evaluation of "Ask the Specialist": a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia.* Health Sociology Review., 2022('Yuwinbir', a special issue of Health Sociology Review on Indigenous and sociological knowledges: Meeting points for health equity).

CHAPTER SEVEN

Listening to Ask the Specialist

This chapter provides what is needed to listen to all 7 episodes of the *Ask the Specialist* podcast. A selection sample of the podcast logo is also below. The logo was designed by my friend Amber Young: a graphic designer who generously donated her time and expertise to create 8 versions of the logo for websites, social media, posters and promotional materials.

Each podcast episodes can be accessed via Apple and Google podcasts and Spotify. Additionally, QR codes have been created for the seven podcast episodes available via Apple podcasts and Spotify. Finally, the chapter includes photos supplied by doctors of the locations where they listened to episodes to evaluate the podcast (chapter 8).

Figure 9 QR code links to www.menzies.edu.au/askthespecialist.

Figure 10 The Ask the Specialist podcast logo

Podcast interface logo

Facebook posts logo

Twitter posts logo

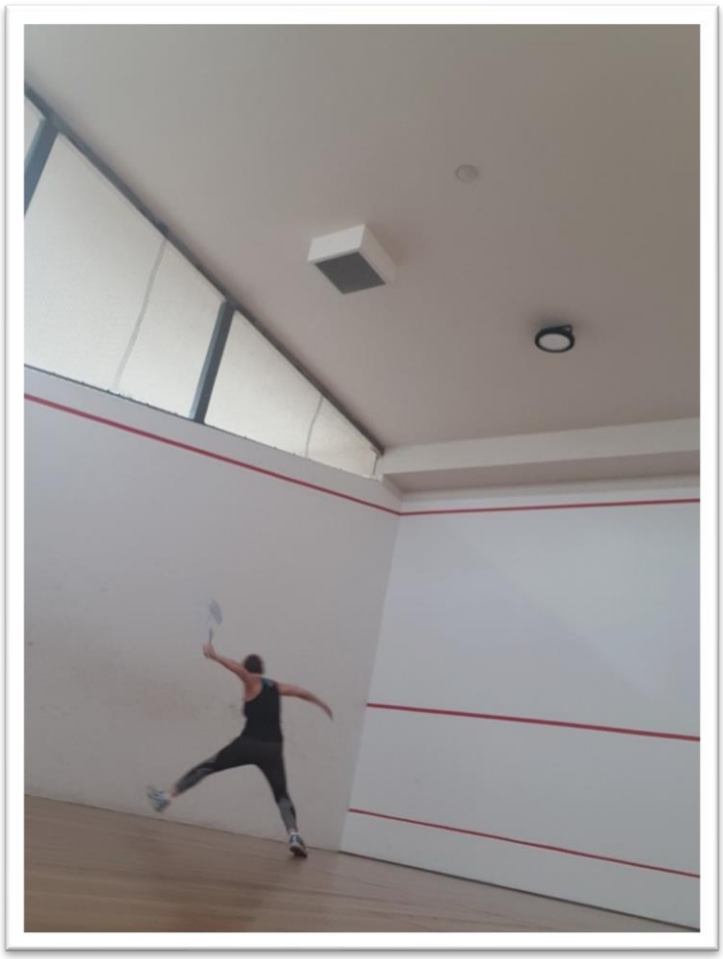
Menzies website header logo

Table 10: Podcast episodes QR codes

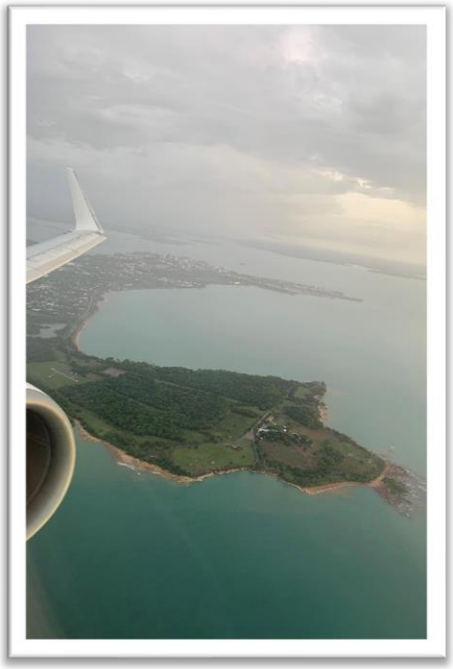
EPISODE	SPOTIFY QR CODE	APPLE PODCAST QR CODE
Ep1: Get to know your patient.		
Ep2: Communicating with your patient.		
Ep3: Communicating with interpreters.		
Ep4: Patient centred care.		
Ep5: Informed consent.		
Ep6: Recognising and addressing racism.		
Ep7: Perspectives on health and wellbeing.		

Figure 11: Podcast listening locations

Cliffs, Arnhem Land, NT

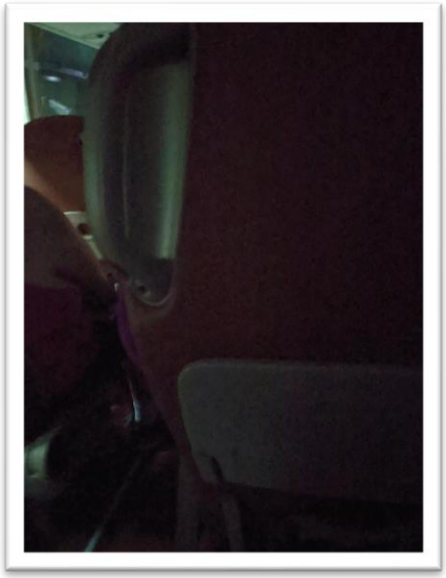


Playing solo squash



Flight to Darwin

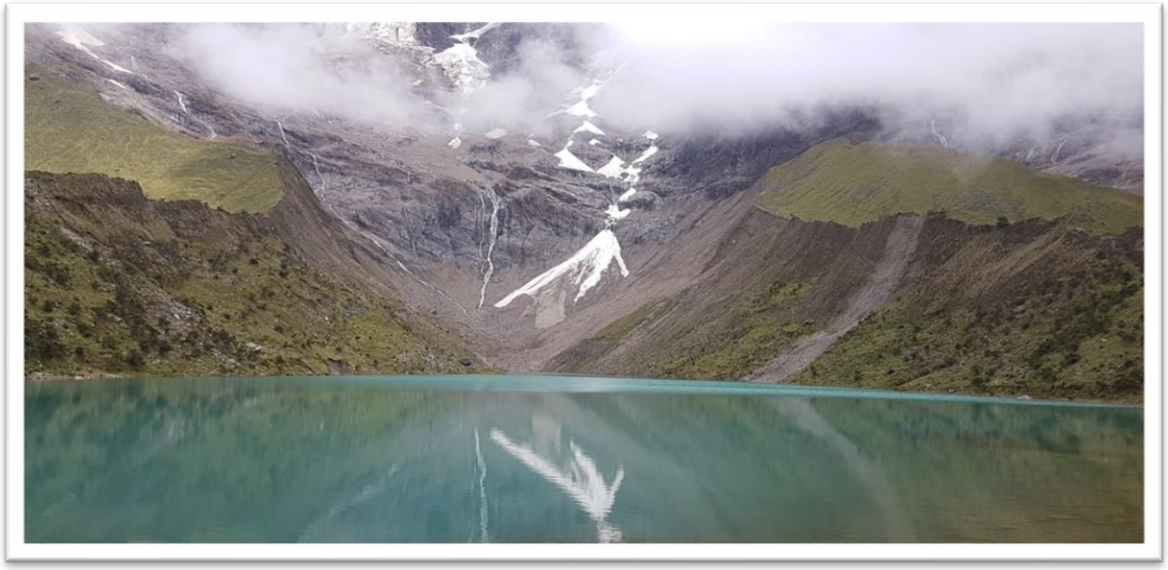
Bushwalking, NSW



Sydney to Canberra bus

Beach walk, Nhulunbuy, NT

Sewing at home



Holiday in South America

Lounge room

Vespa ride to work

CHAPTER EIGHT

Evaluation of 'Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia

Publication: Kerrigan V, McGrath SY, Herdman RM, Puruntatameri P, Lee B, Cass A, Ralph AP, Hefler M. Evaluation of 'Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia. Health Sociology Review. 2022 Apr 2:1-9.

HEALTH SOCIOLOGY REVIEW
https://doi.org/10.1080/14461242.2022.2055484

Taylor & Francis
Taylor & Francis Group

Evaluation of 'Ask the Specialist': a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia

Vicki Kerrigan [a], Stuart Yiwarr McGrath[a], Rarrtjiwuy Melanie Herdman[a], Pirrawayingi Puruntatameri[a], Bilawara Lee[c], Alan Cass[a], Anna P. Ralph [a,b] and Marita Hefler [a]

[a]Menzies School of Health Research, Charles Darwin University, Darwin, Australia; [b]Royal Darwin Hospital, Darwin, Australia; [c]Indigenous leadership, Charles Darwin University, Darwin, Australia

ABSTRACT

In Australia's Northern Territory (NT) most people who access health services are Aboriginal and most healthcare providers are non-Indigenous; many providers struggle to deliver culturally competent care. Cultural awareness training is offered however, dissatisfaction exists with the limited scope of training and the face-to-face or online delivery format. Therefore, we developed and evaluated *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare*, a cultural education podcast in which Aboriginal leaders of Larrakia, Tiwi and Yolŋu nations, known as the *Specialists*, answer doctors' questions about working with Aboriginal patients. The Specialists offer 'counterstories' which encourage the development of critical consciousness thereby challenging racist narratives in healthcare. After listening to the podcast, doctors reported attitudinal and behavioural changes which led to stereotypes being overturned and more culturally competent care delivery. While the podcast was purposefully local, issues raised had applicability beyond the NT and outside of healthcare. Our approach was shaped by cultural safety, critical race theory and Freirean pedagogy. This pilot is embedded in a Participatory Action Research study which explores strategies to improve culturally safe communication at the main NT hospital Royal Darwin Hospital.

ARTICLE HISTORY
Received 1 October 2021
Accepted 15 March 2022

KEYWORDS
Healthcare; communication; cultural safety; training; podcast; racism

Introduction

Aboriginal peoples, the original inhabitants of the unceded lands known as Australia, are the world's oldest continuous civilisations (Burarrwanga et al., 2019). Over the last 200+ years colonisation has resulted in a disproportionate burden of disease and poorer health outcomes for Aboriginal peoples. In the Northern Territory (NT; 'the Territory'), Aboriginal peoples comprise 30% of the population (Australian Bureau of Statistics, 2018) yet

CONTACT Vicki Kerrigan vicki.kerrigan@menzies.edu.au Menzies School of Health Research, Charles Darwin University, Darwin, Northern Territory 0811, Australia

constitute at least 70% of hospitalisations (Northern Territory Government, 2021). Healthcare providers unfamiliar with the diversity and strength of Aboriginal cultures in the NT, struggle to deliver culturally competent care (Amery, 2017; Kelly, Dowling, McBride, Keech, & Brown, 2020; Kerrigan et al., 2021a, 2021b): there is a perception that Aboriginal peoples are 'non-compliant' and 'they don't listen' (Anderson et al., 2012; Kerrigan et al., 2021b). Racist stereotypes of 'suspicious blacks, hostile blacks' were held by colonisers before they arrived in Australia (Moreton-Robinson, 2011, p. 421) and continue today fostered by media reports which link Aboriginal peoples with harmful behaviours (Stoneham, Goodman, & Daube, 2014; Watego, Singh, & Macoun, 2021). This racist discourse seeps into mainstream health services, resulting in Aboriginal peoples feeling unsafe (Thurber et al., 2021; Watego et al., 2021).

For over 50 years, cultural awareness training has been proffered as a panacea to intercultural issues in healthcare, however, the training has been criticised for homogenising Aboriginal cultures (Downing, Kowal, & Paradies, 2011; Shepherd, 2019) and reinforcing negative stereotypes as it perpetuates 'othering' (Brascoupé & Waters, 2009; Byrne & Tanesini, 2015). As an alternative, there is momentum around the concept of cultural safety which was developed to counter racism in healthcare (Ramsden, 2002). Cultural safety requires healthcare providers to develop their critical consciousness in addition to having 'a degree of knowledge and understanding of other cultures' (Curtis et al., 2019, p. 14). When individuals are critically conscious they are aware of the social, economic and political systems that oppress people and have capacity to reflect on their 'assumptions, biases and values' (Kumagai & Lypson, 2009) and can act to change systems of oppression (Freire, 1970). The concept of critical consciousness links cultural safety with Freirean pedagogy and Critical Race Theory (CRT) (Delgado, Stefancic, & Harris, 2017; Freire, 1970). Both Freirean pedagogy and CRT attempt to develop critical consciousness by elevating the 'experiential knowledge of people of color' through storytelling (Smith-Maddox & Solórzano, 2002, p. 71). Previous Australian research has found when healthcare providers are exposed to stories shared by Aboriginal peoples critical thinking relating to Whiteness and privilege occurs (Grogan, Hollinsworth, & Carter, 2019; Sjorberg & McDermott, 2016; Wain et al., 2016). Australian governments have committed to addressing racism in healthcare through ensuring care is culturally safe (Australian Commission on Safety and Quality on Health Care, 2017; Australian Government, 2013; Northern Territory Government, 2021) however, there is a gap between policy and implementation and a paucity of evidence that cultural safety training can achieve its intended outcomes.

At the time of this study, there was no cultural safety training mandated for NT Health staff. Our research of cultural awareness training for NT health found only 30% of staff attend (Kerrigan, Lewis, Cass, Hefler, & Ralph, 2020). Training was perceived to be an institutional tick-box exercise and met with 'eyerolls and groans' (Kerrigan et al., 2021b). We evaluated over 600 cultural awareness training participant feedback forms, to assess if negative attitudes also existed amongst the small percentage of NT Health staff who attended training (Kerrigan et al., 2020). We found the one-day face to face training was considered a valuable starting point by staff who recognised their knowledge gaps. Staff want more training which focuses on intercultural communication which is clinically relevant. Importantly, participants requested training which encourages critical reflection to support the development of critical consciousness (Kerrigan et al., 2020). Additionally, our research found a highlight of cultural awareness training was the

personal stories shared by Aboriginal educators which have the potential to decolonise the healthcare system by reasserting 'Indigenous voice, perspective, and experience' (Behrendt, 2019, p. 175). CRT scholars (Delgado et al., 2017) refer to such stories as 'counterstories', which challenge stereotypes and encourage a reallocation of power. Delgado (1989) argues counterstories are 'the cure' to ongoing racial inequities. Hence, we designed a new cultural education package which privileges Aboriginal peoples' stories of healthcare and encourages critical thinking.

Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare is a cultural education package which consists of a podcast and discussion groups. 'The Specialists' are Larrakia, Tiwi and Yolŋu leaders: Aunty Bilawara Lee, Pirrawayingi Puruntatameri, Rarrtjiwuy Melanie Herdman, and Stuart Yiwarr McGrath. Kriol and Burarra interpreter Bernadette Nethercott from the NT Aboriginal Interpreter Service also shared expertise. The aim of this paper is to explore the impact of the *Ask the Specialist* podcast (7 x <18-minute episodes) on Royal Darwin Hospital (RDH) doctors' attitudes and behaviour. We will explore if the counterstories (Delgado et al., 2017) provided by the Specialists stimulated the development of the critical consciousness (Freire, 1970) required to challenge negative stereotypes and change practice.

Methods

Study design

This pilot study was part of a larger Participatory Action Research (PAR) project in which Aboriginal educators, interpreters and health professionals collaborated with hospital-based doctors and researchers to address barriers to culturally safe communication at RDH (Menzies School of Health Research, 2018). The theoretical framework was guided by Freire's theories on education (1970), CRT (Delgado et al., 2017) and cultural safety (Ramsden, 2002). While Freirean pedagogy originated in Brazil, CRT originated in American legal studies and cultural safety was developed among nurses in New Zealand/Aotearoa, when combined the theories offer an alternative paradigm, as detailed above, to explore the creation of a culturally safe health workforce in the NT (Braun, 2017; Kumagai & Lypson, 2009; Ramsden, 2002). While cultural safety can only be determined by patients, the work to create a culturally safe workforce must be done by the health providers who are required to:

> critique the 'taken for granted' power structures and be prepared to challenge their own culture, biases, privilege and power rather than attempt to become 'competent' in the cultures of others. (Curtis et al., 2019, p. 14)

To create the podcast, we applied the Freirean concept of 'problem posing education' and the CRT concept of counterstories. The concepts are embedded in the title, *Ask the Specialist: Larrakia, Tiwi and Yolngu stories to inspire better healthcare*. The title promises that problems will be posed, and answers provided by voices marginalised by the mainstream. Furthermore, the title dislodges Eurocentric meritocracy (Delgado et al., 2017) by valuing the experiential knowledge of Aboriginal peoples. To produce podcast content, hospital-based doctors were invited to articulate the problems they encounter when working with Aboriginal patients. Doctors' questions ranged from the practical: 'When should I get an interpreter?' to issues at the heart of cultural safety and social

justice: 'I want to know what Aboriginal people feel like when we talk to them, what makes them think that we're racist?'. Anonymised questions from doctors were then presented to the Specialists who provided their perspective thereby exposing counterstories, so often 'hidden or minimised in the dominant discourse' (Bell, 2003, p. 8), which reveal the reality of the hospital experience for Aboriginal peoples in the NT's Top End. A detailed manuscript explaining how the podcast was created is underway.

Researcher backgrounds

Aunty Bilawara Lee is an Elder of the Larrakia nation. She has more than 50 years' experience in education, health and the community sector and is acknowledged internationally as a healer and teacher of the ancient wisdoms of Aboriginal spirituality. Pirrawayingi Puruntatameri is a Tiwi Elder, his name translates to 'someone who represents his people'. He has 40 years experience working in health, education, justice and the community sector. He is bilingual: Tiwi and English. Stuart Yiwarr McGrath is a Gumatj man from the Yolŋu nation; he is an Aboriginal Health practitioner, a student of nursing and researcher. He is bilingual: Djambarrpuyŋu (Yolŋu Matha dialect) and English. Rarrtjiwuy Melanie Herdman is a Gälpu women from the Yolŋu nation. Her work spans the health, environmental, political and research sectors and is encompassed in the Yolŋu phrase Rrambaŋi djäma: (working together). Rarrtjiwuy is bilingual: Dhaŋu (Yolŋu Matha dialect) and English. Vicki Kerrigan is an Australian born English speaking White researcher of Anglo-Celtic heritage, communication researcher and former radio broadcaster. The term White is capitalised in line with Whiteness studies stemming from the scholarship of Du Bois (2003). Reflecting on her proclivity as a White settler to assume the colonising role of the 'cultural overseer' (hooks, 2014) in the research space, Kerrigan uses PAR to work alongside Aboriginal collaborators to facilitate the collective production of knowledge (Hall, 1985). Academic supervisors Anna Ralph, Alan Cass and Marita Hefler are White researchers who have extensive history working collaboratively with Aboriginal peoples and organisations on health issues.

Study setting

In Australia's far north, the Top End Health Service provides over 100,000 episodes of inpatient care annually and employs over 4200 full time staff across four hospitals: RDH, Palmerston, Katherine and Gove Hospital, and 57 remote health clinics (Northern Territory Government, 2018). Aboriginal peoples make up 70% of hospitalisations and 89% of remote clinic presentations (Northern Territory Government, 2021). Most staff are non-Indigenous, not from the NT and staff turnover is high. Often healthcare providers on short term contracts do not undertake cultural education, instead privileging the biomedical approach to health without considering Aboriginal ways of knowing, being and doing (Martin & Mirraboopa, 2003).

Participant sampling

RDH-based doctors who had been identified through personal and professional networks including referrals, from co-author APR who was a doctor at RDH, were purposefully

sampled (Patton, 1990). Doctors were invited to participate because the doctor–patient relationship is at the heart of communication in healthcare (Brown, Noble, Papageorgiou, & Kidd, 2015) and they are considered opinion leaders and agents of change (Gabel, 2012). Doctors came from diverse cultural backgrounds, levels of professional experience and were eligible to participate if they planned to remain in the region for 12 months or more. This ensured doctors had opportunities to implement new culturally safe ways of working at NT Health thereby encouraging individual and institutional change.

Data collection

Over seven weeks (29 January 2020 to 11 March 2020), one episode per week was shared with doctors via a link to a password protected podcast host site. After listening to each episode doctors provided weekly reflections, guided by a list of feedback prompts. Weekly reflections, also called journal entries were shared via email, voice memo or text message. Reflections generated data to analyse, provided ideas to explore in final feedback interviews and as per cultural safety practice (Wilson, 2014) encouraged a continuous cycle of participant reflection, action and change over 7 weeks as explored in this paper. Finally, feedback interviews were recorded with doctors after listening to all seven episodes. Interviews occurred outside of work hours to remove the risk of impacting patient care.

Data analysis

Critical theory (Bronner, 2002), which underpins CRT, Freirean pedagogy and cultural safety, shaped analysis. Initially, inductive narrative analysis was applied to doctors' reflections and interview transcripts were transcribed verbatim. Narrative analysis (Clandinin, 2007), conducted in NVIVO12, explored the data for turning points in doctors' attitudes and epiphanies related to power and privilege. Codes were then deductively grouped into four categories aligning with Kirkpatrick's training evaluation framework (Kirkpatrick, 1996). Kirkpatrick's framework provided a structure to methodically describe changes in attitude, behaviour and systems. VK led analysis with input from co-authors. Through reviewing manuscript iterations, direct feedback from the Specialists, who are co-authors, was incorporated into the discussion. This approach recognises 'Indigenous ways of thinking about the world are authentic sources of human knowledge' (Turner, 2021, p. 184).

Ethical considerations

Regarding language and naming conventions, we use the nation collaborators belong to: Larrakia, Tiwi, Yolŋu and so on. The term 'Aboriginal' is used to refer collectively to the original occupants of mainland Australia. We recognise the term Aboriginal is a constructed category which exists in relation to European colonisation and, as Moreton-Robinson states, it does not capture 'our respective ontological, epistemological, axiological and cultural subjectivities' (2011, p. 413). Approval to conduct the study was provided by the NT Department of Health and Menzies School of Health Research Ethics

Committee. Participation was voluntary and doctors could withdraw at any stage understanding that anonymised data would be retained. Doctors were given pseudonyms to ensure anonymity which are used in this paper. If doctors had concerns relating to the project, they were encouraged to speak to their workplace supervisor or the research team.

Findings

Participating doctors, interns to senior clinicians with more than 40 years experience in the region, worked across all four Top End hospitals: RDH, Palmerston, Katherine and Gove. Doctors had diverse cultural backgrounds: 9 White Australian, 2 Aboriginal, 1 Indian-Malaysian, 1 Irish, 1 American, 1 Zimbabwean and 1 English. Of the 16 doctors who posed questions to Specialists, 14 provided feedback about the podcast. One doctor didn't listen to any episodes but participated in a follow up interview. Two doctors were uncontactable for feedback interviews.

Findings demonstrate doctors developing critical consciousness and how changes in attitude resulted in action. At times doctors struggled with their reflections as they recognised personal biases and system failures. Kirkpatrick's four domains to evaluate training: reaction, learning, individual behaviour change and organisational impact are used to systemically present findings.

Reaction to training

Episodes were listened to by participants quietly at home, commuting to work, on aeroplanes, completing household chores, exercising, at work during a break and for Bridget listened 'in bed at 4.30am unable to sleep'. The flexible format did not interfere with clinical or administrative responsibilities. Most did not listen at work; Susan explained completing the current online cultural training at work did not allow for reflection. Most doctors listened to episodes more than once: a senior clinician who had worked in the Top End for 4 years, Ian, said he 'picked up different things each time'. At the end of each episode, there was a call to action asking doctors to reflect and consider how they can change to improve the delivery of culturally safe care:

> That always really got me. A little bit of a dagger. It was great and I think it was really important for people to listen to this and to be self-critical and say … 'If I proclaim to care about Indigenous health, that's one of the reasons that I'm here, then why am I not putting my money where my mouth is and actually engaging like I should?'. (Simon)

Doctors appreciated that one episode was delivered per week over 7 weeks. A senior clinician in the Top End for 9 years, Bridget said because critical reflection is not encouraged in the acute care setting, she valued the staged roll out which 'kind of forced me not to just listen to it but to really consider it and apply it to my practice'.

Doctors said the podcast contributed to professional development. A senior registrar who had worked in the Top End for 10 years, Melinda, said the podcast was 'more useful than a didactic lecture or having an online learning module'. After listening to all episodes, Penny wrote in her journal that she noticed each episode built on concepts

previously discussed: 'So it's a good teaching tool that way that it's structured'. Doctors said the content covered cultural competencies and also inspired cultural safety practice. Aaron said: 'this is the training that is required'.

> Clinical care gold. This project will change the healthcare professional-patient communication landscape. Should provide the best outcomes for all our patients!! (Aaron, journal)

Doctors also valued the clinical vignettes shared by the Specialists which mirrored their experiences and provided examples of how to change behaviour. Penny journaled: 'You have very successfully understood doctor culture and how our brains work'. She elaborated, in an interview, the podcast encouraged her to take responsibility for making change:

> I think, the whole point of the podcast, is that it's always, always about the listener. It's about what you can do. How you can improve on these shitty situations which have happened to us … it's really beautiful how you've placed this high-powered doctor in a listener's seat, but still given them responsibility that it's their job to do stuff differently, I think that's magical. (Penny)

Doctors appreciated the Specialists made themselves vulnerable by sharing personal experiences. They recognised they can learn from patients if, as Ian said: 'we just listen to them and show genuine interest'. Most doctors valued listening to the Specialists who held respected positions of authority in the community, although one doctor Ben questioned 'how much these four voices are a good sample' of Aboriginal perspectives. In contrast, Simon said:

> It's a specialist podcast for the same reason that I wouldn't get a plumber to give a presentation about auto immune hepatitis. These are Specialists who are experienced with healthcare, who are cultural leaders, who have thought deeply about these issues and they're the people you want to hear from. (Simon)

Doctors enjoyed hearing a variety of opinions which were at times contradictory. After listening to episodes 1–4 Toby journaled: 'it's clear that Aboriginal people are not a single entity as sometimes it is portrayed in the media, by hospital staff and in cultural education sessions.' Whilst the diversity of Aboriginal cultures was evident, Ben and Ian were concerned doctors were presented as a homogenous group.

> When they say, 'Oh all the doctors always do this', and you're a bit like, 'Well not all of us all do that'. But yeah, I guess that's just being a bit defensive really isn't it. (Ian)

Melinda explained doctors take criticism 'as a personal attack' because they are expected to be 'perfect'. One doctor, Paula, was reassured by what the Specialists said:

> What was reassuring to me was that when doctors do – or other health professionals do – go to the effort to show respect and to engage with people, that that is noted and appreciated and that was a really nice thing to hear. (Paula)

After listening, some felt ashamed. A junior registrar in the Top End for 5 years, Simon, said: 'I felt a bit of shame about perhaps not using interpreters and not engaging with patients in a way that I feel like I should.' However, he and others, recognised this was a growth opportunity. Simon said talking about racism in healthcare 'is a really

emotional thing, it's not purely cerebral' and hearing directly from patients was different to other cultural education:

> The anger is real … It's not some conceptive image of Aboriginal people that are put on PowerPoints and everything, sort of rosy and peachy, it's the messy reality. It gets ugly. We need to acknowledge that. (Simon)

One doctor, Susan was disappointed by how the podcast addressed racism:

> I felt like it sort of skipped around the edges a little bit, sort of nibble, nibble … We tiptoe around racism, and I think even the Specialists kind of did. They gave some stories and some anecdotes, and it was more so thinking that people can't read and write or whatever … it was a little bit around hospital procedures and incidents, but I think it failed to talk about maybe more the social determinants of health … I probably would have loved a bit more meat in those sort of hard-hitting type topics … because I identify as an Aboriginal woman, so I'm more in tune with some of this stuff than some other people. (Susan)

Toby also wanted the podcast to delve further into the ongoing impact of colonisation on health outcomes for Aboriginal peoples: 'Can you talk more about the history of doctors in relation to the history of colonisation and oppression? It'd be uncomfortable but important listening.'

Penny described the podcast as 'authentic to the Territory'. Simultaneously, doctors recognised the Specialists' experiences, as Aboriginal peoples interacting with White health services, was repeated globally. Aaron said the stories were relevant to all patient-provider interactions: 'I think this will actually go across cultures because what they were discussing is an absence of respect in care.'

All doctors, minus one, stated the podcast should be available to all staff. Melinda said allied health, nursing staff, cleaners and ward clerks 'all create the culture of the hospital'. However, there was conflict over making the training mandatory. Some viewed mandatory training as an institutional tick-box exercise and were concerned if the podcast was institutionally branded staff would reject it because Drew explained 'there's a history of things being inadequate'. For others, the podcast should be mandated for all including senior clinicians who role model behaviour:

> When I see senior doctors who have worked in the NT a long time, I have realised I have an expectation they will be good at communication and will have special knowledge of cultural differences. But they don't! They use medical jargon and don't check patients' understanding. They explain things in English and keep the interactions brief, telling the patient what's going to happen and then leaving. I hope to see these podcasts become widely available and to be embedded in a broader culture of changing the way we do things – one day. I hope that senior staff who run our hospital see their shortcomings as much as junior staff like me see our own. (Joanne, journal)

Drew was concerned senior staff would resist the podcast:

> You'll have a few people who have been around for a long while whose kneejerk reaction is, 'I don't need this. I've been talking to Aboriginal people up here for 15, 20 years'. (Drew)

One doctor did not listen to any episodes. Anthony, a senior clinician who had worked in the Top End for over 20 years, said communication and cultural safety was not an institutional priority therefore it was not an individual priority. He explained that in the acute care setting the White biomedical approach to healthcare takes precedence

over 'the soft power skills, the ideas around communication, around engagement with patients, around culturally safe practice, these broad concepts are always deprioritised by us'.

Participant learning

We identified five major areas of learning which indicated participants were becoming critically conscious: the importance of communicating in a culturally safe manner, creating partnerships with patients, awareness of spiritual practices, countering stereotypes and addressing racism.

Culturally safe verbal and non-verbal communication

Doctors recognised a common theme was the importance of communication. After listening to episodes 1 and 2 Bridget journaled that improving communication is 'relatively simple' and it 'has the potential for large benefits to both patients and my own career satisfaction'. Concrete examples of how to communicate respectfully, including asking older patients if they would like to be referred to as Uncle or Aunty were considered useful because doctors admitted they sometimes did not know what to say. Penny said that medical school taught her to communicate in a manner which is in direct contrast to the style recommended by the Specialists:

> We're meant to be in control of the conversation, and that is taught power. We're taught how to get on top of people and to control what information they're coming out with. When to stop them, when to start them, all of that, which I think you need to unlearn. (Penny)

Regarding non-verbal communication, in episode 4, Aunty Bilawara Lee recommended health providers wear Indigenous prints or local woven earrings to show respect because uniforms can trigger anxiety due to a history of institutional ill treatment. Toby journaled: 'I wear Aboriginal prints a lot. "If you're a racist or a bigot you will not wear an Aboriginal print" from Aunty Bilawara blew me away. I never thought of it in that way.'

Creating patient partnerships

Doctors learnt about the value of creating a partnership with patients. Simon said healthcare providers 'lose sight of patient-centred care' in overstretched and underfunded hospitals. Aaron realised many Aboriginal patients feel 'degraded' even though he believes his patients receive the best clinical care available. Penny said the Specialists stories reminded her that she was delivering care to 'humans' with complex histories:

> We get taught that patients are often 'things'. I think that's what medicine teaches us … I feel like by doing that, it makes it easier to get on top because you can do 'things to things' … sometimes our job turns us into these robots. (Penny)

Awareness of spiritual beliefs

Doctors became aware of spiritual beliefs which may be subjugated to the delivery of biomedical healthcare. Episode 7 discussed the spiritual significance of blood to some

Aboriginal peoples. Afterwards, Susan questioned whether taking blood was necessary to determine the treatment plan:

> Talking about spirituality and blood, that wasn't something that I was really aware of … And we just routinely take so much blood … in medicine, we tend to probably take more bloods than we probably need as well. So, I think it's just maybe that awareness about: 'is this going to change what we do in the next day? Do we need this blood test today? How urgent is this?' (Susan)

Countering stereotypes

A commonly held stereotype that Aboriginal peoples self-discharge from hospital because they are 'non-compliant' was countered. After listening to episodes 1–4 Bridget journaled that she now appreciated 'the strong cultural/family responsibilities and how this impacts on patients "compliance" with healthcare'. For Aaron the podcast overturned the stereotype he believed a lot of healthcare providers hold: 'Aboriginal people coming from these communities, are not very well educated.' Aaron said the stereotype exists because Aboriginal patients don't complain when healthcare is inadequate, so providers assume health literacy is low. However, he learnt this was incorrect and that many don't feel comfortable questioning the authority of doctors even when care was inadequate. Doctors realised that instead of questioning authority some exercise their limited power by self-discharging.

Addressing racism

Doctors learnt that institutional decisions created a culturally unsafe hospital. Episode 6 revealed there was no space for smoking ceremonies at RDH or Palmerston hospital. A smoking ceremony is an ancient ritual for Aboriginal peoples; among its functions is to promote healing. When the NT government opened Palmerston hospital in 2018, plans to create a space to conduct ceremonies were abandoned. Susan described the decision as institutional racism:

> I'm so angry that there was meant to be a designated space at Palmerston (hospital) and that just got gobbled up in the bureaucracy. It's absolutely, like we're catering for other people and their needs in terms of having … the (Christian) prayer rooms and the Muslim prayer rooms … We're trying to encourage people to come to hospital if they're sick, use hospital services, engage in healthcare, and then we're kind of half-arsed doing it. (Susan)

However not all doctors linked institutional decisions to their personal practice. Ben struggled to see the benefits of learning about systemic issues because he was unsure how the information was going to help him 'change my practice tomorrow'.

The podcast also prompted doctors to recognise the everyday nature of racism. After episodes 1-6, Paula journaled: 'Racism at RDH is often insidious.' Simon described the hospital as 'exhausting'. He added: There are so many little micro-aggressions that you see on a day-to-day basis and…it's facilitated by this environment that treats Aboriginal patients as second-class citizens. Doctors realised they don't know how to report racist incidents. A junior registrar in the Top End for over a year, Susan said: 'I don't know if there are any formal avenues to actually report things like that.'

On-the-job behaviour change

Critical reflection, prompted by listening to the Specialists' stories, led to behaviour change to equalise the power imbalance between patient and provider in four major areas: investing time to build patient rapport, changing communication, working with interpreters differently and improving consent processes.

Investing time to build patient rapport

Doctors worked on building rapport to foster patient trust. A Top End doctor for 5 years, Drew said he was unaware Aboriginal people were looking for that connection and is now role modelling new behaviour: 'We're not going to just charge into this ward round, we're going to slow down and we're going to take time and that's where we put value in the consult.' Toby said he started to focus on 'the stuff that brought us together rather than the things that pulled us apart'. He built 'solidarity' with a Tiwi Elder who was a patient through their mutual love of boy bands: 'the biggest thing that brought us together was Boyzone, Westlife, Daniel O'Donnell (laughs). I've never seen a man love Boyzone that much'.

Changing communication with patients

After episodes 1–3, many asked Aboriginal language-speaking patients to teach them a few words. Bridget recognised this contributed to a 'shift in power'. Aaron learnt how to greet his patients in 6 languages which helped establish 'culturally therapeutic rapport'. During ward rounds a senior clinician Ben, who had worked in the Top End for 3 years, asked a Tiwi patient to teach him and his team of 7 doctors a few words:

> And she totally brightened up … she stayed in our ward for something like two weeks because she ended up having quite a complicated course … So every time I would see her, I would say 'Good morning' in Tiwi or 'Good evening' in Tiwi … She taught me how to say 'Goodbye'. And then the last day, when I went to say goodbye and I told her it was a real pleasure taking care of her and she said, in Tiwi, 'Goodbye friend' to me … And then she asked me another thing which was both gut wrenching and embarrassing … I said: 'I'll use what I've learned for other Tiwi speaking patients'. And she goes: 'Oh, you've never taken care of Tiwi patients before?' And it was just like, such an indictment … But I said: 'No, I have taken care of a lot of Tiwi patients, and I have just never taken the time to do what I've done with you, and that was a mistake'. (Ben)

In episode 3, doctors were asked to consider rephrasing the question they ask patients at the end of every consult: do you have any questions? Asking questions for some Aboriginal patients may be considered impolite. Joanne reported better engagement after she started asking: 'Do you have any worries?'. Susan was working with a senior clinician who was also involved in the pilot and noticed the clinician had rephrased the standard final question:

> I've noticed that she actually will say to patients: 'What questions have you got?', rather than 'Do you have any questions?' So, it's sort of opening up that space a little bit more … and it was something that stuck with me, because I'm like 'Oh shit, how do I actually ask that question?'. So, I've tried to be a little bit crafty about how I go about that with my patients now. (Susan)

Working differently with interpreters

Doctors changed how they collaborated with Aboriginal interpreters. After episode 3, doctors told patients they, the healthcare provider, need the interpreter. Drew recognised the issue was his lack of language skills: 'I have the problem because I don't speak Tiwi.' Although Penny was concerned about respecting patient autonomy and not perpetuating colonial dominance by insisting on an interpreter. Doctors also started to brief interpreters before meeting the patient. Paula, a Darwin-based doctor for 15 years, said: 'I hadn't ever realised I should be doing that.'

Improving consent processes

Gaining informed consent from Aboriginal patients was of major concern to all doctors. In episode 5, Tiwi Elder Pirrawayingi Puruntatameri shared his experience as an RDH patient which entailed being handed a consent form with all boxes pre-ticked. Toby, a junior doctor in the Top End for 2 years, journaled: 'Boxes ticked is an every time thing, god even I've been guilty of it in the past.' After listening to episode 5, Toby saw the same thing repeated with another Tiwi Elder who required an operation:

> I just remember seeing … a surgeon … who had completed a consent form and had ticked all the boxes already and it was just missing the signature in the notes and I just, I was very angry and it was very hard to sort of … articulate how angry I was to the other members of the team who saw me just rip the consent form up and throw it in the bin. (Toby)

About a year before listening to the podcast, Bridget's team performed a major surgical procedure on a patient who was in custody. The consent for surgery was conducted in English even though the patient's English proficiency was described as 'poor'. Between the time of admission and surgery, the patient interacted with approximately 10 different doctors, nurses, Aboriginal Liaison Officers and other members of the multidisciplinary team, yet no one asked the patient what language they spoke at home or suggested an interpreter. After the patient was discharged, the prison doctor lodged a complaint with the hospital: the patient had not understood nor wanted the surgery which was performed on them. A year after the incident, Bridget was unsure how the institution addressed the complaint. However, individually Bridget continued to consider her power as a doctor, how the patient was disempowered by both the hospital and the prison system and how gratuitous concurrence was possibly at play:

> And throughout the podcasts, and the Specialists talking about their culture and the nodding and agreeing to things because they don't want to conflict with what the White doctor's saying and this and that, so they just agree that they understand. (Bridget)

Wanting to ensure she did not repeat the situation described, Bridget sought to change systems. She journaled that she had started work within her department 'to improve our consent processes for Aboriginal patients and use of interpreter services'.

Value gained by the organisation

As the critical consciousness of individuals grew, they were able to identify the potential impact on the organisation. Doctors realised the hospital benefits from staff being culturally competent because it reduces self-discharge rates. Bridget said she better

understands why patients may self-discharge and said she could have 'avoided patients taking their own leave, if we had the dialogue about why they needed to leave'. Ben believed while the Tiwi patient interaction described above didn't change clinical outcomes it may have contributed to the patient feeling culturally safe:

> Those types of interactions, sort of build upon themselves so the next time she needs hospitalisation, the feeling of not wanting to come in may be a little bit less, hopefully, for her. And, you know, that sometimes can translate into people presenting earlier and not being so far along in their disease process, that it's hard to take care of them. (Ben)

Delivering cultural education via a podcast meant doctors who had previously not attended cultural awareness training completed the task. Simon said the podcast provided 'a real opportunity for self-development' which does not currently exist. Doctors overwhelmingly stated cultural education should not be delivered during induction because Susan explained the content 'gets lost'. New staff are overwhelmed by administrative tasks, keen to start their clinical placement, and have not yet experienced the strength and diversity of Aboriginal cultures and how that intersects with mainstream healthcare. Susan supported the podcast because she believed the Top End should be a leader in cultural education: 'I think things need to be a bit more forward-thinking up here.' Melinda suggested building on the current series:

> I'd love to have another podcast perhaps about the similarities … emphasising in fact that, yes we've got some differences but in fact above and beyond, our similarities are also there and they need to be harnessed as a way of kind of working together. (Melinda)

Doctors requested a sustained education package delivered in protected time which included facilitated discussions after listening to each episode. Ian journaled he wanted to spend hours with the Specialists: 'Each explanation they give leads me to another question!' Before the podcast, doctors felt alone with their concerns regarding culturally unsafe care hence appreciated hearing their colleagues had similar questions. Ian said: 'I like that it tackled some things that we never get to ask.' Ben predicted that if health providers could discuss issues together with the Specialists, they could create a groundswell for institutional change:

> It's such a rare thing that we get to have these types of interactions, you know, where you kind of ask questions that you may be embarrassed to ask. And to do so in a group and in public, and be able to hear other people ask questions and sort of build upon each other. (Ben)

Discussion

Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare podcast facilitated critical consciousness which led to attitudinal and behavioural change amongst hospital-based doctors in the Top End. Doctors learnt about the benefits of culturally safe communication and patient-centred care, the importance of spiritual practice and how institutional decisions can diminish cultural identity. Doctors changed behaviour in relation to building rapport with patients, asking patients questions, working with Aboriginal interpreters, and gaining informed consent. Doctors also reflected on long-held stereotypes and the everyday nature of racism. However, two doctors said the

podcast did not adequately address racism or the impact of colonisation on health outcomes. Finally, the podcast format was preferred over face-to-face or online cultural awareness training as it allowed time-poor health professionals to engage with information when convenient (Berk, Trivedi, Watto, Williams, & Centor, 2020).

Podcast collaborators appreciated the critical feedback which will be considered for future projects. Aunty Bilawara Lee likened the podcast to a bidjpidji: 'dragonfly' in Larrakia. Like dragonflies symbolise enlightenment, the podcast shed light on a variety of clinically relevant issues pertaining to the delivery of culturally safe care. Whilst the podcast was uncomfortable listening for some, 'courageous dialogue' (Freire, 1970, p. 128) is required to create change. Our findings align with previous Australian research which found 'good cultural safety education generates disquiet, but makes the uncomfortable comfortable enough' (McDermott, 2012).

The *Ask the Specialist* podcast provided healthcare providers with an opportunity to listen to Aboriginal peoples talk authentically, emotionally and honestly about their healthcare experiences. As Pirrawayingi Puruntatameri explained, listening to the podcast may have been the first-time doctors had heard directly from Aboriginal peoples on these issues. The stories humanise patients which encourages the provider to move beyond prioritising the 'voice of medicine' to consider the 'voice of the lifeworld' which is commonly ignored in hospitals (Mishler, 1984). We agree with Wain et al. (2016) that, 'stories enable learners to experience a new reality and encourage reflection on their own assumptions and values as well as on issues of social justice'.

The aural nature of podcasts is ideal to explore personal experiences, which are 'intimately whispered into our ears' creating a bond between storytellers and the listener (Lindgren, 2016). Intimacy generated through the podcast created an opportunity for doctors to have indirect positive contact experiences (Allport, 1954) with Aboriginal patients who may otherwise be perceived as perpetrators, social deviants or victims in the segregated society (Kerrigan et al., 2021b). Indirect contact, such as listening to a podcast, whilst not as potent as direct contact is often a practical alternative in segregated contexts (Brown & Paterson, 2016). Increasing intergroup contact is commonly used in anti-racism training and is considered 'the most important approach for reducing prejudice' (Elias, Mansouri, & Paradies, 2021, p. 324). Indirect contact has previously been found to change attitudes and behaviour and can lay the foundation for future successful direct contact (Brown & Paterson, 2016).

Freire's theories on transformative education inspired the podcast question and answer format. Freire (1970) asserted 'problem-posing' education, which encourages critical thinking, has the capacity to liberate oppressed peoples from the societal status quo which maintain inequities. Problem-posing education 'strives for emergence of consciousness and critical intervention in reality' (Freire, 1970, p. 81). We believe the oppressor, as referred to by Freire, can also benefit from problem-posing education. Placing the onus for change onto the oppressor, in this case health providers, aligns with cultural safety praxis: those who hold power, and the potential to perpetuate racism, also hold power to change the systems that subjugate (Ramsden, 2002).

This study focused on supporting health professionals to change; this is 'the key feature' of cultural safety (Ramsden, 2002, p. 171). However as cultural safety can only be determined by patients there remains a need to assess if training improves patient experience and outcomes (Lock, Burmeister, McMillan, & Whiteford, 2020). Based on

pilot findings reported here, our team have been funded by the National Health and Medical Research Council to explore patient experiences across four NT hospitals over 5 years. Our project aims to improve cultural safety by scaling up the *Ask the Specialist* training package and increasing availability of Aboriginal language interpreters and Aboriginal health practitioners at RDH, Palmerston, Gove and Katherine hospital. We will measure patient experience quantitively through self-discharge rates which is an indirect measure of cultural safety (Australian Institute of Health and Welfare, 2019), Aboriginal interpreter uptake and qualitatively through in-depth interviews in the patients first language.

Regarding study limitations, we recognise that doctors who participated in the pilot may be more receptive to this work than others. However as early adopters of the innovation (Rogers, 2003) and opinion leaders, they have the power to lead change. Interviews documenting the impact of the podcast were conducted between 2 weeks and 3 months after listening to the podcast. Further research is required to examine if behaviour change can be sustained beyond the short term. Finally, the podcast was designed to be a catalyst to inspire further learning, with weekly episodes priming listeners for reflexive discussion groups with Aboriginal healthcare users and professionals including the Specialists. The design moved away from one-off cultural awareness training to a model which encourages healthcare providers to take 'responsibility for their own learning and to do "more work"' through ongoing group discussions (Fredericks & Bargallie, 2020, p. 302). However due to the COVID-19 pandemic, which restricted physical interactions and placed an increased burden on providers, we were initially unable to pilot the discussion groups. As restrictions around COVID-19 eased in the NT, we have subsequently piloted the full education package. Evaluation is underway.

Conclusion

Our findings provide evidence that cultural education, which addresses the problems doctors face, delivers 'counterstories' from Aboriginal peoples, and encourages the development of critical consciousness, can change attitudes and behaviour of health providers. The podcast format was rated highly by doctors who also appreciated the 7-week program which allowed for cycles of listening, reflection, and action. Whilst the podcast was designed to be deliberately local and specific to the individuals and cultures represented, universal truths applicable beyond the NT and outside of healthcare were apparent to listeners. *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare* podcast is publicly available through Apple and Google podcasts and Spotify.

Acknowledgements

The authors would like to thank: Top End Health Service particularly the anonymous doctors who participated in this project and Sean Taylor for his support; Bernadette Nethercott, Curtis Roman and all staff from the NT Aboriginal Interpreter Service. We also thank the anonymous reviewers and journal editors who provided us with beautifully considered and constructive feedback. We are very grateful for their time.

Disclosure statement

At time of writing, Anna P Ralph was employed by Top End Health Service. Bilawara Lee was a member of the Top End Health Service Health Advisory Group and a member of the NT Health Ministers Advisory Committee. Alan Cass was Deputy Chair of the NT Clinical Senate. No competing interests were declared by other authors.

Funding

Vicki Kerrigan was supported by an Australian Government Research Training Program Scholarship and Improving Health Outcomes in the Tropical North: A multidisciplinary collaboration (HOT NORTH)', (NHMRC GNT1131932). Stuart Yiwarr McGrath was supported by HOT NORTH Indigenous Development and Training Award (NHMRC GNT 113193). Anna P Ralph was supported by an NHMRC fellowship 1142011. Alan Cass was supported by a NHMRC Investigator [grant number 1194677]. Funding to undertake data collection was provided by the Menzies School of Health Research Grants Scheme.

Authorship statement

All authors meet ICMJE requirements for authorship.

ORCID

Vicki Kerrigan http://orcid.org/0000-0001-6863-1528
Anna P. Ralph http://orcid.org/0000-0002-2253-5749
Marita Hefler http://orcid.org/0000-0002-1709-1098

References

Allport, G. W. (1954). *The nature of prejudice*. Oxford, England: Addison-Wesley.

Amery, R. (2017). Recognising the communication gap in Indigenous health care. *Medical Journal of Australia*, *207*(1), 13–15. doi:10.5694/mja17.00042

Anderson, K., Devitt, J., Cunningham, J., Preece, C., Jardine, M., & Cass, A. (2012). If you can't comply with dialysis, how do you expect me to trust you with transplantation? Australian nephrologists' views on indigenous Australians' 'non-compliance' and their suitability for kidney transplantation. *International Journal for Equity in Health*, *11*(1), 21. doi:10.1186/1475-9276-11-21

Australian Bureau of Statistics. (2018). *Estimates of Aboriginal and Torres Strait Islander Australians*. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001

Australian Commission on Safety and Quality on Healthcare. (2017). *National safety and quality health service standards second edition*. Retrieved from https://www.safetyandquality.gov.au/sites/default/files/2019-04/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf

Australian Government. (2013). *National Aboriginal and Torres Strait Islander health plan 2013–2023*. Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/02/national-aboriginal-and-torres-strait-islander-health-plan-2013-2023.pdf

Australian Institute of Health and Welfare. (2019). *Cultural safety in health care: Monitoring framework*. Retrieved from https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/summary

Behrendt, L. (2019). Indigenous storytelling: Decolonizing institutions and assertive self-determination: Implications for legal practice. In J.-A. Archibald, Q. U. Xiiem, J. B. J. Lee-Morgan, & J.

De Santolo (Eds.), *Decolonizing research: Indigenous storywork as methodology* (pp. 175–186). London: Zed Books.
Bell, L. A. (2003). Telling tales: What stories can teach us about racism. *Race, Ethnicity and Education*, *6*(1), 3–28. doi:10.1080/1361332032000044567
Berk, J., Trivedi, S. P., Watto, M., Williams, P., & Centor, R. (2020). Medical education podcasts: Where we are and questions unanswered. *Journal of General Internal Medicine*, *35*(7), 2176–2178. doi:10.1007/s11606-019-05606-2
Brascoupé, S., & Waters, C. M. (2009). Cultural safety exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health*, *5*(2), 6–41.
Braun, L. (2017). Theorizing Race and Racism: Preliminary Reflections on the Medical Curriculum. *American Journal of Law & Medicine*, *43*(2-3), 239–256. doi:10.1177/0098858817723662
Bronner, S. E. (2002). *Of critical theory and its theorists* (2nd ed.). Routledge. doi:10.4324/9780203951972
Brown, J., Noble, L. M., Papageorgiou, A., & Kidd, J. (2015). *Clinical communication in medicine*. Chichester, West Sussex: John Wiley & Sons.
Brown, R., & Paterson, J. (2016). Indirect contact and prejudice reduction: Limits and possibilities. *Current Opinion in Psychology*, *11*, 20–24. doi:10.1016/j.copsyc.2016.03.005
Burarrwanga, L., Ganambarr, R., Ganambarr-Stubbs, M., Ganambarr, B., Maymuru, D., Wright, S., … Lloyd, K. (2019). *Song spirals: Sharing women's wisdom of country through songlines*. Crows Nest, Australia: Allen & Unwin.
Byrne, A., & Tanesini, A. (2015). Instilling new habits: Addressing implicit bias in healthcare professionals. *Advances in Health Sciences Education: Theory and Practice*, *20*(5), 1255–1262. doi:10.1007/s10459-015-9600-6
Clandinin, D. J. (2007). *Handbook of narrative inquiry mapping a methodology*. Thousand Oaks, CA: Sage. doi:10.4135/9781452226552
Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. doi:10.1186/s12939-019-1082-3
Delgado, R. (1989). Storytelling for oppositionists and others: A plea for narrative. *Michigan Law Review*, *87*(8), 2411–2441. doi:10.2307/1289308
Delgado, R., Stefancic, J., & Harris, A. (2017). *Critical race theory (third edition): An introduction* (3rd ed.). New York University Press. doi:10.18574/9781479851393
Downing, R., Kowal, E., & Paradies, Y. (2011). Indigenous cultural training for health workers in Australia. *International Journal for Quality on Health Care*, *23*(3), 247–257.
Du Bois, W. E. B. (2003). The souls of white folk. *Monthly Review*, *55*(6), 44. Retrieved from https://link.gale.com/apps/doc/A111269074/ITOF?u = ntu&sid = ITOF&xid = 7b708c01
Elias, A., Mansouri, F., & Paradies, Y. (2021). Countering racism: Challenges and progress in anti-racism efforts. In A. Elias, F. Mansouri, & Y. Paradies (Eds.), *Racism in Australia today* (pp. 319–351). Springer. doi:10.1007/978-981-16-2137-6_10
Fredericks, B., & Bargallie, D. (2020). An Indigenous Australian cultural competence course: Talking culture, race and power. In J. Frawley, G. Russell, & J. Sherwood (Eds.), *Cultural competence and the higher education sector: Australian perspectives, policies and practice* (pp. 295–308). Springer. doi:10.1007/978-981-15-5362-2_16
Freire, P. (1970). *Pedagogy of the oppressed*. New York: Herder and Herder.
Gabel, S. (2012). Power, leadership and transformation: The doctor's potential for influence. *Medical Education*, *46*(12), 1152–1160. doi:10.1111/medu.12036
Grogan, J., Hollinsworth, D., & Carter, J. (2019). Using videoed stories to convey Indigenous 'voices' in Indigenous studies. *The Australian Journal of Indigenous Education*, *50*(1), 38–46. doi:10.1017/jie.2019.15
Hall, B. (1985). Research, commitment and action: The role of participatory research. *International Review of Education*, *30*(3), 289–299. doi:10.1007/BF00597906
hooks, b. (2014). *Yearning: Race, gender, and cultural politics*. New York: Routledge.

Kelly, J., Dowling, A., McBride, K., Keech, W., & Brown, A. (2020). We get so task orientated at times that we forget the people': Staff communication experiences when caring for Aboriginal cardiac patients. *Australian Health Review*, *44*(1), 1–6. doi:doi:10.1071/AH17290

Kerrigan, V., Lewis, N., Cass, A., Hefler, M., & Ralph, A. P. (2020). 'How can I do more?' Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload. *BMC Medical Education*, *20*(1), 173. doi:10.1186/s12909-020-02086-5

Kerrigan, V., McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., … Ralph, A. P. (2021a). From 'stuck' to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital. *BMC Health Services Research*, *21*(1), 548. doi:10.1186/s12913-021-06564-4

Kerrigan, V., McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., … Ralph, A. P. (2021b). 'The talking bit of medicine, that's the most important bit': Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care. *International Journal for Equity in Health*, *20*(170), 1–15. doi:10.1186/s12939-021-01507-1

Kirkpatrick, D. (1996). Great ideas revisited. Techniques for evaluating training programs. Revisiting Kirkpatrick's four-level model. *Training and Development*, *50*(1), 54–59.

Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine*, *84*(6), 782–787. doi:10.1097/ACM.0b013e3181a42398

Lindgren, M. (2016). Personal narrative journalism and podcasting. *Radio Journal*, *14*(1), 23–41. doi:10.1386/rjao.14.1.23_1

Lock, M., Burmeister, O., McMillan, F., & Whiteford, G. (2020). Absence of rigorous evidence undermines cultural safety reforms. *Australian Journal of Rural Health*, *28*(1), 4–5. doi:10.1111/ajr.12606

Martin, K., & Mirraboopa, B. (2003). Ways of knowing, being and doing: A theoretical framework and methods for indigenous and Indigenist re-search. *Journal of Australian Studies*, *27*(76), 203–214. doi:10.1080/14443050309387838

McDermott, D. R. (2012). Can we educate out of racism? *Medical Journal of Australia*, *197*(1), 15. doi:10.5694/mja12.10936

Menzies School of Health Research. (2018). *The communicate study (Stages 1 and 2)*. Retrieved from https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/The_communicate_study_stages_1_and_2/

Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex Pub. Corp.

Moreton-Robinson, A. (2011). The white man's burden: Patriarchal white epistemic violence and Aboriginal women's knowledges within the academy. *Australian Feminist Studies*, *26*(70), 413–431. doi:10.1080/08164649.2011.621175

Northern Territory Government. (2018). *Candidate information pack, Chief Operating Officer, top end health service*. Hardy Group. Retrieved from https://hardygroupintl.com/uploads/information-packs/5b1091eb066ce763010388.pdf

Northern Territory Government. (2021). *NT Aboriginal health plan 2021–2031*. Retrieved from https://health.nt.gov.au/__data/assets/pdf_file/0015/1035501/nt-aboriginal-health-plan-2021-2031.pdf

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Ramsden, I. M. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* (Doctoral dissertation). Victoria University of Wellington.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.

Shepherd, S. M. (2019). Cultural awareness workshops: Limitations and practical consequences. *BMC Medical Education*, *19*(1), 1–10. doi:10.1186/s12909-018-1450-5

Sjorberg, D., & McDermott, D. (2016). The deconstruction exercise: An assessment tool for enhancing critical thinking in cultural safety education. *International Journal of Critical Indigenous Studies*, *9*(1), 28–48. doi:10.5204/ijcis.v9i1.143

Smith-Maddox, R., & Solórzano, D. G. (2002). Using critical race theory, Paulo Freire's problem-posing method, and case study research to confront race and racism in education. *Qualitative Inquiry*, *8*(1), 66–84. doi:10.1177/107780040200800105

Stoneham, M. J., Goodman, J., & Daube, M. (2014). The portrayal of Indigenous health in selected Australian media. *International Indigenous Policy Journal*, *5*(1). doi:10.18584/iipj.2014.5.1.5

Thurber, K. A., Colonna, E., Jones, R., Gee, G. C., Priest, N., Cohen, R., … on behalf of the Mayi Kuwayu Study Team (2021). Prevalence of everyday discrimination and relation with wellbeing among Aboriginal and Torres Strait Islander adults in Australia. *International Journal of Environmental Research and Public Health*, *18*(12), 6577. Retrieved from https://www.mdpi.com/1660-4601/18/12/6577

Turner, D. (2021). On the politics of Indigenous translation: Listening to Indigenous peoples in and on their own terms. In B. Hokowhitu, A. Moreton-Robinson, L. Tuhiwai-Smith, C. Andersen, & S. Larkin (Eds.), *Routledge handbook of critical Indigenous studies* (pp. 175–188). London: Routledge International Handbooks.

Wain, T., Sim, M., Bessarab, D., Mak, D., Hayward, C., & Rudd, C. (2016). Engaging Australian Aboriginal narratives to challenge attitudes and create empathy in health care: A methodological perspective. *BMC Medical Education*, *16*, 156. doi:10.1186/s12909-016-0677-2

Watego, C., Singh, D., & Macoun, A. (2021). *Partnership for justice in health: Scoping paper on race, racism and the Australian health system*. Lowitja Institute. Retrieved from https://www.lowitja.org.au/content/Image/Lowitja_PJH_170521_D10.pdf

Wilson, A. (2014). Addressing uncomfortable issues: Reflexivity as a tool for culturally safe practice in Aboriginal and Torres Strait Islander health. *Australian Journal of Indigenous Education*, *43*(2), 218–230. doi:10.1017/jie.2014.24

CHAPTER NINE

Integrated discussion

This general discussion aims to summarize the problem I started with, how the findings of my research addressed the problem, acknowledges the limitations and explores what will happen next.

Summarising the problem

Across colonised countries including Canada, New Zealand, the United States and Australia Indigenous peoples do not receive equitable healthcare. [1-8] This can be attributed to the fact that health services are based on White values, systems and structures which were built to favour colonisers. [9-13] These culturally unsafe services, in which patient provider communication is ineffective, puts Indigenous lives at risk. Healthcare inequities came into sharp focus during the COVID-19 pandemic. Research from the US found that Black, Latino and Indigenous peoples suffered disproportionate rate of infections, hospitalisations and death. [2, 14, 15] In Australia, many of the interventions and health promotion campaigns created to curb the spread of COVID-19 did not cater for the social, cultural and communication norms of Aboriginal peoples. [16, 17]

In the tropical north of Australia, where this research was conducted, the practice of medicine has historically been linked with scientific racism. [11, 18] Even though overt displays of racism have declined in recent decades, Aboriginal patients and their families still experience racism when engaging with the healthcare system Australia-wide. [12, 19-21] In NT hospitals, most health providers are White and Aboriginal peoples account for the majority of patients due to the disproportionate rates of sickness and disease. [22] At least 60% of the Aboriginal

population in the NT speak an Aboriginal language as their first language. Interpreters can be accessed to overcome language discordance however interpreters in hospitals globally are underused. [23, 24] Miscommunication is not restricted to language barriers. Culturally unsafe communication can occur for Aboriginal patients who speak English as their first language. [25-27] Intercultural communication is guided by health provider attitudes which have been influenced by negative media representations, as discussed in Appendix A, not by personal experiences with Aboriginal peoples. [12, 28-30] Culturally unsafe care has resulted in death, absence of informed consent, unnecessarily elongated hospital stays and amputations without patient permission. [31-40] These reasons contribute to Aboriginal peoples, both patients and staff, feeling distrust towards healthcare providers and the institutions they work in.

Trust can be built through respectful and effective communication. However, as mentioned in Chapter 1, doctors have a reputation for poor communication, so much so it has become a laughing matter amongst fellow healthcare providers. That said, it is undeniable that doctors are motivated by a desire to help people and would be upset to be the butt of such a joke. There are many, such as those who participated in this Participatory Action Research (PAR) project, who recognise that effective and respectful communication will improve patient outcomes and their own personal job satisfaction. [31, 41-43] When patient provider communication is clear, respectful and effective doctors can accomplish their complex role to be a healer, educator, advocate, supporter and treatment provider. [44]

This research project responded to unacceptable Aboriginal patient experiences and the needs of Royal Darwin Hospital (RDH) doctors who often feel unprepared to work with high Aboriginal caseloads. NT based healthcare providers recognise they require training to help

them communicate with the culturally diverse patient cohort. Previous research found that as doctors progress through medical training, communication skills can decline as they are taught to suppress empathy and control the patient interaction. [45, 46] NT healthcare providers have also expressed concern about the limitations of workplace training offered. [9, 10, 27, 47-51] In Australia, governments and stakeholders including medical colleges have committed to delivering health services free from racism. [52-60] To achieve that goal cultural safety training has been promised. [58, 61, 62] However, words on paper have not translated into practice changing behaviours.

Cultural safety is a decolonising practice, developed in Aotearoa, which requires the "colonising culture to engage in processes of self-reflection" [28 p.14] to allow for a redistribution of power from "service providers to healthcare consumers" to ensure equitable healthcare delivery. [63 p.110] Cultural safety represents a shift from providing care regardless of difference, to providing patient centred care which takes account of people's unique cultural needs. [64] Whilst cultural safety can only be determined by Aboriginal peoples, the onus for change rests with healthcare providers, in this case doctors. Doctors in the NT continue to look for cultural safety training opportunities which aims to improve their cultural competency and communication skills and encourage critical consciousness.

Supporting doctors to develop their critical consciousness is a key component of this work. A critically conscious healthcare provider is: aware of the social, economic and political systems that oppress people; reflects on their values, bias and attitudes that can manifest as racism; changes their individual behaviour with the aim of creating new systems and institutional practices which do not violate the patient's sovereignty. [65, 66] By collaborating with influential doctors working inside the system, my aim was to influence systems change:

"systems are complex; but because they are people-made and people-run, they can be transformed." [4 p.186]

Integrated findings and discussion

Communication has been identified as one of the major barriers to delivering culturally safe care. With a critical focus on hospital-based doctors this thesis, and appendices B and C, documented the personal and systemic barriers to culturally safe patient-provider communication at RDH. [31, 40-43, 67]

I found that doctors, and other healthcare providers, recognised their personal limitations which included: limited or no ability to name commonly spoken Aboriginal languages in the NT, limited skills to work effectively with Aboriginal language interpreters, limited knowledge of the diversity and strength of Aboriginal cultures, expectations that patients will control communication interactions (eg. a patient has the power to request an interpreter) and negative attitudes towards Aboriginal peoples. Systemic issues identified included: hospital expectations around limited time with patients, a culture of undervaluing patient-provider communication, pressure to follow the culturally unsafe communication style of senior clinicians, ineffective systems which do not accurately document Aboriginal patient languages or patient names and limited training opportunities to improve cultural competence and communication skills of staff. RDH operates according to White values and norms: staff were socialised into an institution that diminished Aboriginal cultures and a bio-reductionist approach to healthcare which ignores social and cultural determinants of health.

The issue of doctors exerting power, afforded to them by White medical systems, over Aboriginal peoples underpins both the individual and systemic issues identified. Power, and the ability to exert it over others, is a key feature of racism.[68] As described in chapter 5,

doctors can be perceived by Aboriginal language interpreters, who have also been patients at RDH, as “intimidating” and “just like police”. However, this research found when doctors are provided with opportunities to authentically engage with Aboriginal peoples the unbalanced power dynamic can be equalised as doctors develop their critical consciousness. I have provided evidence that doctors who developed critical consciousness through dialogue with Aboriginal patients, interpreters and leaders were able to abandon the “colonial ethics of paternalism” [69 p.117] towards Aboriginal peoples. This led to power sharing between doctors, Aboriginal patients, and Aboriginal interpreters. Findings from this project, which exists within the health services research-policy interface, will be applicable in other healthcare settings in colonised countries.

Addressing thesis aims

The overarching goal of my thesis was to encourage systemic changes at RDH, by supporting doctors, to ensure Aboriginal patients were engaged through culturally safe communication practices. Below I have listed the 4 thesis aims as listed in chapter 1 and provided a summarised discussion relating to each point.

Aim 1. Examine interest in cultural awareness training and identify opportunities for expansion

A baseline evaluation of 596 cultural awareness training feedback forms from NT healthcare providers was conducted. [41] Kirkpatrick’s evaluation model which examines the impact of training over 4 levels was used to explain the findings.

- Kirkpatrick level 1, reaction to training: a training highlight was the personal stories shared by Aboriginal educators. NT health staff valued cultural awareness training so much they requested more: they want ongoing clinically relevant training,

designed & delivered by local people which focuses on improving intercultural communication. Participants also recognised to be culturally competent they must reflect on their own cultural biases that can manifest as racism. Finally, time-poor healthcare providers want flexible training modules.

- Kirkpatrick level 2, participant learning: participants valued the foundational knowledge relating to Aboriginal cultures provided in cultural awareness training. They became aware of the history of colonised Australia and how it relates to social determinants of health, they learnt about Aboriginal ways of communicating which differ from White norms and valued clinically relevant advice about how best to work with Aboriginal Liaison Officers' and Aboriginal Health Practitioners.

Due to the retrospective nature of this evaluation, I was unable to assess the impact of training on individual behaviour change (Kirkpatrick's level 3) and the value of the training to the organisation (Kirkpatrick level 4). However, the *Ask the Specialist* podcast evaluation generated data in that regard.

This baseline evaluation shaped my research focus in two ways. Firstly, the evaluation paved the way for both interventions: the *Ask the Specialist* podcast (Aim 2) and the interpreter ward round pilot (Aim 3). Secondly, it confirmed my belief (which developed after many years as a journalist) that stories, or counterstories, have the potential to create positive changes in society. This led to the development of Aim 4.

Aim 2. Develop and explore the use of a podcast to deliver clinically relevant local cultural education

Following on from the baseline evaluation discussed under Aim 1, I worked with Larrakia, Tiwi and Yolŋu leaders, the NT Aboriginal Interpreter Service (AIS) and RDH based doctors to

create, and pilot, a cultural education podcast. To the best of my knowledge, this is the first time a podcast has been created as a stimulus to promote culturally safe health communication.

Chapter 6 documents the creation of the podcast: *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare.* Over 7 x <18 minute episodes doctors ask Larrakia, Tiwi and Yolŋu leaders plus an Aboriginal language interpreter to share insights regarding the problems they have experienced working at RDH with Aboriginal patients. [70] Inspired by Freire's problem posing education, doctors participated in creating the podcast by reflecting on their own limitations and articulating the problems they faced which became questions for the *Specialists* to answer. This contrasts with existing approaches to cultural awareness training which has traditionally deposited facts about Aboriginal peoples into learners. Engaging doctors in this way meant the podcast addressed issues specific to working at RDH (and across the Top End). Whilst this resulted in a geographically, socially and culturally site-specific podcast, the technique used could be adopted in any jurisdiction. The strength of this technique is that the training can address how racism manifests at a local level.

Chapter 8 presents the evaluation of the podcast using Kirkpatrick's framework. I found that by combining key principles from CRT, Freirean pedagogy and cultural safety a new and engaging form of cultural education, which has impact, could be developed. My research shows that locally designed, clinically relevant cultural education which centres Aboriginal experiences can stimulate individual attitudinal and behaviour change (critical consciousness) which challenges the Whiteness of the health system. RDH benefitted from doctors listening to the podcast: culturally competent staff were better equipped to work with Aboriginal patients and families. My findings are significant because no other research in this jurisdiction

has found the correlation between training and on the job behaviour change (Kirkpatrick level 3) and organisational value (Kirkpatrick level 4).

My research contributes to the international literature which has questioned the value of cultural awareness and cultural safety training due to a lack of evidence regarding impact. For most doctors, this was the first time they had committed to, and connected with, cultural education which was previously perceived as a tick-box exercise with no relevance to delivering clinically safe and equitable healthcare. The podcast format was welcomed by doctors who considered podcasts to be an enjoyable pastime that they could easily integrate into their busy lives. I recognise the novelty of the flexible podcast format may have contributed to positive engagement. The lesson here is for educators to experiment with delivering training via unconventional modes because it is abundantly clear online training modules are universally loathed.

There remains work to be done. As discussed in chapter 8, *Ask the Specialist* was designed to be a complete training package that consisted of the podcast and weekly facilitated discussions to explore ideas raised in each episode. However due to the COVID-19 pandemic we were unable to pilot the discussion group format. As restrictions around COVID-19 eased, I have piloted the full *Ask the Specialist* training package and an evaluation is underway. Details on how *Ask the Specialist* will be scaled up across other NT hospitals is outlined below under the heading, Future Research.

Aim 3. Explore the impact of a new model of working with Aboriginal language interpreters at RDH on doctors, interpreters, and patients

A key finding from the baseline evaluation described in Aim 1 was a desire and need to improve intercultural communication. This finding was reinforced during data collection to

achieve Aim 2 as I observed the language discordance between English speaking doctors and Aboriginal language speaking patients across RDH wards. This led to a pilot designed in collaboration with RDH and the NT AIS in which two Yolŋu Matha and two Tiwi interpreters were embedded in a renal medical team over 4 weeks. The pilot was supported by formal working with interpreter training sessions and informal in-situ training opportunities in which doctors and Aboriginal language interpreters were able to share knowledge as they worked together.

During the interpreter ward round pilot, patients, doctors and Aboriginal interpreters all reported a positive shift in the power dynamics when they had the opportunity to move from being “strangers, to friends, to family”. [42 p.9] This quote from Yolŋu Matha interpreter Carly, in chapter 5, brings into sharp focus the importance of relationships in the professional clinical environment. White people focus on the academic qualifications they have been awarded so they can be confident to interact in the hospital; for Aboriginal peoples the academic qualifications are secondary to relationships of trust and reciprocity. This disconnect between the person-centred values of Aboriginal health professionals and the values dictated by health services shaped by Whiteness has also been documented in Queensland. [71]

During this experiential learning program as doctors’ critical consciousness developed, they adapted their work routines to ensure they were working in a culturally competent manner. Aboriginal interpreters also benefited from these changes. Interpreters who previously felt unwelcome, underconfident and culturally unsafe working at RDH reported feeling valued and respected as skilled professionals. My research also documented the diversity of Aboriginal languages spoken in the renal ward at RDH. I found 15 Aboriginal languages were

spoken amongst renal patients during the pilot period. This data was meaningful because RDH had no way of documenting Aboriginal languages spoken by patients therefore were unable to confidently and effectively address language discordance.

Crucially, through this pilot I was able to document how the culturally unsafe hospital became safe for Aboriginal language speaking patients when doctors changed their attitudes and behaviour. Before the pilot, Yolŋu Elder Matthew felt "stuck" but after having consistent access to trusted interpreters he felt satisfied with care. The power imbalance between patients and healthcare providers was equalised through the presence of interpreters. Consistent access to interpreters meant Tiwi and Yolŋu patients were able to question the treatment offered, exercise choice and make decisions based on their priorities. Effective, respectful and culturally safe communication also resulted in a reduction in patients prematurely self-discharging from hospital. Self-discharge rates are an indirect measure of cultural safety and high self-discharge rates are of major concern to RDH executive who recognise the economic benefits of patients completing treatment.

A culturally unsafe system which diminished and neglected patients' needs was overturned by a small but significant system change. I recognise that to sustain this change a suite of programs to improve cultural safety at RDH should be implemented including regular cultural safety training for staff which highlights the value of communication on patient outcomes. Finally, this pilot assisted in diminishing the Whiteness of the health service thereby providing evidence that given the right circumstances change is possible. Although some resistance to working with interpreters remained among some members of the Multi-Disciplinary Team. Addressing the Whiteness of institution will be long term ongoing process.

Aim 4. Examine the power of "counterstories" to promote critical consciousness amongst hospital-based doctors

This final aim was central to the overall thesis. Inspired by cultural safety, CRT and Freirean pedagogy, I examined the idea that if doctors had opportunities to listen to Aboriginal peoples' stories outside of clinical interactions, individuals' critical consciousness would develop. Both interventions piloted (discussed under Aim 2 and 3) created opportunities for counterstories to be shared by Aboriginal peoples. Over the course of this research project counterstories were provided by:

- Yolŋu and Tiwi hospitalised patients [31, 42]
- Yolŋu Matha and Tiwi interpreters [31, 42]
- NT AIS trainer [31, 42]
- Larrakia, Tiwi, Yolŋu leaders and a Kriol/Burarra interpreter. [43, 70]

Counterstories challenged the negative stereotypes perpetuated by mainstream media, as explored in Appendix A, and increased positive contact experiences. Increasing positive contact experiences amongst doctors and Aboriginal peoples who commonly do not interact outside the clinical environment was a key feature of these interventions. The interpreter ward round pilot increased direct face to face contact and the *Ask the Specialist* podcast increased indirect contact between doctors and Aboriginal professionals. These interventions generated empathy between parties which inspired critical consciousness amongst doctors. This led to behaviour change which contributed to improved levels of cultural competency and patients feeling culturally safe. This is a notable finding because it is commonly asserted that doctors, trained in the "hard sciences", are concrete thinkers who expect a list of instructions to ensure they interact with patients effectively. I acknowledge that in the *Ask*

the Specialist podcast and during the interpreter ward round pilot direct instructions were sometimes given to doctors however there were also many conversations and situations which were not didactic in nature but instead prompted doctors to critically reflect on their values, beliefs and attitudes. I have provided evidence that when doctors, who aspire to be culturally competent allies, listen to counterstories from Aboriginal Elders, interpreters and leaders they can develop their critical consciousness. Henceforth counterstories have the power to disrupt the dominance of Whiteness in healthcare and contribute to the creation of a hospital service which is more responsive to the needs or Aboriginal peoples.

However, challenges remain. Across the health sector, stories continue to be undervalued in favour of statistics. Therefore, future research plans (outlined below) involve collaborating with quantitative researchers and health economists.

Recommendations

My research identified patterns of ingrained behaviour requiring institutional attention. Low levels of interest around culturally safe communication create a self-perpetuating cycle of staff dissatisfaction which contributes to a culturally unsafe service. These recommendations are not revolutionary but necessary: inaction and silence about the poor-quality status quo makes us all complicit in perpetuating racism. [72, 73]

Findings presented in this thesis plus Appendices B and C resulted in more than 20 recommendations over 6 publications for both NT Health and the NT AIS. Some recommendations are repeated across publications therefore I have streamlined the recommendations. Also, recommendations presented here focus on NT health which has been the critical focus of this thesis:

1. NT health should employ additional staff to deliver cultural awareness training. The number of trainers needs to increase to improve attendance rates at cultural awareness training which is required as a baseline.
2. Cultural awareness training should be developed locally and include a focus on information about Aboriginal languages spoken in the NT. The aim is to improve staff knowledge of Aboriginal languages which was found to be very poor.
3. Develop at a local level, cultural safety training to allow NT health staff to examine their own culture (values, beliefs and bias) and how culture can influence delivery of care. Training should:
    a. be ongoing and not treated as a one-off tick box exercise. There is no end point to developing cultural competency. [64]
    b. include regular reflexive learning circles for health staff to address and trouble shoot issues which arise; and
    c. include opportunities to engage with Aboriginal peoples beyond the clinical setting.
4. Staff need “protected” paid time away from clinical duties to attend both cultural awareness and cultural safety training. Training should be attached to continuous professional development requirements.
5. Responsibility for booking interpreters should be delegated to an identified staff member in each Multi-Disciplinary Team.
6. Language should be documented on the “patient list” alongside name and date of birth. This patient list - a daily printout of who a given doctor’s patients are for the day – does not currently have scope to include language. Inclusion of ‘language spoken’

on the patient list would ensure language discordance is considered at the same time as clinical discussions. It would also improve familiarity of Aboriginal languages.

7. Healthcare providers require an interpreter, not the patient:
    a. The habit of staff judging a patient's English proficiency must be stopped. Staff assert interpreters are not required because the patient speaks "good English". If the provider does not speak the patient's language, an interpreter is required.
    b. Staff commonly state patients do not require an interpreter because they did not request one. The idea ignores that all exchanges between healthcare providers and patients are power laden in favour of the provider. Healthcare providers control both clinical treatment and communication.
8. Patients should be registered with healthcare facilities using their correct names, not their colonised names. The format of Australian legal documents often forces name changes to conform with White norms which is a form of assimilation.
9. Employers must understand, respect and adapt to the personal circumstances, family and cultural obligations Aboriginal interpreters and other professionals juggle alongside the expectations of non-Indigenous colleagues who work within "'Western' models of clinical governance and management". [74]
10. Aboriginal interpreters require health training to ensure they are equipped, and confident, to work in the clinical setting. This training could be developed as a collaboration between the NT AIS and NT Health.
11. The small number of trained interpreters may be associated with casual employment conditions. Employment conditions of Aboriginal interpreters should be reconsidered in consultation with employees and community leaders.

12. The cultural safety training package *Ask the Specialist* which consists of a podcast plus group discussions should be implemented across NT Health. This requires upskilling NT health staff to deliver the training.

My findings and these recommendations have been provided back to NT health services and the NT AIS, through meetings, presentations to committees, hospital 'Grand Rounds', emails and other opportunities. Findings have also been shared nationally and internationally through papers and conferences (Table 1 and Table 3). I will continue to pro-actively disseminate these findings, advocate for these recommendations, and collaborate with services to support innovative ways to implement the recommendations.

Future research

This PhD has laid the groundwork for future PAR projects which will continue to work towards improving patient provider communication between healthcare providers and Aboriginal peoples in the NT. The relationships solidified during my doctoral research project continue: Larrakia Elder Aunty Bilawara Lee, Tiwi Elder Pirrawayingi Puruntatameri, Yolŋu leader Rarrtjiwuy Melanie Herdman and my co-researcher Stuart Yiwarr McGrath and I continue to work together. They, alongside other Aboriginal leaders, NT health, the NT AIS and the National Accreditation Authority for Translators and Interpreters are involved in expanding the work presented in this thesis. Our team led by my primary supervisor Professor Anna Ralph has been funded by the National Health and Medical Research Council (NHMRC) for 5 years to scale up the *Ask the Specialist* training package and increase availability of Aboriginal language interpreters and Aboriginal health practitioners across four NT hospitals (RDH, Palmerston, Katherine and Gove). Recognising that the anti-racism work presented in this thesis was conducted at a single site and to some extent relied on charismatic champions,

[75] the upcoming expanded project will test the viability and sustainability of the work. Patient experience will be measured quantitively through self-discharge rates which is an indirect measure of cultural safety, [76] and qualitatively through in-depth interviews in the patient's first language. We will also expand sampling of health staff to include nurses, allied health professionals and others to explore the impact training and working with Aboriginal professionals in hospitals has on all healthcare providers. Finally, we will undertake an economic analysis of the costs and cost benefits of this program of work.

Reconsidering my position

Wrapping up this thesis, I reflect on how much I have learned, how little I know, how some of my views have changed and some have remained the same. Just as society has progressed in terms of equality for women (with still much to be done) there is potential to progress race relations. I have provided evidence that given the right supports and circumstances, White people can develop a "more progressive understanding of race relations" [77 p.358] which has the potential to decolonise hegemonic insitutions. That said, in my experience over the last few years, projects such as this which are defined as cultural safety initiatives can be side-tracked due to confusion around the definition of the term. Cultural safety advocates for changing systems which enables a transfer of power from healthcare service provider to healthcare consumer however initiatives in Aotearoa have not lived up to Ramsden's vision. [69] Instead Came and DaSilva assert that a diluted form of cultural awareness training has been delivered across government services because Pākehā decisionmakers have failed to develop the understanding required to change practice. This is exactly what I fear as I continue to work with NT health to attempt to translate research findings into practice. As others have noted, a lot of time can be wasted on defining the differences between cultural awareness,

cultural competency, cultural safety and so on. Consequently, I have been reconsidering the language I use. I can see benefits in limiting references to cultural safety as the term has the potential to hide the intentions of the work and skew focus towards associating health disparities with cultures. Aboriginal cultures are not to blame for health inequities, the issues stem from the structures and systems that were created to maintain White supremacy. [38] To that end, I am interested in exploring further anti racism praxis:

> *Anti-racism praxis is about listening, respecting, understanding, building relationships, and nurturing trust. A fundamental goal of anti-racism organizing is to bring people together who are targeted by racism and allies who are committed to addressing racism to increase their collective agency to promote change in power relations and address the root cause of social and health inequities*. [4 p.183]

As a White woman who has never experienced racism but has perpetuated it, I continue to work on becoming an ally who can contribute to creating positive change. I come to this space, like many before me, motivated by a desire to contribute to an anti-racist praxis whilst recognising that my perspectives and values are shaped by Western knowledges and cultural traditions. [78-80] Like the committed people who participated in my research, I am developing my critical consciousness: constantly reflecting on my opinions and actions, making mistakes, learning from Aunty Bilawara, Pirrawayingi, Rarrtjiwuy, Stuart and many others, and working on unlearning White ways of thinking and patterns of behaviour. This ongoing work occurs in the colliding colonised space Nakata referred to as the "cultural interface" where "things are not clearly black or white, Indigenous or Western". [81 p.9]

I am interested in perpetuating the idea that decolonising work which aspires to address racism is not adversarial, but it is about love. This became abundantly clear to me only recently after reading a paper from Nelson Maldonado-Torres [82] and listening to Professor Linda Tuhiwai Smith author of the seminal text *Decolonising Methodologies* [83] speak at an anti-racism conference. [84] Professor Smith acknowledged that talking about racism is considered a negative topic but went on to explain that it is in fact a very positive conversation because the aim is to create an equitable society where we exist in relationship to each other. Hearing Professor Smith articulate this was revelatory for me because throughout this research process it has often felt like I am in conflict particularly with other White people. Conflict created by colonisation and colonisers is explored by Maldonado-Torres. [82] He explained that historically colonisers have waged war by forcibly occupying lands, raping women and killing people to expand capitalist empires. Whilst these violent acts of war against Aboriginal peoples no longer occur in Australia the mentality associated with superiority which was used to justify the colonisers invasion remains. Colonisation and racialisation are “expressions of the dark side of being”. [82 p.260] Whereas decolonisation opposes war and is “oriented by ‘love’”. [82 p.256] In this context Maldonado-Torres explains that love is understood as the desire to restore ethics and justice and to create a society which supports generous interactions amongst diverse peoples. Decolonisation invites White people like me to engage in dialogue, and develop relationships of trust and reciprocity, with the people colonisers (my ancestors) attempted to make invisible. [82] A decolonised individual is generous, open, listens to, learns from, and lives in relationship with those who have been marginalised by the hegemony. Therefore, I hope to continue this decolonising anti-racist work by being in respectful relationships with those who wish to share stories, and counterstories, so we may positively orient ourselves towards love.

References

1. Jones, C.P., *Levels of racism: A theoretic framework and a gardener's tale.* Am. J. Public Health, 2000. **90**(8): p. 1212-1215.
2. Chokshi, D.A., M.M.K. Foote, and M.E. Morse, *How to Act Upon Racism—not Race—as a Risk Factor.* JAMA Health Forum, 2022. **3**(2): p. e220548-e220548.
3. Gau, J., et al., *Things we do for no reason™: Routine inclusion of race in the history of present illness.* Journal of Hospital Medicine, 2021. **n/a**(n/a).
4. Came, H. and D. Griffith, *Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis.* Social science & medicine (1982), 2018. **199**: p. 181-188.
5. Jull, J., et al., *Shared decision making with Aboriginal women facing health decisions* AlterNative: An International Journal of Indigenous Peoples, 2015. **11**(4): p. 401-416.
6. Came, H., et al., *From Gorse to Ngahere: An Emerging Allegory for Decolonising the New Zealand Health System.* The New Zealand Medical Journal, 2020. **133**(1524).
7. Bond, C., D. Singh, and H. Kajlich, *Canada–Australia Indigenous Health and Wellness Racism Working Group, Discussion Paper Series*. 2019, The Lowitja Institute, Melbourne.
8. The Lancet, *Institutionalised racism in health care.* The Lancet, 1999. **353**(9155): p. 765.
9. Eckermann, A.-K., *Binan Goonj: bridging cultures in Aboriginal health*. 3rd ed. 2010, Sydney: Churchill Livingstone.
10. Trudgen, R.I., *Why warriors lie down & die : towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact : djambatj mala*. Djambatj mala. 2000, Darwin: Darwin : Aboriginal Resource & Development Services Inc.
11. Bashford, A., *'Is White Australia possible?' Race, colonialism and tropical medicine.* Ethnic and racial studies, 2000. **23**(2): p. 248-271.
12. Watego, C., D. Singh, and A. Macoun, *Partnership for Justice in Health: Scoping paper on race, racism and the Australian health system.* . 2021, The Lowitja Institute: Melbourne.
13. Davis, G. and H. Came, *A pūrākau analysis of institutional barriers facing Māori occupational therapy students.* Australian Occupational Therapy Journal, 2022. **n/a**(n/a).
14. Evans, M.K., *Covid's Color Line — Infectious Disease, Inequity, and Racial Justice.* New England Journal of Medicine, 2020. **383**(5): p. 408-410.
15. Thompson, C.N., et al., *COVID-19 outbreak — New York City, February 29–June 1, 2020.* MMWR. Morbidity and mortality weekly report, 2020. **69**(46): p. 1725-1729.
16. Kerrigan, V., et al., *Stay Strong: Aboriginal leaders deliver COVID-19 health messages.* Health Promotion Journal of Australia, 2020. **32**(S1): p. 203-204.
17. Crooks, K., D. Casey, and J.S. Ward, *First Nations peoples leading the way in COVID-19 pandemic planning, response and management.* Medical journal of Australia, 2020. **213**(4): p. 151-152.e1.
18. Mayes, C., *White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare.* Journal of Australian studies, 2020. **44**(3): p. 287-302.
19. Paradies, Y., M. Truong, and N. Priest, *A systematic review of the extent and measurement of healthcare provider racism.* J Gen Intern Med, 2014. **29**(2): p. 364-87.

20. Kairuz, C.A., et al., *Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review.* BMC Public Health, 2021. **21**(1): p. 1302.

21. Kelaher, M.A., A.S. Ferdinand, and Y. Paradies, *Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities.* Medical Journal of Australia, 2014. **201**(1): p. 44-47.

22. Gardiner, F.W., et al., *Indigenous Australians have a greater prevalence of heart, stroke, and vascular disease, are younger at death, with higher hospitalisation and more aeromedical retrievals from remote regions.* EClinicalMedicine, 2021. **42**: p. 101181.

23. Karliner, L.S., et al., *Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature.* Health Serv Res, 2007. **42**(2): p. 727-754.

24. Blay, N., et al., *Healthcare interpreter utilisation: analysis of health administrative data.* BMC Health Services Research, 2018. **18**.

25. Jennings, W., C. Bond, and P.S. Hill, *The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication.* Aust J Prim Health, 2018.

26. Kelly, J., et al., *'We get so task orientated at times that we forget the people': staff communication experiences when caring for Aboriginal cardiac patients.* Australian Health Review, 2020. **44**(1): p. 1-6.

27. Lowell, A., *Communication and Cultural Knowledge in Aboriginal Health Care. A review of two subprograms of the Cooperative Research Centre for Aboriginal and Tropical Health's Indigenous Health and Education Research program*. 1998, Cooperative Research Centre for Aboriginal and Tropical Health: Casuarina, NT.

28. Taylor, K., *Health care and Indigenous Australians : cultural safety in practice*. Second edition.. ed. Cultural safety in practice, ed. P. Guerin. 2014, South Yarra, Vic.: South Yarra, Vic. : Palgrave Macmillan.

29. Moreton-Robinson, A., *Imagining the Good Indigenous Citizen: Race War and the Pathology of Patriarchal White Sovereignty.* Cultural Studies Review, 2009. **15**(2): p. 61-79.

30. Kerrigan, V. *Whitefella broadcasting: Why non Indigenous journalists struggle to tell Aboriginal stories in Australia*. in *Journalism Education and Research Association of Australia 2017 Conference*. 2017. Newcastle: The Journalism Education and Research Association of Australia Incorporated (JERAA Inc).

31. Kerrigan, V., et al., *From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.* BMC Health Services Research, 2021. **21**(1): p. 548.

32. Dinku, Y., et al., *Language use is connected to indicators of wellbeing: Evidence from the National Aboriginal and Torres Strait Islander Social Survey 2014-15, Working Paper no.137/2020*. 2020, Centre for Aboriginal Economic Policy Research, Australian National University, Canberra.

33. McKivett, A., D. Paul, and N. Hudson, *Healing Conversations: Developing a Practical Framework for Clinical Communication Between Aboriginal Communities and Healthcare Practitioners.* Journal of Immigrant and Minority Health, 2018.

34. Allam, L., *Darwin hospital left Aboriginal man to die alone and in agony from surgical injury. Northern Territory coroner issues scathing report detailing multiple failures by Top End health service*, in *The Guardian*. 21st September 2018.

35. NT Coroner Court, *Inquest into the death of Henry George Wilson aka Albert George Wilson [2018] NTLC 022. Findings of Judge Greg Cavanagh*. 2018: Darwin, Northern Territory. p. 1-24.

36. Shankar, M., et al., *Nonmedical Transdisciplinary Perspectives of Black and Racially and Ethnically Diverse Individuals About Antiracism Practices: A Qualitative Study.* JAMA Network Open, 2022. **5**(2): p. e2147835-e2147835.

37. Williams, D.R. and R. Wyatt, *Racial Bias in Health Care and Health: Challenges and Opportunities.* JAMA, 2015. **314**(6): p. 555-556.

38. Berger, J.T. and D.R. Miller, *Health Disparities, Systemic Racism, and Failures of Cultural Competence.* American journal of bioethics, 2021. **21**(9): p. 4-10.

39. Topp, S.M. and J.M. Chipukuma, *A qualitative study of the role of workplace and interpersonal trust in shaping service quality and responsiveness in Zambian primary health centres.* Health policy and planning, 2016. **31**(2): p. 192-204.

40. Mithen, V., et al., *Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care.* Health Promot J Austr, 2021. **32**(S1): p. 155-165.

41. Kerrigan, V., et al., *"How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload.* BMC Medical Education, 2020. **20**(1): p. 173.

42. Kerrigan, V., et al., *"The talking bit of medicine, that's the most important bit": Doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care.* International Journal for Equity in Health, 2021. **20**(1): p. 170.

43. Kerrigan, V., et al., *Evaluation of "Ask the Specialist": a cultural education podcast to inspire improved healthcare for Aboriginal peoples in Northern Australia.* Health Sociology Review., 2022('Yuwinbir', a special issue of Health Sociology Review on Indigenous and sociological knowledges: Meeting points for health equity).

44. Cushing, A., *History of the Doctor-Patient Relationship*, in *Clinical communication in medicine*, J. Brown, et al., Editors. 2016, John Wiley & Sons Inc. : Chichester, West Sussex. Ames, Iowa.

45. Kurtz, S.M., J. Draper, and J. Silverman, *Teaching and learning communication skills in medicine*. 2nd ed. ed. 2005, Oxford: Radcliffe Publishing.

46. DiMatteo, M.R., *The role of the physician in the emerging health care environment.* West J Med, 1998. **168**(5): p. 328-33.

47. Anderson, K., et al., *"All they said was my kidneys were dead": Indigenous Australian patients' understanding of their chronic kidney disease.* The Medical Journal of Australia, 2008. **189**: p. 499-503.

48. Brennan, G., *The need for interpreting and translation services for Australian Aboriginals, with special reference to the Northern Territory : a research report*, ed. S. Australia. Dept. of Aboriginal Affairs. Research. 1979, Canberra]: Canberra : Research Section, Dept. of Aboriginal Affairs.

49. Cass, A., et al., *Sharing True Stories Improving communication between Aboriginal patients and healthcare workers.* Medical Journal of Australia, 2002. **176**(10): p. 466-70.

50. Lowell, A., et al., *Health literacy communication and cultural competence towards an integrated approach in Indigenous health care*. 2014, Northern Territory Department of Health.

51. Ralph, A.P., et al., *Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory.* BMC Health Services Research, 2017. **17**(1): p. 733.

52. Northern Territory Department of Health, *2016-17 Annual Report*. 2017, Northern Territory Government: Darwin, NT. p. 1-269.

53. Northern Territory Government, *Northern Territory Health Strategic Plan 2014-2017* 16 November 2014: Darwin, Northern Territory,.

54. Northern Territory Government and Top End Health Service, *Improving TEHS Culture. Organisational Culture Assessment. Summary Report.* August 2016: Darwin, NT. p. 1-19.

55. Northern Territory Department of Health, *NT Health Aboriginal Cultural Security Policy*. 2016: Darwin, NT. p. 1-8.

56. Northern Territory Government, *Department of Health Annual Report 2019-2020*. 2020, Department of Health: Darwin, Australia.

57. Northern Territory Government, *Department of Health Annual Report 2020-2021*. 2021: Darwin, Australia.

58. Australian Government, *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. 2013.

59. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. Second Edition. Overview*. 28 November 2017: Sydney, NSW.

60. Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards. User Guide for Aboriginal and Torres Strait Islander Health*. 2017: Sydney, NSW.

61. Australian Health Practitioner Regulation Agency, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*. 2020. p. 28.

62. Northern Territory Government, *NT Aboriginal Health Plan 2021-2031*. 2021, NT Health: Casuarina, NT, Australia.

63. Ramsden, I.M., *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. 2002, Victoria University of Wellington: Wellington, New Zealand. p. 211.

64. Curtis, E., et al., *Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition.* International Journal for Equity in Health, 2019. **18**(1): p. 174.

65. Freire, P., *Pedagogy of the oppressed*. 30th Anniversary Edition ed. 2005 (1970), New York: The Continuum International Publishing Group.

66. Kumagai, A.K. and M.L. Lypson, *Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education.* Academic Medicine, 2009. **84**(6): p. 782-787.

67. The Communicate Study group, *Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study.* Medical Journal of Australia, 2020. **213**(4): p. 180-181.

68. Hage, G., *White nation : fantasies of white supremacy in a multicultural society / by Ghassan Hage*. 1998, Sydney: Pluto Press.

69. Came, H.A. and S. da Silva, *Building political competencies for the transformation of racism in Aotearoa.* Kōtuitui: New Zealand Journal of Social Sciences Online, 2011. **6**(1-2): p. 113-123.

70. Kerrigan, V., et al., *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare.*, V. Kerrigan and S.Y. McGrath, Editors. 2020, Menzies School of Health Research: Darwin.

71. Topp, S.M., et al., *Building patient trust in health systems: A qualitative study of facework in the context of Aboriginal and Torres Strait Islander health workers' role in Queensland, Australia.* Social Science & Medicine, 2022: p. 114984.

72. Mkandawire-Valhmu, L., *Cultural safety, healthcare and vulnerable populations : a critical theoretical perspective*, ed. C. Proquest Ebook. 2018: Abingdon, Oxon. New York, NY : Routledge, Taylor & Francis Group.

73. McDermott, D.R., *Can we educate out of racism?* Medical journal of Australia, 2012. **197**(1): p. 15-15.

74. Topp, S.M., A. Edelman, and S. Taylor, *"We are everything to everyone": a systematic review of factors influencing the accountability relationships of Aboriginal and Torres Strait Islander health workers (AHWs) in the Australian health system.* International Journal for Equity in Health, 2018. **17**(1): p. 67.

75. Kidd, J., H. Came, and T. McCreanor, *Using vignettes about racism from health practice in Aotearoa to generate anti-racism interventions.* Health & Social Care in the Community, 2022. **n/a**(n/a).

76. Australian Institute of Health and Welfare, *Cultural safety in health care: Monitoring framework*. 2019, AIHW: Canberra.

77. Taylor, P.S. and D. Habibis, *Widening the gap: White ignorance, race relations and the consequences for Aboriginal people in Australia.* The Australian journal of social issues, 2020. **55**(3): p. 354-371.

78. McGloin, C., *Considering The Work of Martin Nakata's "Cultural Interface": a Reflection on Theory and Practice by a Non-Indigenous Academic.* Aust. J. indig. Educ, 2009. **38**(1): p. 36-41.

79. Cohan, D., *Racist Like Me - A call to Self-Reflection and Action for White Physicians*. February 28, 2019: The New England Journal of Medicine. p. 805-807.

80. McGuire-Adams, T., *Settler allies are made, not self-proclaimed: Unsettling conversations for non-Indigenous researchers and educators involved in Indigenous health.* Health Education Journal, 2021. **0**(0): p. 00178969211009269.

81. Nakata, M., *the Cultural Interface.* Aust. Journal of Indigenous Education, 2007. **36**(S1): p. 7-14.

82. Maldonado-Torres, N., *On the coloniality of being: contributions to the development of a concept.* Cultural Studies, 2007. **21**(2-3): p. 240-270.

83. Smith, L.T., *Decolonizing methodologies: research and indigenous peoples*. Second edition. ed, ed. C. Proquest Ebook. 2012, London, New York: Zed Books: distributed in the USA exclusively by Palgrave Macmillan.

84. Smith, L.T., *A conversation with Professor Linda Tuhiwai Smith*, in *Te Tiriti-based futures + Anti-racism*. 27th May 2022: online.

APPENDIX A

Whitefella broadcasting: Why non-Indigenous journalists struggle to tell Aboriginal stories in Australia.

Publication: Kerrigan, V. *Whitefella broadcasting: Why non Indigenous journalists struggle to tell Aboriginal stories in Australia*. in *Journalism Education and Research Association of Australia 2017 Conference*. 2017. Newcastle: The Journalism Education and Research Association of Australia Incorporated (JERAA Inc).

Whitefella broadcasting: Why non-Indigenous journalists struggle to tell Aboriginal stories in Australia.

Vicki Kerrigan

Menzies School of Health Research

Abstract

At the Australian Broadcasting Corporation [ABC] the dominant worldview is white and western. This is despite various strategic plans which focus on increasing cultural diversity of staff with the intention of increasing the diversity of stories told from differing cultural perspectives. As an ex-ABC employee with a career spanning more than two decades, I was complicit in reinforcing the dominant hegemony and neocolonial values which effectively silenced Aboriginal people from public debate. However, there were also opportunities to work in a way which allowed the subjugated Aboriginal perspective to be aired. Working at the national youth ABC network Triple J in the year 2000, I secured an interview with Bonita Mabo, Aboriginal and Torres Strait Islander activist. When producing that interview, I became acutely aware of the differences between the Anglo Australian culture I operate within and Aboriginal and Torres Strait Islander culture.

This paper explores the culture of journalism, entrenched implicit bias among non-Indigenous journalists and employing institutions, and the intercultural differences which all contribute to substandard reportage on Aboriginal affairs by ABC radio broadcasters. To that end, ABC journalists in the Northern Territory currently struggle to fulfil their fourth estate function in regard to Aboriginal issues. The paper also includes a case study where I reflect on my own journalistic practice around reporting on Indigenous people.

Keywords

journalism; radio; intercultural communication; cross cultural communication; Aboriginal and Torres Strait Islander; Australia

Paper

At the Australian Broadcasting Corporation [ABC] diversity is a buzz word. In the ABC's corporate documents the organisation pledges to accurately reflect the cultural diversity of Australia.

> The ABC is one of Australia's most important cultural institutions. As the primary national public broadcaster, it reflects Australia's national identity and cultural diversity. (Australian Broadcasting Corporation, 2016a, p. 12)

However, the ABC has anecdotally been described as the Anglo Broadcasting Corporation - an unfortunate moniker which alludes to the cultural perspective which shapes how stories are told. Research which unpacks the culture of journalism can help tease out the subtle yet important issues which lead to current ABC radio journalistic practice. Hanitzsch's theory of journalism culture describes an arena where "diverse professional ideologies struggle over the dominant interpretation of journalism's social function and identity" (2007, p. 370). Journalists worldwide value impartiality and objectivity however journalistic culture can make it difficult for journalists to provide a value free account of the truth (Hanitzsch, 2007). Hanitzsch argues:

> Journalism culture becomes manifest in the way journalists think and act....journalists consciously and unconsciously legitimate their role in society and render their work meaningful for themselves and others. (2007, p. 369)

A typical Australian journalist is likely to be female, tertiary educated and of Anglo-Saxon origin (Hanusch, 2013). Despite best intentions, many reporters and producers inevitably tell stories shaped by their own cultural worldview. The media plays a powerful role in "shaping, perpetuating and reinforcing racial ideology" (Armstrong, 2011, p. 103). Given these theories on journalism culture, this paper will reflect on my 20 year ABC radio broadcasting practice, while considering if the ABC can truly reflect the cultural diversity of Australia when there are so few Aboriginal and Torres Strait Islander people employed by the organisation.

In 2016 the ABC employed 4183 full time employees nationally (Australian Broadcasting Corporation, 2016a). Figures from December 2016 state 2.5% of staff at ABC Radio, TV and online were Indigenous (Australian Broadcasting Corporation, 2016b). In 2014, ABC Northern Territory set an Indigenous employment target of "15% in order to better reflect the Indigenous population in the NT" (Australian Broadcasting Corporation, 2016b, p. 6). The current Indigenous employment rate at ABC NT is 9.91% (King, 2017). Yet Aboriginal people in the Northern Territory make up 25.5% of the total NT population, the highest proportion of all states and territories (Australian Bureau of Statistics, 2017).

Context

There is no mass medium as ubiquitous as radio; it is the original electronic mass medium (Mollgaard, 2012). Despite the advent of television, growth of the internet and popularity of social media, radio continues to have high social penetration because it's free, easy to access and immediate (Castelló & Montagut, 2011). ABC Darwin's broadcast footprint includes the major centres of Darwin, Palmerston and Katherine and remote towns including Nhulunbuy, Jabiru and the numerous remote Aboriginal communities and homelands scattered across the Top End and the Tiwi

Islands. Across the Northern Territory, more than 100 Aboriginal languages and dialects are spoken (Northern Territory Government, 19 July 2018) and for many English is a second, third or sometimes fourth language. ABC Darwin is unique in the metro radio landscape as it broadcasts to the hundreds of remote Aboriginal communities across the Top End, communities which can seem like "a kind of parallel universe"(Mahood, 2012, p. 2) for many outsiders.

In writing this paper, I am mindful of the dangers of referring to Aboriginal people as one homogenous cultural group. As Behrendt states: "Indigenous communities are not culturally homogenous" however Aboriginal and Torres Strait Islander people share a history of past government dispossession and genocide which has influenced the Aboriginal psyche (Behrendt, 2004). It is from this overarching perspective that the intercultural communication issues which affect journalistic practice will be considered.

Many Australians have limited personal contact with Aboriginal and Torres Strait Islander people hence views "are shaped by secondary sources, like the media, that may not present a balanced perspective"(Reconciliation Australia, 2013)p.5. High levels of prejudice in Australian society, supported by negative Aboriginal narratives, lead to low levels of understanding about each other (Reconciliation Australia, 2013). Veteran Australian journalist Jeff McMullen argues that:

> Mass media is the principal propaganda machine marketing a neo-liberal vision aimed ultimately at dispossessing the First Australians of their land and distinctiveness....The Australian mass media attempts to strangle the Aboriginal voice....trapping Aboriginal people in stereotypes of victimhood and hopelessness. (Creative Spirits, 2015)

How the media portrays Indigenous issues impacts on the relationship Indigenous Australians have with mainstream society (Stoneham et al., 2014). For a government to effectively govern, it should have a solid understanding of the "character of society and its values" (Keating, 2000) but this is difficult to achieve when a stream of negative news feeds divisiveness. Such reporting practices contribute to and reflect the ungovernableness of Indigenous policy (McCallum, 2012). A 12 month Curtin University survey of 335 articles about Aboriginal health found 74% of the articles were negative, 11% neutral and only 15% positive (Stoneham et al., 2014). News stories fuel racism and ignorance and enforce negative stereotypes (Creative Spirits, 2015). The media focuses on problems, while the exploration of solutions is reduced to one minute sound grabs (Keating, 2000). President of the Indigenous Social Justice Association Ray Jackson explains:

> Our media tends to make our issues only front page news on Aboriginal matters when it can be spun into a report whereby all those lazy, drunken, etc, etc, can be blamed for the mistakes of government and their departments. (Creative Spirits, 2015)

This negative stereotype is inflated by a lack of Indigenous people being interviewed. When whitefellas are interviewed on Indigenous issues it perpetuates the neo-colonial paradigm. Listen to the radio today and you will hear examples of how Indigenous people are routinely silenced. Recently the ABC's flagship current affairs radio program AM broadcast from the 2017 First Nations National Constitutional Convention at Uluru. In the first program broadcast from Uluru, AM did not give voice to one Traditional Owner, the Anangu people. Instead, host Sabra Lane asked the Uluru Katja Tjuta National Park manager, Mike Misso to explain how the Anangu are connected to Uluru and to explain Tjukurpa:

> Sabra Lane: Dreamtime is not a word that is used in this area, instead locals talk about Tjukurpa. What does that mean?
>
> Mike Misso: It's a really hard concept to explain and as a non-Anangu person very hard for me to understand but I'll give it my best explanation... (Misso, 2017)

Asking a non-Anangu person to explain Tjukurpa is akin to asking an Anglo Australian visiting India to explain Sikhism. When Aboriginal people are talked about rather than spoken or listened to it is "a form of racist discourse" (Waller, 2012, p. 52). Via Twitter, AM host Sabra Lane explained her team had spoken to Anangu people but none wanted to speak on the radio, she ended with "There are still 4 days to go" (Lane, 2017). An assessment of the five-day AM broadcast from Uluru revealed AM shared the voice of one Anangu Traditional Owner [T/O]. An eleven second audio grab of T/O Sammy Wilson formally 44 welcoming convention attendees was included in an AM radio package about the opening of the forum (Wilson, 2017). ABC radio was broadcasting from a constitutional recognition convention where the discussion centred on how to secure respect and recognition for Aboriginal voices on national issues and yet the national broadcaster missed an important opportunity to respectfully and accurately represent the Anangu Traditional Owners and the issues which were most important to them and their unique circumstances as T/O's of Uluru.

The aim of this paper is not to shame ABC journalists but to raise awareness of some of the intercultural complexities faced by reporters who strive to share stories about Aboriginal and Torres Strait Islander people. It is understandably challenging for the outwardly egalitarian journalist to accept that implicit bias may affect their ability to report on Aboriginal issues. However, evidence indicates individuals who hold anti-racist beliefs may still have high levels of implicit bias (Byrne & Tanesini, 2015). Implicit attitudes are unconscious ideas which can be difficult to acknowledge and control, they include stereotypes and negative attitudes which can contribute to racial/ethnic disparities (Hall, 2015). Implicit bias research indicates that individuals who work in stressful

environments where decisions need to be made quickly (like a newsroom) are more prone to making culturally biased decisions (Byrne & Tanesini, 2015).

Reflective practice methodology

My research process is informed by my own experience as an ABC radio broadcaster at Triple J, Radio National and ABC local regional and metro radio stations over 20 years. The ideas presented here have been shaped by reflective practice which allows professionals to "develop a greater level of self-awareness" (Leigh & Bailey, 2013, p. 161) creating opportunities to improve performance (J. Wilson, 2008). In 'Educating the Reflective Practitioner', Donald Schön (1987) argues that a practitioner reflects-in-action by applying:

> standard rules, facts, and operations; then to reason from general rules to problematic cases, in ways characteristic of the profession; and only then to develop and test new forms of understanding and action when familiar categories and ways of thinking fail (Schön, 1987, p. 40)

For the last eight years of my ABC career, I presented the weekday 4-6pm 'Drive' shift at ABC Darwin. Living in the capital of the Northern Territory, completing a Masters in Community Development, and working as a senior ABC local radio broadcaster, I became acutely aware that the majority of stories about Indigenous people were negative, often using a non-Indigenous academic, business leader or politician as 'talent'. In my experience, whitefellas working on Indigenous issues were easy to contact, often in offices with reliable phone connections, and culturally available to be interviewed.

Through reflective practice it became evident that ABC broadcasters unwittingly perpetuate racist ideas held by the dominant hegemony for various reasons including the increasing number of daily deadlines [journalists no longer work to one medium, instead supply stories for radio, online and TV which all demand 24 hour news] which accompanies the "churn and burn" mentality of newsgathering (Waller, 2012). Idealists argue journalism seeks "to broaden the boundaries within which information is known and understood" (Shapiro, 2014, p. 560), however a journalist's ability to broaden the boundaries of public debate is constrained by cultural contexts and personal limitations (Castelló & Montagut, 2011). The day to day reality of working as a reporter in the age of the 24 hour news cycle and diminishing budgets means the above definition of journalism is more often than not just an ideal. These ideas have led to an exploration of the epistemological reasons behind why it is difficult for a non-Indigenous journalist to fairly and accurately produce stories about Aboriginal issues from an Aboriginal perspective.

Below is an example of reflective practice from my own career. The case study centres on an interview for Triple J in the year 2000 with Indigenous rights activist Bonita Mabo. This pivotal professional experience changed my approach to interviews with Indigenous participants.

Inter cultural communication differences

When an individual belongs to the dominant cultural group it is easy to assume that worldview is applicable to everyone. However Folds debunks that assumption in Crossed Purposes which is an examination of the history of contact between the Pintupi people of the western desert and whitefellas:

> It is a mistake to believe that two disparate societies should both be on the same path, just because historical circumstances have led to them sharing the same continent. (Folds, 2001, p. 39)

As a way of differentiating between cultures, Hofstede theorised cultures can be broken down into individualistic or collectivist (Kenny, 2011). Individualists prioritise their individual needs over the group, whereas in a collectivist society the needs of the group take priority (Gudykunst et al., 1996; Spencer-Oatey, 2009). The communicative differences between the macro Anglo culture where individualism is valued (Tesoriero, 2010) and the micro culture that is the Indigenous collectivist culture is problematic for journalists who strive to share stories about Aboriginal Australians. Time and patience is needed to observe collectivist cultures but impatience is accepted in individualistic cultures (Kenny, 2011). Former ABC Darwin journalist Katrina Bolton addresses how the collective dynamic affects a journalist's work:

> ...that whole cultural thing of not speaking out of turn, not speaking when it's not your land, not speaking when you're not senior enough, is really, really, really limiting. (Waller, 2012, p. 53)

The frustration expressed above is an example of how collective needs are prioritised. This reflects the Indigenous epistemological concept of "relationality" in which all things are related (S. Wilson, 2008, p. 58). A relational way of being is at "the heart of what it means to be Indigenous" (S. Wilson, 2008, p. 80) and an understanding of relationality can help explain that decision making processes are community based (Wilson 2008 p.110). Indigenous people's worldview is different to non-Indigenous people "because of their relationships to land, their cultures, histories and values" (Waller, 2012, p. 89). That said, culture is dynamic and non-static in nature (Ife, 2002) and, despite the shared indoctrination into a cultural group, the common values and beliefs may be adapted by individuals to suit themselves (Spencer-Oatey, 2009).

At first glance, the oral storytelling medium of radio should easily compliment the oral storytelling traditions of Aboriginal people. The intercultural communication work of anthropologist Edward Hall, in which he explains the difference between “high context” and “low context” communicators, is useful to consider.

> High context (HC) communication or message is one in which most of the information is either in the physical context or internalized in the person while very little is in the coded, explicit, transmitted part of the message. A low-context (LC) communication is just the opposite; i.e. the mass of the information is vested in the explicit code. (Gudykunst et al., 1996, p. 516)

Daily radio journalism aligns with low context communication, which is associated with being dramatic (Gudykunst et al., 1996, p. 525). Radio relies on vivid personal anecdotes and extreme opinions to create ‘ice-cream melting moments’ (when the listener can’t turn off the car radio even though they are sitting in the garage and the frozen dessert is melting in the boot!). High context cultures, dominant in collectivist societies, such as Aboriginal Australians, communicate by being reserved, employing understatement and silence (Gudykunst et al., 1996, p. 517), placing a low value on verbal communication(Gudykunst et al., 1996, p. 525). This creates a communication schism between reporters and Aboriginal people. Journalism relies on asking questions: Who, What, When, Where, How and Why? However in many remote communities the question of “why?” is rarely asked; instead, observation is used as a learning device (Australian Broadcasting Corporation, 2008). As Hagan notes, “the wise person learns by careful observation and by personal experience” (Hagan, 2008, p. 35). It can be difficult to create ‘ice cream melting moments’ when direct communication aimed at soliciting an individual’s opinion is not culturally appropriate.

The difference between the culture of journalism and Indigenous culture is vast, as explained by former ABC Darwin journalists Katrina Bolton:

> ..like your time frames and your budget and the time frames that pushes on you, are really like direct opposite to what is considered polite in Indigenous culture. (Waller, 2012, p. 52)

It could be argued that when it comes to reporting Aboriginal affairs from an Aboriginal perspective, the journalist’s primary stumbling block is time. In radio stations it is common to hear reporters justify speaking to a white person about an Aboriginal issue because they were unable to contact an Aboriginal person to meet the ‘top-of-the-clock’ deadline. The work of Edward Hall (Kenny, 2011) in which he defines monochronic and polychronic cultures is helpful. The dominant non-Indigenous cultural group in Australia tend to be monochronic – time is measurable, activities are planned,

punctuality is important and schedules are adhered to (Kenny, 2011). Talk radio is strictly monochronic. In polychronic cultures, time is flexible and "nurturing relationships, such as with family, is more important than keeping schedules" (Kenny, 2011, p. 321). Former ABC Darwin veteran reporter Murray McLaughlin said in relation to reporting in remote Indigenous communities:

> You've just got to have patience because people run their own timetable. It's no use saying I'll see you at two o'clock next Wednesday. It's a matter of rolling up on Wednesday and just sitting around and waiting and sometimes it never happens, and I've learnt not to feel any frustration about that. (Waller, 2012, p. 52)

Time costs money (Schultz, 1998). The ABC's diminishing budget has been well documented. In 2014, the federal government announced the "ABC's budget would be further reduced by $207 million" over 5 years (Australian Broadcasting Corporation, 2016a, p. 10). ABC radio staff are consistently asked to produce more stories across more platforms with fewer staff and less money. This can result in journalists relying heavily on press releases to generate new content. Economic constraints, different perceptions of time and intercultural communication issues are just a few of the ingredients which limit a journalist's ability to get 47 past the press release, to report the stories which truly "reflect Australia's national identity and cultural diversity" (Australian Broadcasting Corporation, 2016a, p. 12).

The following anecdote highlights the theories discussed. In 2000, as a reporter with the ABC's national youth network, Triple J, I travelled to Townsville to cover the National NAIDOC[3] week celebrations. Townsville was home to Bonita Mabo, wife of Eddie Mabo, the Indigenous land rights trailblazer. Facing the daily deadline of a national current affairs radio program, I needed to arrange a ten minute face to face interview with Bonita Mabo by day's end. After speaking via phone to one of Mrs Mabo's adult children, I was told to attend a NAIDOC BBQ. I expected to do a quick interview over a steak sandwich but Mrs Mabo declined, saying she was busy with family, and instructed me to call later. When I called again, she was again busy; instead I was invited to a family function a few nights later. I remember walking into the community hall, filled with big groups chatting, the matriarch was surrounded by family and friends but I couldn't get close enough to utter "Hello". On reflection, I realise my need to speak stems from low context communication patterns. With the persistence of a terrier on a trouser leg, another phone call, and another daughter told me to try again in a few days. After 10 days of just turning up, Bonita Mabo finally invited me to her house.

[3] "NAIDOC stands for the National Aborigines and Islanders Day Observance Committee. Its origins can be traced to the emergence of Aboriginal groups in the 1920s which sought to increase awareness in the wider community of the status and treatment of Indigenous Australians." ("NAIDOC," 2016)

She shared stories of her late husband's quest, her Aboriginal and South Sea Islander ancestry and her thoughts on the importance of non-Indigenous people deeply listening to Indigenous people:

> They say to forget the past but that's one thing we can't do because it's so much hurting inside. We've gotta talk about it and that way people understand a bit more about us and why we're starting to crack up about these sort of issues because we have freedom of speech these days and before you couldn't do that kind of thing, you'd get put in gaol. And now with that Stolen Generation, those people couldn't talk out and now freedom of speech is making everybody say their piece. The non-Indigenous people just sit down and listen to their stories and feel their hurt. You sit down long enough, you feel it. Once you start listening to them, it'll bring tears to your eyes to hear how they have been treated and it helps them to get a lot of the hurt out of them when you sit down and listen to them. If they do that, it'd be really good and people can understand what they are on about. (Mabo, 2000)

Over cups of tea, we recorded an hour-long conversation. Unfortunately, due to the style of youth radio I was producing ("talk" was short to cater for the alleged attention span of young people – low context communication), the interview was cut to seven minutes for broadcast. It is difficult to portray the complexity of issues when the radio format dictates interviews are tightly edited for broadcast. As Bonita Mabo said to truly understand Aboriginal and Torres Strait Islander issues, non-Indigenous people need to allow more time to listen: "…just sit down and listen to their stories and feel their hurt. You sit down long enough, you feel it."

Discussion

The communal nature of Indigenous social structures (displayed by the Mabo family), means it is often necessary to consult a group of people when researching a story (Australian Broadcasting Corporation, 2008) but this form of collective communication is in contrast to the direct individual communication style employed by journalists. Reporters expect to make one phone call and confirm the interview, but if they wish to uncover the real story "respect for Indigenous time frames and decision making processes are essential" (Australian Broadcasting Corporation, 2008, p. 13). High context communicators/collectivist cultures prioritise personal relationships "which prevent them from getting to the point quickly" (Schilling, 2009, p. 3) instead engaging in 'small talk' builds trust, it is the "key to getting everyone into mutually respectful relations" (S. Wilson, 2008, p. 99). Bonita Mabo and her family were displaying high context communication patterns. The family's refusal to conform to low context communication patterns to satisfy the demands of daily radio resulted in an insightful and revealing interview with their mother. As a young reporter, the Mabo family taught

me to respect Indigenous communication styles and timeframes if I aspired to produce stories which broadened the boundaries of public debate.

To increase cultural competence, cultural awareness training can be useful however many are critical of such training which is often tokenistic. Behrendt (2004) argues even a week of study would not be enough for the non-Indigenous person to understand the Indigenous worldview. In my 20 years at ABC radio I participated in two ABC instigated cultural awareness sessions. One was a self-guided online information package to be completed by employees at their desk and the other was a face-to-face session which was facilitated by a non-Indigenous ABC employee from Sydney who travelled to Darwin. The content of the training was generic and largely inapplicable to the Northern Territory. Research around improving intercultural communication in health has found "one-shot" cultural awareness training sessions carried out in a classroom have serious limitations (Byrne & Tanesini, 2015). Instead negative stereotypes associated with minorities (implicit bias) may be addressed by providing counter stereotypical stimuli and increasing positive experiences with minority groups (Byrne & Tanesini, 2015). This is a challenge for journalists who work in a professional environment which highlights the negatives of our society. The old journalistic adage "if it bleeds, it leads" continues to dictate what is considered newsworthy.

A deep level of political sensitivity surrounds Indigenous issues which can contribute to the lack of media and political interest (McCallum & Waller, 2012). The sensitivity may be compounded by journalists feeling ill equipped to report on Aboriginal issues. For example, ABC Darwin is seen as a training ground for young reporters and producers keen to 'cut their teeth' on croc stories, cyclone coverage and Aboriginal affairs. After a couple of years in Darwin, most head back down south. The high staff turnover means there are few ABC NT journalists who have the long term relationships required to produce authentic stories which hold governments to account regarding Aboriginal affairs.

To help ABC employees overcome some sensitivities, the organisation developed an editorial policy for Indigenous content in which reporters are asked to consider the terminology used when referring to Indigenous people. Unfortunately the policy is misleading:

> Advice should be sought before using regional terms such as Koori (New South Wales), Nunga (South Australia), Yolŋu (Northern Territory) and Murri (Queensland) and on the use of the word 'black' in various contexts. (Australian Broadcasting Corporation, 2015)

To suggest Yolŋu can be used in a similar way to Koori and Murri to refer to Aboriginal people as a collective is misleading. Yolŋu refers only to a language group from Arnhem Land, Anangu are from central Australia, Jawoyn are from the Katherine region and so it goes. According to "Appropriate

Terminology, 49 Indigenous Australian Peoples"(Flinders University, 1996) there is no generic term for Aboriginal people living in the Northern Territory unlike Murri (Queensland and north west NSW) and Koori (NSW). The term Nunga is also questionable as many Indigenous South Australians prefer others not to use their word Nunga (Flinders University, 1996).

Conclusion

The 24-hour news cycle, encouraged by the pace of social media, and diminishing budgets limit a reporter's ability to consider the cultural and communicative differences between Indigenous and non-Indigenous Australians. In addition, neo-colonial values support the culture of journalism which, despite promises of objectivity, fertilises the dominant hegemony subjugating Aboriginal and Torres Strait Islander people. Institutional changes are required to allow individuals to develop more culturally sensitive journalistic practices. The Bonita Mabo case study highlights the importance of allowing ABC journalists time to work within polychronic Indigenous time frames. By allowing journalists time to develop relationships, an opportunity to share authentic stories is created between high context and low context communicators. Otherwise non-Indigenous journalists at ABC radio stations will continue to struggle to fulfil the ABC's promise to reflect Australia's cultural diversity.

Furthermore, if the ABC is sincere in its pledge to reflect Australia's national cultural identity the institution should support journalists to increase their knowledge of Aboriginal and Torres Strait Islander culture and become aware of the implicit biases which can lead to racist reporting. By developing a series of localised cultural awareness training programs, there is potential the negative narrative around Indigenous affairs may change. By accurately reflecting the lives of Indigenous Australians, the ABC may be in a better position to fulfil the fourth estate role. One final hypothesis is that by changing the negative narrative on Indigenous issues, the ABC will be a more appealing workplace for Aboriginal and Torres Strait Islander people which may lead to higher rates of Indigenous employment. However, this requires further research.

References

Armstrong, K. L. (2011). Lifting the Veils and Illuminating the Shadows: Furthering the Explorations of Race and Ethnicity in Sport Management. *Journal of Sport Management*, *25*(2), 95-106.

Australian Broadcasting Corporation. (2008). *ABC Message Stick, Cultural protocols for Indigenous reporting in the media* (http://pzja.gov.au/wp-content/uploads/2011/06/TSSAC-27-August-2008-Meeting-46_5.1A-abc-cultural-protocol.pdf

Australian Broadcasting Corporation. (2015, October 8). *ABC Indigenous content, editorial policies*. Australian Broadcasting Corporation https://edpols.abc.net.au/guidance/abc-indigenous-content/

Australian Broadcasting Corporation. (2016a). *ABC Corporate Plan 2016-2017* (http://about.abc.net.au/reports-publications/abc-corporate-plan-2016-17/

Australian Broadcasting Corporation. (2016b). *ABC stretch Reconciliation Action Plan report 2016-2018. First report against the plan, January-December 2016* (

Australian Bureau of Statistics. (2017). 2016 Census shows growing Aboriginal and Torres Strait Islander population. Australian Bureau of Statistics.

Behrendt, L. (2004). Cultural Conflict in Colonial Legal Systems: An Australian Perspective. In C. Bell (Ed.), *Intercultural Dispute Resolution in Aboriginal Contexts,* (pp. 116-127). UBC Press.

Byrne, A., & Tanesini, A. (2015). Instilling new habits: addressing implicit bias in healthcare professionals. *Advances in Health Sciences Education: Theory Practice*, *20*(5), 1255-1262. https://doi.org/10.1007/s10459-015-9600-6

Castelló, E., & Montagut, M. (2011). Journalists, Reframing and Party Public Relations Consultants. *Journalism Studies*, *12*(4), 506-521. https://doi.org/10.1080/1461670x.2010.530969

Creative Spirits. (2015, 17 June 2017). *Mainstream media coverage of Aboriginal Issues*. Retrieved January 27th from https://www.creativespirits.info/aboriginalculture/politics/media-coverage-of-aboriginal-issues#ixzz3yL2Xz9js

Flinders University. (1996). *Appropriate Terminology, Indigenous Australian Peoples* (

Folds, R. (2001). *Crossed purposes: the Pintupi and Australia's indigenous policy*. UNSW.

Gudykunst, W. B., Matsumoto, Y., Ting-Toomey, S., Nishida, T., Kim, K., & Heyman, S. (1996). The Influence of Cultural Individualism-Collectivism, Self Construals, and Individual Values on Communication Styles Across Cultures. *Human Communication Research, International Communication Association*, *22*(4).

Hagan, S. (2008). *Whitefella Culture* (4th ed.). Australian Society for Indigenous Languages.

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S.H., Coyne-Beasley, T. . (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. *American Journal of Public Health*, *105*(12). https://doi.org/10.2105/AJPH.2015.302903)

Hanitzsch, T. (2007). Deconstructing Journalism Culture: Toward a Universal Theory. *Communication Theory*, *17*(4), 367-385. https://doi.org/10.1111/j.1468-2885.2007.00303.x

Hanusch, F. (2013). Journalists in times of change : Evidence from a new survey of Australia's journalistic workforce. *Australian Journalism Review*, *35*(1), 29-42. https://eprints.qut.edu.au/68322/

Ife, J. (2002). *Change from below, Community Development: Community based alternatives in an age of globalisation* (2nd ed.). Longman.

Keating, M. (2000). The pressures for change. In G. D. M. Keating (Ed.), *The Future of Governance: Policy Choices* (pp. 8-40). Allen & Unwin.

Kenny, S. (2011). *Developing Communities for the Future* (Fourth edition ed.). Cengage Learning.

King, C. (2017). ABC NT Indigenous employment rate. In V. Kerrigan (Ed.).

Lane, S. (2017). @VickiKerrigan @dannynitv Thanks for the feedback Vicki. We have spoken with Anangu people at length, none wanted to speak on radio. There are still 4 days to go.

Leigh, J., & Bailey, R. (2013). Reflection, reflective practice and embodied reflective practice. *Body, Movement and Dance in Psychotherapy*, *8*(3), 160-171. https://doi.org/10.1080/17432979.2013.797498

Mabo, B. (2000). Profile interview with Bonita Mabo. In V. Kerrigan (Ed.), *Triple J Morning Show*.

Mahood, K. (2012). Kartiya are like Toyota: White workers on Australia's cultural frontier. *Griffith Review*, *36*. https://griffithreview.com/articles/kartiya-are-like-toyotas/

McCallum, K. (2012). Introduction (*The Media and Indigenous policy: how news media reporting and meditatized practice impact on Indigenous policy - a preliminary report*. Journalism & Communication Studies, Faculty of Arts & Design, University of Canberra.

McCallum, K., & Waller, L. (2012). Managing the optics of Indigenous policy. In K. McCallum (Ed.), *The Media and Indigenous policy: how news media reporting and mediatized practice impact on Indigenous policy - a preliminary report*. Journalism & Communication Studies, Faculty of Arts & Design, University of Canberra.

Misso, M. (2017). National Indigenous Convention to be held at 'living cultural landscape' of Uluru. In S. Lane (Ed.), *AM, ABC Radio*. Australian Broadcasting Corporation.

Mollgaard, M. (2012). *Radio And Society: New Thinking For An Old Medium*. Cambridge Scholars Publishing.

Northern Territory Government. (19 July 2018). *Aboriginal languages in NT* https://nt.gov.au/community/interpreting-and-translating-services/aboriginal-interpreter-service/aboriginal-languages-in-nt

Reconciliation Australia. (2013). *Australian Reconciliation Barometer 2012: An overview*. Reconciliation Australia https://www.reconciliation.org.au/wp-content/uploads/2013/12/2012-Australian-Reconciliation-Barometer-Overview.pdf

Schilling, E., & Kozin, A. . (2009). Migrants and Their Experiences of Time: Edward T. Hall Revisited. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research,*, *10*(1). http://www.qualitative-research.net/index.php/fqs/article/view/1237/2684

Schön, D. (1987). *Educating the reflective practitioner: toward a new design for teaching and learning in the professions.* Jossey-Bass.

Schultz, J. (1998). *Reviving the Fourth Estate: Democracy, Accountability and the Media*. Cambridge University Press.

Shapiro, I. (2014). Why democracies need a Functional Definition of Journalism now more than ever. *Journalism Studies*, *15*(5), 555-565. https://doi.org/10.1080/1461670x.2014.882483

Spencer-Oatey, H. F., P. (2009). *Intercultural Interaction: A Multidisciplinary Approach to Intercultural Communication*. Palgrave MacMillan.

Stoneham, M. J., Goodman, J., & Daube, M. (2014). The Portrayal of Indigenous Health in Selected Australian Media. *International Indigenous Policy Journal*, *5*(1). https://doi.org/10.18584/iipj.2014.5.1.5

Tesoriero, F. (2010). *Community development: Community based alternatives in an age of globalisation* (4 ed.). Pearson.

Waller, L. (2012). *Journalists, 'remote' Indigenous sources and cultural competence* (

Wilson, J. (2008). Reflecting-on-the-future: a chronological consideration of reflective practice. *Reflective Practice*, *9*(2), 177-184. https://doi.org/10.1080/14623940802005525

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Fernwood.

Wilson, S. (2017). Constitutional recognition summit underway at Uluru. In B. Brennan (Ed.), *AM, ABC Radio*. Australian Broadcasting Corporation.

APPENDIX B

Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study.

Publication: Communicate Study group*. Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study. Medical Journal of Australia. 2020 Aug;213(4):180-1.

Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study

The Communicate Study group*

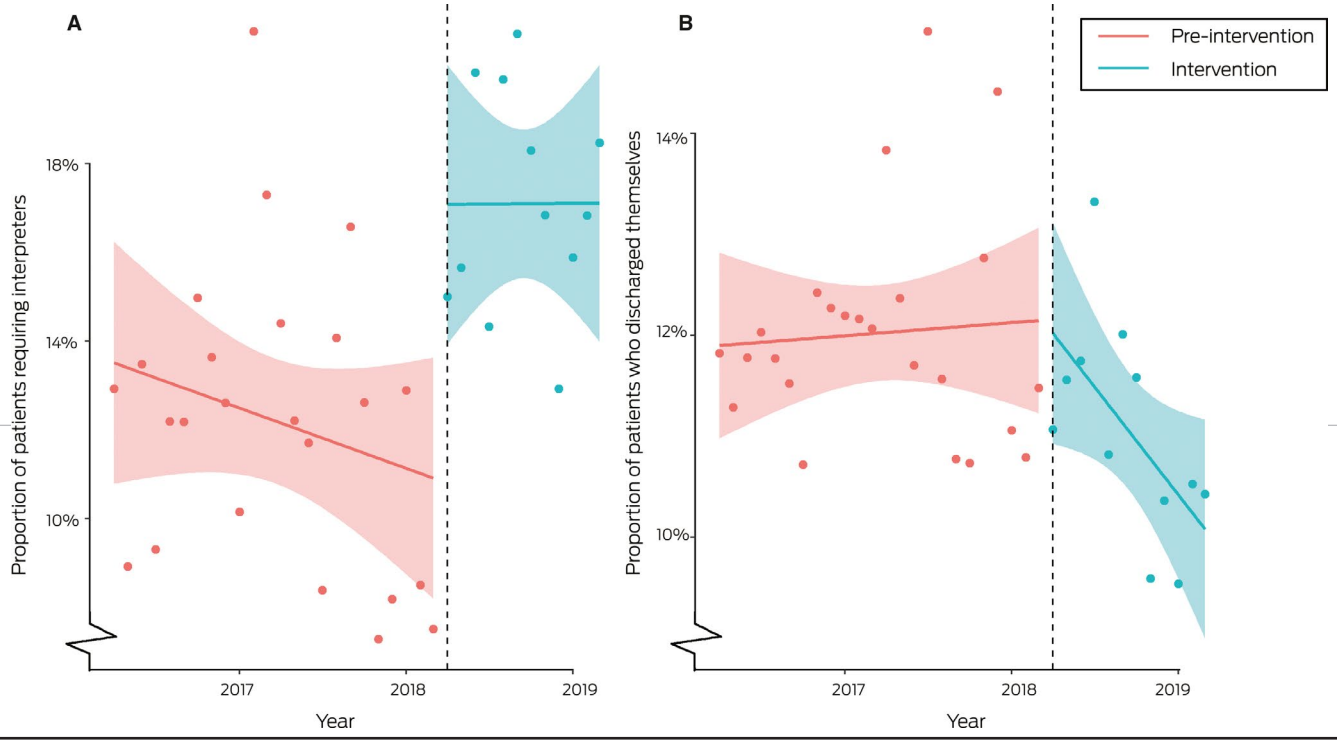
As 60% of Indigenous people in the Northern Territory primarily speak languages other than English,[1,2] greater use of interpreters in health care could improve outcomes for patients.[3,4] Barriers to using Aboriginal interpreters at Royal Darwin Hospital have been described.[1]

We undertook a quasi-experimental pilot study to determine the effects of a package of measures on the use of interpreters and patient outcomes at Royal Darwin Hospital. The intervention comprised employment of an Aboriginal interpreter coordinator (to advocate the use of interpreters, coordinate their efficient use, and support interpreters in the hospital), training for health care providers in working with Aboriginal interpreters, and the promotion of interpreter use. The primary outcome was the number of interpreter bookings by clinicians; secondary outcomes were the number of completed bookings — 20–30% of bookings are not completed because no interpreter with the required language is available, or the patient declines an interpreter, is discharged, or dies[1] — and self-discharge rates by Aboriginal patients. Language documentation and interpreter booking processes at the hospital are described in the online Supporting Information. The Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research approved the study (references, 2017-3007, 2018-3245).

Interpreter bookings data (provided by the Aboriginal Interpreter Service) and hospital separations data were obtained for all Aboriginal people admitted as public patients to Royal Darwin Hospital during 1 April 2016 – 31 March 2019. Torres Strait Islander patients, patients admitted for dialysis or same-day procedures, and patients receiving care in psychiatry units (with an already high level of interpreter use) were excluded from our analysis. Outcomes were assessed by interrupted time series analysis:[5] the baseline period was April 2016 – March 2018, and the intervention period was April 2018 – March 2019 (Supporting Information).

The intervention was associated with an immediate increase in Aboriginal interpreter bookings and a decline in self-discharge numbers. During the baseline period, 10 582 of 21 163 Aboriginal inpatients (50%) required an interpreter; interpreters were booked for 1333 (12.6% of those needing an interpreter; 755 completed bookings, 57%). During the intervention, 5460 of 10 919 Aboriginal inpatients (50%) required an interpreter; interpreters were booked for 958 (17.5%; 607 completed bookings, 63%). The

Study outcomes during the baseline and intervention phases. A. Proportion of Aboriginal patients requiring interpreters for whom interpreters were booked. B. Proportion of hospital admissions of Aboriginal people ending in self-discharge*



* Data points: monthly mean values; solid line: line fitted by linear regression; shaded envelope: 95% confidence interval for fitted line; dotted line: commencement date of Aboriginal Interpreter Coordinator appointment. ◆

*The members of the writing group and their affiliations are listed in the online Supporting Information. anna.ralph@menzies.edu.au.

difference in regression slopes for bookings before (–0.35) and during (+0.16) the intervention was 0.51 (95% confidence interval [CI], 0.13–0.90) (Box). The difference in regression slopes for completed bookings was 0.21 (–0.11 *v* +0.10; 95% CI, 0.03–0.39). Self-discharge rates fell from 12.0% to 10.1% (slope difference, –0.19; 95% CI, –0.34 to –0.04) (Box). The Aboriginal Interpreter Coordinator role appeared to be the most important component of the intervention, based on the timing of its introduction and its scope (data not shown).

Increased use of Aboriginal interpreters, critical for improving the quality of care and patient outcomes, can be achieved by targeted strategies. By the end of the study period, however, fewer than one in five Aboriginal patients needing interpreters had access to one. Considerable improvement is needed in the supply, demand and efficiency domains. Supply must be increased with recruitment and retention strategies, including interpreter mentoring. Drivers of demand include health care providers being equipped to deliver culturally safe care by knowing the names of Aboriginal languages, identifying which patients need interpreters, and knowing how to book and work effectively with interpreters. Efficiency requires new models for integrating interpreters in different contexts (ward rounds, outpatient care) and service coordination. These aspects are being examined in the further stages of this project.

Acknowledgements: Our study was supported by the Menzies School of Health Research Grants Scheme, and by the National Health and Medical Research Council (Improving Health Outcomes in the Tropical North: A Multidisciplinary Collaboration [HOT NORTH], GNT1131932). Anna Ralph is supported by a National Health and Medical Research Council fellowship (1142011). We greatly thank the Aboriginal Interpreter Service and Top End Health Services for providing the data.

Competing interests: No relevant disclosures. ■

Received 25 March 2020, accepted 28 May 2020

1 Ralph AP, Lowell A, Murphy J, et al. Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory. *BMC Health Serv Res* 2017; 17: 733.

2 Australian Bureau of Statistics. 4713.7.55.001. Population characteristics, Aboriginal and Torres Strait Islander Australians, Northern Territory, 2006. May 2010. http://www.abs.gov.au/AUSSTATS/abs@.nsf/MF/4713.7.55.001 (viewed May 2020).

3 Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev* 2005; 62: 255–299.

4 Karliner LS, Jacobs EA, Chen AH, at al. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res* 2007; 42: 727–754.

5 Linden A. Conducting interrupted time-series analysis for single- and multiple-group comparisons. *Stata J* 2015; 15: 480–500. ■

Supporting Information

Additional Supporting Information is included with the online version of this article.

APPENDIX C

Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care

Publication: Mithen V, Kerrigan V, Dhurrkay G, Morgan T, Keilor N, Castillon C, Hefler M, Ralph AP. Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care. Health Promotion Journal of Australia. 2021 Feb;32:155-65.

Received: 5 May 2020 | Revised: 21 August 2020 | Accepted: 21 August 2020

DOI: 10.1002/hpja.415

SPECIAL ISSUE ARTICLE

Health Promotion Journal of Australia | Australian Health Promotion Association | WILEY

Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care

Vincent Mithen[1] | Vicki Kerrigan[1] | Galathi Dhurrkay[1,2] | Talena Morgan[1,2] | Natasha Keilor[3] | Craig Castillon[3] | Marita Hefler[4] | Anna P. Ralph[1,3]

[1]Global and Tropical Health division, Menzies School of Health Research, Charles Darwin University, Darwin, NT, Australia

[2]Aboriginal Interpreter Service, Darwin, NT, Australia

[3]Royal Darwin Hospital, Top End Health Service, Darwin, NT, Australia

[4]Wellbeing & Preventable Chronic Diseases Division, Menzies School of Health Research, Charles Darwin University, Darwin, NT, Australia

Correspondence
Anna P. Ralph, Menzies School of Health Research, Charles Darwin University, Darwin, NT, Australia.
Email: anna.ralph@menzies.edu.au

Funding information This study was supported by the Menzies School of Health Research Grants Scheme and Improving Health Outcomes in the Tropical North: A Multidisciplinary Collaboration (HOT NORTH), National Health and Medical Research Council GNT1131932. APR is supported by a National Health and Medical Research Council fellowship (1142011).

Editor: James Smith

Abstract

Issue addressed: Improving equitable delivery of health care for Aboriginal people in northern Australia is a priority. This study sought to gauge patient experiences of hospitalisation and to identify strategies to improve equity in health care for Aboriginal patients. Aims were to validate an experience of care survey and document advice from Aboriginal interpreters.

Methods: Medical charts of Aboriginal patients were audited for documentation of language and interpreter use. Aboriginal inpatients were surveyed using an adapted Australian Hospital Patient Experience Question Set. Multiple-choice responses were compared with free-text comments to explore validity. Semi-structured interviews were conducted with Aboriginal interpreter staff.

Results: In 68 charts audited, primary language was documented for only 30/68 (44%) people. Of 73 patient experience survey respondents, 49/73 (67%) indicated satisfaction with overall care; 64/73 (88%) indicated hospital staff communicated well in multiple-choice responses. Respondents who gave positive multiple-choice ratings nevertheless reported in free text responses concerns relating to social-emotional support, loneliness, racism and food. Key themes from interviews included the benefits to patients from accessing interpreters, benefits of hospital-based support for interpreters and the need for further service redesign.

Conclusions: Multiple-choice questions in the survey were of limited utility; respondents' free comments were more informative. Social and emotional wellbeing must be addressed in future experience-of-care evaluations. Aboriginal patients' language and cultural needs can be better met by improved systems approaches. Aboriginal interpreters are uniquely placed to advise on this.

So What?: Improving health communication is critical to equitable and effective health care. Interventions must be driven by Aboriginal perspectives.

KEYWORDS

Aboriginal and Torres Strait Islanders, health advocacy, health equity

1 | INTRODUCTION

Effective communication between health care providers and patients is essential for delivery of equitable health care. It supports health literacy and patients' ability to make informed decisions regarding their health.[1,2] In Australia's Northern Territory (NT), Aboriginal and Torres Strait Islander peoples constitute 25.5% of the population.[3] About 60% of Aboriginal people speak an Aboriginal language at home.[4] Cultural and language differences between health care providers and patients can impair communication, with dire consequences.[5,6] Use of professional interpreters can improve patient engagement, satisfaction and comprehension of care, and clinical outcomes.[7,8]

Effective interpreter use in the hospital setting requires health care providers to recognise what language their patient speaks and whether an interpreter is needed, and requires systems to support efficient interpreter access. Both these elements are underpinned by institutional cultural safety. Cultural safety requires health care professionals and institutions to recognise and reflect on their own culture(s), and to ameliorate any actions which diminish, demean or disempower the cultural identities and wellbeing of care recipients.[9] Strong institutional cultural safety would ensure that all patients have their language needs appropriately responded to, and would ensure that Aboriginal interpreters feel welcome and supported in the hospital environment.

In a partnership between Top End Health Service (TEHS), the Aboriginal Interpreter Service (AIS) and Menzies School of Health Research, activities were implemented to address identified communication barriers. Activities comprised employment of an Aboriginal Interpreter Coordinator (AIC), training sessions for health care providers on working with Aboriginal interpreters, and promoting interpreter uptake through clinical champions (doctors who advocated for Aboriginal interpreter use through their daily practice at the hospital).[10] During implementation, continuing knowledge and practice gaps were evident including limited understanding of Aboriginal patient experience and ongoing obstacles in responding to patient language needs, such as lack of language documentation and employment challenges faced by interpreters. This study sought to gauge current experience of care and understand what strategies can improve delivery of equitable care for Aboriginal patients, focusing on language documentation and interpreter access. Specific aims were to validate a survey of Aboriginal patients' experience of care and document advice from Aboriginal interpreters on strategies for improving service delivery in a northern Australian tertiary care setting.

Summary

This study gauges Aboriginal patient experiences of hospitalisation, tests a patient experience survey and draws on interviews with Aboriginal interpreters, identifying strategies to improve equity and cultural safety in health care for Aboriginal patients in Northern Australia.

2 | METHODS

2.1 | Setting and context

The study was conducted at Royal Darwin Hospital (RDH), a 360-bed tertiary referral centre in the NT, where approximately 60% of inpatients identify as Aboriginal. Around 100 Aboriginal languages and dialects are spoken in the NT.[11] Aboriginal interpreters are available by placing a booking with the AIS, usually requiring advanced notice of 24-48 hours, and through a rostered system where one interpreter is onsite at the hospital for a 4-hour period most week days, depending on availability. During this study, interpreters were employed by the AIS and one Aboriginal Interpreter Coordinator was employed by TEHS. The Aboriginal Interpreter Coordinator provided an advocacy and facilitation role and mentored Aboriginal interpreters providing a service to the hospital.

Data collection took place during the second stage of the "Communicate Study," a project to improve communication between health care providers and Aboriginal patients.[12] This sub-study does not assess the effectiveness of the intervention (described separately[13]) but rather, assesses the underlying context at the hospital during this time.

2.2 | Design

This is a single-centre, prospective study[14] using interview and survey data, supplemented by a retrospective medical chart audit, to determine current practices relating to interpreter use and patient language documentation, and patient experiences of care.

2.3 | Data collection and analysis

A retrospective chart audit of Aboriginal patients admitted between 31 April 2018 and 31 August 2018 was conducted. Charts were randomly selected from a list of all patients transported to RDH by an aeromedical service from remote communities during the period. This approach was used to maximise capture of remote-dwelling Aboriginal patients more likely to speak an Aboriginal language at home. Information extracted to an electronic database (Microsoft Excel) for analysis comprised: language, requirement for Interpreter and interpreter use. Audit data were tabulated and summarised using descriptive statistics. Charts for non-Indigenous patients, neonates, patients admitted to high dependency units or psychiatric care were excluded.

A patient experience survey was undertaken separately of Aboriginal adult inpatients and adult guardians of paediatric inpatients during March 2018-September 2019. Survey respondents

Health Promotion Journal of Australia

were not necessarily intended to be the same patients as those included in the audit, although overlap was permitted and may have occurred for patients in 2018 (Figure 1). The experience survey was based on the "Australian Hospital Patient Experience Question Set" devised by the Australian Commission on Quality and Safety in Health care.[15] Surveys were conducted between March 2018 and September 2019 (Figure 1). Collaboratively developed by consumers, health professionals, academics and policymakers, the question set aims to capture patient perspectives to improve the safety and quality of health care. The survey was revised by the NT Department of Health in further collaboration with consumers and carers. This included expanding the number of questions to add demographic variables, rephrasing questions in plain English, asking patients if they wanted to be contacted by the hospital to discuss their stay, and providing additional free text comments (Supporting Information). The revised questions also included response options such as "always/ mostly/ sometimes/ rarely/ never." Survey completion was facilitated by GD and TM, both of whom are professional Aboriginal interpreters (both females), employed as researchers and coauthors of this research. All surveys were conducted in the shared language(s) of the researcher and patient or were self-administered by patients. Patients approached to participate were selected by the Aboriginal researchers on the basis of having a language in common; females were more likely to be approached reflecting cultural appropriateness, and participants were also more likely than the general Aboriginal inpatient population to have received access to an interpreter during admission.

We did not conduct formal sample size calculations but estimated that at least 50 chart audits and at least 50 patient experience surveys would be likely to provide adequate insight into documentation of language and interpreter use, and experience of care.

Paper survey responses were entered into a RedCAP database.[16] Descriptive summary statistics were tabulated and presented as bar charts. The free-text comments were analysed using inductive thematic analysis. Individual comments were triangulated against survey responses to assess discrepancies between survey multiple-choice responses and free text. This was done by collating the individual's survey responses under the headings of "Communication" (questions 13, 16, 17 [Supporting Information]) and "Satisfaction" (questions 11 and 14). Where responses to questions under each heading were all positive, the person was deemed to have provided a positive response; where responses to these questions were mostly positive, the individual was deemed to have provided a more positive than negative response, and so on. After assigning an overall tally of their responses (positive, more positive than negative, more negative than positive, negative), tallies were compared with the main messages provided in the person's free-text comment. The degree of consistency was then considered.

Semi-structured interviews were conducted with three Aboriginal interpreters who had regularly worked at RDH over the preceding 18 months, including TM who also conducted patient surveys and is a coauthor, and the RDH Aboriginal Interpreter Coordinator (CC) who had been in the role for 10 months at the time of data collection and is also a coauthor. All interviews were undertaken by VM between January and September 2019 (Figure 1), prior to analysis of survey data. Two interviews were recorded and transcribed verbatim and two were not recorded, in accordance with the preferences of respective participants; instead handwritten notes taken by the interviewer were transferred to a word document. All transcripts and notes were verified by participants as accurate. The interviews sought to understand: interpreters' daily work flow; interpreters' experiences at RDH; their perceptions of benefits of their role to patients; the risks and challenges of the job; the impact of the newly introduced Aboriginal Interpreter Coordinator role; and to elicit any recommendations for changes to practice. Inductive thematic analysis was undertaken using NVivo 12.[17] Analyses of interviews and surveys were completed separately; themes from both were then compared to identify similarities and differences. Combined themes relating to patient experience are presented in *Results* under *Theme 1*. All analysis was conducted by VM, AR, VK and MH.

2.4 | Ethics

Approval was provided by the Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC 2017-3007).

3 | RESULTS

During the study period, 73 patient experience surveys, 68 chart audits and 4 interviews were undertaken (Figure 1).

3.1 | Chart audit

Sixty-eight charts were audited. Seven separate administrative and clinical hardcopy forms that included a space for documentation of language and interpreter requirement were identified in most charts (Table 1). Some forms, such as consent for procedure forms, were not present in all charts. Despite these multiple opportunities,

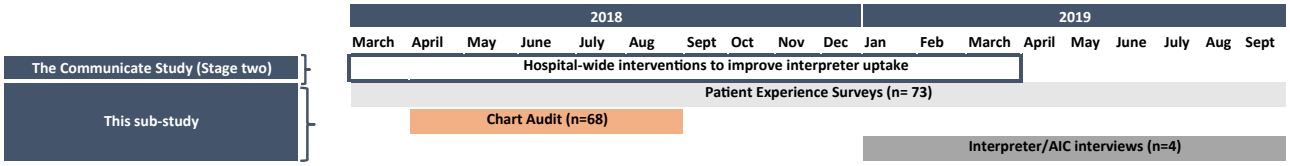


FIGURE 1 Study diagram showing data collection

language was documented for only 30 (44%) patients (Table 1). Eighteen (60%) were identified as speaking an Aboriginal language, 10 (33%) as needing an interpreter and 2 (7%) were documented to have received an interpreter. Where language was identified, in seven instances it was documented incorrectly; eg, the Burarra language from Arnhem Land was spelt "Bakkada" and in six instances language was documented as "Aboriginal language," "Indigenous language" or "local language."

TABLE 1 Documentation of language spoken, interpreter requirement and interpreter use among randomly audited medical files of Aboriginal inpatients

Audit field	Number	%
Documentation of language located in medical file[a]	30/68	44
Language spoken		
Any Aboriginal language	18/30	60
"Aboriginal language" only documented	12/30	40
"Aboriginal language and English" documented[b]	6/30	20
"English" documented	12/30	40
Aboriginal language name documented correctly[c]	11/30	37
Requirement for interpreter documented	10/30	57
Interpreter use documented in those labelled as speaking an Aboriginal language	2/18	11

[a]Administrative and clinical forms that included space for patient language and/or interpreter requirement were; Aboriginal Liaison Officer File Note; Emergency Department Nurse Assessment; Goals of Care; Consent forms for procedures; Emergency Department Nurse Handover Checklist; Adult Multi-disciplinary Admission/ Discharge Tool; Risk Admission Discharge Tool.

[b]Where Aboriginal people speak an Aboriginal language and English, the first language is usually the Aboriginal language

[c]Examples of incorrect specification include "Aboriginal language", "Bakkada" (instead of Burrara), "local language" and "Indigenous".

3.2 | Patient experience of care survey

Seventy-three Aboriginal inpatients completed a patient experience survey: fifty-one (70%) were female (Table 2). Seventy one (98%) spoke an Aboriginal language at home; 21 (29%) reported that they received access to an interpreter during the current admission (Table 1). The majority of respondents (59 [81%]) said that they had a positive experience of hospital (q. 14; "As a Yolngu person/Aboriginal person, how did you find the hospital workers?"). Fewer (49 [67%]) were satisfied overall with the care they received (q. 11; "The doctors, nurses, specialists and other hospital workers who cared for you in hospital, who did you see? Were you satisfied with them or unhappy/unsatisfied or what?"). A similar number (45 [62%]) responded that hospital staff worked well together in providing care (q. 29; "Did those hospital workers work well with each other to help you?"). Around 64 (88%) said that hospital staff communicated with them well (q. 13; "When the hospital people talked to you, how did you feel? Good or bad or what?"), yet, only 35 (48%) stated that treatment was explained clearly (q. 16; "Did those doctors and hospital workers explain everything clearly and carefully to you? Did you understand what was happening to you in hospital?") (Figure 2).

The survey included questions on fear, worry and pain, and whether these needs were addressed. Some respondents noted fear or worry (26 [36%]) (q. 21; "Were you worried or afraid when you were sick?") and 67 (92%) indicated they experienced pain during admission (q. 23), all of whom reported receiving pain relief. Some questions related to advice about postdischarge plans: 19 (26%) respondents reported receiving advice from staff about taking care of oneself after discharge (q. 27; "Did any of the doctors or hospital workers tell you how to look after yourself properly at home?"), and 3 (4%) recalled being advised to seek primary health care postdischarge (q. 28; "Have you talked with any of the hospital workers so that when you go home, maybe you can go to another clinic for help?").

3.3 | Thematic analyses

Comments in the survey provided more detail about patient concerns than was obtained from the multiple-choice questions and often dealt with issues not covered in the survey, particularly social and emotional wellbeing. In addition, comments sometimes contradicted the ratings provided in the multiple-choice responses. Generally, the mismatch was that survey responses to the collected "Communication" and "Satisfaction" questions had been "positive" or "more positive than negative" yet comments highlighted negative experiences.

Key findings from interviews with Aboriginal Interpreters and the hospital-based Aboriginal Interpreter Coordinator included; interpreters are well placed to provide in-depth feedback about Aboriginal patient experiences and ways to improve language and cultural responsiveness; interpreters face unique challenges in the hospital environment; the AIC plays a valuable role in supporting interpreters; and that interpreters and the AIC have unique insight into avenues for improving service delivery systems.

Patient and interpreter perspectives on the practical and social and emotional issues faced by patients are described in Themes 1 and 2. The challenges experienced by interpreters are explored in Theme 3, and service system issues and the role of the Aboriginal Interpreter Coordinator are examined in Theme 4.

3.3.1 | Theme 1: Patient perspectives of social and emotional wellbeing issues

Prominent themes were loneliness, homesickness, problems with the hospital physical environment, racism and a lack of staff

Health Promotion Journal of Australia

TABLE 2 Patient experience survey results

Questions	Responses n =	%
Sex		
All respondents	73	100
Male	19	26
Female	51	70
Unknown	3	4
Age	n=	%
0-24	10	14
25-44	21	29
45-64	33	45
65+	9	12
Language spoken at home	n=	%
Aboriginal languages[a]	48	66
Aboriginal languages[b] and English	23	32
English	1	1
Language not specified	1	1
Interpreter use	n=	%
Interpreter offered	26	36
Interpreter used	21	29
Survey Responses	"Yes" (n=)	(%)
11. Were you satisfied with the care you received?	49	67
13. Did hospital staff speak to you in a good way?	64	88
14. Did you have a positive experience of hospital as a Yolngu/Aboriginal person	59	81
16. Did the hospital staff explain your treatment to you clearly?	35	48
17. Did those doctors and hospital workers talk to you about what was going to happen to you in hospital?	44	60
18. Did you or your family or a close friend want to talk to those doctors and hospital workers?	13	18
19. Did you give consent for HCPs to talk to your family?	11	15
20. Did the hospital staff talk to your family?	12	16
21. Were you worried or afraid when you were sick?	26	36
22. Did the hospital staff talk to you when you were worried or afraid?	32	44
23. While in hospital, were you in pain?	67	92
24. Do you think the HCPs gave you something for the pain?	67	92
25. In hospital, if you were unable, did HCPs help you to shower and go to the toilet?	15	20
26. In hospital, were the toilets and bathrooms clean?	64	88
27. Did any hospital staff tell you how to look after yourself properly at home?	19	26

(Continues)

TABLE 2 (Continued)

Questions	Responses n =	%
28. Have you talked with any hospital staff so that when you go home, maybe you can go to another clinic for help?	3	4
29. Did hospital staff work well with each other to help you?	45	62
30. Do you feel strong today?	38	52

[a]Yolngu Matha, Burarra.
[b]Yolngu Matha.

understanding and support for patients' emotional concerns and cultural obligations. Two individuals commented on privacy issues – that family members should not know one's business, particularly in relation to the inappropriateness of accompanying family members being used as interpreters. Complaints about hospital food were very common in survey comments.

Inconsistencies between experience of care documented in survey questions versus comments made by individuals was evident. In the multiple-choice options, one respondent indicated positive attitudes to communication in hospital and satisfaction with care but the same respondent commented that non-Aboriginal patients were allowed more freedom, and less likely to be admonished for smoking on hospital grounds. This respondent also said that patients were subjected to racist remarks from both clinical and nonclinical (including security guards) RDH staff:

> *"Nurses disrespect cultural activities such as family gatherings, like death of a family member in the ward or sitting around outside. … (If) patients ask for anything we are given excuses. Only in their own time do they do our requests. We complain about the food. They don't see to it; they don't change the food."* (Survey Respondent 8)

Another respondent who also provided positive survey responses asserted in free text comments that clinical staff required better cultural education (referred to as "awareness court") to ensure they deliver culturally safe care:

> *"When the nurses are shouting or screaming at patients, I write letter to the boss of the ward, to treat patients equally. Nurses should go through awareness court more often."* (Survey Respondent 16)

One comment revealed concern about both the stressful nature of the hospital environment, and lack of awareness of prescribed treatment regimens which may require overnight dosing:

> *"Nurses that are on night shift wake us up all night. Hospital meant to be a resting place. Can we take pills at daytime only and only at night if we in pain? Feel like we are not getting enough rest."* (Survey Respondent 9)

Of note, some positive experiences of care were also reported.

> *"I find the workers very humble and respectful." (Survey Respondent 56)*

3.3.2 | Theme 2: Interpreter perspectives of patients' social and emotional wellbeing issues

The Aboriginal Interpreter Coordinator reported that Aboriginal patients often arrive in Darwin via the aeromedical service with little understanding of the reason for hospitalisation: "*They just get told to come on the plane*". Patients feel lonely, frustrated and isolated, particularly when an escort is not available and interpreters not used. The emotional stress associated with isolation can result in patients disengaging with treatment, compromising adherence.

> *"People don't take medication and don't listen to the doctors because they're lonely and scared and need someone to support them."* (Interpreter A)

One interpreter described the benefits patients can experience when they access an interpreter, including improved understanding of diagnosis and treatment. The interpreter explained that after experiencing the benefits of communicating through an interpreter, some patients were empowered to request interpreters and in one instance refused to participate in subsequent consults without an interpreter.

> *"There was this one old man who was refusing to see the doctors or anyone except with the interpreter."* (Interpreter A)

The benefits patients experience from accessing interpreters were also highlighted by the Aboriginal Interpreter Coordinator.

Health Promotion Journal of Australia

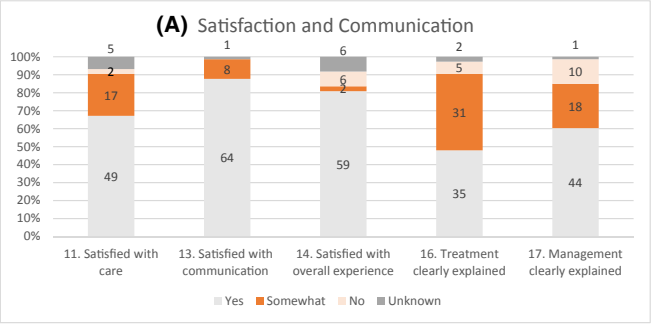


Chart A: Satisfaction and communication
Bar 1: The doctors, nurses, specialists and other hospital workers who cared for you in hospital, who did you see? Were you satisfied with them or unhappy/unsatisfied or what? (Question 11)
Bar 2: When the hospital people talked to you, how did you feel? (Question 13)
Bar 3: As a Yolngu/Aboriginal person, how did you find the hospital workers? (Question 14)
Bar 4: Did those doctors and hospital workers explain everything clearly and carefully to you? Did you understand what was happening to you in hospital? (Question 16)
Bar 5: Did those doctors and hospital workers talk to you about what was going to happen to you in hospital? (Question 17)

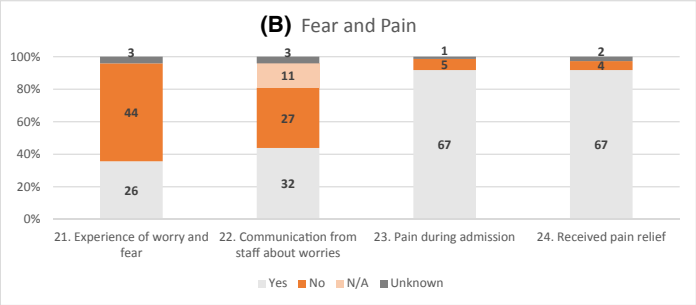


Chart B
Bar 1: Were you worried or afraid when you were sick? (Question 21)
Bar 2: Did the doctor or hospital workers talk to you when you were worried or afraid? (Question 22)
Bar 3: While you were in hospital, were you in pain? (Question 23)
Bar 4: Do you think that those doctors and hospital workers give you something for the pain? (Question 24)

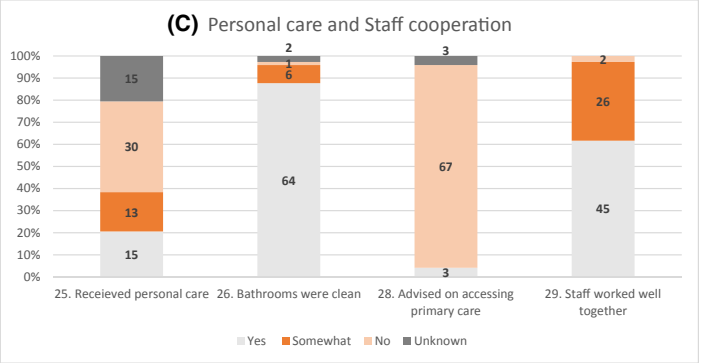


Chart C
Bar 1. In hospital, if you could not take a shower or go to the toilet by yourself, did any of those hospital workers help you? (Question 25)
Bar 2. In hospital, were the toilets and bathroom really clean, or a little bit clean, or dirty? (Question 26)
Bar 3. Have you talked with any of the hospital workers so that when you go home, maybe you can go to another clinic for help? (Question 28)
Bar 4. Did those hospital workers work well with each other to help you? (Question 29)

FIGURE 2 Patient experience survey findings. Chart A: Satisfaction and communication. Chart B: Fear and pain. Chart C: Personal care and staff cooperation. Numbers on bars show numbers of respondents; *y* axis shows percentage of respondents. Survey questions shown on *x* axis are abbreviated. Exact wording of survey questions is provided below

"I think being able to speak in language and feeling a part of something has got potential to grow. I know a particular patient whose journey wasn't so great … Having that language support just made him feel that he could open up and he could discuss something, regardless of him needing an amputation and then a second amputation … Now, that's a hard, hard thing to accept, but communication, I think, was quite key

in that whole journey for him." (Aboriginal Interpreter Coordinator)

3.3.3 | Theme 3: Challenges experienced by interpreters working in the hospital

Interpreters face numerous challenges in their work relating to cultural matters (respecting cultural protocol while also maintaining fidelity in interpreting for non-Indigenous health care providers) and logistic arrangements (office space, workflow). Interpreters described feeling excluded within the hospital due to a lack of designated office space. Between jobs, interpreters share desk space with Aboriginal Liaison Officers: "*Once I accidently walked into an office where a patient was talking with the Centrelink people."* (Interpreter A).

One interpreter described the internal conflict experienced when they witness culturally inappropriate behaviour from hospital staff, and the challenge of remaining impartial due to the interpreters' code of ethics:

> *"it is difficult because, as an interpreter you're thinking, oh, your job is to interpret what they saying directly, you know? You're not there to talk … 'cause they won't understand what you are doing at a cultural level 'cause they don't have that knowledge. They're not educated in the cultural side of things and um, it's a bit tricky when you're doing that."* (Interpreter B)

The following experience illustrates systemic failures in cultural safety:

> *"a lady who … was there by herself … she was a cancer patient and they told her that day was that she only had a few days to live. And in a Yolngu way there is a cultural part to it that wasn't covered by the hospital. I could see that that was very distressing … asked her directly if she wanted to die in the community or move to the hospice while she was still processing the information of what they'd just told her and then giving her more … you could just see that the patient was in distress … I don't think that was done right."* (Interpreter B)

This also raises the issue that interpreters lack avenues of reporting and debriefing, to communicate and escalate breaches in cultural safety.

Engagement of interpreters in noninterpreter roles was common. Patients reportedly prefer to communicate with Aboriginal interpreters because Aboriginal Liaison Officers "*are all from Darwin, they are not from the communities"* (Interpreter B). At the time of the study, none of the Liaison Officers were first language speakers from remote communities. This impacted on some interpreters' perception of Liaison Officers' ability to understand the needs of Aboriginal language speakers. Interpreters reported being required to act as a patient escort, counsellor, liaison officer and security guard, and to assist patients with travel and social services. Interpreters reported sometimes even being required to act as an intermediary in aggressive circumstances:

> *"I've been in a situation like that where a patient just wanted to hit people and when you come then they sort of know you, they calm down, but the problem was that the patient has an ear problem, so the patient wears those ear hearing things and they were trying to talk to him without the hearing aid, and it's, just a little miscommunication."* (Interpreter B)

3.3.4 | Theme 4: Health service systems and the Aboriginal Interpreter Coordinator role

The interface between Royal Darwin Hospital and the Aboriginal Interpreter Service was discussed by all interviewees. Upon commencing in the role, the Aboriginal Interpreter Coordinator identified limitations in planning, resources and relationships between key stakeholders, and that the quality and efficiency of the interpreting service within the hospital could be improved. The existing strategy to evaluate the communication requirements of patients assumes that health care providers and Aboriginal Liaison Officers are capable of assessing patients' need for an interpreter; however, one interpreter described that an interpreter is best placed to do this. Another interpreter suggested that the development of an overall strategy requires more than a single Aboriginal Interpreter Coordinator. Interpreters sought clear instructions on how they could achieve better efficiency:

> *"… you can come up with a good structure to deliver those services for everyone … give them good instructions: "this is how the interpreter is going to run" … At the moment, this piece of paper [strategy] is not there yet. That's where the gap is."* (Interpreter B)

Another interpreter commented on the difficulty involved in coordinating the workflows of interpreters and doctors:

> *"Once the doctors are available, I'm not available. When the doctors are available, I'm busy with other people!"* (Interpreter A)

Two respondents reported that prior to the Aboriginal Interpreter Coordinator position, there had been few systems to support efficient deployment of interpreters, leaving them to develop their own procedures for navigating the hospital.

Health Promotion Journal of Australia

> *"now I just go to the ward … and I tell the Team Leader or Ward Clerk, if you know of anyone who needs an interpreter you can page me. Before I would dawdle around and talk to the patients … I think the new way is better."* (Interpreter C)

Interpreters spoke positively about the Aboriginal Interpreter Coordinator position. Significance was attached to the fact that the coordinator had spent time in remote Aboriginal communities, which gave some interpreters confidence that he had genuine understanding of the needs of Aboriginal people living in remote communities and urban communities. The AIC role also provided support to interpreters who previously felt unwelcome in the hospital setting. Interpreters identified that less experienced interpreters who do not receive dedicated orientation and support are more likely to "burn-out" and choose not to work in the hospital:

> *"He [the Interpreter Coordinator] supported me from day one, showed me a lot of places around the hospital, all the wards and introduced me to all the doctors … there were two full days of orientation, which made me really confident and made my routine good. This really opened my eyes that we need more interpreters."* (Interpreter A)

4 | DISCUSSION

We have identified critical opportunities to improve equitable delivery of health care and the experiences of care for Aboriginal peoples in northern Australia. Foremost is that Aboriginal patient needs can be better responded to by improved systems approaches including better documentation of patient language, greater efficiency in use of interpreter services and improved assessment of patients' experiences of care. Institutional efforts to listen to and address patients' expressed needs, and to learn from the unique perspectives of Aboriginal interpreters, would be important steps towards improving equity in this setting.

4.1 | Patient experience survey

Key needs articulated by patients were; better social and emotional support in hospital to combat loneliness; greater understanding and respect amongst staff for patients' cultural obligations; freedom from racism; and more visible responsiveness to requests which seemed to be ignored.

The research group found the patient experience survey repetitive, in parts incomprehensible, and that some questions (q. 11 and 16) were double-barrelled and, therefore, unanswerable. Nevertheless, we chose to test the "official" tool in circulation at the time, which had already been through multiple reviews by consumer groups and stakeholders. The survey has since been revised by the Northern Territory Department of Health to incorporate more feedback and reduce ambiguity. A key strength of the study was the use of Aboriginal language speakers – external to the health service – to facilitate patient experience surveys. This is likely to have enabled patients to clearly articulate their concerns – rather than having to communicate in a second language (English) – and with greater openness than were it administered by hospital staff. Comments made by respondents highlighted that Aboriginal patient concerns were not well addressed in the questions provided; a finding supported by previous research indicating that patient priorities and those of health systems are not always aligned.[18]

Institutions seek patient experience measures that are readily comparable over time and between institutions. Multiple-choice surveys are amenable to that, whereas interpretation and comparison of comments is considered less feasible on a large scale. We assert that collecting quality information is more beneficial than collecting a large quantity of information which does not reveal the reality of the patient experience. We recommend that future patient experience surveys in this setting are developed within an Indigenous paradigm and address Indigenous priorities.[19] Our research found that questions should address cultural and emotional wellbeing, loneliness, racism, communication, and food. While food may seem relatively trivial, clearly for Aboriginal survey respondents it was a serious issue – the most likely to attract comment. Realistically, inpatients can work with dieticians to request special meals which may be more culturally or personally acceptable, but this did not often seem to be presented as an option. When food is consistently alienating, this adds to the discomfort of the hospital experience. If requests for change appear unheeded, the sense of not being listened to is heightened.

To advance the delivery of culturally safe care, which represents a shift from a one-size-fits-all approach to provision of patient centred care taking account of people's unique cultural needs,[20] we recommend multiple-choice surveys be abandoned in this context. The cost of investment in survey design, delivery, analysis and reporting is substantial. There would be value in diverting costs to implement a survey asking Aboriginal patients in first language to describe their experience of hospitalisation, to enable the hospital to improve its performance. Simple thematic analysis of such comments could be an efficient way of collating results.

4.2 | Aboriginal interpreter perspectives

We are unaware of previous studies from this setting exploring Aboriginal interpreter perspectives of tertiary health care delivery. Participating Aboriginal interpreters explained they provide a critical role which involves much more than direct translation. Being of the same cultural background as their clients, interpreters are often the only professional the patient can truly relate to during their admission. Interpreters who "walk in two worlds" are uniquely placed to comment on the cultural safety of the institution and advise on improvements. Aligning with previous research,[21] interpreters described the need to diversify Aboriginal employment in the hospital so that Aboriginal staff truly represent the diverse patient population.

Key needs articulated by interpreters included clearer structure to their roles, workplace supports ranging from office space to debriefing opportunities, and better cultural training for health care providers. Previous research in the same setting has found health professionals have an appetite for ongoing cultural education developed by local Aboriginal leaders which can be applied to the clinical environment.[22]

4.3 | Health system strengthening

Systems issues apparent from interviews with interpreters and the Aboriginal Interpreter Coordinator are being shared with Top End Health Service and the Aboriginal Interpreter Service, and a memorandum of understanding between the services is under development. Issues being considered for inclusion in the memorandum include: electronic documentation of language, displaying patient language above beds, wider use of audio-visual interpreting, clearer workflows, employing hospital-based interpreters directly through the health service, ensuring adequate workplace supports for interpreters, increasing roll-out of "working with interpreters training" for staff and establishing and responding to key performance indicators around interpreter use.

Knowledge of Aboriginal languages remains inadequately prioritised. This foundational information is vital to ensure the delivery of culturally safe health care. The languages Aboriginal people speak, and whether they would benefit from an interpreter, let alone receive one, remain largely undocumented according to these findings. Even during this study period when hospital-wide activities were underway to improve Aboriginal interpreter use, this remains low, in keeping with previously published data.[23] Given that seven standard hospital forms include space for language documentation and interpreter requirements, we conclude that TEHS recognises the theoretical importance of this information. However, patient language was only documented in 44% of cases. A lack of knowledge of Aboriginal language names can be remedied through better information accessible at point of need (such as electronic language recording prompted by a decoder linking place names to local languages), and better staff education.

4.4 | Limitations

A limitation of this study is that sample sizes for the survey and audit were small and not based on prespecified parameters, and that participant selection for the survey was not representative of all language groups. We acknowledge that the findings relate to those individuals sampled, that is, Aboriginal people most likely to be from remote communities who primarily speak an Aboriginal language. The findings should not be extrapolated to the diversity of Aboriginal peoples in northern Australia, although common principles may apply more widely. Although patient experience data were collected by Aboriginal researchers, coding of qualitative data was undertaken by non-Aboriginal researchers, which we also acknowledge as a potential limitation. Responses to some survey questions such as receipt of postdischarge advice may be inaccurate as patients were opportunistically surveyed at different stages of their admission and may have received postdischarge advice after completing the survey.

5 | CONCLUSION

This study reveals that despite collaborative efforts to improve patient experience of care, complex, systemic issues impede the delivery of culturally safe care. Hospitalised Aboriginal people would have a more positive experience of care if they felt more respected. This could be achieved through better training of health care providers, cultural mentoring of health care providers, a stronger Aboriginal workforce presence on the wards, and through health care providers having more time to achieve effective knowledge transfer with patients and their families, either through increased staffing or restructuring of current systems and processes. Aboriginal patients and interpreters are well placed to lead discussions about the service redesign steps required. Measurement of Aboriginal patients' experiences of hospitalisation should address their true priorities through open-ended questions. Considerable scope exists for hospital staff to improve their knowledge, responses and documentation of Aboriginal patients' languages and cultural needs. Rather than creation of additional forms to record patient language and interpreter requirement, we advocate for more staff training in patient-centred, culturally engaged care, and better systems to support this practice.

ETHICS STATEMENT

Approval was provided by the Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC 2017-3007).

ACKNOWLEDGEMENTS

This study was supported by the Menzies School of Health Research Grants Scheme and Improving Health Outcomes in the Tropical North: A Multidisciplinary Collaboration (HOT NORTH), National Health and Medical Research Council GNT1131932. We thank Dr Martin Hansen and Dr Elise O'Connor for being clinical champions of interpreter use and Associate Professor Bhavini Patel for providing approval on behalf of the Top End Health Services research committee. We also thank the Aboriginal Interpreter Service for their ongoing support and commitment to the Communicate Study. APR is supported by a National Health and Medical Research Council fellowship (1142011).

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

ORCID

Vincent Mithen https://orcid.org/0000-0002-0634-6913
Vicki Kerrigan https://orcid.org/0000-0001-6863-1528
Marita Hefler https://orcid.org/0000-0002-1709-1098
Anna P. Ralph https://orcid.org/0000-0002-2253-5749

Health Promotion Journal of Australia

REFERENCES

1. Australian Commission on Safety and Quality in Health Care. Health literacy: Taking action to improve safety and quality. 2014 [Cited 2020 Mar 3]. Available from: https://www.safetyandquality.gov.au/sites/default/files/migrated/Health-Literacy-Taking-action-to-improve-safety-and-quality.pdf
2. Australian Commission on Safety and Quality in Health Care. Communicating for safety standard. 2019 [Cited 2020 Mar 3]. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard
3. Australian Bureau of Statistics. 2016 census QuickStats. Northern territory. 2019 [cited 2020 Mar 3]. Available from: https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/7?opendocument
4. Australian Bureau of Statistics. 2076.0 - census of population and housing: characteristics of Aboriginal and Torres Strait Islander Australians, 2016. Main language spoken at home and English proficiency. 2019 [Cited 2020 Mar 3]. Available from: https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2076.0Main%20Features1012016?opendocument&tabname=Summary&prodno=2076.0&issue=2016&num=&view=
5. NT Coroner Court. Inquest into the death of Kristelle Ruby Mulladad aka Oliver NTMC 64. In: Findings of Mr Greg Cavanagh. 2010.
6. Flores G. Language barriers to health care in the United States. N Engl J Med. 2006;355(3):229–31.
7. Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. Med Care Res Rev. 2005;62(3):255–99.
8. Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res. 2007;42(2):727–54.
9. Australian Health Practitioner Regulation Agency. The national scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025. 2020.
10. Kerrigan V. The 'communicate' study: improving communication with hospitalised Aboriginal patients to ensure quality & safety in healthcare. 2018 [cited 2020 Mar 4]. Available from: https://www.menzies.edu.au/icms_docs/301374_The_%E2%80%98Communicate%E2%80%99_Study_Poster.pdf
11. Northern Territory Government. Aboriginal languages in NT. 2020 [cited 2020 Mar 4]. Available from: https://nt.gov.au/community/interpreting-and-translating-services/aboriginal-interpreter-service/aboriginal-languages-in-nt
12. Menzies School of Health Research. The Communicate study (Stages 1 and 2). 2020 [cited 2020 Mar 4]. Available from: https://www.menzies.edu.au/page/Research/Projects/Primary_health_care/The_communicate_study_stages_1_and_2/
13. Communicate Study Group. Improving communication with Aboriginal hospital inpatients: a quasi-experimental interventional study. Med J Aust. 2020;213(4):180–1.
14. Webb P, Bain C. Essential epidemiology: an introduction for students and health professionals. 2nd ed. Cambridge: Cambridge University Press; 2011. 445 p.
15. Australian Commission on Safety and Quality in Health Care. Australian Hospital patient experience question set. 2019 [cited 2020 Mar 3]. Available from: https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/australian-hospital-patient-experience-question-set
16. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap) - a metadata-driven methodology and workflow process for providing translational research informatics support. J Biomed Inform. 2009;42(2):377–81.
17. QSR International. NVivo12 Qualitative Data Analysis Software [Software]. [12 Pro]. 2020. Available from: https://qsrinternational.com/nvivo/nvivo-products/.
18. Pannick S, Archer S, Long SJ, Husson F, Athanasiou T, Sevdalis N. What matters to medical ward patients, and do we measure it? A qualitative comparison of patient priorities and current practice in quality measurement, on UK NHS medical wards. BMJ Open. 2019;9(3):e024058.
19. Walter M, editor. Social research methods. 3rd ed. South Melbourne, Australia: Oxford University Press; 2013.
20. Ramsden IM. Cultural safety and nursing education in Aotearoa and Te Waipounamu; A Thesis Submitted to the Victoria University of Wellington in Fulfilment of the Requirements for the Degree of Doctor of Philosophy in Nursing. Victoria University of Wellington; 2002.
21. Kelly J, Dowling A, McBride K, Keech W, Brown A. 'We get so task orientated at times that we forget the people': staff communication experiences when caring for Aboriginal cardiac patients. Aust Health Rev. 2020;44(1):1–6.
22. Kerrigan V, Lewis N, Cass A, Hefler M, Ralph AP. "How can I do more?" Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload. BMC Med Educ. 2020;20(1):173.
23. Ralph AP, Lowell A, Murphy J, Dias T, Butler D, Spain B, et al. Low uptake of Aboriginal interpreters in healthcare: exploration of current use in Australia's Northern Territory. BMC Health Serv Res. 2017;17(1):9.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Mithen V, Kerrigan V, Dhurrkay G, et al. Aboriginal patient and interpreter perspectives on the delivery of culturally safe hospital-based care. *Health Promot J Austral*. 2020;00:1–11. https://doi.org/10.1002/hpja.415

APPENDIX D

Stay Strong: Aboriginal leaders deliver COVID-19 health messages

Publication: Kerrigan V, Lee AM, Ralph AP, Lawton PD. Stay Strong: Aboriginal leaders deliver COVID-19 health messages. Health Promotion Journal of Australia. 2020 May 19.

Received: 24 April 2020 | Revised: 12 May 2020 | Accepted: 14 May 2020
DOI: 10.1002/hpja.364

LETTER TO THE EDITOR

Health Promotion Journal of Australia
Australian Health Promotion Association
WILEY

Stay Strong: Aboriginal leaders deliver COVID-19 health messages

COVID-19 caused by Severe Acute Respiratory Syndrome-Coronavirus-2 (SARS-CoV-2) has constituted a pandemic unparalleled in modern history. The spread, case numbers and socioeconomic consequences have resulted in pandemic control measures attempting to "flatten the curve." Australia recorded its first case of COVID-19 on the 25th of January 2020. The federal government responded to the virus spread by escalating human movement controls: during February any person arriving from countries with high rates of infection were expected to quarantine for 14 days in a third country before entering Australia. On the 11th of March when the World Health Organisation declared COVID-19 a global pandemic there were more than 118 000 cases in 114 countries and 4291 people had died.[1] Seven days later the death toll in Australia had risen to six and the government effectively closed the border by raising international travel advice to its peak level – "do not travel." By this stage, mainstream media channels were saturated with international COVID-19 stories which focused on the rising rates of transmission and death contributing to confusion and panic. As restrictions on human movement intensified (border controls, social distancing and limiting public gatherings) panic buying of food, hoarding of toilet paper and other extreme herd behaviour resulted. Fear about COVID-19 spread faster than the virus in the sparsely populated Northern Territory of Australia where 30% of the population identifies as Aboriginal. Myths circulated communities: Aboriginal peoples are immune; heat kills the virus so people in Australia's tropical north are immune; the disease had been unleashed to kill Aboriginal peoples. The NT has experienced the lowest rate of infections nationally – around half that seen in other Australian jurisdictions; no cases have occurred in Aboriginal peoples and no community transmission has occurred to date. Described as the "safest place in Australia," this may be attributed to pandemic control measures implemented before the rates of infection took hold.

Despite the relative safety of the NT bubble, enforced by human biosecurity controls including a ban on all nonessential travel to and from Aboriginal communities, leaders were worried. During previous pandemics (H1N1 in 2009), Aboriginal peoples were not identified as a priority group and experienced higher rates of illness.[2] The ongoing impacts of colonisation have been well documented as a driver of Indigenous poor health. For Aboriginal peoples in the NT rates of rheumatic heart, cardiovascular, lung and end-stage kidney disease and psychological distress are disproportionately high.[3] Families were scared that COVID-19 could make their children with rheumatic heart disease or partners with chronic kidney disease more unwell. Fears were well-founded: most people with severe or fatal COVID-19 have had underlying chronic conditions.[4]

About 7 weeks after the first reported Australian SARS-CoV-2 case, the Federal Government launched a COVID-19 information campaign for the general population: stay at home, wash your hands, use appropriate cough etiquette and practice social distancing.[5] There are 150 Aboriginal languages spoken in Australia[6] and initially just four radio advertisements were translated into languages indigenous to Australia: Warlpiri, Pitjantjatjara, Meriam Mer and Torres Strait Creole.[5] Recognising the need to develop information in Aboriginal languages for the 60% of Aboriginal people in the NT who speak one of the 100 languages,[6] NT land councils, Aboriginal controlled health organisations, arts and language centres produced (often entertaining) videos with the same government-sanctioned message to be shared on social media platforms, particularly Facebook which has been used by Aboriginal peoples to build and express self-determination narratives.[7] However, targeted materials for people with pre-existing chronic conditions, most vulnerable to the threat of COVID-19, were missing.

In response to community concerns, a Darwin-based nephrologist, a health communication researcher and a media producer partnered with Aboriginal leaders to fill the information gap. NT medical practitioners also recognised that in times of crisis, medication adherence becomes a low priority. A message tailored for patients with comorbidities focussed on wellness was crafted: (a) Stay strong – take your medicine, attend dialysis, get your rheumatic fever prevention needles, if you have breathing problems use your medicine; (b) stop smoking; (c) wash your hands with soap; (d) talk to a clinic health worker if you are worried; (e) stay calm, stay on country and care for family. "Stop smoking" was included due to high rates of smoking amongst Aboriginal people[8] and given concern about a higher severity of COVID-19 disease in smokers compared to nonsmokers. The message encouraged people to take control of their health and to cross-check with a reliable source the accuracy of information.[9] To ensure videos remained relevant during the pandemic, information about transmission rates or changes in government protocols was not included.

Elders, cultural educators, former politicians and health professionals from Darwin, Barunga, Lajamanu, Wurrumiyanga and Galiwinku created five short videos in English, Kriol, Warlpiri, Tiwi and Djambarrpuyngu catering to the largest language groups across the Top End of the NT (http://www.menzies.edu.au/resources/?keywords=coronavirus). Two of the leaders were undergoing treatment for serious illnesses: end-stage kidney disease and cancer. In addition, to the medical messages which were workshopped with leaders (not delivered as a script), community concerns were addressed. About 400 km southeast of Darwin in Barunga, leaders were worried those

with comorbidities were avoiding the clinic fearing that nonIndigenous workers could transport the virus with them. This fear was addressed by explaining the quarantine protocols for persons travelling to communities. On the Tiwi Islands, 100 kms from Darwin, Elders asked family not to share cigarettes, concerned that could transmit the virus. Smartphones were used to film messages in selfie mode, by grandkids, via video conference and by a dialysis nurse in Lajamanu, 900 kms southwest of Darwin. Messages were back translated to the nonIndigenous English-speaking video producers by other language speakers. To rapidly disseminate the messages, videos were freely shared with government departments, clinicians, Aboriginal community-controlled health organisations, chronic illness peak bodies, local radio and TV networks, and Facebook (including remote community noticeboards), Twitter and health professionals WhatsApp groups (with a message encouraging clinicians to show patients videos). One month after posting, the videos reached 20 thousand views.

While COVID-19 messages created for the general population and translated into local Aboriginal languages were vital, many were created using actors overdubbed by anonymous interpreters. Successful dissemination of health information requires more than a translation. Mainstream public health campaigns have been known to inspire resistance amongst Aboriginal and Torres Strait Islander peoples,[10] whereas messages delivered by trusted members of the community who can act as a cultural broker between the medical advice and their community have been shown to be more effective.[8,10,11]

Pre-existing personal and professional relationships between doctors, communication professionals and NT community leaders meant health promotion messages for chronically ill people from Aboriginal communities could be produced and disseminated rapidly (within 2 weeks) despite COVID-19 movement restrictions. Aboriginal leaders best placed to reassure their communities, delivered supportive health advice and addressed community anxiety in culturally appropriate ways.

AN ETHICS APPROVAL STATEMENT

No requirement for ethics.

ACKNOWLEDGMENTS

We thank Yikaniwuy Dhamarrandji, Maralampuwi (Francis Xavier) Kurrupuwu, Anne Marie Lee, Aunty Bilawara Lee and Elma McDonald for partnering with us to produce these health promotion videos.

CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

FUNDING INFORMATION

Self-funded (PL).

Vicki Kerrigan
Anne Marie Lee
Anna P. Ralph
Paul D. Lawton

Menzies School of Health Research, Charles Darwin University, Casuarina, NT, Australia

Correspondence
Vicki Kerrigan, Menzies School of Health Research, P.O. Box 41096, Casuarina, Northern Territory 0811, Australia.
Email: vicki.kerrigan@menzies.edu.au

ORCID

Vicki Kerrigan https://orcid.org/0000-0001-6863-1528
Anna P. Ralph https://orcid.org/0000-0002-2253-5749
Paul D. Lawton https://orcid.org/0000-0002-5754-4821

REFERENCES

1. World Health Organisation. WHO Director General's opening remarks at the media briefing on COVID-19-11 March 2020. Geneva, Switzerland: World Health Organisation; 2020.
2. Crooks K, Casey D, Ward JS. First nations people leading the way in COVID-19 pandemic planning, response and management [Preprint, 29 April 2020]. Med J Aust. 2020.
3. Australian Institute of Health and Welfare, editor. Aboriginal and Torres Strait Islander health performance framework 2017 report: Northern Territory. Canberra, Australia: Australian Institute of Health and Welfare; 2017.
4. Richardson S, Hirsch JS, Narasimhan M, Crawford JM, McGinn T, Davidson KW, et al. Presenting characteristics, comorbidities, and outcomes among 5700 patients hospitalized With COVID-19 in the New York City area. JAMA. 2020. https://doi.org/10.1001/jama.2020.6775
5. Department of Health, Commonwealth of Australia. Launch of the coronavirus (COVID-19) campaign. 2020. Available from: https://www.health.gov.au/news/launch-of-the-coronavirus-covid-19-campaign.
6. Australian Bureau of Statistics. Main language spoken at home and English proficiency. 2018. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2076.0Main%20Features1012016?opendocument&tabname=Summary&prodno=2076.0&issue=2016&num=&view.
7. Carlson B. The 'new frontier': emergent Indigenous identities and social media. In: Harris M, Nakata M, Carlson B, editors. The politics of identity: Emerging indigeneity. Sydney: University of Technology Sydney E-Press; 2013: p. 147–68.
8. Kerrigan V, Herdman RM, Thomas DP, Hefler M. 'I still remember your post about buying smokes': A case study of a remote Aboriginal community-controlled health service using Facebook for tobacco control. Aust J Prim Health. 2019;25(5):443.
9. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Health Promot Int. 2020. https://doi.org/10.1093/heapro/daaa042
10. Bond C, Brough M, Spurling G, Hayman N. 'It had to be my choice' Indigenous smoking cessation and negotiations of risk, resistance and resilience. Health Risk Soc. 2012;14(6):565–81.
11. Haynes E, Marawili M, Marika BM, Mitchell AG, Phillips J, Bessarab D, et al. Community-based participatory action research on rheumatic heart disease in an Australian Aboriginal homeland: Evaluation of the 'On track watch' project. Eval Program Plann. 2019;74:38–53.

SUPPORTING INFORMATION

Additional Supporting Information may be found online in the Supporting Information section.

APPENDIX E

COVID-19 health promotion videos, 2020/2021

Appendix E contains the QR codes to watch the research related COVID-19 videos connected to Appendix D and a publication underway.

Research related output: 2021 COVID-19 vaccine information videos and 2020 COVID-19 "Stay Strong on country" videos. Webpage: www.menzies.edu.au/page/research/covid-19

Table 11: COVID-19 vaccine videos QR codes

Language	Video	QR code
Burarra	COVID-19 vaccine information with the Chair of the Mala'la Health Service Charlie Gunabarra	
Central Arrernte	COVID-19 vaccine information	
Eastern and Western Arrernte	COVID-19 vaccine info in Eastern and Western Arrernte	
English	"We're dealing with life and death here": talking about the COVID-19 vaccine in the NT."	
English	COVID-19 vaccines: What you need to know	
English	A message about the COVID-19 vaccine for renal patients	

English	COVID-19 vaccine Q & A with Charlie King and Dr Jane Davies	
English	COVID-19 vaccine info from Aunty Bilawara Lee	
English	NT legend Charlie King got the COVID-19 vaccine jab	
Kriol	COVID-19 vaccine Q and A with A/Prof Jaqui Hughes, Karen Rogers and Junior Daniels	
Kunwinjku	COVID-19 vaccine information in Kunwinjku	
Kunwinjku	COVID-19 vaccine Q and A in Kunwinjku: is the vaccine safe?	
Kunwinjku	COVID-19 vaccine Q and A in Kunwinjku: what will happen when I get the vaccine?	
Murrinh-Patha	COVID-19 updated vaccine information now COVID-19 is in the NT	
Murrinh-Patha	COVID-19 vaccine information in Murrinh-Patha	

Ngangi'kurunggurr	COVID-19 vaccine info in Ngangi'kurunggurr	
Tiwi	COVID-19 vaccine message in Tiwi	
Warlpiri	COVID-19 vaccine information in Warlpiri *updated December 2021*	
Warlpiri	COVID-19 vaccine information in Warlpiri *May 2021*	