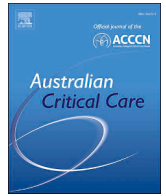




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Research paper

“There has to be an element of trust first”: An exploratory descriptive study of caring for Indigenous Peoples, family, and the wider community in Australian intensive care units



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ABSTRACT

Background: Indigenous Peoples are distinct cultural and social groups in Australia, representing almost 4% of the Australian population. Health inequities and poorer social determinants of health contribute to a greater burden of disease and injury. In critical care contexts, patterns of admission and resultant outcomes are known. What is less well known is how intensive care unit (ICU) clinicians approach the care of Indigenous Peoples.

Aim: The aim of this study was to explore the experiences of ICU clinicians in caring for Indigenous patients, their family, and the wider Indigenous community in the ICU.

Method: An exploratory qualitative descriptive study using in-depth interviews was undertaken. Convenience sampling was used to recruit health professional participants from two ICUs in one metropolitan health service in Adelaide, Australia. Individual interviews were conducted in-person, using an interview guide to prompt exploration.

Findings: Twenty clinicians working in the ICU participated in this study, and three primary themes were identified: (i) contextual factors, such as acknowledging cultural difference and the implications for care; (ii) priorities for ICU care, which encompasses access to health care, establishing and maintaining trust and optimising communication and the support of Indigenous staff; and (iii) building understanding, which refers to the importance of health literacy for Indigenous patients and clinicians' desire for specific education and training to enhance care of Indigenous patients.

Conclusion: These findings exemplify clinicians' desire to meet the needs of Indigenous patients in the ICU, their family members, and the wider community. However, striving for care that is culturally sensitive must be underpinned by an organisational commitment embedded in policy and action. Greater funding and alternate models of care that overtly embed Indigenous staff into ICU care teams

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are essential, not just to support our Indigenous Peoples, families, the wider Indigenous community, and the clinicians who care for them.

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1. Introduction

Australia's Indigenous Peoples are two distinct cultural and social groups, made up of Aboriginal and Torres Strait Islander Peoples,¹ who share collective ancestral ties to lands where they live, occupy, or from which they have been displaced.² Indigenous identities, cultures, and physical and spiritual wellbeing are unique and separate from those of the mainstream society or culture.² In Australia, Indigenous Peoples comprise many different and distinct Aboriginal and Torres Strait Islander groups, representing 3.8% of the population.³

Globally, health inequities for Indigenous Peoples are well documented and underpinned by ongoing and multigenerational impacts, including the legacy of colonisation, intergenerational trauma,⁴ ongoing inequality and institutional racism,⁵ and poorer social determinants of health.⁶ Life expectancy continues to be lower for Indigenous Peoples than for the non-Indigenous population in Australia,⁵ and Indigenous Peoples continue to experience an overall burden of disease and injury at 2.3 times the rate of the non-Indigenous population in Australia.⁷

In critical care contexts, patterns of admission differ for Indigenous Peoples in Australia compared to the non-Indigenous population. For example, a retrospective analysis of adult intensive care unit (ICU) trauma-related admissions demonstrated consistently higher admissions for Indigenous Peoples than for the non-Indigenous population.⁸ A study of sepsis identified that Indigenous Peoples present to hospital at a younger age (median [interquartile range]: 53 [43–60] vs. 62 [52–73] years), were more likely to have chronic comorbidities (58% vs. 23%), and died younger in the ICU (median [interquartile range]: 54 [50–60] vs. 70 [61–76] years).⁹ While this evidence is important to building understanding of Indigenous critical care outcomes, they do not provide a full picture.

What and how care is provided for Indigenous Peoples in the ICU is a broader issue. Indigenous Peoples may experience systemic disadvantage, increasing the risk of ICU admission.¹⁰ Equally, the experiences of Indigenous Peoples admitted to the ICU is poorly characterised because system inadequacies do not adequately capture cultural characteristics.^{4,11,12} Australian Indigenous Peoples also face pragmatic challenges associated with existing health inequities and uncertainty around the provision of support during and after ICU admission.¹³

There is a clear expectation that all Indigenous Peoples in Australia receive culturally safe care.¹⁴ To meet this expectation, Australian health services must improve cultural awareness and cultural competency among clinicians,^{15,16} warranting an exploration of ICU clinicians' experiences in caring for Indigenous patients, their family members, and the wider community.

1.1. Aim

The aim of this study was to explore the experiences of ICU clinicians in caring for Indigenous patients, their family, and the wider Indigenous community in the ICU.

2. Method

An exploratory qualitative descriptive design, grounded in naturalistic inquiry,¹⁷ was used because this approach allowed in-context exploration of participants' experiences, without theoretical interpretation.¹⁷ The study is reported in line with the Consolidated Criteria for Reporting Qualitative guideline.

2.1. Setting

This study was conducted in two adult ICUs within a metropolitan health service in Adelaide, South Australia. The first is a 48-bed medical-surgical ICU at a quaternary referral hospital, the largest referral centre for central Australia. The second is a 14-bed medical-surgical ICU in a tertiary hospital. Together, these hospitals manage 6000 admissions per year, of which internal estimates indicate that 8% (n = 480) are Indigenous.

2.2. Participants and recruitment

Convenience sampling was used to recruit ICU medical, nursing, and allied health clinicians involved in patient care and primarily employed in the study ICUs. An email about the purpose, inclusion criteria, and the voluntary and confidential nature of participation was sent to all clinicians. Flyers were also placed in staff-only areas. Those interested in participating were asked to register their interest with via email with the principal investigator (KS). Due to the nature of self-selection, reasons for nonparticipation could not be determined.

2.3. Researcher positionality statement

This research was conducted by a multidisciplinary team of Indigenous and non-Indigenous researchers and experts, with experience with health care and ICU care. We acknowledge how our diverse positionalities, worldviews, and personal experiences shape how we approached and interpreted this research with cultural humility and deeply committed to transparency and learning continuously. We value the critical insights, lived experience, community connection, and cultural authority of our Indigenous team members and colleagues.

2.4. Ethical considerations

Ethical approval was granted by the health service Human Research Ethics Committee (Reference 18930). While this research did not involve recruitment or collection of data from Indigenous Peoples, additional specific guidance was sought from the Human Research Ethics Committee to ensure the research was conducted with recognition and respect for Indigenous ways, values, and worldviews.

While some participants may have had pre-existing relationships with the research team, voluntary participation minimised any risk of coercion. In accordance with the National Statement on the Ethical Conduct in Human Research,¹⁸ clinicians were given an

opportunity to ask questions and reminded of their right to withdraw at any time, before providing informed consent. Support strategies were in place to manage participant distress. To ensure trustworthiness, participants were offered the opportunity to review their interview transcript; one opted to do so, but no changes were made. All participants received a summary of aggregate findings.

2.5. Data collection

Semistructured in-depth individual interviews were conducted between June, 2024 and March, 2025 by the lead researcher, an experienced critical care researcher (KS). An interview guide, developed from the extant evidence and refined through team consultation, was used (See [Supplementary File 1](#)). This approach was considered most appropriate, allowing flexibility in the flow and direction of interview conversations.¹⁹ Interviews were conducted in-person at a mutually agreed time and in a private location, audio recorded, and autotranscribed using otter.ai.²⁰ Recruitment continued until information sufficiency was reached. Transcripts were checked for accuracy, edited as necessary, and names were removed prior to analysis.

2.6. Data analysis

Data were analysed using inductive content analysis.²¹ One researcher (MJB) repeatedly read the transcripts to gain an overall understanding, creating an inductively derived coding scheme, drawn directly from the raw data. Preliminary themes and supporting data were reviewed by the lead researcher (KS), and extensive consultation was undertaken with team members who identified as Indigenous and/or who had specific expertise in supporting Indigenous Peoples, enhancing credibility.²² The wider research team then reviewed and refined the provisional findings and exemplar quotes until consensus was reached.

3. Findings

From the two study ICUs, 20 clinicians took part, including doctors (D, n = 8), nurses (N, n = 7), physiotherapists (PHY, n = 2), social workers (SW, n = 2), and a pharmacist (PHA, n = 1). To protect participant anonymity, further participant characteristics were not collected. Three primary themes were identified: (i) contextual factors, which includes acknowledging difference and Indigenous culture; (ii) priorities for ICU care which includes establishing and maintaining trust, healthcare access challenges, acknowledging the wider Indigenous community, optimising communication, and support of Indigenous staff; and (iii) building understanding, which includes patient health literacy and clinician training and education ([Fig. 1](#)). Participant quotes are labelled according to participant number and profession.

3.1. Contextual factors

Several contextual factors were identified by participants, including that their approach to care started with acknowledging difference, and implications for care associated with the Indigenous culture.

3.1.1. Acknowledging difference

There was acknowledgement that Indigenous Peoples are a unique entity (P18D), and “a one-size-fits-all approach doesn't work” (P11N). Thus, what was important was “not dealing with everyone the same” (P4SW) because Indigenous Peoples may have “a different cultural framework from which we work in” requiring “some introspection of what bringing their own cultural baggage to any sort of clinical interaction ... means” (P18D). Acknowledging assumptions and their origin was important.

... assumptions come from a variety of different things. What's written in the notes, the way the patient looks, things other staff might have said, but as best we can, I think we need to try and, you know, remove that and make our own interpretation ... [challenging] cognitive bias (P7PHY).

Recognising that the ICU was an intimidating and foreign environment (P20N), the priority was to address this with sensitivity (P3SW). Attempting to understand Indigenous cultures, the role of the family and wider community was fundamental.

3.1.2. Indigenous culture and implications

In describing Indigenous cultures, participants posited that Indigenous Peoples have alternate belief systems (P5D), views on health and illness (P2D), and death (P17D). Indigenous Peoples may “expect us to understand the culture, but they don't necessarily inform us about what it entails” (P14D). Differences between Indigenous Peoples' timeframes and expectations and “hospital time” (P15N), the reality that “English may be their second language, third, fourth, fifth language” (P18D), and the implications of travel away from their home and community were also described:

... some of the Indigenous patients that we get here, some of them from the city, some of them are actually from maybe Alice Springs, Northern Territory, like Darwin area, other rural areas, and this then trying to understand them in their cultural ways because they're very much used to being on the land. We're bringing them from country into a very uncomfortable environment for them (P9N).

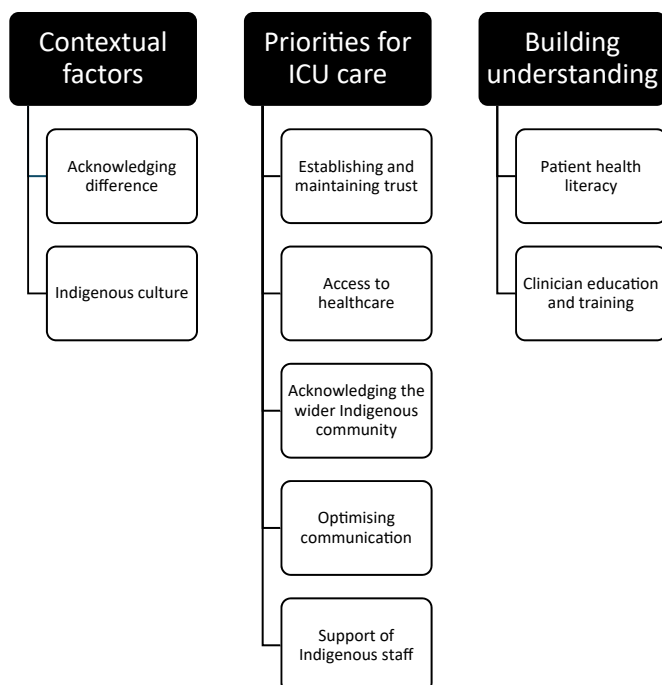


Fig. 1. Study themes. ICU, intensive care unit.

Family structure and dynamics were also understood to be different. Participants described how Indigenous patients may have large families, with complex structures, composition, and dynamics, where broader family and cultural connections are more important than the nuclear family (P18D). This was exemplified by a participant describing having 35 family members travel from a remote area with the Indigenous patient (P10D). Thus, understanding the family structure and dynamics and what this meant for communication and decision-making was important. Decision-making was described as family oriented in that *“the family takes the call ... meetings were always large because they would want to bring a lot of different family members”* (P3SW). Who to direct communication to and who makes decisions are important to identify:

... the younger ones, who gravitate towards the elder ones for guidance and decision-making. And I think when you explain it to the Elder, and the eldest one is on board, everybody else just falls in line. Even though there was a father, there was also a maternal aunt the father looked up to, perhaps to acknowledge her understanding (P17D).

Importantly, most participants raised the issue of trust, referring to a trust deficit (P7PHY), population trust (P13PHA), a trust equation (P18D), and mistrust and marginalisation (P11N). A pattern of prior negative experiences (P19N), the foreignness of the environment (P5D), and the *“caucasian-ness”* of clinicians (P11N) were all posited as impacting trust:

... slight guilt associated with my race in, in, really undermining this, this culture, way of life. And I'm trying to do the best I can for these people, moving forward in my career, and terms of health, literacy and, you know, the trust factor, which can sometimes play a part because of that. You know, a checkered history that colonialism and Indigenous communities have had over the years (P16D).

Others reflected on being a white person, representing everything that had happened to Indigenous Peoples (P4SW), such as

I was working on Christmas Day last year ... I walked in and said, 'Merry Christmas, it's Christmas Day'. And his response was, 'I don't f***g care about Christmas. It's for white men. It's a white man's business. Piss off ... ' That was, you know, a really explicit example of the disconnect for me ... and it was a point of contention for him. That took me back a bit and made me realise the need for self-control and reflection (P16D).

Even if they sought to understand Indigenous cultures, their actions may not be efficacious because Indigenous Peoples' *“... relationship with the healthcare system is very, is often very challenged”* (P7PHY), and the historic background of the hospital system and the cultural norms underpinning it were not designed for Indigenous Peoples (P20N).

3.2. Priorities for ICU care

In contemplating the priorities for ICU care for Indigenous patients, establishing and maintaining trust, overcoming challenges associated with access to healthcare, acknowledging the wider Indigenous community, optimising communication, and addressing health literacy were identified.

3.2.1. Establishing and maintaining trust

Given the descriptions of trust deficits described earlier, building trust with the Indigenous patients, spokespersons, family members, and the wider community is critical to ICU care. Participants stated that trust cannot be assumed, rather, it develops over time (P17D), required gentleness, patience (P20N), and being *“quite raw and vulnerable and appreciating where they're coming from”* (P8N). Rapport was key to trust, such as

letting them know that, you know, we are here to help them. Yeah, asking permission for anything, I always, you know, make sure. And our team is good. You know, anything that we're doing, we want to explain what we're doing (P19N).

Trust was considered especially important in the ICU because *“if we're seeking permission to do what are fundamentally pretty awful things to people ... there has to be an element of trust there first”* (P18D). Building and maintaining trust in relation to ICU admission, and the community's broader view of health care also meant flexibility was needed:

maintaining trust in the healthcare system sometimes will mean that I will admit somebody to the intensive care for whom I know that treatment is futile ... But to my mind, the cost of putting somebody into intensive care and the use of those resources for a potentially futile treatment cause is outweighed by the broader good to the family in the community of maintaining trust. Because if you've lost the trust, you're not only going to lose the patient who is dying in front of you but also the rest of the community who will stop coming (P18D).

3.2.2. Access to health care

Access to health care was raised by several participants as a problem, with implications for ICU care. The *“tyranny of distance”* (P20N) undermines patient compliance with self-care requirements, particularly when some may have not received any healthcare prior to an ICU admission:

You know, they might not have any previously diagnosed health history, and they come in and suddenly; they find out they have several things wrong with them. So working through their health issues from the start, ensuring that we provide the proper education, and having the right teams come through to give them that (P19N).

3.2.3. Acknowledging the wider Indigenous community

An ICU admission necessitates that the needs of family members and the wider Indigenous community must be acknowledged for Indigenous Peoples, who:

have been transferred down from a remote community into ICU ... the isolation and then, the understanding, comprehension of the patient about what's happened to them, but also the foreign environment ... the family member who was sent down to be that primary, you know, next of kin, support person having little concept of the medical terminology environment, who to trust, language barrier, literacy issues (P20N).

Seeking to understand patient's kinship within the wider community was a priority. In the absence of a nominated spokesperson, an Elder may be asked for assistance to identify a

spokesperson, trusted by the community (P2D). A nominated spokesperson may not be the next of kin typically associated with a nuclear family structure or defined within a legal framework (P18D). Rather, in end-of-life situations, *“it often seems to be the patient’s mother’s brother who becomes the family spokesperson”* (P18D). The spokesperson may also be someone nominated by the Indigenous community (P15N) or the person who was available when the plane was leaving the remote area (P20N). Once the spokesperson is known, the priority for ICU care was to:

navigate what’s important to them, what’s going to work for them, and then that would help the rest of the healthcare sort of team to navigate those challenges (P7PHY).

3.2.4. Optimising communication

Optimising communication started with overcoming language barriers. Acknowledging that Indigenous languages are separate languages, not dialects (P11N), and that some Indigenous Peoples speak multiple languages, of which English may or may not be one (P14D), one of the challenges raised was that there were no staff members in the unit who spoke the Indigenous languages (P10D). Participants reported relying on simple phrasing (P17D), iPads (P9N), Google, and photos to communicate (P19N). Another reported attempting to engage by using the Indigenous language to say hello, which even if incorrect, the attempt was thought to be appreciated (P15N). Communication was further complicated because for many English words, there was not an equivalent word in Indigenous languages (P19N); hence, expressions could be quite different such as

a gentleman who was very sick from around Alice Springs, who presented himself with the complaint of being hit in the stomach by a rock. We took [it] literally, but then after a while, and I think an Aboriginal Liaison Officer mentioned that that was just an expression of severe abdominal pain (P16D).

Multiple participants stated Aboriginal health workers and Aboriginal Liaison Officers were important to bridging cultural gaps and facilitating communication including understanding Indigenous expressions of pain and delirium (P16D), the pace of verbal communication (P5D), and the terminology to use and to avoid, such as

I distinctly remember being told ... that if you’re having an end-of-life discussion ... if you’re not being clear and using non-euphemistic terms, you’re not doing your job. The rule of thumb was to mention dead, death, dying as many times as you can in the first five minutes, so that everybody is very clear about what’s being said. But as it transpires for certainly the Aboriginal Peoples of Central Australia, those terms are highly offensive, and using euphemistic terms such as finishing up, passing on, passed away, someone is no more, are well understood and better used (P18D).

3.2.5. Support of Indigenous staff

The majority of participants stated that Indigenous staff members such as Aboriginal Health Workers were fundamental to ICU care, emphasising the cultural distinctions between Indigenous Peoples depending on their origin (P20N). Indigenous staff

members were also appreciated for creating a support system (P5D), advocating for the patient (P14D), and demonstrating that someone with similar-shaded skin was on their team (P17D). Even if the Indigenous patient and Indigenous staff members were not from the same areas, a shared connection and a trusting hand (P20N) was considered valuable.

... they have somebody who understands them, and they don’t have to worry about the fact that we were doing something that’s ‘white man’s medicine’ and not understanding their culture (P14D).

Indigenous staff members were perceived as critical to patient care, anticipating gender preferences, such as a female nurse for a female Indigenous patient, patient dietary preferences, and arranging accommodation, travel vouchers, and other necessities for the spokesperson or the wider family in attendance (P15N). However, there were difficulties in accessing Indigenous staff members, who were either not available at all or only available during business hours (P9N). A greater physical presence of Indigenous staff was desired by the majority of participants. One participant suggested that hospitals may “pay lip service” (P14D) to advocating for Indigenous Peoples but fail to follow through. Another suggested that *“next to the salary of a doctor, the salary of [Indigenous staff] is peanuts”* (P18D), and given the benefits to ICU care, increasing the physical presence of Indigenous staff in the ICU is a logical and beneficial strategy for all.

3.3. Building understanding

Building understanding has a twofold meaning, referring not only to the importance of health literacy for Indigenous patients, their family, and the community but also to ICU clinicians’ desire for education and training to enhance their ability and confidence in caring for Indigenous patients. For Indigenous patients, it was important to acknowledge not only that some Indigenous patients have a clear understanding of their illness and care needs (P13PHA) but also that those from remote communities *“may have poorer health literacy ... through no fault of their own”* (P16D). In understanding Indigenous patients’ health literacy, participants suggested the key was not making assumptions and taking the time to ask questions (P7PHY) and *“recognising that there are alternative ways of looking at health and wellbeing”* (P18D).

For clinicians, access to education and training to enhance care of Indigenous patients varied. Many spoke of online and mandatory learning packages provided by their employer, focusing on cultural awareness, cultural humility, and cultural sensitivity, suggesting the training provides a solid foundation but *“likely requires some refinement to gain a deeper understanding”* (P15N). Others described alternate sources of learning, such as the *“BAME” Black and Ethnic Minority* training in the United Kingdom (P10D), and a DonateLife communication course which included a discussion around cultural sensitivities (P5D). Others shared they were continuously trying to learn from Elders (P2D) and Indigenous staff.

I think I learned more ... in the 6 or 9 months we had an Aboriginal health practitioner in the unit than I learned in the entire 12 years of prevocational training ... we have a lot to learn from the Aboriginal liaison officers and Aboriginal health

practitioners about the nuances ... that we are not exposed to in our prevocational training period (P17D).

4. Discussion

This research explored the experiences of clinicians in caring for Indigenous patients, their family members, and the wider community in the ICU, a perspective previously overlooked in critical care research. With extensive existing evidence of health inequity,⁴ institutional racism,⁵ challenges in accessing health care,²³ poorer health outcomes,^{9,24} and greater overall burden of disease burden for Indigenous Peoples,⁷ these findings provide important additional perspectives, with clinicians emphasising the importance of building and maintaining trust and recognition of Indigenous cultures, traditions, family structure, and relationships as critical to ICU care. To rely on assumptions about needs and preferences for care and/or to assume that the provision of the highest-quality clinical care is enough to meet the needs of Indigenous patients and their families is flawed. ICU care must not be limited to clinical care. Rather, culturally safe care for Indigenous Peoples must be founded on negotiated partnership,¹ shared respect, meaning, and knowledge.²⁵ Thus, optimising communication and seeking to identify, understand, and address the needs and preferences of family members and the wider Indigenous community is just as important as clinical care in the ICU.

There is clear evidence that Indigenous Peoples want greater access to Indigenous staff²⁶; these findings demonstrate that clinicians want the same: to have Indigenous staff not just involved but also integrated as partners in the wider care team, using their Indigenous culture, knowledge, and expertise to contribute to care planning and provision. While role descriptions and scope of practice may vary for Indigenous staff according to organisation workforce structures,²⁷ what remains constant is that their role as cultural brokers, well described in other contexts,²⁴ is demonstrative of their cultural expertise and the nuanced cultural support they can provide, bridging differences between Indigenous Peoples and clinicians. As such, Indigenous staff can enhance care provision and the care experience in ways not possible without their involvement. Thus, to increase access to and embed Indigenous staff in ICUs across Australia is a critical priority.

This research represents a first step in acknowledging and understanding clinicians' perceptions of caring for Indigenous Peoples in the ICU. Future research must similarly seek to explore and build understanding about the experiences of Indigenous staff who contribute to care in the ICU so that their unique value and contribution are described. Finally, it is critical that the views of Indigenous Peoples admitted to the ICU, their family members, and wider communities are explored, without which, our understanding is incomplete.

4.1. Strengths and limitations

The multisite design and inclusion of participants from multiple disciplines are strengths of this study, enabling comprehensive descriptions pertinent to sensitively supporting Indigenous patients and their family members in the ICU. Given the diversity of Indigenous Peoples and communities, the findings from this study conducted in Adelaide, South Australia, may not be entirely generalisable or transferable to other Indigenous Peoples or

communities or ICU contexts across Australia, for whom beliefs and value systems may vary.

5. Conclusion

This research highlights the complex interplay of cultural, structural, and interpersonal factors shaping ICU care for Indigenous patients. Clinicians' desire to meet the needs of Indigenous patients in the ICU, their family members, and the wider community is critical to overcoming systemic disadvantage and system inadequacies. However, striving for care that is culturally sensitive and aligns with diverse beliefs and priorities requires a commitment from all clinicians, leaders, and managers, underpinned by policy and action. Greater resourcing and models of care that integrate Indigenous staff with the ICU workforce are essential to support not just our Indigenous Peoples but also the clinicians who provide care.

CRedit authorship contribution statement

Krishnaswamy Sundararajan: Conceptualisation, Literature review, Methodology, Ethical Approval, Data Collection, Data analysis, Manuscript writing and review, and Project leadership.

Ashwin Subramaniam: Literature review, Ethical Approval, Data Collection, Manuscript writing and review.

Caroline Phelan: Literature review, Methodology, Data Analysis, Manuscript review.

Scott Hanson-Easey: Literature review, Data Analysis, Manuscript review and editing.

Campbell Thompson: Conceptualisation, Manuscript writing and review.

Sarah Doherty: Ethical Approval, Methodology, Manuscript review.

Trae Milera: Interpretation of analysis, Manuscript review.

Nick Cowling: Interpretation of analysis, Manuscript review.

Mark Plummer: Manuscript review, editing, ethical advice.

Mohammad Afzal Mahmood: Conceptualisation, Literature review, Data Analysis, Manuscript review and editing.

Melissa J Bloomer: Lead Data Analysis, Manuscript writing and editing.

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Data availability statement

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data are not available.

Declaration of competing interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this manuscript.

Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.aucc.2025.101465>.

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