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research article

Addressing Cultural Barriers in Australia's Acute Care System: Problems the United States Can Learn From

—Allison Reilly (Edited by Emily Robbins)

Sitting in seat 52A on my way to Melbourne, Australia, in June 2009, I had twenty-four hours to reflect on how my experience working in hospitals as a nursing student had made me aware of the cultural barriers that exist even in a New Hampshire setting. During one of my clinicals (hours in the field required by nursing school), I had cared for a Brazilian patient who spoke only Portuguese. Throughout the morning I tried to understand his requests, until his family, who spoke English, came to visit. I explained to them how important it was for me to ask the patient a few basic questions and to explain to him why he could not eat anything before his procedure. Fortunately, his family was able to translate that eating before surgery could cause complications in the operating room. Struggles such as this sparked my interest in the importance of cultural and language barriers in nursing.

My mentor at the University of New Hampshire, Dr. Gene Harkless, who has worked with Canadian Aboriginal peoples, suggested that I apply to the UNH's International Research Opportunities Program (IROP) to study Aboriginal health care in Australia, where wide disparities exist between the health of the Aboriginal and Torres Strait Islander people and the majority of the population. Aboriginal people are the original inhabitants of the Australian continent, and Torres Strait Islanders are indigenous to the Torres Strait Islands off the northeastern tip of Australia. According to the Australian Bureau of Statistics (2006), Aboriginal people comprise only 2.5% of the country's population, yet have very pressing health needs; they have a higher incidence of heart disease, trauma, and cancer, and often require the advanced hospital services of Western medicine. Because Aboriginal and Torres Strait Islanders comprise so little of Australia's population, they are often unfamiliar with hospital practices; and hospital staff often do not know how to, or want to, deal with their cultural differences. The majority of hospital staff in Australia are non-Aboriginal and, in turn, do not understand traditional Aboriginal belief systems. As a result, Australia's Aboriginal and Torres Strait Islander population does not always receive culturally sensitive care.



The author visiting with a kangaroo, one of Australia's indigenous animals.

One tangible example of how this affects Aboriginal people is that their life expectancy is seventeen years less than that of the rest of the population (Renhard et al., 2009). Even more disturbing is that this number is not restricted to remote areas but includes Aboriginal people from urban and rural settings as well. Even though Aboriginal people make up a small percentage of their country's population, an increasing number of Aboriginal rights advocates have decided to take action. This increase in support has in part led to health research focused on system change such as the Improving the Culture of Hospitals Project.

Improving the Culture of Hospitals Project

To address these disparities, the Cooperative Research Centre for Aboriginal Health (now known as the Cooperative Research Centre for Aboriginal and Torres Strait Islander Health) launched the Improving the Culture of Hospitals Project (ICHP) in 2007. Leading this project were six Aboriginal and non-Aboriginal researchers from a variety of healthcare sectors including nursing and health policy, among others. Their overall goal was to achieve equality in health status and life expectancy for marginalized Aboriginal communities by providing hospitals with a quality improvement framework along with a “tool kit” that provided information and ideas on how to improve the cultural sensitivity of their services. The tool kit consists of various text-based materials such as pages of talking points for practitioners to use with patients, lists of suggestions for quality care improvement and techniques to train hospital staff to promote patient-centered, “culturally adequate” care for Aboriginal and Torres Strait Islander patients (Renhard et al., 2009). The ICHP team’s ultimate goal is to have specific standards for Aboriginal and Torres Strait Islander health built into the accreditation system for Australian hospitals.

When I arrived in Australia, the ICHP team had finished the research portion of their project, so I interviewed the team members about their development of the tool kit. I asked questions such as, “What has been your experience participating in this study?” and “What have been the most challenging aspects of this project?” I followed up with more specific inquiries based on each team member’s specialty. For example, I asked the team’s nurse questions about patient outcomes and I asked the researchers about the project logistics. Their answers revealed to me the many challenges faced by hospitals, the traits defining so called “best practice” hospitals,” and how these traits helped inform development of the tool kit.

Problems that Australian (and many American) Hospitals Face

The team identified three main challenges to providing culturally sensitive care: language barriers, the urban setting of major hospitals, and miscommunication. For many Aboriginal people living in remote Australia, English is their third or fourth language. I had been fortunate to have the help of my Brazilian patient’s family during my clinical, but many Australian hospitals do not have translators for all of the different Aboriginal languages.



One of the urban hospitals in which the author and the Improving the Culture of Hospitals team conducted research: Royal Brisbane and Women's Hospital in Brisbane.

The urban setting of major hospitals is a challenge because a significant number of Aboriginal people live in remote areas where they are accustomed to more open spaces and fewer medical services. For them, being in a large city is as different as being in a foreign country. Because Aboriginal peoples have a higher incidence of major medical problems, there often is no choice but to fly them into cities for surgery. Monica Lawrence, a nurse on the project team, told me about a man who walked ten miles from the airport to the hospital because he did not know that he was going to be picked up. Sadly, he had a heart attack and died along the way (personal communication, June 17, 2009). While this tragedy partly resulted from the patient’s need to travel to an unfamiliar urban setting, it also illustrates the third major issue identified by the ICHP team: miscommunication.

Miscommunication is a problem for both Aboriginal peoples and the doctors who are trying to assist them. While Western practitioners are sometimes ignorant of Aboriginal traditions and beliefs, Aboriginal peoples also are unfamiliar and often misinformed about the practices of Western medicine. Lawrence shared with me several stories that show how harmful miscommunication can be to Aboriginal patients. One man, who was prescribed Coumadin (a blood thinner that can be very dangerous if given to the wrong patient or if blood levels are not monitored), was not warned of the drug’s risks and, thinking that the heart tablets were “good,” gave one to every member of his family.

Lawrence also cited the examples of hospital staff finding a family of four sitting outside the hospital because they did not know they needed to go inside to receive treatment, and of an Aboriginal woman who misunderstood a common Western medical practice, the angiogram. (An angiogram is a procedure that uses X-ray imaging to project the inside of the heart’s

blood vessels on a computer monitor.) When the woman saw her coronary arteries on the screen, she thought it was being televised nationally (personal communication, June 17, 2009).

Differences in perspectives often lead to disagreements between patients, patients' families and medical practitioners. Lawrence told me about the father of a pediatric cardiac patient who questioned the medical care his son was receiving from the hospital. When the nurses asked the father how he thought his son got a "sick heart," he replied, "When he was a little boy, he climbed up the side of the house and he fell down and hitched his left foot on a tree." The father used his finger to draw a line from his left foot to his heart, indicating his belief that the childhood injury must have caused his son's heart complication (personal communication, June 17, 2009). The doctor, however, did not take the father's explanation seriously and insisted on conventional medicine to right the condition. This experience both offended the patient's father and made him feel mistreated. In Lawrence's words, this is a "typical scenario."

Such examples highlight the fact that many Aboriginal people are as unfamiliar with hospital systems as doctors are with their belief system. To address these issues in the tool kit, the ICHP team cited such examples to reinforce the idea that hospital staff must engage with *all* patients to ensure their needs are looked after appropriately.

Developing the Tool Kit

In order to best develop this tool kit, the ICHP team asked Aboriginal and Torres Strait Islander peoples to be involved with the tool kit's design and delivery. This inclusive approach meets the wishes of Aboriginal rights advocates such as Dr. William Jones, whose beliefs are expressed in the following:

For indigenous peoples to participate in Australian society as equals requires that we be able to live our lives free from assumptions by others about what is best for us . . . It requires respecting our difference and celebrating it within the diversity of the nation (Renhard et al., 2009).

To be as inclusive as possible, the ICHP team surveyed Aboriginal peoples, asking them to identify which hospitals they feel provide their communities with the "best," or highest quality services. The participants were then asked to identify common traits that contributed to the success at these "best practice" hospitals.

Hospitals identified as best practice hospitals had the following similarities: 1. they had strong partnerships with Aboriginal communities; 2. hospital management advocated for and had policies on improving the health of Aboriginal patients; and 3. the hospitals had staff supports throughout the hospital, such as an Aboriginal Liaison Officer who acts as a social worker specifically for Aboriginal patients. Some of these hospitals have even gone so far as to have Aboriginal Health Committees, units, or health teams (Renhard et al., 2009). These traits informed the development of materials included in the ICHP tool kit.

Successes of the Tool Kit

By providing "non-best practice" hospitals with the resources to facilitate communication between hospital staff and Aboriginal communities, the ICHP tool kit has been able to "break the ice" between the two groups. This toolkit has also helped to increase hospital management's awareness of the issue. Because the ICHP team is familiar with Aboriginal customs, they effectively conveyed through the tool kit the dangers of ignoring the effects of cultural differences within hospitals. And because the tool kit encourages the hiring of Aboriginal staff members, specifically Aboriginal Liaison Officers, it has garnered the attention of many CEOs and Quality Improvement Committees. Even though some non-best practice hospitals already had Aboriginal Liaison Officers, this position was not receiving enough support from CEOs, Quality Improvement Committees, and the majority of hospital staff. Having an independent third party such as the ICHP team come into these hospitals and speak with CEOs has increased awareness of the issue.

After documenting these observations, I realized something important: the issues challenging culturally sensitive care in Australian hospitals are not unique to the continent; the lessons learned from my interviews could be applied to State-side clinics, too. How, then, might this inform my own career?

Nursing Ideals

Hearing Australian health care professionals speak about their experiences within their health care system made me think about the ideals of nursing. It reminded me that health literacy is a critical component of caring for patients. The U.S. Department of Health and Human Services (2000) defined health literacy as, “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” If the nurses caring for the Aboriginal man who gave his medicine to family members had explained how the individualized medication would affect his body, he might never have made the mistake of sharing his pills.

The nursing ideals that I have learned and believe in revolve around holistic care; this requires meeting biological, psychological, and social needs of the patient in addition to their physical care. At a basic level, nurses should teach each patient about the medications and services that he or she receives. This includes educating the patient to ensure shared decision making between the patient and his care providers so that each patient understands the choices he makes. To meet this expectation, the ICHP team’s tool kit taught me that all hospital practitioners—especially nurses, as they are often the primary point-of-contact—need to use multiple teaching methodologies, including audio, visual, and printed materials to ensure that their patients fully understand the care they receive.

My work in Australia confirmed to me that it is essential for a medical professional to overcome any language or cultural barriers to help her patient understand his health care and its consequences, even down to the logistics of care—from where he will go after being discharged to how he will get there and how he will return for follow-up visits. If this had been done properly, the Aboriginal man who walked ten miles from the airport to the hospital may not have died. Simple misunderstandings such as these can mean the difference between life and death.

Implications of My Research

My experience in Australia taught me that in order to provide the most culturally sensitive care to minority populations, I must educate myself about their traditions. To do this in Australia, I set out to learn about Aboriginal history and contemporary beliefs. First, I visited the Koorie Heritage Trust, an organization that has Aboriginal exhibits ranging from artwork and artifacts to oral histories. I also participated in Melbourne’s National Aboriginal and Islanders Day, a week-long celebration held at the beginning of July to celebrate the history, culture, and achievements of Aboriginal and Torres Strait Islander peoples (NAIDOC, 2009). As part of this celebration, I attended the flag raising ceremony of the Aboriginal and Torres Strait Islander flags in front of the Melbourne Town Hall. This was a symbol of coming together between non-Aboriginal and Aboriginal populations in Australia.



The Australian and Aboriginal flags flying side by side: a symbol of unity.

On my return flight to the United States in August, I looked down at the ring I’d bought at an Aboriginal museum and it reminded me that it does not matter where you are in the world, cultural differences are universal and the practices taught in the ICHP tool kit can be applied to all nurses. As a result of my experience, I know I will put forth all of my effort to understand my patients’ cultures, beliefs, and values, and I will use this understanding to improve the care I provide. I hope, too, that I will have opportunities to educate other nurses about the importance of approaching patient care in a culturally sensitive way.

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Author Bio

Allison Reilly's desire to advocate for patients extends far beyond her home town of Long Island, New York, and the University of New Hampshire campus. The senior Honors in Major nursing student was awarded a grant by the International Research Opportunities Program (IROP) to learn how another country's culture affects their health care system. She chose to travel to Australia, where she joined a team of health care professionals on the Improving the Culture of Hospitals project, an initiative whose goal is to improve hospital care for the country's Aboriginal population. Allison is confident that her IROP experience will make her a better all-around nurse, no matter the location. "I now believe that being a patient advocate is just as important as administering medications," she says. "I feel natural when helping people in need."

Allison will graduate with a B.S. in May 2010, and plans to pursue eventually a doctorate in nursing, following in the footsteps of her mentor. "I hope to someday be a mentor to a nursing student as Dr. Harkless has done for me," says Allison, who is a member of the Sigma Theta Tau International Honor Society of Nursing. "I know that I will always be interested in research," she says, "but I will never lose touch with working with patients themselves."

Mentor Bio

Gene Harkless, DNSC, ARNP, is an associate professor in the Department of Nursing. A family nurse practitioner who has taught at the University of New Hampshire since 1985, Dr. Harkless is a frequent mentor and enjoys working with students such as Allison as they take on international endeavors. "For past IROPers, it has been life-changing. They create a whole new lens through which to see the world," she says. "Students grow to understand their own academic abilities, to ask a question and search for answers and perspectives outside of expert text materials."

Allison couldn't agree with her more. "This experience has opened my eyes to the rest of the world," she says, citing Dr. Harkless' support through the entire research process as being essential to her positive experience. "I respect her opinion more than anyone else in the nursing field," says Allison.