

Intercultural communication in Central Australian Indigenous health care: A critical ethnography

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Publications

- Taylor, K. & Guerin, P. (2010). *Health care and Indigenous Australians: Cultural safety in practice*. Melbourne: Palgrave Macmillan.
- Edwards, T. & Taylor, K. (2008). Decolonising cultural awareness. *Australian Nursing Journal*, 15(10), 31-33.

Selected presentations

- Taylor, K. (2010). *Intercultural communications in Central Australian health care*, Poster presentation, International Conference on Communication in Health Care, European Association for Communication in Healthcare, (September 5th-8th) Verona, Italy.
- Taylor, K. (2010). *Cultural safety*, Rheumatic heart disease workshop presentation, for Rheumatic Heart Disease Foundation, (April 22nd) Alice Springs, Australia.
- Taylor, K. (2010). *Indigenous health—a cultural safety approach*. Medical Grand Rounds presentation, (April 9th) Alice Springs Hospital, Alice Springs, Australia.
- Taylor, K. (2009). *It's amazing how you can get by with body language*. Intercultural communication in Central Australia, Council of Remote Area Nurses Australia (CRANA) Conference, Alice Springs, Australia.
- Taylor, K. (2009). *Privileging English in Central Australian health care communications*. Seminar series, (February 25th) Centre for Remote Health, Alice Springs, Australia.
- Taylor, K. (2009). *Informed consent for Indigenous patients*. [Invited panel member] The Northern Territory Peri-operative Nurses (NTPN) Conference, (May 8th) Alice Springs.
- Taylor, K. (2006). *Practical strategies in enhancing health care communications*. Paper presented at the Chronic Diseases Network 10th Annual Conference, (May 9th) Darwin, NT.

Transcripts

Throughout the thesis, participants' transcripts (quotes) appear in italics using pseudonyms. The quotes are indented. The pseudonym and date identify the excerpts from the participant interviews or observation. Quotes from Indigenous First Language participants appear in shaded text, whilst the quotes from English only speaking participants are simply italicised.

For example:

Our people are dying ... because they don't understand what doctors and nurses are saying to them (Jakamarra, 2007)

Not a priority at all. Totally – no priority. Aboriginal Languages are not appreciated in the hospital ... (Sally, 2007)

Field notes

Field notes are identified by the abbreviation FN and are presented in italics and indented. My own comments in relation to the field notes immediately follow on in standard indented text. For example:

He rolled his eyes and looked uncomfortable. (FN, 2006)

This young nurse was a new graduate. He appeared disapproving of the medical officer's approach, but seemed powerless to say anything.

Abstract

Communication is crucial to safe, effective health care. There is growing realisation however, that ineffective intercultural communication may be thwarting efforts to address the unacceptable state of Indigenous health in Australia today. English is Australia's language of government and mainstream populations. In Central Australia, Indigenous languages remain 'unexpectedly' in current use, albeit tenuously so. Consequently, the rights and needs of Indigenous language speakers have been overlooked at times, within Australian health care services. This thesis contends that systemic and individual lack of attention to intercultural communications and the wider social discourses that influence this inattention, impacts on health professionals' capacity to provide culturally safe, effective care.

The aim of this study therefore, was to explore and examine the experiences of intercultural healthcare communications in Central Australia. To allow cultural issues, discrimination, racial and systemic inequalities and power differentials to surface, a critical ethnography involving Indigenous First Language speakers and English First Language speaking health professionals was undertaken. Given the recent and arguably ongoing colonising experiences of Indigenous people within Central Australia, this study considered post-colonial theoretical frameworks incorporating operationally defined cultural safety philosophies.

Two broad cultural groups were involved. Indigenous language speakers who were also health service users and non-Indigenous English-speaking health professionals shared their experiences of intercultural communications within Central Australian health care settings. Data collection strategies involved in-depth interviews, non-participant observation of client-worker interactions, video recording of selected health care encounters, and a review of other mediated communications such as signage and targeted health resources. Data analysis involved synthesising and applying three approaches to thematic analysis.

Findings showed common themes that characterised intercultural communications as relevant to both participant groups. These common themes were about fear, power,

acceptance, barriers, and facilitators. Themes related to individual issues and broader systemic levels. Health care communications were described as frustrating, difficult, ineffective, and personally and financially costly. Both groups identified systemic, institutional and individual barriers to effective communication, while key components of cultural safety, namely dialogue and de-colonisation, were mostly absent. Providers and recipients of care were unable, or sometimes unwilling to recognise health consequences of ineffective intercultural communication. There was also a tacit acceptance of these barriers as somehow relating to the unique context of Central Australia. Most health care communications were culturally unsafe, which resulted in an inferior standard of care for Indigenous clients and a sense of powerlessness for participants. From a more positive perspective, both groups acknowledged their goodwill and genuine desire for more effective dialogue, Australia's rich Indigenous cultural and linguistic heritage, and a changing relationship between non-Indigenous English First Language health professionals and Indigenous people.

Interpreting the findings from a cultural safety perspective within a post-colonial framework highlighted on-going colonising practices, attitudes, beliefs and power structures. These influences affect health care communications in potentially harmful and/or counterproductive ways. A model of intercultural communication based on critical reflection and cultural safety principles was developed to facilitate an improved experience of intercultural communications, and health care for Indigenous language speakers and English-speaking health professionals.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

K. A. Taylor

Kerry Taylor

Date: 1st October, 2010

Chapter 1

Intercultural communication in Central Australian health care: *They don't understand...*

1.1 Introduction

Our people are dying ... because they don't understand what doctors and nurses are saying to them (Jakamarra¹)

As a resident and worker in remote Central Australia² since 1988, I had long *believed* that effective communication held the key to better health for Indigenous Australians. Through experience and observations, I have come to conclude that communication between Indigenous Australians and non-Indigenous³ health professionals specifically, was an issue requiring much greater attention than it has received. Yet, even as I undertook this study of Intercultural⁴ Health Care Communications (IHCC) in Central Australia, it seemed something of an overstatement for one of the participants, Jakamarra, quoted above, to suggest that people were dying because of an inability to talk effectively to one another.

Yuwa (yes) they feel shame⁵ and they just walk away and finish up (die) (Jakamarra)

Indigenous Australians experience health outcomes however, that are generally far below those enjoyed by other Australians, and even other Indigenous peoples in countries with similar colonising histories. Furthermore, Indigenous populations within Central Australia

-
1. Jakamarra—a classificatory name for an Indigenous male from the Luritja Language group of Central Australia (see 10.2 —Kinship structures/classificatory relationships).
 2. Central Australia —variously defined geographic region of Australia (see Figure 1 in 2.1).
 3. Indigenous—term used to describe First Peoples of Australia; Non-Indigenous—sometimes referred to as European, White or Western (see 10.2).
 4. Intercultural—a term used to describe interactions that occur across linguistic and/or cultural divides. It is sometimes referred to in the literature as ‘cross-cultural’ (see 10.2).
 5. Yuwa = Luritja word for yes (see 10.3); shame = Aboriginal English term meaning profound embarrassment; finish up = Aboriginal English term meaning to die (see 10.4).

and the Northern Territory suffer even higher mortality and morbidity rates than Indigenous people in other parts of Australia (Healthinonet <http://www.healthinonet.ecu.edu.au/health-facts/overviews/mortality>, accessed 22nd September 2010). An inability to communicate effectively across cultural and linguistic divides however, may hinder efforts to address these disparities in health.

The primary argument of this thesis is that in Central Australia today, the lack of preparation and/or inability of health professionals to communicate effectively with Indigenous language speaking clients, compromises the cultural safety and effectiveness of health care. Furthermore, this occurs in the context of wider social dynamics that create and perpetuate ongoing inequities. The potential for health professionals to engage in a dialogue with Indigenous clients is limited by a seemingly taken-for-granted notion that most Indigenous Australians do, and more importantly *should*, speak English, or speak it well enough to ‘get by’. Importantly, assumptions about how Indigenous recipients of care should and should not communicate, locates perceived communication barriers and deficits with Indigenous clients. In turn, this shifting of responsibility for failed communications away from service providers and systems, may contribute to an ongoing colonisation that continues to undermine potential health care outcomes for Indigenous Australians.

Participant data does not traditionally appear in a thesis at the point of introduction. However, Jakamarra’s statement poignantly expresses the importance of this research concerning intercultural communication in Central Australian health care settings. Jakamarra’s statement also affirmed previous research findings that identified communication or ineffective communication at least, as a major barrier to positive health outcomes for Indigenous Australians (Cass et al., 2002; Coulehan et al., 2005; Lawrence, 2007; Liberman, 1985; Watson, 2006). An Indigenous Language speaker (ILS)⁶, Jakamarra, made the statement above using his third language of English. He seemed sincere, all too

6. Indigenous language speakers are operationally defined as an individual who speaks an Indigenous language as their first or other language, and includes those who may speak English, but had primary care givers who were Indigenous first language speakers (see 10.2).

close to the experience, and adamant that some of his countrymen and women had, and continue to miss out on potentially lifesaving care from Australian health services. The cause from his perspective was due largely to communication barriers between Indigenous Language speakers and English-speaking health professionals. Because this study was concerned with intercultural communications and English dominance in health care services, a primary concern for me was to ensure that the voices of Indigenous people were not only included, but given due prominence. Therefore, the first and some final words in this thesis are Indigenous voices.

While not extensive in the literature, various authors have identified challenges in health care⁷ and other communications involving Indigenous Australians (Bain, 2005; Blackford, Street, & Parson, 1997; Cass, et al., 2002; Folds, 2001; Lawrence, 2007; Lawrence et al., 2009; McGrath & Holewa, 2007; McGrath & Phillips, 2008; Trudgen, 2001). Most often however, they are non-Indigenous authors and researchers, and the focus has been on identifying and analysing miscommunications. There is little in the Australian literature that considers the impact of these challenges on *both* clients and practitioners within English dominant health care services or that situates the research within a post-colonial theoretical framework.

The site of this Intercultural Health Care Communication study however, is in the Central Australian region of the Northern Territory where the demography differs substantially to the rest of the country. Indigenous people comprise 25-30% of the Territory population, while Australia's overall Indigenous population is approximately 3% of the total population (Australian Bureau of Statistics, 2009). Whilst the rest of the country might perceive the needs of Indigenous Language speakers to be less of a priority, the very different context in which this study sits suggests otherwise. The higher proportion of Indigenous people within the region, along with a disparity in health service up-take, sees the number of Indigenous

7. Health care communications are defined for the purposes of this study as any health related communications between health professionals and Indigenous Language speaking clients that may be verbal, non-verbal, written or visual in nature (see 10.2).

health service users increase on average to 70-80% (Department of Health and Community Services, 2009). Communication in Central Australian health care is affected by variables not as apparent or influential as they might be in other parts of Australia. In this region, Indigenous Language speakers are linguistic minorities who constitute a majority in terms of health service usage. This anomaly suggests a need to examine the impact on and experiences of those involved in intercultural communications in the region's health care settings.

1.2 Why focus on intercultural communications?

Cultural and linguistic minorities are vulnerable groups within culturally dominant health care services globally as well as in Central Australia. Research indicates that being part of a linguistic minority can compromise health care, resulting in poorer access, treatments and outcomes for some (Benavente, 2004; Blackford, 2005; Crawford, 1999; Fadiman, 1997; Institute of Medicine, 2002) (see 3.3). In Australia, the linguistic needs of specific populations has generally focused on immigrant populations, with Indigenous Australians largely overlooked in relation to their particular communication requirements (Blackford, et al., 1997; Buttow, 2010; Pauwels, 1995). Why Indigenous Australians are regarded differently in terms of their communication needs can be examined in the context of post-colonial theories, which seek to uncover the taken-for-granted assumptions underpinning non-Indigenous individual, State and Indigenous relations.

The research undertaken and discussed in this thesis arose from constant personal and professional frustrations that seemed to underpin intercultural communications between Indigenous and non-Indigenous Australians. I have lived and worked with Indigenous people in Central Australia for over twenty years. My work experiences include health and education roles in remote Indigenous communities, and I am a registered nurse and University lecturer in remote health practice with over twelve years tertiary teaching experience. I love languages and cultural issues, I have previously taught in English Second

Language (ESL) settings, and yet my communications with Indigenous language-speaking people remains limited and unsatisfactory. The longer and more closely I reflect upon my own and others' attempts at intercultural communications in this setting, the more aware I become of the magnitude of the problem. For me, Jakamarra's statement used to open this thesis, took on added meaning when examining *who* it was that did not understand and *what* it was that was not understood. While he may have been referring to his own people, the '*they*' referred to by Jakamarra when he suggested '*they* don't understand...', could equally apply to the health professionals and the broader systems and social dynamics in which they operate. This interesting ambiguity seems to characterise the nature of intercultural communications in Central Australian health care.

Health services in Central Australia usually describe their services as *culturally safe* or *culturally respectful*, *competent* or *secure*, depending on the preferred terminology⁸ (see 10.2). There is increasingly a variety of terms used nationally and internationally for describing health care that incorporates cultural considerations into service delivery and practice. Although often used interchangeably, when examined more closely, these terms are fundamentally different in meaning and intent. These differences pose a problem when the terminology may be conceptualised and implemented quite differently by various users (N. Thomson, 2005).

The Northern Territory Department of Health and Families (NTDH&F) for example, developed a *cultural security* framework for implementation across services from 2009 (Department of Health and Community Services, 2008). However, in 2010, it remains an outline on the department's web site rather than a fully articulated and implemented framework for practice. Whatever the actual or intended cultural framework purported to underpin health services, effective intercultural communication is a key element.

8. Cultural safety, cultural respect, cultural competency and cultural security definitions (see 10.2 and 3.7).

Cultural safety as a philosophy⁹ was endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) as an approach that was relevant for health care provided to Indigenous Australians (Goold, Turale, Miller, & Usher, 2002). However, this endorsement has until recently, been by-passed in favour of other frameworks that align more with the national trend for competency-based approaches. The Nursing Council of New Zealand (2010, p.4) defined cultural safety as:

The effective nursing practice of a person or family from another culture, and is determined by that person or family...The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

<http://www.nursingcouncil.org.nz/download/97/cultural-safety09.pdf>,
accessed 22nd September, 2010

Further development and redefinition both within New Zealand and internationally has seen cultural safety expand from a mainly culturalist idea to one that considers the wider social and systemic influences that perpetuate inequities within health care services (see Chapter 3 and 8). Ramsden (2002) resisted the terminology of post-colonialism due to its literal interpretation that implies colonisation was something already past. However, it is acknowledged that the philosophy of cultural safety has arisen from within a post-colonial context in New Zealand. Ramsden's preference for the term *neo-colonial* was intended to reinforce the ongoing and current influences of colonialism. Other authors such as Browne et al (2005) have conceptualised post-colonialism as a term that can refer to events since colonisation.

9. Philosophy in this thesis is used to suggest an approach to practice that reflects certain beliefs, values, attitudes and way of thinking (see 10.2 and 3.7)

Cultural safety has increasingly been embraced by other health professions as a valuable approach to intercultural practice in Australia (Zon et al., 2004) but as a reflective process, rather than a competency that can be acquired through the development of discrete knowledge and practices. However, the nursing and medical professions in Australia appear to prefer competency based approaches, which allow for checklists of skills and knowledge, instead of an internal process of reflection on practice. My rationale for choosing to focus on cultural safety is discussed further in 3.7 and 4.4.

The key principles of cultural safety however, require dialogue with the health care consumers. Dialogue is a communicative process that in the research setting is inherently intercultural when occurring between the dominant English-speaking service providers and Indigenous Language speaking clients. In Central Australian health services, this research and other research, observations and experiences suggest that flawed and ineffective communications between Indigenous Language speakers and English-speaking health professionals may be implicated in the ongoing poor health outcomes of Indigenous populations (Bain, 2005; Cass, et al., 2002; Coulehan, et al., 2005; Weeramanthri, 1996). This makes the issue of intercultural communication one requiring far greater attention than it has received to date and some consideration of the factors that perpetuate the seeming lack of interest in what is a keystone of all health care interactions.

Dialogue is difficult to achieve however, when participants are not well equipped for the experience. If culturally safe, or even culturally competent or culturally secure care is indeed a goal of health service delivery, an understanding of the experience of intercultural communications, along with any barriers and facilitators, is essential. This Intercultural Health Care Communication study is important to gain a picture of factors that may hinder or enable efforts to provide culturally safe health services to Indigenous Language speaking clients, who although a linguistic minority, constitute the major users of health resources in Central Australia.

1.3 Responses to Indigenous Language Speakers in Australian health care settings

Apart from some early efforts to learn local languages to assist with survival, and the interests of linguists and anthropologists, Indigenous languages have not and do not figure prominently in Australia's multicultural policies (Rigney, 2002). Immigrants and/or visitors can usually access interpreter services readily. It is not the same for Indigenous Australians however, trying to navigate Australian health care services in what is essentially a 'foreign' language. English is the country's only official language, yet English is not a first language for a significant number of Indigenous Australians. Although difficult to gauge accurately it has been suggested that at least 30,000 Australians still speak an Indigenous language as their first language, and the majority of them live in the Northern Territory (Pauwels, 1995). In some areas, English may not even be their second or third language, but way down the list in terms of languages used routinely by some Indigenous Australians (Bain, 2005; Eckermann et al., 2006; Eckermann et al., 1992; Trudgen, 2001).

It is also fair to say that the majority of Australians may be unaware of this fact. Unlike countries such as New Zealand, Australian Indigenous languages have not historically been taught in mainstream schools, nor heard to any great degree on television and radio or enshrined in the collective consciousness of the dominant culture (Rigney, 2004). In this sense, English enjoys a privileged position as the language of daily use, and it is certainly a prerequisite for accessing safe and effective health care in Australia that perpetuates systemic inequities, power and privilege. So taken-for-granted is the expectation for health service clients to speak English, that health professionals have received few resources and even less preparation to communicate effectively with Indigenous language speakers. These expectations require scrutiny to establish how they have arisen.

Interpreter services have been relatively slow to develop within Northern Territory health facilities. Some reasons for the lack of development can be found in the attitudes of previous local and Federal governments, as well as the historical responses of Australia's early

colonisers to Indigenous people (see 2.5). Parliamentary records attribute the Northern Territory's previous Chief Minister Dennis Burke (1999-2001) as saying that providing an interpreter to an Indigenous person would be '*...akin to providing a wheelchair for someone who should be able to walk*' (Crossin, 1999). As recently as 2007, the Federal Minister for Families, Community Services and Indigenous Affairs, Mal Brough (2006-2007) expressed the view that Indigenous Australians should be '*forced or compelled*' to learn English (Karvelas & Megalogenis, 2007), effectively negating the role of Indigenous languages and the need for interpreter services for Indigenous Australians. Furthermore, such language used in response to a single group within society, of '*forced or compelled*' reflects on ongoing colonising mindset that squarely identifies the power relationships between the state and Indigenous Australians.

The under-development and under-utilisation of interpreter services for Indigenous Australians in the Northern Territory highlights historic and prevailing attitudes that characterise mainstream responses. That is, Indigenous users of health services were *never intended* to need interpreters for negotiating health care in contemporary Australia. This is in contrast to the legal professions, which established interpreter services much earlier, having long recognised the implications of not providing interpreters to communicate with Indigenous Language speakers (Eades, 1995; Inglis, 2002). The consequences for health care outcomes would be no less important, and in fact could be argued to have an even greater importance when the consequences influence matters of life or death. Yet health services remain under-resourced in providing Indigenous interpreter services, and even where interpreters are available, a number of factors at individual and system levels that may inhibit the effective uptake of these services (Cass, et al., 2002; McGrath & Phillips, 2008) (see 3.5).

The potential for communication problems is not restricted to situations where clients speak an Indigenous first language. The use of English by many Indigenous Australians also

requires some attention. Aboriginal English¹⁰ or Aboriginalised English and Creoles¹¹ (see 10.2) are in common contemporary use among Indigenous Australians (Eades, 1991). These too present challenges to English-speaking health professionals who are unprepared for the characteristics of Indigenous communication styles that influence even their use of English, resulting in frequent and serious miscommunications (Pauwels, 1995).

Rather than ensuring health professionals are well prepared to communicate with Indigenous language speaking clients, there appears to be an acceptance of a different and often lower standard of care, which can have negative effects on health outcomes and service delivery (Cunningham, 2002; Fisher & Weeramanthri, 2002). Various studies have focused on identifying and describing communications problems between Indigenous and non-Indigenous people (Cass, et al., 2002; Davidson, Hansford, & Moriarty, 1983; Eades, 1991) but there are few if any, that critically examine the impact of these communication problems within a colonising context. Much of the research undertaken in this field focuses on Indigenous language speaking clients as somehow problematic and suggests strategies for health professionals to employ to bridge or minimise existing communication barriers. My study however, referred to in this thesis as the Intercultural Health Care Communication study, sought to understand the experience of intercultural communication by focusing mainly on the preparedness, attitudes and responses of health professionals and health services to engage in effective intercultural communications with Indigenous language speaking clients.

Australia's colonial past has undeniably influenced the status of Indigenous people and the dominant culture's responses toward the First Peoples. Unlike other countries with a similar colonising history, Australia is yet to enter into any form of treaty with the original inhabitants, who were at various points in time, expected to no longer exist under the

10. Aboriginal English, a form of English in which the syllable emphasis, grammar and use of certain words has been modified to fit Indigenous language structures and functions (see 10.2).

11. Creoles—a creole is a distinct language which has taken most of its vocabulary from another language ..., but has its own unique grammatical rules (Eades, 2009) (see 10.2).

influence of colonialism (Eckermann, et al., 2006; Rigney, 2002). Chapter 2 provides further discussion of historical issues, as understanding past responses to the country's First Peoples¹² is important to understanding responses to Indigenous language speakers within Australia today.

1.4 Why focus on intercultural communications with Indigenous language speakers?

The health of Indigenous Australians is a national priority. Indigenous Australians currently live some 17 years less than non-Indigenous Australians (Oxfam Australia, 2009). Significant resources and expenditures have been directed toward '*Closing the Gap*'¹³ in life expectancy and quality of life (Rudd, 2008). Yet the ambition to achieve this national priority remains unfulfilled. Considerable emphasis has been given to various disease-focused programs, incentives for health workforces, (although these are heavily weighted toward medical professionals), health service infrastructure, and more recently consideration of the social determinants of health. However, the *communication* gap between Indigenous and non-Indigenous Australians remains substantial.

While Australia is '*one of the most linguistically and ethno-culturally diverse nations in the world...*' according to Pauwels, (1995, p.1) there is something within the national psyche that has to date, failed to offer Indigenous language speakers the same rights and respect afforded newcomers to this country. This response may have been created by the foundation view of Australia as a Terra Nullius¹⁴ or '*empty land –belonging to no-one*' (see 2.5) or the expectation much later in our shared history, that Indigenous Australians would simply and willingly '*assimilate*' (Eckermann, et al., 2006).

12. First Peoples is also used to denote Indigenous Australians (see 10.2).

13. Closing the Gap is a national policy direction aimed at closing the disparities between Indigenous and non-Indigenous Australians in terms of life expectancy and other disadvantage (see 10.2).

14. Terra Nullius – the condition under which the British claimed Australia conceptualizing the land as belonging to no-one (see 10.2).

Increasingly authors have identified ineffective communication between Indigenous and non-Indigenous populations as playing a very important role in preventing the realisation of our national priority to '*close the gap*' (Cass, et al., 2002; Folds, 2001; Trudgen, 2001). In speaking specifically about health disparities, Trudgen has long pushed the notion that language barriers and cultural misunderstandings are at the heart of the crisis in Indigenous health today (Trudgen, 2001, 2005). He attributes the lack of attention to Indigenous language speakers as stemming from the dominant culture's¹⁵ monolingualism (Trudgen, 2001). His personal stance, based on an intimate involvement with Yolngu¹⁶ people and research conducted, advocates the need for health professionals to learn local Indigenous languages and to pay greater attention to the issue of language within health care practice (Trudgen, 2001). Numerous factors however, make Trudgen's suggestion to learn an Indigenous language impractical in the context of Central Australia, including the diversity of languages within the region and the transience of health workforces.

These factors of language diversity and workforce transience however, are only part of the reason for focusing on the needs of Indigenous language speakers in this Intercultural Health Care Communication study. In Central Australia (and the Northern Territory as a whole), the morbidity and mortality of Indigenous people is comparable to rates within developing countries (Oxfam Australia, 2006). To have such a major disparity in the midst of a developed nation demands attention from a range of perspectives. Whilst culture is widely accepted as influencing health care and outcomes for culturally diverse people, the response of dominant cultures to 'others' is the problem in a colonising context, rather than culture itself. In spite of several decades of cultural awareness training, limited as it has been in some areas, major change has not yet occurred in health outcomes for Indigenous people in the region. From a cultural safety perspective, learning *about* culture is not enough to change practice and attitudes in most instances (Papps, 2005). A different approach is required. For

15. Dominant culture in this context is considered to be the mainly Anglo Australian populations, sometimes referred to as the 'settler cultural group' in other literature (see 10.2).

16. Yolngu refers to the linguistic and cultural group who are traditionally associated with lands in the North east of the Northern Territory, known as Arnhem Land. (See 10.2).

this reason, I have chosen to focus on intercultural communication between health professionals and Indigenous Language speakers, as communication is a keystone of all health care interactions.

1.5 Language and culture in health care

Language is an element of culture and the major means by which culture is transmitted, but it has been culture more broadly that has received much of the attention in health service policy developments (Pauwels, 1995). Culture is often made problematic with dominant cultural groups constructing other's cultures as something to be overcome, rather than accommodated. There is a direct relationship between first language capacity and the capacity to learn other languages (Evans, 2010; Pauwels, 1995). If Indigenous language speakers are 'expected' to learn English proficiently, then opportunity must be given to ensuring capacity in their first language. Without this opportunity, the individual operates ineffectively between the dominant language and their first language. For this reason, it is important to preserve Indigenous languages and encourage their use even in situations where English dominates to avoid rendering a section of society isolated from their own and broader communities. Edwards (2005) also suggests that the links between self-esteem and identity is another reason to consider First Language capacity as a determinant of health.

If health professionals wish to communicate health literacy,¹⁷ prevention, promotion and maintenance messages, then this must take place in a meaningful manner. Words and word use alone do not equate to understanding. Only when Indigenous speakers are free to operate in their preferred language is health care communication likely to succeed, but they must also interface with English speakers. Importantly, yet an issue that has received scant attention, English speaking staff also deserve to be well prepared for their responsibilities when it comes to health care involving Indigenous clients, given the already complex and

17. Health literacy is defined as the shared understanding in regard to health concepts, language and terminology— involves an ability to read, interpret and use information for health benefits (see 10.2).

multiple health needs of this population. Health professionals therefore also need a model of intercultural communication that will facilitate culturally safe health care for Indigenous language speakers.

Culture can be constructed as both a facilitator and impediment to safe and effective health service delivery for Indigenous Australians. However, the real facilitators and impediments to be examined, may exist within the mindsets and systems that uphold dominant culture thinking. The last two decades in particular, (1990-2010), has seen health services asked to consider the influence of culture within their systems. Policy frameworks such as *cultural respect*, *cultural competency* and *cultural safety* have emerged around the country (Thomson, 2005) and are endorsed in Central Australian health services, as mentioned in section 1.2 and 10.2. One of the difficulties in applying such frameworks however is variability in the definitions and conceptualisation of what exactly each approach implies.

An introduction to the concept of *cultural safety* during a workshop in 1998 ignited my interest in exploring its potential within professional and personal contexts (see section 1.7). Chapters 3 and 4 provide further discussion of the rationale for choosing this approach over some of the others that have emerged. However, in short, cultural safety as developed in New Zealand was perhaps one of the more fully articulated philosophies in terms of principles for implementation. It is a philosophical approach does not make culture a *problem*. Instead, this approach asks the dominant culture and its practitioners to examine their responses to cultures that are different to their own.

Cultural safety is a philosophy that requires self-examination on the part of the dominant culture health professional (Ramsden, 2002). In considering the principles put forward by the New Zealand developers (Ramsden, 2002), language and intercultural communication, although not overtly identified, are core components of any culturally safe practice, given the need to engage in dialogue with care recipients. The New Zealand context possibly does not require such explicit description of these elements, as Maori language and culture are more

embedded within the New Zealand national identity than are Indigenous languages and cultures in Australia.

Cultural safety also places responsibility on the service provider to reflect upon and decolonise one's own practice rather than continuing efforts to change the behaviour of care recipients (Papps & Ramsden, 1996; Ramsden, 2002). From one Australian Indigenous perspective, decolonisation is a process of acknowledging and comprehending: *...the impact that invasion, imperialism, colonisation, research and policy have had on the Indigenous people of this country* (Sherwood & Edwards, 2006, p. 179)

In the context of this Intercultural Health Care Communications study, decolonisation has been operationally defined as using acknowledgement and understanding of the impact of colonisation on Indigenous Australians and acting in a way as to ensure that elements of colonisation such as dominance, oppression, individual and systemic discrimination and racism are not continued (see 10.2). Dialogue, decolonisation and reflective practice all resonated for me when considering my own and others' experiences of intercultural communication with Indigenous Language speakers.

The right to speak one's own language would seem to many an undebatable issue. However, invading or colonising groups have used language subjugation as a tool of colonisation and conquest for millennia (Evans, 2010; Rigney, 2004). The debate over whether individuals and groups should speak the nation's official language is a moot point in the current context of Central Australia, the last region to be colonised in Australia. The fact is, the majority of health service users do not speak English with a level of proficiency that enables safe and effective communication with health professionals (Pauwels, 1995). Repeated examples of communication failures between Indigenous and non-Indigenous participants within Central Australian health care prompted the question of how to engage in effective dialogue, when the dominant culture privileges its language over others.

An examination of power relationships is also inherent in a culturally safe health service, giving rise to the question of which group is in the best position to make any necessary change. Indigenous language speaking clients are frequently characterised as deficient for their lack of English, rather than linguistically sophisticated and competent for their capacities to switch between several Indigenous languages (Harkins, 1994; Pauwels, 1995). If culturally safe and effective care for all Australians is the intended goal of health care providers, then greater understanding of power within the experience of intercultural communication is an ethical and professional imperative.

In Central Australia, Indigenous people with complex and multiple health problems, encounter health services repeatedly throughout generally shortened life spans. Even for those Indigenous people who, as a result of detrimental government policies (see 2.2) grew up without knowing their first language, communication with English-speaking health professionals can be challenging and unsatisfactory (Eades, 2009). Conversely, few health professionals employed in Central Australia are prepared for the complexities of communication with Indigenous people, or even aware of the need to prepare for communication issues.

I am *not* suggesting that Indigenous Australians should not learn English. On the contrary, I believe that English language proficiency is a key to social power and inclusion in any country where it is the official language. The justice of this position is not relevant in a practical sense. I do believe however, that when a person, indigenous to a country, has to negotiate their health care needs as if in a foreign country, then this position requires examination. There are also numerous compelling arguments put forward for language rights and maintenance that can be demonstrated to have benefits reaching far beyond individual rights, with health outcomes not the least among them (P. Edwards, 2005; Mühlhäusler & Damania, 2004; Rigney, 2004). Given such arguments, it follows that those providing health care services, need to be equipped for the particular challenges presented in the study's context.

According to Trudgen (2001) and reinforced by Jakamarra's opening statement of this thesis, Indigenous Australians are literally dying because of a current inability to communicate with the dominant population. This seems like a very strong statement to make and one that should elicit serious attention. However, successive governments have largely ignored Indigenous First Language speakers in what Fishman described by the oxymoron, 'benign neglect' (Mühlhäusler & Damania, 2004, p. 10). Furthermore, Mühlhäusler and Damania (2004) offer an economic reason for preserving and facilitating the use of Indigenous Languages in Australia. Whenever there is a group rendered dependent on the mainstream population, the economic burden will be substantial and potentially unsustainable. Policies of the past derived with an expectation that the 'problem' of Indigenous existence would eventually disappear. Far from disappearing, Indigenous Australians have defied such expectations, but at an intolerably high cost to themselves and consequently, the country.

1.6 Re-orienting my thinking

My experiences of communicating across cultural and linguistic divides extend to my earliest working life as a schoolteacher and later as a nurse educator and University lecturer. The first phases of my career involved teaching in large multicultural schools in a major city. The next phase focused on working with Indigenous Language speaking adults in remote communities until entering the academic world, where cultures (not all defined by ethnicity) continue to feature in my work, and in which communication across cultures is inherent. Repeatedly I observed and possibly unwittingly contributed to problematising people who did not possess English language proficiency. Even beyond the health care setting, those who do not possess English as their primary language are defined as deficient rather than different (Harkins, 1994; Pauwels, 1995).

It seemed to me however, that for any perceived deficit that may exist in English, there was an obvious, although rarely acknowledged deficit on the part of the English-only speakers to communicate more effectively with speakers of languages other than English. This

realisation prompted a closer examination of my own and others' dialogues around Indigenous and other non-English speaking Australians. For this reason, I have chosen to describe speakers of Languages Other Than English (LOTE)¹⁸ by their capacities rather than their perceived deficiencies. Instead of using terms such as LOTE, English Second Language (ESL),¹⁹ or non-English Speaking Background (NESB)²⁰ as has been the practice in education and government for the last few decades (Pauwels, 1995), I have deliberately re-oriented my language and thinking. I prefer to use the term Indigenous First Language (IFL), or Indigenous Language Speaker (ILS)²¹ or simply Language speakers²² with 'Language' capitalised. An example of my own re-orientation in thinking is evident in a presentation I developed on communication issues within Central Australian health services (and subsequently published in a text to illustrate the issue more broadly (Taylor & Guerin, 2010). Nurses and other health professionals were often heard describing Indigenous clients as '*non-compliant; non-communicative; poor historians*' amongst other labels. Rarely, if ever, is it acknowledged that the situation might more accurately be described as: *Ineffective client history obtained due to poor cross-cultural communication skills of staff. Further staff education required* (Taylor & Guerin, 2010, p. 125).

In considering the use of labels and terminology, there is no widespread agreement on the terminology used to define Indigenous Australians, who in spite of repeated efforts to do so defy being categorised as an homogenous group. *Indigenous Australians* is the terminology used throughout this thesis, with the caveat that there is no implied notion of homogeneity or even general acceptance. Section 10.2 outlines specific operational and other definitions used in this thesis.

18. LOTE—implies people whose primary or first language is other than English. English may not necessarily be the speaker's second language, but may be third, fourth or other if at all (see 10.2).

19. ESL—implies people whose first language is other than English, but who do speak English as their second language (see 10.2).

20. NESB—implies people who come from areas where English is not the primary language and therefore English is not their first language (see 10.2)

21. ILS is defined as someone who speaks an Indigenous language, but may not speak it as their first language (see 10.2).

22. Language with a capital in text is used to denote Indigenous languages—a commonly used term in Central Australia. For example: she speaks Language—implying an Indigenous language (see 10.2).

1.7 Locating self in the research

In 1994, I was a participant in what was for me a very influential workshop on Aboriginal Cultural Awareness in Central Australia. The learning curve was steep concerning my knowledge of Aboriginal cultural beliefs, practices and worldview. The most powerful part of the workshop for myself however, was a speech made by a young Aboriginal man who was asked what he thought was the reason behind the appalling health state of Aboriginal people. He was passionate and emphatic when he declared, '*our biggest problem today is English*' (Mills, 1994). He went on to say that English was wholly inadequate when it came to explaining so much about Aboriginal beliefs and concepts. For example,

...when we talk about a connection to land being at the core of our health... you all go, mm... yes, we understand, **but you don't!** (speaker's emphasis). You can't possibly, because we can't tell you what that really means. You don't have the words in your language. You don't know because if you did, you wouldn't take this so lightly (Mills, 1994 personal communication.).

Furthermore, he stated that the way non-Aboriginal people speak to Aboriginal people was a problem. Non-Indigenous people 'talk down to them'. There is a perception according to Mills (1994, personal communication) that non-Indigenous people like to keep Aboriginal people speaking quaint sub-standard English while keeping the '*secret English*'²³ to themselves (Mills, 1994, personal communication). Mills' words made such an impact on me that I diarised them at the time and have become more attentive to issues of English privilege and language right since. Years later, Robbie Mill's speech still has impact. One irony however, is that it had such impact because he was extremely articulate in *my* first language of English. I wonder if a less fluent messenger would have made the same impact.

As rarely a day passed without the need to engage in an intercultural encounter in both my professional and personal worlds, reflection on my own and others' interactions became imperative. From frequent observations of health professionals struggling to communicate

23. Secret English – An Aboriginal English term for language that is too difficult to understand (see 10.2).

with Indigenous language speakers, to my own personal and professional struggles, the experience of intercultural communication became the focus of much discussion, reflection and attempts to understand what was occurring. Having worked with other language groups previously, I also wanted to examine why encounters in Central Australia with Indigenous language speakers seemed more challenging.

I am a non-Indigenous person originally from a low socio-economic background. However, my place as a member of the dominant population, along with undoubtedly some personal attributes, has afforded me opportunities not readily available to Indigenous Australians. Official government policies did not deny me as a non-Indigenous Australian, the right to my own language, the right to an education or the right to an equivalent standard of health care. This thesis however, is not about feeling guilt for my whiteness²⁴ or the inherent privilege it offers, as I do not ascribe to such a position, but I do support challenging my own privilege when it affects others.

My first language, English, is my country's official language. As such, it is the language of government and its various institutions of law, education and health, among others. As previously mentioned, this is not the same for Indigenous Australians however, who find their own languages foreign in their own country (Marcus, 2005). This inequitable position prompted my interest to better understand what was the experience and consequences of accessing health care in settings where English was dominant, and Indigenous clients were described in daily discourses as *'non-communicative'*, *'non-compliant'* and *'unable to comprehend their own health care needs'*. Locally, my own perceived 'authority' on Indigenous communication compelled me to examine how I acquired the role in my professional and personal life as someone who is sometimes called upon to 'interpret' or facilitate intercultural exchanges. At the same time as my developing interest in intercultural communication, I became aware of cultural safety, then a relatively new philosophy that

24. Whiteness – a concept that is not so much concerned with skin colour but with the inherent privileges of being part of a dominant cultural group (see 10.2).

arose from Maori experiences of health care in New Zealand. This philosophy has considerable relevance for the colonised environment at the centre of this Intercultural Health Care Communication study.

The phenomenon of culture has been widely explored in nursing and other health related research (Blackford, 2003; Ferguson & Candib, 2002; Kanitsaki, 2003; Leininger & McFarland, 2002; Papps & Ramsden, 1996). The consequences of language dominance and/or language awareness however, and how this impacts on those health professionals involved in English-dominant services, do not appear prominently in the literature of these disciplines. The focus is most often on linguistic minorities as the subjects of research, rather than on the linguistic majorities who control health services. Transcultural nursing literature is one such example that focuses on the clients' difference rather than the health professionals' capacity to accommodate any perceived difference:

As nurses discover a client's particular cultural beliefs and values through research, they learn ways to provide culturally sensitive, compassionate and competent care that is satisfying and meaningful to the client and congruent with their life ways practices. (Leininger and McFarland 2002, p. 45)

In spite of claims to the contrary by Madeleine Leininger, transcultural philosophy appears mainly concerned with nurses being made aware of exotic cultural differences, rather than on developing ways to enhance communication through an understanding of barriers and facilitators (Leininger, 1985; Leininger & McFarland, 2002; Papps, 2005). This is understandable given the theoretical foundations of transcultural approaches that derived from the discipline of anthropology. Cultural safety on the other hand, distinguishes itself from transcultural nursing approaches, by placing the onus more overtly on the health professional and the health care systems to reflect on their interactions and the power relationships implicit in working with cultural minorities (Papps, 2005; Papps & Ramsden, 1996; Ramsden, 2002; Wepa, 2005). Post-colonial theories are the foundation of cultural safety approaches and therefore take the attention away from anthropological determinants,

to consider the historical, social, and political contexts more fully. Learning about exotic differences is a beginning step in the cultural safety process, which then contextualises any such knowledge within a decolonising framework.

My own experiences undoubtedly influence this research, which is why my views and experiences are strongly apparent throughout. Rather than seeing this apparent bias as problematic and self-indulgent, Fook's (1999) explanation of the role of reflexivity and reflectivity in research was helpful. In choosing a cultural safety philosophy for this research, self-reflection or reflectivity and reflexivity became integral to my chosen methodology. Reflexivity is the '*ability to locate yourself in the picture*' (Fook, 1999, p.11) — a position, whilst reflectivity is the process:

... in which you are able to reflect upon the ways your assumptions and actions influence a situation and thus change your practice as a direct result of this reflective process ... reflectivity becomes a type of research method, one which allows a practitioner to research his or her own practice (or that of others) in order to change or improve it. (Fook, 1999, p. 11)

Once I had chosen critical ethnography as an appropriate methodology, and selected cultural safety located within a post-colonial context as the most suitable theoretical framework, I needed to locate myself in the study as a reflective participant. Chapter 4 provides further explanation of this decision to include my experiences and views overtly. Reflectivity and reflexivity played prominent roles during the conceptualisation, implementation and development of this study of Intercultural Health Care Communications in Central Australia, not only for myself as researcher, but also for participants.

1.8 Potential significance of the IHCC study

Communication skills and knowledge of language facilitators and barriers may prove critical to the provision of culturally safe health care. A better-equipped workforce, with insight into the intercultural communication needs of people in Indigenous health settings, has the

potential to improve service delivery in any context. Understanding the experience of communicating health care issues with Indigenous Language speakers may also influence the preparation and further education of health professionals. Intercultural communication in Indigenous health care settings needs to be analysed, and health professionals provided from undergraduate level with the tools to communicate better with Indigenous language speakers. This is an area of health education in Australia that is not prominent in current nursing, midwifery, medical or other health curricula (Pauwels, 1995).

In addition, considerable time and money has been invested in communicating health care information to people from diverse linguistic backgrounds and educational levels. Health information provided for Indigenous Australians often employs flip charts,²⁵ and cartoon-formatted publications that are simplistic with sometimes child-like English language. These formats have been promoted for use with Indigenous clients in the belief that these are culturally appropriate means of communicating. This study also briefly explores, describes and analyses some examples of culturally targeted modalities and health care communications for their effectiveness in Central Australian health care. Recommendations concerning their effectiveness may improve both the message and the mode of delivery and contribute to de-colonising health care practices.

Understanding the experience of intercultural communications in Central Australian health care has the potential to improve health outcomes and service delivery, inform educational and training curricula and more effectively identify and target health care resources. It will add to the increasing but still limited body of knowledge relating specifically to intercultural communication involving Indigenous language speakers in Australia. Further, I hope that such understanding contributes to the will and preparedness of the dominant culture to seek meaningful dialogue with Indigenous people to ensure the delivery of culturally safe health care for all participants.

25. Flip charts are usually A3 or A4 sized publications designed to be used as teaching tools for audiences with low English proficiency. They are often characterised by large font size, plain English and numerous graphics.

1.9 Rationale for study

It has become increasingly apparent from being both an observer and participant in health care settings in Central Australia that at the heart of so many frustrations, stressors and poor outcomes have been failures of communication that arise from a post-colonial legacy within this context and all the social dynamics this has created. A quote from playwright George Bernard Shaw in 1901, may seem to have little bearing on Central Australian intercultural communications. However, Shaw's suggestion that, '*the single biggest problem in communication is the illusion that it has taken place*' sums up so many of my own and others' experiences in Central Australian health care settings.

With the best of intention and sometimes without it, health professionals are often ill prepared for the type of communication skills required to interact effectively with clients who speak an Australian Indigenous language. Although communication issues are accepted as problematic, the attention given to addressing these issues is inadequate (Pauwels, 1995). There is a need to examine the impact of these communication issues on both clients and health professionals in order to explore what underpins this neglect of a key component of effective health care practice. By including a focus on health professionals as participants, a more complete picture of intercultural communications may be achieved. In addition to examining the impact of such experiences on participants and the underpinning causes of communication difficulties, there are ethical, legal and even economic rationales for examining health care communications between English-speaking health professionals and Indigenous Language clients.

Ethically, it is a universal human right to possess and maintain one's own language, particularly within one's own country (May, 2005; Rigney, 2004). Language subjugation or destruction is a tool of colonisation and dominance (P. Edwards, 2005; Evans, 2010). By both overt and covert methods, colonisers have historically sought to 'divide and conquer' through making the language of state that of the colonisers. According to May (2005, p319), '*a*

dominant language group usually controls the crucial authority in the areas of administration, politics, education and the economy'.

Language is linked to issues of self-esteem and identity and consequently to health. Without a mutual respect for the Indigenous Language clients' right to their own language and identity, health may be unobtainable. Legally, issues of informed consent, treatment options, and duty of care are dubiously applied in a setting where communication is poorly executed (McGrath & Phillips, 2008). Language barriers '*... can create obstacles to gaining genuine informed consent*' (McGrath & Phillips, 2008, p. 27). When health professionals admit to operating in an environment of doubtful legal adherence, the potential for litigation is substantial. These barriers are discussed further in Chapter 8. In situations where communication is ineffective or not even identified as problematic, health care is clearly compromised, which highlights the need for this study.

Economically speaking, the cycle of ineffective treatments, unresolved health problems, and a lack of attention to preventable health concerns, cost the community at large. Millions of dollars have been spent on less than 3% of the population with relatively little impact. The social costs of failure concerning Indigenous health also cost the nation in terms of its relationships with all sectors of the community as well as Australia's standing in the world. Social justice, reconciliation and a genuine commitment to decolonisation are also powerful reasons for the need to examine this issue. However, the reality may be that until legal and economic arguments are made, those with the power to change often remain impervious to more humanistic motivations. The issues identified throughout this study have ethical, legal and economic consequences that are highlighted in the data chapters (see Chapters 6 & 7).

1.10 Aim

This research aims to critically analyse health care communications between health professionals who were essentially English only language speakers and Indigenous First Language clients. In essence, it is concerned with analysing the *intercultural* contexts of

health care communication in Central Australia to identify barriers and/or facilitators to culturally safe communication with Indigenous First Language clients. This thesis does not aim to criticise health professionals who are placed in positions not intentionally sought by them. Few if any health professionals in my view would deliberately engage in practices and procedures that contribute to the ongoing trauma of colonisation of Australian Indigenous people. On the contrary, colleagues and others have sometimes seen their roles as health practitioners as dealing with the consequences, direct and indirect, of colonisation, rather than participating in the process today. It does however, seek to uncover the underlying assumptions, attitudes and responses that underpin healthcare and other systems and structures operating within the research setting, which hinder or facilitate intercultural communications with Indigenous Language speakers today.

1.11 Research questions

The specific research questions posed within this study were:

- What is the experience of being an English-speaking health professional providing care to Indigenous language speaking clients? (To be explored through face-to-face interviews with health professionals across a range of Central Australian health services.)
- What is the experience of being an Indigenous language speaker in an English dominant health care system? (To be explored through face-to-face interviews with Indigenous language speakers who were also health service users.)
- What do video, audio, written and/or field observed examples of health communications between Indigenous and English first language speakers reveal about intercultural communication in the study context?

- What do the experiences and examples reveal about barriers and facilitators, current workforce preparations and attitudes toward intercultural communications within a post-colonial context?
- What can be done to improve the cultural safety of communications in Central Australian health care?

1.12 Scope of the Study

Perspectives were obtained from both Indigenous Language clients and English-speaking health professionals. My major source of data was from the health professionals, being a member of this cultural group myself. At the time of commencing this study, the majority of health professionals employed in the Central Australian region was monolingual, with English their first and only language.

Over the past decade (since 2000) however, there has been a major increase in the numbers of overseas trained personnel employed in Central Australia, which has added another layer of complexity to an already difficult practice area (Wren, 2007). Health professionals who spoke languages other than English were not included in this particular study, but were mentioned by participants. For example, during the interview phase of the study there had been an active recruitment of nurses from Zimbabwe and India (since 2006). These nurses came in for particular mention in the study but were not interviewed, as they spoke other languages in addition to English. The variability of recruitment and preparatory strategies over time may make investigation of other groups relevant, but those who speak English only are likely to remain the demographic majority for health professionals. The specific references made in interviews are commented upon in the data analysis where appropriate, with further consideration of the issue of speakers of other languages in the discussion chapter.

I started this thesis with an Indigenous voice and declared early that I wanted to provide due prominence to such voices. In this thesis however, I make no claim to represent Indigenous people other than through the voices of a small number of Indigenous participants who volunteered their perspectives of intercultural communication in health care settings in Central Australia. As an outsider to this cultural group, I felt it was not an appropriate role for a non-Indigenous researcher to attempt to present a comprehensive Indigenous voice, as the very issues under scrutiny in this study would surely affect my capacity to do justice to this group. Indigenous led and conducted research would be more appropriate for collecting such data (Smith, 2003).

Instead, the Indigenous participants who provided rich data to consider in relation to the health professionals' perspectives were people with whom I had long-standing established relationships, and therefore formed a convenience sample only. Methodological issues that arose during my interviews with Indigenous First Language people confirmed my belief that it would have been unwise to attempt to obtain and analyse data from Indigenous Language speakers as an English only speaking researcher, even though other researchers have done so using interpreters. This aspect of the research methods is discussed further in Chapter 5.

1.13 Overview of study

Chapter 1 sets the scene for the study, by providing a background and justification. It also presents the issue of communication in health care as critically important and considers the significance of this study in a wider context.

Chapter 2 provides an overview of the study's contexts. It describes the geographical, political, personal, cultural and historical locations for this study and outlines the main influences of each of these contexts on understanding the study.

Chapter 3 reviews the literature and examines the complexities and consequences of intercultural communication problems in health care settings, as well as identifying gaps in the literature, concerning Australian Indigenous language users.

Chapter 4 explains the theoretical and methodological basis for the research design. An exploration is made of post-colonialism as the theoretical framework for the study, underpinned with cultural safety as a relevant philosophy. The methodology of critical ethnography is discussed and a rationale for its use in this study is provided.

Chapter 5 is the methods chapter, which details specific activities undertaken in the conduct of this research and approaches to analysis. It provides rationales for the chosen approaches, describes decision-making in relation to planning and implementation, and addresses issues of ethics and rigour.

Chapter 6 presents data from the English-only speaking health professionals, derived mainly from analyses of semi-structured interviews with English-speaking health professionals in Central Australia. The data also includes some analyses of video-recorded and field observed health care communications between professionals and clients from across a range of service settings.

Chapter 7 presents the data from Indigenous First Language participants. Semi-structured interviews, videotaped and field observed health care communications and targeted communications such as signage and health resources were analysed. When sequencing the presentation of data, there has been a deliberate choice to ensure the first and last words, usually considered the more privileged in English communications, are those of Indigenous language speakers.

Chapter 8 discusses the findings from chapters 6 and 7 in relation to the literature. Discussion of findings from each category of data, followed by a more detailed examination of the issues inherent in communicating with Indigenous First Language speakers in English,

is given. The theoretical framework of post-colonialism and the philosophy of cultural safety guide interpretation of the findings.

Chapter 9 returns to answer explicitly the research questions outlined in chapter 1. It highlights what this study has contributed to intercultural health care communications in Central Australia, presents the limitations of the study and its main recommendations. A model of culturally safe intercultural communication for Central Australian health care is proposed, before concluding this thesis.

1.14 Summary

This chapter has introduced the issue of intercultural communications in Central Australian health care as an issue worthy of attention. It has identified a number of reasons for focusing on what has been a largely overlooked issue in analyses of the current state of Indigenous health in Australia today. Given that Indigenous health is a national priority, this Intercultural Health Care Communication Study turns the critical lens on a key element of health care—the capacity of health professionals to provide culturally safe care to Indigenous health service clientele.

This chapter outlined the aims and objectives of the study, provided a background, rationale and purpose for undertaking an analysis of health care communications between Indigenous Language speaking clients and English Language speaking health professionals. Intercultural communications involving Indigenous language speakers are known to create potential barriers to effective health service delivery in Indigenous settings in Australia. Unfortunately, they have received relatively little emphasis in the preparation and ongoing professional development of health practitioners. The next chapter will provide an overview of the context of intercultural communications and communication issues in health care that are relevant to the subject of this study.

Chapter 2

The research setting and context: *Its different here*

2.1 Introduction

The research setting for this Intercultural Health Care Communication study is physically located in the Central Australian region of the Northern Territory of Australia (see Figure 1, section 2.1). It has been my home for over twenty years at the time of writing (since 1988). Although that makes it a convenient location for me personally, there are numerous reasons for focusing on health care communications in this specific area. The unique geographical, historical, political and cultural elements that interact within this region have significant influence over health service delivery and outcomes.

This chapter provides a brief overview of the context and some of the issues relevant to the research setting. Section 2.2 describes national health services to provide a context for understanding key aspects of the local health care environment within Central Australia. In section 2.3, is a description of the geographical, historical, political and cultural contexts. Sections 2.4 to 2.7 then consider each context separately in relation to this Intercultural Health Care Communication study.



Figure 1: Central Australian Health services area (approx. 1 million km square) and the position of the research context within the Northern Territory and Australia.

2.2 National health services

The Australian healthcare system is unique among those of comparable English-speaking countries such as the United Kingdom, Canada, New Zealand, and the United States of America. Some services, regulation and funding are provided by the Commonwealth Government, while other Australian health services are generally the responsibility of separate State and Territory governments. In recent years however, there has been increasing pressure for Federal (Commonwealth Government) intervention to address failing State health care systems, particularly in the Northern Territory. In spite of identified problems, most of the population enjoy relatively good accessibility and availability of health care services. When it comes to remote and Indigenous populations however, there are noticeable disparities in terms of access and availability (Wakerman, 2004). The following synopsis provides a brief overview of Australia's health system from the Australian Government Medicare Australia (2010):

The Australian health system is widely regarded as being world-class, in terms of both its effectiveness and efficiency. The system is a mixture of public and private sector health service providers and a range of funding and regulatory mechanisms:

The Australian government with the primary role of developing broad national policies, regulation and funding.

State and Territory and Local governments who are primarily responsible for the delivery and management of public health services and for maintaining direct relationships with most health care providers, including regulation of health professionals and private hospitals.

Private practitioners including general practitioners, specialists and consultant physicians.

Profit and non-profit organisations and voluntary agencies.

The Australian Government's funding includes three major national subsidy schemes, [*Medicare*](#), the [*Pharmaceutical Benefits Scheme*](#) and the [*30% Private Health Insurance Rebate*](#).

Medicare and the Pharmaceutical Benefits Scheme cover all Australians and subsidise their payments for private medical services and for a high proportion of prescription medicines. Under Medicare, the Australian and State governments also jointly fund public hospital services so they are provided free of charge to people who choose to be treated as public patients. Australian Government funding of the 30% Rebate and other key incentives support people's choice to take up and retain private health insurance. (Australian Government, 2010)

The Northern Territory as the name implies, is a territory within Australia and as such is not politically equivalent to the six states that make up the rest of the country. Although the States and Territories are responsible for the delivery of their own health services, the Northern Territory, with its differing constitutional status is more reliant upon Federal input. Central Australia is a flexibly defined geographical region within the Northern Territory of Australia. In terms of access to health care, users of Central Australian health services may reside in any of the three states that border the Northern Territory. States in Australia enjoy a level of self-government. As a territory, however, Federal powers can constitutionally override the Northern Territory government. This has implications for health service delivery, with Federal priorities often taking precedence over local concerns. A major example of this was the overturning of the Northern Territory's euthanasia laws by the Commonwealth Government in 1996.

Although the majority of Australians live in large metropolitan coastal areas, our ageing population and the existence of vulnerable and/or marginalised groups has seen an attempt to

re-orient health services toward more affordable, equitable and sustainable health promoting and preventative care. Australia has been a signatory to the World Health Organization's (WHO) commitment to primary health care²⁶ (PHC) since 1978 (Eckermann, et al., 2006). However, by comparison with curative and treatment health services PHC is poorly resourced or prioritised. The 2010 opening of a second renal dialysis unit in Alice Springs in addition to already having the largest dialysis unit in Australia demonstrates the preference and resulting need for treatment services. At the same time, PHC services remain under-resourced in terms of prevention, even though job descriptions for remote health services identify PHC as core business (Gruen, Weeramanthri, & Bailie, 2002).

2.3 Central Australian health services

The remoteness of Central Australian health services means that access to high technology specialist treatment services is limited. The majority of health services in the region are classified as remote or very remote according to national classificatory scores, known as Australian Standard Geographic Classification—Remoteness Areas (ASGC-RA) introduced in 2009 (Australian Government Department of Health and Ageing & DoctorConnect, 2005). As shown in Figure 2, the Northern Territory differs significantly from the east coast of Australia where the majority of the population and health services are located. Bordered on three sides by the remotest regions of Queensland, Western Australia and South Australia, the Central Australian region faces challenges in health service provision that in combination with the historical, political and cultural influences, make the research setting worthy of attention.

26. Primary health care is both a philosophy and level of health care. It is first level care with a focus on prevention and health promotion (see 10.2).

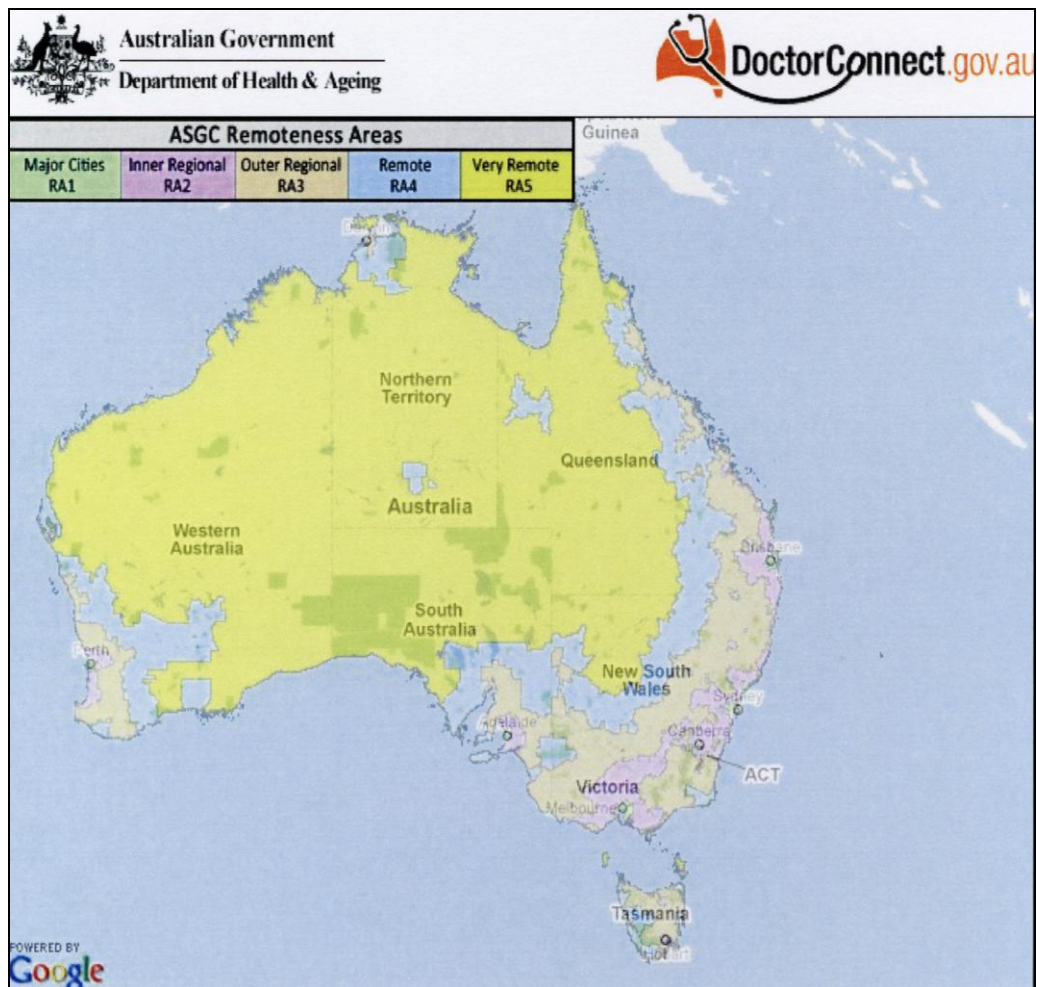


Figure 2: ASGC-RA Map of Australia (DoctorConnect, 2010)

Central Australian Indigenous people are disproportionate users of health services. Whilst comprising approximately 25% of the Central Australian population, Indigenous clients occupy on average some 80% of all hospital bed stays and account for 98% of remote health centre attendances (Department of Health and Community Services, 2009). Indigenous people in Central Australia use health services most often for symptom relief, and many still pursue traditional therapies in tandem with western medicine (Nathan & Leichlietener, 1983; Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council Aboriginal Corporation, 2003; Palmer-Thompson, 2007). Some health centres within the region are known to support the use of traditional Indigenous medicines and facilitate access to traditional Indigenous healers for their clients (Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council Aboriginal Corporation, 2003).

Central Australian health services consist of both government controlled and community-controlled facilities. Government controlled services come under the Northern Territory Department of Health and Families (NTDH&F) (the third departmental name change during the last decade—see 10.3). Within Central Australia, tertiary health services are controlled by the Northern Territory Government, but reliant on Federal funding and subject to Federal intervention.

Government controlled services in the region include two tertiary services, the larger Alice Springs Hospital and a smaller twenty bed hospital 500kms to the north at Tenant Creek. Alice Springs Hospital is well equipped to act as the major tertiary care centre for the region, but experiences considerable difficulties in recruiting and retaining staff in an isolated area (Department of Health and Community Services, 2009). There was a failed attempt to open a private hospital wing within the public Alice Springs Hospital in 2006. Given the remoteness and challenges of attracting specialist services to the region, few private hospital clients actually chose private health care when they were accessing the same health professionals employed in the public hospital. In the town of Alice Springs, there is also a government controlled community health service responsible for aged, adult and paediatric community care, renal dialysis and dental services. There is one Aboriginal Controlled Dialysis Service, located in Alice Springs that breaks the mould for its innovative approach to holistic renal management, known locally and for simplicity as ‘the Purple House’.²⁷ The Western Desert Nganampa Walytja Palyanjaku Tjutaku (WDNWPT) Renal Dialysis Unit was established in response to a need to address the impact of dislocation and cultural safety for Western Desert²⁸ people requiring treatment for renal disease (Brown, 2010; Rivalland, 2006). A genuine example of Aboriginal self-determination, this renal unit was established in 2000 to provide renal treatment and education that would facilitate patients being able to return to

27. The Purple House is the Alice Springs base for WDNWPT Dialysis—named pragmatically for the colour the house is painted.

28. Western Desert is a geographic and cultural region that incorporates Indigenous language groups who live in the deserts to the west of Alice Springs. These traditional lands extend into Western and South Australia.

their homelands for visits and/or ongoing treatment within their home communities (Rivalland, 2006).

There are also a number of Aboriginal Controlled Health Services (ACHS) or Aboriginal Medical Services (AMS) in the Central Australian region, which has the largest proportion of Indigenous people nationally. Whilst the overall representation of Indigenous people is around 3% nationally, Central Australia's Indigenous population is approximately 25–30% of the total (Department of Health and Community Services, 2009; J. Taylor & Biddle, 2008). The difference between Central Australia and the national representation of Indigenous peoples is amplified by the disparity in health. In this region 70–80% (more in remote communities) of health service users on average are Indigenous people (Department of Health and Community Services, 2009).

This demographic gave rise to the need for culturally appropriate health service to meet the needs of Indigenous people in the region. The Central Australian Aboriginal Congress (CAAC or Congress) is one of the oldest Aboriginal community controlled services in the country. Commenced in 1973 as a congress to provide representation and advocacy for Aboriginal people in the region, by 1975, the need for a more culturally appropriate health service became a priority for the organisation (Central Australian Aboriginal Congress, 2009). Although offering an alternative service to mainstream organisations, Indigenous clients by virtue of their often-serious health problems, require treatment and contacts within the government controlled health sector. Congress today is largely involved in providing a generalist practitioner clinic, as well as a comprehensive range of prevention and promotion activities and outreach services.

There are also a number of remote primary health care clinics located across the region, varying in size from single-nurse posts to larger multidisciplinary teams. There are currently some sixteen Northern Territory government-controlled remote clinics and ten Aboriginal Controlled Health Services or Aboriginal Medical Services within Central Australia. The

closest Territory-controlled health centre is 130kms from Alice Springs via a sealed road. The most distant is an eight-hour drive via unsealed roads.

Seasonal extremes and cultural activities can affect access to and from remote communities. Flooding or other damage can close roads and airstrips, whilst community activities such as funerals or ceremonial events may also limit access for some people. Registered Aboriginal Health Workers²⁹ (AHWs) and Remote Area Nurses³⁰ (RANs) constitute the onsite workforce in most remote clinics. Medical officers are generally, though not exclusively, located in Alice Springs, and usually visit remote communities on a fortnightly basis. Depending on populations and need, they also provide clinical support and medical consultations to AHWs and RANs via telephone. Internet remains unreliable in some remote communities, but tele-health facilitated by internet is increasingly being considered for remote services. More recently, medical officers who are resident in interstate metropolitan areas have begun conducting consultations by phone. This development of having medical support located out of the region has increased recently due to the implementation of the Northern Territory Emergency Response (NTER)³¹ in 2007. The impact and efficacy of such a model is yet to be fully evaluated, with some medical officers, never having visited the communities they service.

The current reality of high morbidity, mortality, chronic and acute concerns of Indigenous people in particular however, leaves little time and few resources to implement genuine PHC services in many areas of Central Australia. Health in this context therefore, may be more accurately defined by the contradiction that most health professionals spend the bulk of their time focusing on illness, disease and injury. Added to the tensions between policy and practice, is the influence of mainstream responses to Indigenous and other cultures in Central

29. Aboriginal Health Workers are registered health professionals in the Northern Territory who are historically trained as primary health care workers (see 10.2).

30. Remote Area Nurses are registered nurses who practise in isolated settings, requiring advance clinical skills (see 10.2).

31. Northern Territory Emergency Response (NTER)—the 2007 Federal Government's response to child abuse allegations in Indigenous communities that initiated a range of interventions directly affecting Indigenous people within the Northern Territory (see 10.2).

Australian health care, discussed briefly in Chapter 1 and addressed further in section 2.7 of this chapter. Whilst culture is generally the identified factor influencing service delivery and health outcomes, in a post-colonial context, it may more accurately be considered that it is what underpins responses to culture rather than culture itself that is the more critical influence. Henry and Tator (2006) describe a concept called *democratic racism* that is further discussed in Chapter 3. Democratic racism considers systemic inequities as less related to specific cultural variables than to the tension that arises when dominant cultures are caught between their own ethnocentrism and their belief in social justice and equity principles (Henry & Tator, 2006). Pursuit of such principles however may inevitably threaten the status quo and the inherent privilege of being a member of the dominant culture.

2.3.1 Workforce Issues

Western biomedical models and definitions of health generally underpin services in Central Australia. Personnel must meet the criteria for registration as a health professional (doctor, registered nurse, enrolled nurse, etc) or hold certain suitable qualifications for their particular discipline (e.g., allied health). Recruiting and retaining health professionals in Central Australia is an ongoing challenge. It is a chronically understaffed environment. Alice Springs Hospital for example, is a modern 180 bed well-equipped facility, but the staff turnover of has been as high as 300% (Department of Health and Community Services, 2009) with new staff orientated fortnightly and an average length of stay that has been as low as 3–6 months. The majority of staff stem from urban backgrounds, many of them originating from Ireland, New Zealand or England (Department of Health and Community Services, 2009).

Alice Springs also sits nicely on the ‘backpackers’ route for many nurses, who have a short working experience in the Centre before heading on to Darwin, the capital city of the Northern Territory and then over to Cairns in Queensland, a well-known beachside city. This transience seems to be the nature of workforces today, reflected in the generational changes that see workforce longevity as outdated (McCrindle, 2006). Remote health services in

Central Australia have an even greater test in attracting and retaining staff, with heavy reliance on agency staff (Davey, 2010).

2.4 Geographical context

This study takes place in an environment renowned for its unique and somewhat exotic geographical and cultural aspects (Marcus, 2005). Even within Australia today, there are many who have only an image and assumptions on which to base their understanding of the setting. Central Australia as the name suggests, is located in the geographic heart of the country. The majority of Australians, through literature and other media portrayals, know it as the 'Red Centre' or the 'outback'.

From a global perspective, the isolation of Australia as an island continent in the southern hemisphere ensures geography continues to play a role in the country's development and place in the world. Australia was colonised in the late 1780s by the British, having been 'claimed' earlier by the explorer James Cook in 1770. While British colonists attempted to transplant northern hemisphere notions of altering the environment to suit their needs, the First Australians lived in concert with existing geography and ecology (Eckermann, et al., 2006). Such conflicting ideologies between cultures continue to affect the delivery of health services in remote Australia today.

The media often portrays Central Australia as a place fraught with dangers and disincentives for living there. Climatic extremes, vast distances, scarce resources and a lack of comforts can make Central Australia sound unappealing to coastal-hugging populations. The natural landscapes of Central Australia however, are rich in aesthetic and cultural significance. Consequently, many relative newcomers willingly call it home. More importantly, there are those First Peoples whose connections to the region extend back tens of thousands of years.

In relation to health service provision, geography influences clinical decision-making, funding, resource allocation, staffing and access to services amongst other things. The

nearest major hospitals to Alice Springs are both 1500kms away in Darwin to the north and in Adelaide to the south. The overlapping of ‘official’ State borders with existing well-defined Indigenous *countries*³² means that clients whose place of residence is interstate often seek health care within the NT, adding to the complexity and cost of health service delivery (Brown, 2010; Medew, 2009).

Geographical distance from the major centres influences the Federal definitions of remoteness, which in turn influence resourcing and service availability. Central Australia is classified remote to very remote (see Figure 2, in 2.3). Climatic extremes including long periods of drought or brief periods of flooding, impact service delivery and the health of individuals and communities. Environmental health risks such as dust and seasonal hazards including smoke from land management, cooking and heating fires,³³ pose significant health risks to Indigenous people, as does culturally incongruent housing provided in remote communities (Musharbash, 2008).

2.5 Historical context—Colonisation of Australia and Central Australia

Australia is one of a great number of countries that became the target of European competition for lands, resources and peoples during the 17th and 18th centuries. So fiercely contended between the European superpowers of the day, it became necessary for an international court to regulate the rules by which countries could be claimed (Eckermann et al., 2006). The three agreed-to terms for claiming territories were through conquest, negotiation of a treaty with existing inhabitants or by the declaration of a land as empty or belonging to no one. Australia was the only territory to be claimed under what is now acknowledged as a legal fiction—that of *terra nullius*³⁴ (empty land, belonging to no-one)

32. Countries, country used in the sense of Indigenous land connections indicates clearly defined territories, acknowledged as belonging to or being the traditional lands of specific Language groups.

33. Fires remain a prominent feature of everyday life in remote Aboriginal communities in the region, whether for cooking, heating or as light for night time. Even when electricity is readily available the role of fires is integral in many people’s daily activities. Burning of land for land management is also continued in some regions.

34. *Terra nullius*—A European concept meaning land belonging to no-one (see 10.2).

(Eckermann, et al., 2006). All that was required was the planting of a British flag on the soil in question and the region had become part of the British Empire, according to European standards of the day.

It is beyond the scope of this thesis to describe processes of history that took place over several hundred years. However, some cursory discussion may be relevant in identifying influences that have shaped outcomes today. While the Americas, Canada, New Zealand and other colonised countries contested their future paths through conflicts, bargaining and treaty making, Australia and its First Peoples were considered differently. The continent was empty according to some British eyes that saw no recognisable system of government, law and no people considered worthy of notice. According to archived communications between the British authorities and those sent to establish new colonies:

The Aborigines' lives and livelihoods were to be protected and friendly relations with them encouraged, but the Instructions make no mention of protecting or even recognising their lands. It was assumed that Australia was terra nullius, that is, land belonging to no one. This assumption shaped land law and occupation for more than 200 years (National Archives of Australia, 2010).

The impact of British colonisation on Australia's First Peoples since 1788 is well documented (National Archives of Australia, 2010; Perkins, Langton, Atkinson, & et al, 2008). Within a relatively short period, Indigenous east coast populations around Sydney had dwindled, with some language groups totally decimated within 30 years of contact (Schmidt, 1993). While the colonisers settled the coastal regions relatively quickly, Central Australia remained somewhat of an enigma. Colonisation took much longer to reach the Centre of the continent.

Central Australia was one of the last areas to be 'settled' by Europeans who had largely avoided the mysterious and somewhat frightening interior. That was until the need for contact with the outside world established a telegraph line through the centre of the country in 1872, linking Adelaide to Darwin and then to the rest of the world (A. Thomson, 1999).

Prior to this there has only been a handful of non-Indigenous explorers searching for what was believed to be an inland sea, who been into Australia's centre. This history created a very different environment to the rest of Australia, where European settlement was established much earlier and the effects of colonisation already played out in the preceding century. Even within the Northern Territory, Central Australia had a different experience of colonisation in comparison to the northern parts that had established contacts with groups from Asia stemming back centuries (Perkins, et al., 2008; Trudgen, 2001). The northern regions were less isolated in terms of contact with the world beyond Australia. Although pastoralism and mining in the late 1800s brought Indigenous and non-Indigenous populations into contact in Central Australia, such encounters were often characterised by conflict as settlement *'forced or enticed removal from traditional country'* equating to removal from *'self'* (Watson, 2006, p. 11).

Today's remote Indigenous communities arose as a result of stringent attempts to bring Christianity to the 'natives'³⁵ through the establishment of missions or later attempts to apply a succession of policy responses to *segregate, assimilate and protect*³⁶ Indigenous peoples within church or government run reserves (Taylor & Guerin, 2010). Prior to colonisation, Indigenous Australians lived highly mobile existences throughout Central Australia, moving purposefully and seasonally within their respective countries. Communities today are fixed by the placement of infrastructure such as a clinic, store, council office and school, but the mobility of people remains quite pronounced (Musharbash, 2008). In the few areas where reserves were not established, some groups remained within traditional homelands, but competed for resources with pastoralists and mining groups, with varying outcomes. Within the more isolated desert regions of Central Australia the last group of Indigenous people to come into contact with non-Indigenous people did so as recently as the 1980s (Batty, 2007; Folds, 2001). The recent nature of this contact is in stark contrast to experiences of other

35. Natives—Indigenous Australians have been variously referred to in historic literature, often with labels that were imposed rather than negotiated. 'Native' was a term in use into the mid 1970s. This terminology seems to be in current usage more in northern hemisphere countries, but is not generally accepted in Australia today (see 10.2).

36. See Policy directions, Table 1 in 2.6

Indigenous Australians across the country who at that time, had been living with the impact of colonisation for several generations in some regions. Access to traditional lands, maintenance of cultural ceremonies and protocols and use of first languages had eroded over time for many Indigenous Australians in other parts of the country.

The influence of history on the health of Indigenous people has been profound, with many of today's health issues linked to experiences of contact and colonialism. The dislocation from traditional lands and the introduction of European diets are implicated in the epidemics of renal, endocrine and cardiac diseases experienced today by many Indigenous people in Central Australia (Eckermann, et al., 2006). The impact of colonisation on pre-existing law, family structures and societal roles and responsibilities has been major, with incidences of family breakdown, violence and mental health problems prominent in the current health status of Indigenous Australians today (Randall & Hogan, 2006).

Construction of Aboriginal people in Australia is typically from a perspective of deficit. This construction reinforces the popular notion of 'white intervention or rescue', implied in the headline that accompanied the reporting in 1984 of the last group of Aboriginal people to enter the government reserves in the Western Desert region. The reporting of this group's entry into the reserve from their traditional lands, labelled '*We find the lost tribe*' gives an example of both the recency of contact in Central Australia and the ethnocentrism of non-Indigenous discourses of the day (Batty, 2007, p27). Just as problematic as the discourse of Cook's³⁷ 'discovery of Australia', the family group depicted on the front page of the Melbourne Herald newspaper were neither 'lost', nor 'found'. They voluntarily came into the settled areas to reconnect with relatives already caught up in the established government reserves. An unprecedented period of drought also played a role in bringing this group in from their country in a pragmatic move on their part according to a nurse who was sent to assess the health of this group (Brown, 2010, personal communication). Central Australia

37. Cook refers to then Lt James Cook who is credited in Anglo-Australian history with 'discovering' Australia in 1770. Given that it was already occupied, the discourse fails to specify that the 'discovery' was only a 'discovery' to the British of the day, who were unsure of the continent's existence and extent.

remains entrenched as the seat of non-Indigenous ‘intervention’ more so than ever with the implementation of the 2007 Northern Territory Emergency Response³⁸ (NTER) (Altman & Hinkson, 2007; Hinkson, 2007).

History permeates every encounter in Central Australian health care. Many events of first Indigenous and non-indigenous contact are within living memory of people in this region. Add to this the strong aural/oral tradition of Indigenous people, and what is considered history to non-Indigenous people, is a current and tangible experience for many Indigenous people of Central Australia. Indigenous people within Australia and particularly within Central Australia have been under some form of non-Indigenous control since first contact with non-Indigenous colonisers. Even though colonisation occurred much later in Central Australia, the nation’s foundation policy of *terra nullius* has undoubtedly influenced the manner in which Indigenous people were subsequently regarded. Of all the Indigenous groups in Australia, Central Australian people, by their later contact and desert lifestyles, were subjected to the most disparaging of descriptions that were underpinned by the de-humanising notion of *terra nullius* (Folds, 2001). It is not hard to see the lack of attention to Indigenous Languages that followed over subsequent years, when the people who spoke them were not even acknowledged as people.

2.6 Political context

As part of the Northern Territory, Central Australia is subject to greater influence from Federal politics, by virtue of its status within a territory. However, even within the Northern Territory, with its seat of government located 1500kms to the north of Alice Springs, there can be complaints about a lack of equitable power for Central Australians who experience control over their lives that is distant geographically, culturally and politically.

38. The NTER is the name given to a suite of wide ranging policies and interventions that were purported to be in response to findings of child sexual abuse in the Northern Territory. Commencing in June 2007, parts of the racial discrimination act were suspended, to allow the Commonwealth Government to take control of Aboriginal communities and impose a range of interventions, including income management for all peoples within prescribed areas.

Politically, the Northern Territory has been dominated by conservative politics, with social justice and Indigenous rights remaining as thorny issues for parties whose main supports stem traditionally from pastoralist, mining and business sectors. Indigenous Land Rights and supports for services such as Indigenous interpreters were stalled, and largely neglected under previous conservative governments. In 2008, the election of a Labor³⁹ (progressive) Government brought in an optimistic period and hopes for a more harmonious relationship between Indigenous and non-Indigenous populations in the Northern Territory. However, such relationships have also failed to eventuate, with the stronger influence of conservative Federal and local politics pushing their agenda of ‘new assimilation’ and so-called ‘normalisation’ for Indigenous Territorians (Altman & Hinkson, 2007).

Politics influences health services significantly. The competing tensions identified within this Intercultural Health Care Communication study are evident at all levels of service delivery. Indigenous Territorians are often portrayed in local media, as anti-progress, anti-tourism and anti-social in their behaviour, placing responsibility for their disadvantaged position within society squarely on Indigenous people themselves. Locally, the term *anti-social behaviour* has become a euphemism for Indigenous people’s behaviour. The obvious inability to communicate interculturally appears to impact across much more than the health sector.

From the outset of non-Indigenous and Indigenous interactions, official policies have sought to deal with the consequences of an early failure to consider the sovereignty of the original people of this land. Health personnel have often been at the interface of many interactions and policy responses in the Central Australian region. These events of culture contact took place over a considerable period, however and it is difficult to capture such history in mere

39. Labor refers to the Australian Labor Party (ALP) whose core values derive from social justice perspectives. Australian politics has traditionally been dominated by two major parties, purported to be philosophically opposite, but increasingly less distinguishable. In 2010, this dominance has been challenged with smaller parties and Independents gaining greater prominence.

paragraphs. Missionaries and ‘protectors’⁴⁰ were at the interface of this shared history, with religious nursing sisters given a duty to care for those Indigenous people subject to Government intervention. Central Australia’s health professionals—the nurses, health workers and medical officers who were confronted with the visible decline in health status of Indigenous Australians were often conflicted about their roles in implementing official policies of the day (Brown, 2009 personal communication). Such conflict continues today with government policies continuing to have a significant impact on the lives of Indigenous Australians (Altman & Hinkson, 2007) as well as on the health professionals who care for them.

To give just a brief overview of the policies that have affected Central Australian Aboriginal people, Eckermann et al. (2006) have provided a summary (see Table 1, in 2.6) that I have updated to reflect more recent policy directions (see shaded sections). This snapshot of Australian Government responses to Indigenous people highlights the lack of personal power that has undoubtedly had an intergenerational impact, and which can be directly linked to some of the health and well-being issues experienced today. Had I been born an Indigenous Australian for example, I would not have full citizenship rights of this country until I was nine years old in 1967. Certainly my parents and grandparents would have lived as ‘non-citizens’, who would have been compelled by policy directions to assimilate, integrate, self determine, self manage and then reconcile with non-Indigenous Australia. Apart from national policy initiatives, each state and territory had its own set of policies that positioned Indigenous people as automatically ‘wards of the state’ until the late 1960s. Control over marriage, employment, education, land ownership and finances were subject to government discretion, creating a situation where some Indigenous people sought to hide their Indigenous identities (Taylor & Guerin, 2010). Indigenous Languages were actively discouraged from use in many areas, contributing to the rapid decline within the relatively short period since British colonisation began in 1788 (Evans, 2010).

40. Protectors were paid officials who were non-Indigenous people placed in positions of responsibility over Indigenous people (see 10.2).

Table 1: Policies affecting Central Australian Indigenous People since 1788 (Eckermann, et al. 2006, pp. 22–24). Shaded areas updated by author.

Policy direction	Years	Policy intent and underpinning beliefs
Terra Nullius European settlement	1788–1880s	Empty land—belonging to no-one Indigenous people constructed as having no culture or humanity—labelled as the ‘Missing link’ in Darwinist theory
Protectionism or segregation	1890–1950s	‘Smoothing the dying pillow’—intent to care for Indigenous people until their inevitable extinction duty to ‘Civilise the savages’ Growth of Missions and missionaries Establishment of Reserves
Assimilation	1950s–1960s	Indigenous people expected to assimilate into white communities
Integration	1967–1972	Pressure to make up for past mistakes ‘Choice’ to integrate or not, say what is wanted
Self determination	1972–1975	Multiculturalism –recognition of different cultures Should be in charge of own affairs
Self management Stage 1	1975–1988	Aboriginal people should be accountable for their decisions and management of own affairs/finances
Self management Stage 2	1988–1996	Aboriginal affairs to be organised under Aboriginal and Torres St Islander Commission (ATSIC)—take responsibility for housing, welfare, health, education & employment. High Court recognition of prior ownership of Australia
Reconciliation—Economic Rationalism	1996	Stolen Generation Inquiry—reluctance to accept impact of colonisation
Mutual obligation	2005-2007	Intent to ‘share responsibility; for health and well-being with government. Indigenous people were to show their commitment to improve living standards in exchange for infrastructure and services most mainstream communities already accessed. Characterised by the example of a remote WA community given a petrol pump in exchange for Aboriginal families’ ensuring their children’s faces were washed and that they attended school. (McCausland & Levy, 2006)
Northern Territory Emergency Response or ‘Intervention’ (NTER)	2007–ongoing	Commonwealth Government response to report into child sexual abuse in remote Indigenous communities. This policy suspended aspects of the Anti-Discrimination Policy, introduced income management for welfare recipients and sought to take over land leases to provide access for programs of infrastructure development.
Closing the Gap	2008–ongoing	Aimed at addressing the discrepancies in Indigenous life expectancies and disadvantage through education and employment.

Table 1 gives just a broad overview of the numerous policy directives and underpinning intent and beliefs. It should be noted that each state and territory also had their own locally applicable policies, subjecting Indigenous Australian's to even greater intervention and control than suggested by this brief summary.

With the opening of inland Australia and the coming of missionaries, protectionism and segregation endured well into the twentieth century. The expected extinction of Indigenous people in Central Australia, which clearly did not eventuate, prompted the need for a new policy direction which was termed '*smoothing the dying pillow*' (Eckermann et al., 2006, p. 22). 'Smoothing the dying pillow' was seen as a way to support the Indigenous populations to their 'inevitable demise' through the establishment of missions and reserves in which Indigenous Australians were compelled to live.

Although some Australians may find comparisons with South African Apartheid offensive, it is a reality that many Indigenous Australians experienced apartheid policies. Segregation policies emerged when it was realised that Indigenous Australians were not in fact dying out, but sustaining population growth in mission and reserve environments where food, irrespective of quality, was in constant supply. Segregation policies prevail still, albeit covertly and rarely officially sanctioned. That is, until the most recent example in 2007 known as the Northern Territory Emergency Response mentioned previously.

For myself, I view assimilation as possibly the most insidious form of colonisation. It presumes a right and a wrong way of living and viewing the world. It is an example of the ethnocentrism that Eckermann et al. (2006) considered to underpin all interactions between Indigenous and non-Indigenous people. It was during assimilation periods in particular that Indigenous Languages were actively discouraged and Indigenous Australians were required to demonstrate their capacity to live as non-Indigenous Australians. When this left many Indigenous people psychologically and emotionally damaged from having to deny their own identities in order to gain acceptance in their own country, the policy shifted yet again to

Integration where it was intended that how one lived was to be theoretically at least, a matter of choice.

Then, after generations of control over every aspect of Indigenous lives and a growing realisation of the failure of such policies, people were suddenly declared to be self-determining and self-managing. The only problem with this new ideology was that Indigenous people were largely unprepared for the dramatic change. In Central Australia at least, experiments in self-determination and self-management left many people confused, abandoned and ultimately blamed yet again for ‘their failures’. One of the few authors to really challenge the futility of past and current policy approaches is Ralph Folds in his book, ‘Crossed Purposes’ (Folds, 2001). He suggests that until all parties share a common understanding of what exactly is meant by *self determination and self management* that Indigenous and non-Indigenous Australians will remain at *crossed purposes* (Folds, 2001).

In 2007 the Northern Territory Emergency Response (NTER) allowed the Federal government to ‘justify’ the suspension of aspects of the Racial Discrimination Act to allow policies to be imposed on Indigenous Australian citizens on the basis of racial identity (Altman & Hinkson, 2007). The effects of the NTER or ‘Intervention’ as it became known are yet to be fully appreciated. However, it has already been suggested that poor intercultural communications have left many Indigenous people confused, angered and disempowered. I was asked by Jakamarra (one of this study’s Indigenous participants) if I could explain why he was suddenly no longer in control of his own finances, as quarantining of social security payments was introduced as part of the NTER in June 2007. When I could not offer a satisfactory answer, he responded that: ‘*I might as well be back in the reserve*’, referring to the government run reserve in which he spent most of his life. Politically, health care in the Northern Territory is driven by multi-layered bureaucracies that are often far removed from the people seeking and needing care.

2.7 Socio-cultural context

Central Australia is home to a diverse mix of peoples, some indigenous to the region and a significant number who come from elsewhere for various periods and reasons. It was not until I became a resident in Central Australia that I really came to appreciate the rich heritage of Indigenous Australia. My previous exposure to Indigenous issues had created a belief that Indigenous cultures and languages were all but gone. Central Australia is a fascinating environment that is often portrayed negatively and yet one that I have found to be quite the opposite.

My own positive experiences and responses to the region however, do not mean that I can gloss over the significant and undeniable social problems found here. There are clear disparities in social conditions between Indigenous and non-Indigenous Central Australians. There are law and order problems, homelessness, public drinking, intoxication and violence that are perhaps more visible than in other communities around Australia. Visibility is a major influence in shaping perceptions of Indigenous people in the region, as most of the same issues impacting non-Indigenous Territorians are less public, hidden within the private spaces that are usually indoors or out of view. Nevertheless, for me, a rich and challenging environment such as this, should be talked up rather than talked down. It can be the middle of nowhere or the centre of everything, depending on how one embraces it. The daily negative and derogatory sentiments expressed by dissatisfied locals and visitors in local media perhaps says more about the issue at the heart of this thesis—an inability to communicate with those who know this environment best, the Indigenous people of Central Australia. This inability to communicate I believe, leads to the development and perpetuation of racism, discrimination, marginalisation and social exclusion that arising from fear, misunderstanding and a lack of connection.

Within what initially might appear as a bicultural context of Indigenous and non-Indigenous populations, each population is diverse in cultures, histories, experiences and motivations for

being in Central Australia. The following section will briefly describe some of the diverse cultural groups that co-exist within the region known as Central Australia.

2.7.1 Indigenous cultural groups of Central Australia

From an Indigenous perspective, territorial borders existed long before the imposition of national state and territory boundaries. The Indigenous Language Group map (Figure 3, in 2.7.1) shows the diversity of tribal countries across Australia. As one of the last regions to be colonised in Australia, the region remains the repository for the few remaining Indigenous languages regarded as *living*—that is, transmitted between generations and in active use (Schmidt, 1993; Walsh, 1993).

Linguistically, Central Australia is home to the 8% of Indigenous languages that remain actively transmitted, from parents to children. Indigenous language speakers, raised in missions and reserves, often speak English due to the policies of the day that enforced schooling and in some instances banned the use of Indigenous languages within the communities. However, even those who were taught or acquired English still experience similar problems of miscommunication due to the influence of First Language parents or grandparents and the use of Aboriginal English⁴¹ (Eades, 1991). Within the Central Australian region indicated in Figure 3 (this section 2.7.1), there are major cultural/language groupings, each with distinct dialects within. The major linguistic groups are the Arandic, (including Central, Southern, Eastern and Western Arrernte languages), the Warlpiri, Luritja and Pintupi, Pitjantjatjara and Alyawarra.

41. Aboriginal English –modified English used by Indigenous people- see 10.2

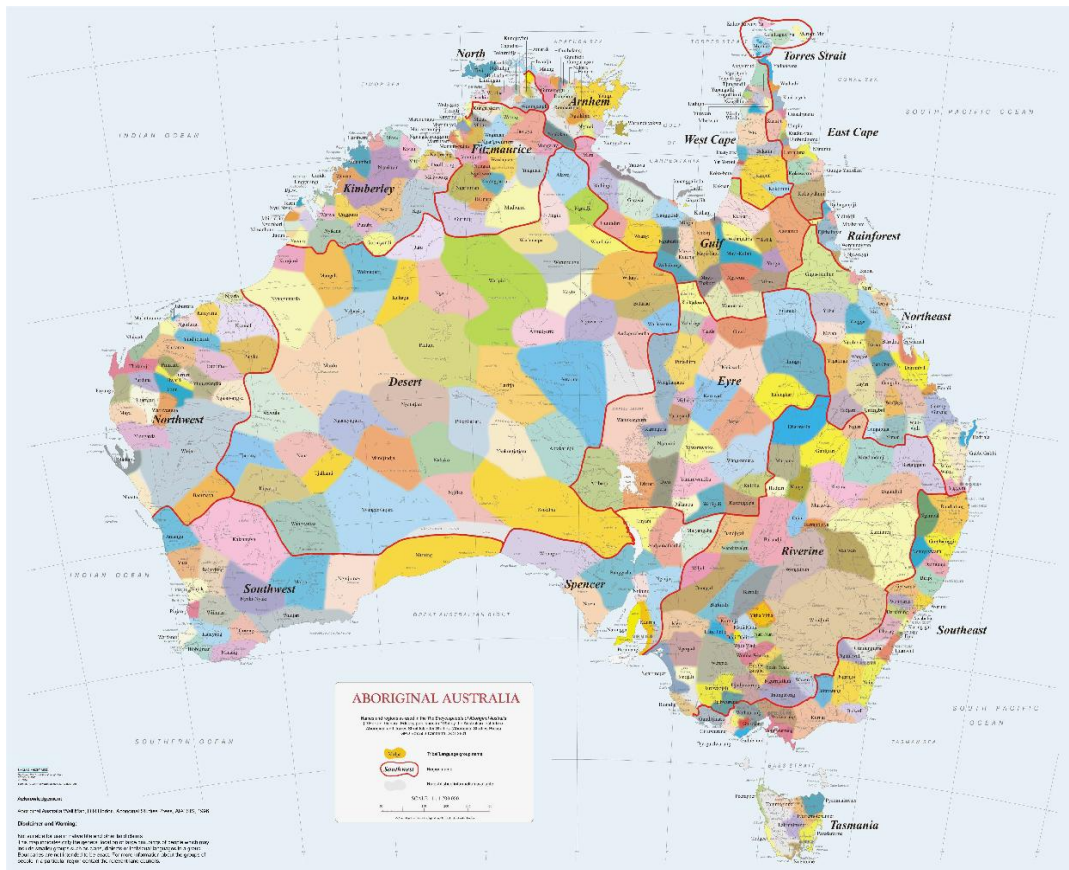


Figure 3: Map of Indigenous language groups (Horton, 1996)

Table 2 (in 2.7.1) shows the specific language groups relevant to the research setting, with dialectical variations within each. This table shows the linguistic diversity of Indigenous people within just the Central Australian region, highlighting the challenge of providing adequate supports and resources to meet the needs of all Indigenous language speakers locally. The groups identified in Table 2 are culturally, linguistically, politically and historically diverse in terms of their respective experiences of colonisation. The Arandic speaking people are those most associated with the area known as Alice Springs and surrounding areas, including the Anmatyerre, Alyawarre and Kaytetye peoples to the north and east. The Western Desert Language groups live mostly to the west and south of Alice Springs, with the Ngarrkic belonging to the north-western regions.

Table 2: Indigenous Language Groups, Languages and Dialects of Central Australia, Institute for Aboriginal Development, 1990 ([Institute of Aboriginal Development](#))

Arandic	Western desert	Ngarrkic	Ngumbin	Other
Arernte (Aranda, Arunta)	Ngaanyatjarra	Warlpiri	Gurindji	Warumungu
Eastern Arernte	Ngaatjatjarra	Warlmanpa	Jaru	Jingili
Central Arernte (Mparntwarenty)	Pitjantjatjara		Mutpurra	Yanyula
Southern Arernte	Yankunytjatjara		Ngarti	Arapanna
Western Arernte	Luritja		Nyininy	Dieri
Anmatyerre	Papunya Luritja		Walmajarri	Kriol
Alyawarre	Pintupi			
Kaytetye	Kukatja			

The Indigenous populations in Central Australia also differ from non-Indigenous populations in their age distributions. While the rest of Australia's populations are increasingly made up of older people, Indigenous groups are mostly under 25 years of age (Indigenous Healthinfonet, 2010). The Indigenous and non-Indigenous population distributions across age groups are almost the reverse of each other. This has implications for health services that are dealing with the burden of a burgeoning aging population in mainstream Australia and the consequences of losing a large sector of elderly people within the Indigenous communities. One anomaly of the relatively younger Indigenous populations however, is the fact that Indigenous people are experiencing diseases of aging much earlier than other Australians (Indigenous Healthinfonet, 2010; Taylor & Guerin, 2010).

Central Australia may be best known nationally and internationally as a place where Indigenous cultures are most prominent. Not all portrayals of Indigenous cultures are positive however. Labels such as *'traditional, contemporary, urbanised, westernised'* and even *'lost'* are used to define and construct culture from mainly non-Indigenous perspectives. These labels can be harmful to Indigenous people in Central Australia as suggested in the incident referred to in Figure 4, the cartoon by Nicholson (2008), *'The real Australians'*.



Figure 4: 'The real Australians' Cartoon by Nicholson from "The Australian" newspaper: www.nicholsoncartoons.com.au (Nicholson, 2008)

Figure 4 depicts a cartoon (Nicholson, 2008) published in the Australian, a national newspaper and in the local Alice Springs newspaper, of a real life incident that exemplifies the tension and contradictions lived out in the town. A group of young Warlpiri⁴² women were attending a leadership course in Alice Springs, when some international tourists staying at the same hotel made a complaint that they felt intimidated by the group's presence. There was no suggestion of intimidating behaviour or any interaction of any kind with the tourists. The group's mere presence was unsettling to the complainants. The management responded by asking the Warlpiri women to leave. The incident illustrates the contradictory and harmful responses to Indigenous Australians that still permeate today. In spite of a flourishing tourism and art industry based on Aboriginal culture, Alice Springs remains a place of tension and contradiction.

Central Australia is not unique in its cultural mix or relationships. It is however, like many places with a tangible colonising history, still coming to terms with how this history positions various groups. Most often however, the rights associated with being the original

42. Warlpiri— Indigenous people whose traditional lands are in the Western Desert region of Central Australia.

inhabitants of this region are illusory in the face of powerful mainstream interests—tourism, pastoral, mining, and business, to name a few. In my experience, Indigenous people of this region are often denigrated for their so-called ‘special treatment’ and the ‘benefits’ of welfare payments. In reality however, this most often translates into shorter, sicker lives, and disempowerment, as confirmed by national statistics on Indigenous health status (Healthinfonet, 2010). The maintenance of culture in such circumstances requires considerable effort, resilience and resistance.

Indigenous cultures are not static. They are highly adaptive, resilient, and responsive to change, even though core values and beliefs may remain. Outward manifestations of culture may change—dress, diets, technologies, and language. However, the underpinning worldview of Indigenous people may remain strong (Folds, 2001). This capacity to retain strong cultural values and beliefs does not discount the fact that many Indigenous people today are living with the impact of intergenerational and ongoing colonisation.

2.7.2 Non-Indigenous cultural groups of Central Australia

Central Australian non-Indigenous cultural groups include pastoralists, miners, and today mostly government employees involved in health, law, education or other public services. Although there are non-Indigenous people who have connections to the Northern Territory that span several generations, the majority of the NT’s non-Indigenous populations are relatively temporary and transient. Tourism is a major focus for the region, with population numbers fluctuating throughout the year, placing added strains on health services. For those who do make Central Australia home for a length of time, a common pattern within conversations is to ask or be asked, ‘Where are you from (originally)?’

There is little doubt that the major employment opportunities for non-Indigenous people in the NT usually derive from servicing Aboriginal populations in some form or another. Employment opportunities for non-Indigenous people are relatively good, compared to other states, with strong financial rewards for those who choose to work in remote regions. The

cultural mix within non-Indigenous populations is mainly Anglo-Australian. Like the rest of Australia however, there is a mix of other non-Indigenous ethnic groups. Increasingly, Sudanese and other African people who have arrived through refugee resettlement schemes are adding to the cultural mix of Central Australia. The health professions in particular are contributing to the diversity with staff recruited from overseas. The last few years has seen a change in the demographics of overseas-trained nurses from Irish, English and New Zealand backgrounds, to those from Zimbabwe, India and China (Wren, 2007).

2.7.3 Health cultures

Interfacing with all of these ethnic and other cultural groups are the health cultures of medicine and nursing. Medical practitioners and nursing personnel have historically been at the forefront of some dubious policy implementation and detrimental health ‘care’ as well as being advocates for improved outcomes and services for Indigenous people. These contradictions mirror what is still occurring today—health professionals act as agents of government and other non-Indigenous institutions to ‘intervene’ in Indigenous lives and well-being, supposedly for the principle of ‘the greater good’ (Altman & Hinkson, 2007). On the other hand, many health professionals also advocate for Indigenous Australians to achieve and expect the same health outcomes as any other member of a developed and affluent country in the 21st century. Many give their entire careers to the field of Indigenous health.

Medical and nursing cultures have historically developed from a sense of beneficence and a vocation to care for the sick and vulnerable. Development of Central Australia’s medical and nursing cultures was strongly tied to religious organisations, with many of the regions first doctors and nurses also being missionaries. The vocation mentality that prevailed for so long however, is now subject to other societal influences. Intergenerational change has seen the influx of health professionals arriving in Central Australia with somewhat different motivations and expectations, such as the financial draw of remote practice or the element of adventure and opportunities for rapid career progression in areas of limited human resources.

When I first came to the Territory in 1988, I was somewhat offended by the frequent question put to newcomers—‘*So, are you mad, missionary or misfit?*’ I did not feel I was any of these. I certainly had not come to ‘save’ or convert Indigenous people. I was of sound mind as far as I knew and I did not think I was a misfit. I came for a visit and like many, unexpectedly found a home. However even today, the motivations of many who visit Central Australian can be categorised similarly, with the addition of a couple of other “M.s”—mercenary, mortgagee, management aspirations or mobile. Money is a major incentive, along with paying off the house. There are many who find that the climb to the top of the career ladder is much quicker in this region, so working one’s way up from the bottom for many Generation X and Ys⁴³ is unnecessary. Then there are those working tourists who are simply moving through to another health service job in the next great tourist destination. It would be unreasonable to those many highly professional and dedicated staff that are simply here to do a great and challenging job, to suggest everyone must fit into these categories. I make no such suggestion, but the cultures and motivations that draw health professionals to Central Australia are certainly influential in determining the experience of care for both clients and staff.

Medical and nursing cultures are hierarchical in nature. Power structures are well entrenched, although contemporary training is possibly producing medical officers who are perhaps more approachable than their previous cohorts and nurses who are more prepared to challenge existing power structures. Within non-Indigenous society however, medical and nursing professions retain a level of social power. Within the context of Central Australia, where medical personnel have held considerable authority to intervene in the lives of Indigenous peoples either through government policies, public health and welfare measures, the cultures of health personnel require examination within this study. Power and colonisation are key themes explored throughout the study and were identified by participants. The responsibility such power imbues in individuals and an organisation is

43. Generational categories defining those born between 1965–1979 as Generation X and 1980–1994 as Generation Y (McCrinkle, 2006)

considered within the historical, political and social contexts of this study. With such a complex mix of geographical, historical, political and socio-cultural influences coming together in this region, communication is an issue worthy of far greater scrutiny and attention than it receives. Competing interests and differing world-views often brought, and continue to bring these groups into conflict (Randall & Hogan, 2006). In the context of health care, without overstating it, communication can be a matter of life and death.

I have worked with diverse cultural groups throughout my career, as a teacher, nurse, health educator and academic. I have observed and sought to analyse the differences between the professional cultures that I have been involved with in my career. In Central Australia, I have developed functional literacy resources for registered Aboriginal Health Workers (AHWs) and Indigenous Language speakers generally. I have been part of health and education systems that largely expected Indigenous people to improve their English communication skills, with no obvious expectation that non-Indigenous staff would improve their capacity to communicate with linguistically diverse groups. When Indigenous people ‘fail’ to take their medicines, to comply with treatments, or act in a way to improve their health and so on, it is often considered to be *their* fault. However, this view did not sit well with my personal observations or experiences and does little to uncover the cultural influences that I myself might bring to bear on interactions. Health cultures in Central Australia exert considerable power within the lives of Indigenous people and consequently on the lives of the health professionals who are shaped by their own cultures.

2.8 Summary

This chapter has outlined the various contexts that have given rise to the research questions and study of Intercultural Health Care Communication. It has described some of the unique geographical, historical, political and socio-cultural elements that have potential to impact on Indigenous health and health care in the Central Australian region. As described in this chapter, geographical isolation has influenced the way in which mainstream Australia

regards Central Australia. Its distance from the mostly coastal dwelling population centres together with its more recent history of colonisation, are implicated in the neglect of Indigenous Australians' cultural and communication needs within health care settings. For those who come to work in Central Australia, it can mean that issues less prominent in other parts of Australia remain current in the health care contexts of this study. Most health and other personnel are ill-equipped for working with Indigenous First Language speakers. The unique political status of the Northern Territory along with very different socio-cultural demographics, all shape the way health services are delivered and who utilises them. These aspects, which combine to make Central Australian health care so challenging, are the very aspects that drew my attention to the issue of intercultural communication and the context of this study.

The next chapter provides a review of literature relevant to communication in health care, looking at global and local research and policies. It considers communication generally and intercultural and health care communications specifically, intercultural communication as a global issue and linguistic minorities in English dominant health services. In the local context, this section examines literature relating specifically to Indigenous First Language speakers, Indigenous languages in Australia and Indigenous health and communication research. Research regarding English First Language speakers and the role of language in colonisation and establishment of power is reviewed. For a philosophical perspective, the developments in nursing and health disciplines are considered with a special emphasis on the philosophy of Cultural Safety. Chapter 4 further explores cultural safety as the philosophical framework underpinning this study of Intercultural Health Care Communications, along with other methodological and theoretical literature. Finally, as this study has implications for the preparation of health professionals, there is a brief review of education and training literature relevant to intercultural communications.

Chapter 3

Closing the research gap: what's in the literature and what's missing?

3.1 Introduction

Health communication and intercultural communications specifically has become a burgeoning area of interest in the last two decades in particular (1990–2010). A review of literature using the search terms *intercultural communication, cross-cultural and/or health communications* reveals potentially thousands of research and other literature. The majority of the literature however is international in origin and content. When search criteria are further refined to look at the Australian context and in particular, focused on Indigenous or Aboriginal Language speakers, the volume of material drops dramatically. This lack of literature suggests that the needs of Indigenous Language speakers may be overlooked in Australian health care settings where English is the dominant tool of communication.

Globally, the literature indicates that being a linguistic minority has a direct and often negative impact on health and uptake of health care (Benavente, 2004; Blackford, 2005; Gerrish, Chau, Sobowale, & Birks, 2004; Institute of Medicine, 2009; Irvine et al., 2006; Smedley, Smith, & Nelson, 2003). In Central Australia, Indigenous people are members of linguistic minorities in a country dominated by English speakers. As established in Chapters 1 and 2, the ability of Indigenous Language speakers to negotiate healthcare services and communicate with health professionals can dramatically affect their health and well-being. This chapter provides a review of literature that looks at communication issues between Indigenous clients and non-Indigenous health professionals. It looks broadly at the issue of cross-cultural communication or *intercultural communication* as operationally defined for this study (see 10.2) and specifically at the role of language in health care. It also touches on

literature relevant to the philosophy of cultural safety, which underpins this research, with a more detailed discussion following in Chapter 4.

The literature reviewed in this chapter is organised within the following sections:

3.2 Communication and intercultural health care communications;

3.3 Linguistic minorities in English dominant health services;

3.4 Indigenous First Language speakers, Indigenous languages, Indigenous health and communication research in Australia;

3.5 Interpreters in intercultural communications;

3.6 English First Language speakers;

3.7 Philosophical developments in nursing and health disciplines;

3.8 Education and training in intercultural communications;

3.9 Indigenous voice.

3.2 Communication and intercultural health care communications

Communication is widely recognised as an integral part of health care interactions. This is increasingly so, in reflection of growing multiculturalism throughout countries such as the United States, Great Britain, Canada and Australia. Communication is described as the beating heart, or the lynchpin on which all else relies:

If information is the lifeblood of healthcare, then communication is the heart that pumps it. Every information exchange is a communication act...(Toussaint & Coiera, 2005)

However, in spite of this acknowledgment, communication skills for health professionals are often relegated to a minor component of health curricula in Australia (Pauwels, 1995). A

considerable amount of literature does focus on communication within health care practice, including intercultural communications (Blackford, et al., 1997; Dawes, 2001; Gerrish, et al., 2004; Gudykunst & Kim, 2003; Hall, 2003; Institute of Medicine, 2009; Irvine, et al., 2006; Smedley, et al., 2003). However, this is less prolific when it comes to the Australian context and the needs of Indigenous linguistic minorities.

Communication is mediated through language, either verbal or written, and includes aspects such as non-verbal communications. Communication barriers have been extensively written about in the literature in relation to speakers of languages from outside Australia (Blackford, et al., 1997; Cioffi, 2003; Kanitsaki, 2003). Global research shows communication breakdowns put clients at risk and limits the care experienced by clients who speak a different language to the health professionals (Cioffi, 2003; Fadiman, 1997). Whilst communication issues have been considered for non-English speaking populations in the United States, Canada, New Zealand and Britain, in Australia, such literature has mainly focused on migrant populations with less attention paid to Indigenous language speakers (Lowell, 2001; Pauwels, 1995).

Health literacy is another layer in which communication barriers can arise in health care. Although not exclusively related to differing language backgrounds, health literacy is what allows individuals to comprehend health care information in a meaningful way. As poor health literacy can also be an issue for clients who share the first language of the health care professionals, this study has not focused more than cursorily on what is undoubtedly a major influence, but one that may be best examined in further research. For me, health literacy can only be facilitated through effective communication and intercultural communication where appropriate. Peerson and Saunders, (2010) also suggest that the lack of clarity in definitions and ability to measure health literacy may need attention before addressing it is practicable. Health literacy as it relates to this Intercultural Health Care Communication study is discussed further in Chapters 8 & 9.

Using the examples of non-English speaking clients globally, the consequences of ineffective communication in health care are indisputable. Language barriers, including health literacy levels, have been implicated in lowering access to primary and preventative services, impaired patient comprehension, a lack of informed consent and compliance, as well as diminished quality of care (Robinson & Phillips, 2003; Schouten & Meeuwesen, 2006; S. Smith, 2006; E. Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). If it is accepted then that communication plays such an integral role in access to and effectiveness of health care, then the gap in the literature relevant to Indigenous Australians requires filling.

3.3 Linguistic minorities in English dominant health services

Belonging to a linguistic minority dramatically influences health status, according to the global literature reviewed in this chapter. It can influence the quality of care received and care outcomes (J Betancourt & Jacobs, 2000; Cioffi, 2003; Fadiman, 1997; Ferguson & Candib, 2002). For example, Wilson et al. (2005, p. 800) state that '*...limited English proficiency is a barrier to medical comprehension and increases the risk of adverse medication reactions.*' While it is usually the clients or users of health services who are identified as having limited English proficiency, the same concerns can arise when the health professionals are themselves from a linguistically different background to the dominant health service workforce (Blackford & Street, 2000). In their study of 1200 Californians conducted in 11 languages, Wilson, et al. (2005, p. 800) concluded that, '*Access to language-concordant physicians substantially mitigates but does not eliminate language barriers*'. Whilst it might be desirable to have language concordance between health professionals and their clients, it is clear that this is not always possible nor a solution in itself, suggesting a need to further examine the experience of intercultural communication to effect any substantial change in the status quo.

Irvine et al. (2006) conducted research in the bilingual health care settings of Wales, focusing on factors that facilitated or impeded language sensitive health care practice. Language sensitive practice and language awareness are concepts that they identified as playing a significant role in improving intercultural communications between health services and linguistic minority clients. Language sensitive practice and language awareness are defined as: '*explicit knowledge about language and conscious perception and sensitivity in language use ...*'. Language awareness and language sensitivity as concepts are not well explored in other literature, yet these have considerable relevance to the Intercultural Health Care Communication Study that is the subject of this thesis.

There are some points of comparison between Indigenous Australian languages and the Welsh language. Welsh language is indigenous to Wales, yet is a minority language in terms of '*prestige, power and populations*' (Irvine et al., 2006, p. 423). Its speakers share challenges of access and quality of care experienced by other linguistic minorities across the world. The Welsh language and sensitivity study by Irvine et al (2006) gave a picture of language sensitivity in practice. They clearly outlined their approach to thematic analysis, which also was useful for analysing the data within this Intercultural Health Care Communication study (see 5.6). Indigenous Language speakers in Central Australia however, are generally not fluent in English, so their problems communicating with health service providers are perhaps more obvious than for a bilingual client in Wales. Indigenous Australian clients who do speak English can still experience miscommunications due to the cultural differences in the way English is used (Bain, 2005; Eades, 1991, 2009) (see Aboriginal English).

Some global literature has examined the impact of having legal and statutory requirements to support linguistic minorities. According to Irvine et al. (2006) the Welsh Language Act of 1993 places legal and statutory requirements to provide services in both languages, giving equality to both languages, but research has found that this is not always matched in practice. The study by Irvine et al. (2006) aimed to capture individual feelings, opinions and

experiences of health professionals to gain an understanding of language awareness in health care practice. This aim was similar to the Intercultural Health Care Communication study in Central Australia that is the subject of this thesis. A key difference however, is the legislative support that Indigenous languages have in countries such as Wales, New Zealand and Canada. Research suggests Indigenous language speakers are still often overlooked in countries with supportive Acts of Parliament, indicating an even greater disadvantage exists for Australian Indigenous language speakers, who remain unsupported by any such legal and statutory requirements.

The Welsh study (Irvine et al. 2006) also identified several themes that included, care enhancement, organisational issues and training implications. In addition, its findings and recommendations offer useful considerations for the Intercultural Health Care Communication study, including that relatively small organisational and attitudinal changes could have a role in improving the quality of care provided to linguistic minorities (Irvine et al. 2006). For example, facilitating language choice through identification of linguistic attributes, documentation, and response to language choice on client identification bands and other documentation, was believed to improve what had been largely ad hoc responses prior to their study in Wales. By showing language sensitivity, assessment is improved, diagnoses that are more accurate are achieved, and effective treatment and improved compliance are obtained, which proved a central consideration for health professionals (Irvine et al. 2006). Organisationally, this Welsh study highlighted the flawed economy of not providing language services and supports where indicated. Training implications identified language learning as a useful preparation for dealing with linguistic minorities, along with language awareness training and health care education (Irvine et al. 2006).

Australia is more multicultural and linguistically diverse than the mainly bicultural makeup of countries like Wales and New Zealand, prompting the question of which languages should be the focus in relation to Indigenous contexts. In Central Australia, the diversity of Indigenous languages within this defined region elicits the same question for the tertiary and

secondary health services who deal with linguistically diverse clients. Remote health services, described briefly in Chapter 2, may have a more obvious choice in terms of which Indigenous language to focus on, with communities usually representative of a particular language group. For example, the remote community of Ntaria⁴⁴ is predominantly a Western Arrernte community, being located in Western Arrernte country, while Yuendumu has a mainly Warlpiri speaking population, being located in the Warlpiri lands. Health professionals therefore may have a clear choice in focusing on a relevant language if they so choose. Even in these contexts with a clearly dominant Indigenous language however, clients may be multilingual rather than bilingual. While some argue over the usefulness of learning one of a number of possible languages for a given region, there seems to be value in the experience and awareness gained when health professionals make the effort to learn even a limited amount of a language other than English. For example, Cioffi (2003) found in Australia, that even limited use of a minority language could help establish a bond between health professionals and clients that results in enhanced care for linguistic minorities.

Wilson et al. (2005) maintain that there is a need to recognise clients with Limited English Proficiency (LEP) as a high-risk group requiring special attention. They looked at the impact of having '*language concordant physicians*' or staff who spoke the language of the client. Where this occurred, it was shown to reduce reports of adverse medication effects and confusion with medication instructions (Wilson et al. 2005). They recommended that other professions be considered for similar research to gauge what impact if any, language concordance between clients and health personnel might have on other areas of care. Indigenous personnel in Central Australia are usually employed because of language concordance with certain client groups in the belief that similar results will be shown. However, research also suggests that being a member of an Indigenous community, irrespective of Indigenous language proficiency, can also improve communications with Indigenous language speakers (Cass, et al., 2002; Genat, 2006).

44. Ntaria is the Arrernte name for the community, also known as Hermannsburg, the name of the Lutheran mission established in the late 1800s.

In Australia, the number of Indigenous language speaking health professionals is negligible, with the exception of the registered Aboriginal or Indigenous health worker and liaison officers who usually require Indigenous language proficiency as a criterion for employment. The overall Indigenous representation of the health workforce is less than 1% nationally, although the Northern Territory has the highest proportional representation of almost 9% (Australian Indigenous HealthinfoNet, 2010). The majority of Indigenous health professionals (40%) are nurses, however in the Northern Territory this trend is reversed, with the majority being employed as Indigenous Health or Liaison Officers. Indigenous medical graduates (at present there are only 100 comprising 2% of the Indigenous health workforce and 0.2% of all medical professionals) and other health professionals will not necessarily also be speakers of an Indigenous language, due to the impact of language loss and colonisation in Australia (Australian Indigenous HealthinfoNet, 2010).

Whilst shown to have positive outcomes, Wilson et al. (2005) also cautioned against any uncritical reliance on language concordant staff. They suggested that this may further segregate health care systems and have unintended consequences in decreasing access to medical resources. Where language discordance existed, Wilson et al. (2005) further identified the need to increase use of trained medical interpreters as their research. Others have shown this to decrease medical communication errors and enhance quality of care (Cass, et al., 2002; Pauwels, 1995; E. Wilson, et al., 2005). With a burgeoning use of new technologies, Wilson et al. (2005) suggested employing innovative techniques such as remote simultaneous interpreting and videoconferencing to increase accessibility of professional interpreter services, which are critical to improve care for limited English proficiency clients. This approach to remote interpreting has relevance for Central Australian health services where a lack of availability of interpreters acts as a disincentive for routinely using them in communications with Indigenous language speakers, although reliability internet access remains a problem in some remote areas.

3.4 Indigenous Language Speakers, languages, health and communication research in Australia

Indigenous Language speakers are relatively few in number in Australia today, even though Australian Indigenous languages are believed to be the oldest continuously spoken languages in the world. In Central Australia where they are *linguistic* minorities however, their over-representation as health service users creates an anomalous majority (Pauwels, 1995; Walsh, 1993). Furthermore, Indigenous languages of Australia did not exist in written form prior to colonisation (Evans, 2010; Schmidt, 1993). As orally/aurally transmitted languages, the relatively recent development of written communications and specifically English language communications means that the Indigenous voice is not as prominent as that of the non-Indigenous voice in Australia.

The literature relevant to this study is often produced by non-Indigenous researchers (like myself) making commentary on Indigenous peoples' experiences. However, literature generated from Indigenous people directly is slowly increasing (Rigney, 2001, 2002, 2004; Sherwood & Edwards, 2006). Linguistic and/or anthropology disciplines provide the majority of literature relating to Indigenous languages and language speakers, along with the education and legal professions, who have seemingly recognised the importance of examining intercultural communications for some time (Lowell, 2001; Pauwels, 1995; D. Thomas, 2004).

Cass et al (2002) provided evidence of the need for attention to miscommunication between Indigenous and non-Indigenous people in health care settings. Their qualitative study of videotaped interactions in a dialysis unit filled exclusively by Yolngu (Arnhem Land clan group) clients, identified factors that limited effective communication. As a participatory action research study, the research team included both Indigenous and non-Indigenous researchers. Cass et al. (2002) undertook their qualitative study in a satellite dialysis unit in Darwin, Northern Territory in 2001. Indigenous participants were from a single language group—the Yolngu people of northeast Arnhem Land. Their study reinforced what was

believed to be the case, but remained largely unexamined at the time; that shared understandings of key concepts between English-speaking health professionals and Yolngu clients were rarely achieved (Cass et al. 2002). The research also identified numerous factors implicated in the frequent and pervasive examples of miscommunication. These included: lack of client control over language, timing, content, and circumstances of interactions, differing modes of discourse, biomedical dominance, along with marginalisation of Yolngu knowledge, lack of staff training in intercultural communication, and lack of involvement of trained interpreters (Cass, et al., 2002).

Other literature related to what was described as the '*crisis in communication*' also involving Yolngu people is found in the earlier published works of Richard Trudgen and the Aboriginal Research Development Services (ARDS) (Trudgen, 2001). With few publications in formal health journals, Trudgen's book, *Why warriors lie down and die...* provides some compelling arguments for a closer examination of communication between English speakers and Indigenous Language speakers. Trudgen sees the communication gap as the main reason underlying '*... the current crisis in health*' where the gap is cemented into the system and simply not noticed (Trudgen, 2001, p. 70), *because* it is a communication problem.

Another interesting insight from Trudgen (2001) is that inadequate preparation applies not only to the non-Indigenous health professionals, but also to Indigenous Language speaking Aboriginal Health Workers (AHWs). These professionals, employed for their linguistic and cultural knowledge, may experience the same difficulties in understanding their English-speaking colleagues as other Indigenous clients. Without adequate preparation for the role of intercultural brokers, the linguistic capacities of AHWs may be limited. The consequences of poor communication identified by Trudgen (2001) include inadequate diagnosis, lack of informed consent, ineffective health education and prevention, culturally unsafe care, and an inability to evaluate and modify care where needed. Whilst most literature looks at the consequences, little of it explores what underpins the problems between English and

Indigenous language speakers other than the work of Trudgen and the ARDS, who have paid attention to this gap for some time.

According to a range of literature, strategies for improving health outcomes for Indigenous Australians have included cultural awareness training, increased use of interpreters, increased availability of Aboriginal Liaison Officers (ALO/ILO), Aboriginal Health Workers (AHW/IHW), and increased employment of Indigenous staff across all sectors of health services (Lowell, 2001). Further efforts have focused on: increased resources; (Eckermann, et al., 2006; Genat, 2006; Goold & Liddle, 2005) separated services (Central Australian Aboriginal Congress, 2004) and recommendations to learn ‘an’ Indigenous language when working in Indigenous health settings (Franks & Curr, 1995; Trudgen, 2001). To date, the gaps identified in health outcomes for Indigenous Australians, as well as the communication gaps and the gaps in focused intercultural communication research relevant to Indigenous Australian health care contexts, remain unfilled.

3.4.1 Indigenous Languages in Australia

At the beginning of British settlement of Australia, Indigenous languages were said to have numbered over 250 distinct languages (Schmidt, 1993; Walsh, 1993). Languages that had been in existence for 40,000 or more years disappeared from use in the face of pressures to communicate with the dominant ‘others’.⁴⁵ The tendency to discuss Indigenous Australians in terms of being ‘the other’ in relation to dominant non-Indigenous Australians is suggested by Kemble (2007) to remain a current example of ongoing colonisation. According to (Ridgeway, 2002) the fact that Australia’s Indigenous languages remain without official language status, leaves them unrecognised even as national languages. While embracing art and other aspects of culture, Indigenous languages remain a mystery, a relic of the problematic label of ‘traditional’ communities that now exist in only the remotest parts of Australia. Ridgeway (2002) also suggests that the government’s official language policy

45. Others—used to indicate difference between cultural groups. The discourse of ‘othering’ suggests one cultural group to be the norm, while all others are by implication not the norm (see 10.2).

privileges English and may restrict or deny access to health and education by Indigenous First Language Speakers, with consequences that impact upon identity and self-esteem.

Lester-Irabinna Rigney is a contemporary Indigenous academic and researcher on the rights of Indigenous people to retain and maintain their first language. According to Rigney (2002) who sees language as core to identity and self-esteem, the links between language and health and well-being are explicit. He maintains that:

Fundamental to all societies ... is the transmission of language, culture and identity to the next generation. Education and language (by Language I mean Aboriginal English, variations of languages and First languages) are the glue needed to maintain, revive and reclaim culture (Rigney 2002, p.2).

Rigney (2002, p. 6) further points out that Australia is the only Commonwealth country that does not have a treaty with the Indigenous peoples:

Legally weak Indigenous languages have struggled to maintain a foothold in Australia against constitutionally protected English. ... Language was and still is the major colonising and assimilating factor in Australia ... It would seem that Australia is slow to incorporate the necessary legal mechanisms to maintain its own linguistic heritage.

In countries with a greater regard for Indigenous languages than in Australian, life expectancy and health status of Indigenous people are substantially better (Rigney 2002).

This link warrants further investigation, and as Refshaugue (2002, p. 3) advises:

We must not forget that the fundamental reason for the state of Indigenous languages is the policies, practices and attitudes of past governments and generations, when not only was Aboriginal culture and heritage denigrated, but Aboriginal people were actively prevented from learning or passing on their languages.

When denigration and active discouragement of language and culture is official policy, individuals and groups are left with an unmistakable message that these attributes have little value. The impact on self-esteem and health in general consequently becomes an accelerant

for language and cultural loss. Today, in Central Australia there is the phenomenon of ‘shame’⁴⁶ experienced by many Indigenous Language speakers in trying to navigate their care in English within mainstream health services (Watson, 2006).

‘Shame’ for Indigenous people is a different concept to the sense given this word for me as an English first language speaker. In Central Australia the use of the English word ‘shame’ by Indigenous people implies a profound embarrassment or feeling of anxiety that might cause humiliation, and that differs in intensity and meaning from an English speaker’s concept of the word (Lowell, 2001). People can use the phrase ‘shame job’ or ‘too shame’ to avoid being seen in certain situations that English speaker might simply describe as embarrassing rather than shameful. ‘Shame’ is implicated in Watson’s (2006) study as a major factor affecting the uptake of health care services by Warlpiri men most specifically, but it is also relevant to other sectors of the Indigenous populations of Central Australia. The fact that ‘shame’ associated with being less proficient in using English, can prevent people from seeking timely help is mentioned in the data and discussion chapters of this Intercultural Health Care Communication study as well (see Chapter 7). However, ‘shame’ is another potential area for research as the literature is scant in relation to its possible role in health seeking behaviours. Further insight into Indigenous notions of shame and what health professionals might do to minimise the impact of shame experienced within English dominant health settings is required.

3.5 Interpreters in intercultural communications

One of the most obvious responses to dealing with intercultural communication challenges usually includes the suggestion to employ the services of an interpreter. Although frequently identified as the solution to the problems of intercultural communications, interpreters for Indigenous language speakers have been less well utilised in the health arena, than they have in other sectors such as law (Lowell, 2001; Pauwels, 1995). Whilst the idea of using

46. See Aboriginal English terms (10.4) and also Chapter 1.

interpreters seems an appropriate solution, in the context of the Intercultural Health Care Communication study, there are various factors influencing the availability, accessibility and uptake of interpreter services in Central Australia. These influences, which are historical, geographical, political, economic and cultural in nature, have been identified in the literature with some analysis as to why health services in particular have been less inclined to routinely employ Indigenous Language Interpreters (Crossin, 1999; Fisher & Weeramanthri, 2002). Fisher and Weeramanthri for example, suggest that Aboriginal patients in the Northern Territory are not as involved in decision-making because of health service failures to recognise the rights and capacity of Indigenous Australians who have been subject to medical control for generations:

The national underdevelopment of key services – Aboriginal Health Workers, Liaison Officers and particularly interpreter services – shows a lack of appreciation by health institutions of the importance of involvement of Indigenous patients in decision making (2002, p. 49).

While some of the international literature cautions that untrained, ad hoc interpreters may result in miscommunication, Wilson et al. (2005, p. 800) suggest that amongst other ethical and privacy considerations *'trained medical interpreters and professional interpreter services can improve communication, satisfaction and adherence ...'*. In the Australian context however, Lowell (2001) found that the use of trained interpreters provides only a partial solution in regards to communicating with Indigenous people. Interpreters are themselves often part of the same cultural world as the people for whom they provide translations, and consequently they may have the same difficulties with conceptual interpretations (Cass, et al., 2002; Lowell, 2001; Trudgen, 2001).

Colonial responses to Indigenous languages arguably remain embedded in Australian culture and politics. A prevailing view of some of Australia's most influential and powerful politicians is that Indigenous Australians should and will speak English whether they like it or not (Karvelas & Megalogenis, 2007). This could be an example of democratic racism as identified by Henry and Tator (2006), as far as there is a belief that speaking English will be beneficial

for Indigenous Australians, whilst at the same time applying a racist and Anglo-centric view that Indigenous languages are in some way, less important. Democratic racism is defined by Henry and Tator (2007, p.15) as...an ideology that permits and sustain people's ability to maintain two apparently conflicting sets of values. One set of values reflects a commitment to a liberal, democratic society motivated by egalitarian values (such as those espoused in health care). Conflicting with those values are attitudes and behaviours that include negative feelings toward those who are racialised within society, and that results in differential treatment or discrimination (Browne, personal communication, 2010). There is little purpose in funding interpreter services when official responses to Indigenous Australians reflect the position that English is a requirement for participation in the benefits of Australian mainstream society. The global literature however, has already suggested that by introducing any other language and culture to the health communications encounter, health is at risk, and some compensatory support is required.

With regard to Indigenous Australians, the research is often less formalised and less abundant. One of the major sources of literature relating to the intercultural communication experience in Australia comes from Richard Trudgen who has spent the last decade (2000–2010) educating non-Indigenous health professionals and services providers to pay attention to the communication needs of Indigenous people. Trudgen discusses the needs of Indigenous language speakers more anecdotally and reflectively than through formal research. It might be well argued however, that story telling is in fact a form of Indigenous evidence-based research (Thomas, 2004).

Trudgen (2001) provides a graphic example of the potential difficulty experienced in health care encounters by using the metaphor of Apple Macintosh and IBM⁴⁷ computers. Both computers are capable of sophisticated thinking, problem solving and analysis, yet until recently, were unable to share and receive information between them. The relationship of

47. Apple and IBM are major brand names for computers that in efforts to dominate the market, were initially incompatible with each other, but have since found greater benefit from developing the capacity for each to communicate.

this analogy to health care is that no such ‘translators’ have been available or effectively employed in health care settings in relation to Indigenous language speaking clients. All that was required in order for an Apple computer to ‘talk’ to an IBM computer was a tool for translation. Trudgen (2001) suggests that in terms of Indigenous/non-Indigenous communications, a suitable translation tool that functions effectively has not been routinely employed, through either indifference or lack of awareness.

Anthropologist Margaret Bain (2005) is another author whose research into communication with Indigenous Australians suggests that what is needed is an effective translation ‘tool’. According to Bain (2005) and Trudgen (2001), the most appropriate translation ‘tool’ is likely to be a non-Indigenous person who has achieved proficiency in one or more Indigenous languages. Neither Trudgen nor Bain explain why they feel a non-Indigenous person best fills the role of the translating ‘tool’. The lack of reasoning behind the suggestions calls into question the concept of ‘whiteness’ and possible ongoing colonising practice. Trudgen and Bain have both been highly influential and valued authorities on the issue of intercultural communication with Indigenous Australians, but there is a question mark over the need for the translating ‘tool’ to be a non-Indigenous person. Furthermore, a number of researchers recommend that health professionals who intend to work effectively with Indigenous First Language people must learn a relevant Indigenous language (Cramer, 2005; Franks, and Curr, 1995; Trudgen 2001). This position however, takes a serious and prolonged commitment that may not be practicable in today’s highly mobile workforces. Furthermore, Lowell (2001) identified the need for more than language proficiency to ensure mutual comprehension, as language use is usually contextualised through culture.

Interpreters can play a key role in facilitating intercultural communications but they can not be the complete solution, and English speaking health professionals need to be advised about how to work effectively (Lowell, 2001; Pauwels, 1995). In the context of Australian Indigenous communications, there are also certain cultural mores that suggest a differing approach from what is advised for other non-English speakers. In some situations for

example, the position of accredited interpreters within local kinship structures may actually limit the ability to be involved in encounters with some individuals. The most appropriate interpreter may in fact be a family member, but this is contrary to established protocols for working with interpreters within health services (Pauwels, 1995) and needs to be carefully negotiated depending on the issues under discussion. However, the variables influencing Indigenous Australian communications are extensive and often unknown to the English-speaking health professionals, without the support of Indigenous Liaison or health personnel.

The key point made in the literature in regard to Interpreters is that the skill of interpreting and working through an interpreter is fundamentally different to translating, and health professionals require education and training to work effectively with interpreters within health care settings (Lowell, 2001; Pauwels, 1995). In summary, the international literature frequently identified the use of suitably trained interpreters as an appropriate strategy to enhance intercultural health care communications. Although quite substantial literature exists concerning the role of suitably trained interpreters and ad hoc interpreters, the research related to interpreters for Australian Indigenous language speakers is minimal.

Of the available literature, certain issues have been identified with regard to availability, access and uptake that differ from some international contexts. Interpreter services for Indigenous language speakers have been historically neglected in Australian health care settings. The literature suggests a need for greater attention to and understanding of the role of interpreters in improving health care communications between Indigenous language speakers and Australian health service providers.

3.6 English first language speakers

English is believed to be spoken by some 400 million people around the world '*...as a mother tongue and an additional 2 billion as a second and/or foreign language ...*' with the projection of up to 40% of the world's population by 2040 (Filmer, 2007). However, whilst there may be advantages in speaking a widely understood language, this dominance is not

necessarily a positive thing when it may be at the expense of other's languages and cultures. Murphy and Kraidy (2003, p. 310) It is suggested that the dominance of English-language publications tends to '*...privilege an Anglo-American perspective that restricts our understanding of broader sociopolitical contexts*'. This global hegemony of English, makes English speakers seem 'normal' and all other language speakers deficient in some way, even though Filmer (2007) sees the monolingualism of many English first speakers as limiting. This deficit mentality toward those who do not speak English is reflected in some of the literature and responses to Indigenous Language speakers within Australia. In spite of its multicultural makeup, Australia is a largely monolingual nation. Health care services in Australia are structured for English language communication, even though individuals from a variety of ethnic and cultural backgrounds staff them.

Research concerning intercultural communications generally indicates that the experience can be anxiety provoking for all participants, which prompted my own examination of the overall experience for both English-speaking health professionals and Indigenous language speaking clients. In some older Australian research that examined the anxieties and attitudes of both staff and patients to cross-cultural encounters for example, Davidson, et al (1983) considered aspects of communication from the perspectives of both Aboriginal and non-Aboriginal participants. Their study looked at communication anxieties of non-Aboriginal people that may impede their communications cross culturally, and identified communication attributes that could enhance or impede the activity. Communication apprehension, anxiety or shyness and receiver apprehension were all identified as influencing the quality of information exchanged. Communication flexibility or the person's ability to read the situation and respond verbally in an appropriate fashion was an important facilitator in intercultural communication.

The study also looked at the non-Aboriginal health professionals' previous exposure to Indigenous communication, attitudes to and concern about Aboriginals, ease and ability of understanding and being understood (Davidson, et al., 1983). Knowledge of communication

rules does not automatically imply that non-Aboriginal participants can use those rules when interacting with Aboriginal people (Davidson, et al. 1983). The performance of non-Aboriginal people depends on their readiness to listen to what others say and on their readiness to change their own behaviour if they feel the situation demands a different approach. Appropriate training that includes prior assessment of apprehensions about listening can reduce anxiety however. Without assessment, experiential training simulations could produce undesirable learning behaviours and lead to misinterpretation of behaviours or future stressful encounters or prejudice (Davidson et al. 1983). This research, while now somewhat dated, is still relevant to training and education for health professionals.

The dominance of English within Australian health care usually means the literature focuses on examining the Indigenous or other language speaker for linguistic features and communication mores. In an auto-ethnography examining English dominance, Filmer (2007, p.755) examined what it would ‘*...feel like to encounter English, or another dominant language, from the other side of the equation*’. Filmer (2007) found the experience of being the minority language speaker had a negative effect on self esteem and confidence. Filmer (2007, p. 755) observed that as an English first language speaker, one could ‘*...enjoy the imperial privilege of having inherited a linguistic currency considered the coin of the realm in most places*’, which is not the case for the majority of people around the world. In relation to this Intercultural Health Care Communication study, Central Australian health professionals, who must be English language speakers as a requirement of employment, are already in positions that place them at an advantage over the people who are not English proficient. Whether there is an awareness of this positioning among health professionals in Central Australia has not been established, and consequently, is considered within the context of this study.

Unless needing to learn another language or without having a particular interest in linguistics, it might be unusual to think about one’s own language much beyond formal school lessons. The linguistic literature offers deep level analysis of English as a language

that is possibly more than any health professional might need or care to know unless possessing a personal interest in languages. What is useful however, is the literature that offers insights into how English functions and the specific features that can be used comparatively to understand points of potential misunderstanding with other language speakers. Silence is one such example. English is a language that does not accommodate silence well, whereas Indigenous languages have silences that are imbued with meaning (Mushin & Gardner, 2009). This may be useful information to reflect upon once health professionals encounter Indigenous languages that have silence as inherent features. As this is not a linguistic study however, I chose to review literature that was more relevant to the health and intercultural communication experience than to go deeply into the linguistic literature.

3.6.1 Language, colonisation and power

Throughout history, invading and colonising groups have achieved dominance over populations often through physical conflict. Colonisation has then continued in the longer term through the deliberate erosion of customs, practices and language (P. Edwards, 2005; Evans, 2010; Perkins, et al., 2008). One of the key tools of colonisation throughout history has been the swift and purposeful subjugation of indigenous languages by imposing the language of the coloniser (P. Edwards, 2005; Evans, 2010). Yet Rigney (2004) maintains that the right to one's first language is, or should be, a fundamental human right.

According to Edwards, (2005, p. 6) the patterns of colonisers throughout history:

... often include physical invasion of ... lands by more powerful groups, which assume that their languages are superior to those of the dispossessed. The next step is to rationalise this assumption by economic or educational arguments. Phrases such as "You'll get nowhere without English" or "Opening to the wider cultural world" come to mind ...

When a dominant culture is monoglot it assumes that the minority should assimilate by forgetting their language. Ignorance of the multilingual abilities of humans could account for this, together with resentment at not understanding what is being said in a place that they assume is "theirs". Or, perhaps worse, a belief that the other language is "primitive".

The Federation of Aboriginal and Torres Strait Islander Languages (FATSIL) publishes a magazine devoted to Australian Indigenous Language maintenance. Examples abound from contributors who can remember the active suppression of their first languages: *'Older generations... were banned from speaking their traditional languages at school'* (FATSIL, 2006). In addition, many young Indigenous people, even relatively recently, have been prevented from maintaining their First Language and marginalised by mainstream educational systems. The obvious educational disadvantage experienced by many today has created entire populations who may not be strong in either an Indigenous language or English. Health professionals therefore, may find younger Indigenous people are also difficult to deal with in relation to intercultural communication.

Even beyond the historical process of colonisation however, language is used daily to either exclude or include individuals and groups. It is not a huge leap for health professionals to see the power of language used in this manner. Discipline-specific language is used in health care all the time and can often serve to control the flow of information for recipients as required (Pauwels, 1995). In the intercultural setting, medical terminology can also allow messages to be lost in translation, particularly when the great majority of words and phrases have no readily translatable equivalent in Indigenous languages. Not only can words be difficult to translate, many may not even be conceptualised in a meaningful way if they fall outside of the worldview of some Indigenous First Language speakers (Pauwels, 1995). The role of discipline-specific language is addressed within this Intercultural Health Care Communication study in explorations of power and possible continued colonising practices found within Central Australian health care. The idea that health professionals themselves may be rendered powerless and colonised by the health care systems in which they operate is not evident in any literature searched. This omission suggests important gaps in the body of knowledge around intercultural health care communications.

On the other hand, the consequences of miscommunication for the health of Indigenous Australians are well documented (Cass, et al., 2002; Cramer, 2005; Lowell, 2001; Trudgen,

2001). The consequences of miscommunications for Indigenous Language speakers become even greater when the impact of intergenerational powerlessness, racism and discrimination, is considered. Cramer highlights some of these consequences in relation to mental health status in remote Indigenous communities:

In many visits people needed social support, seeking a nurse's attention and concern. Behind the daily complaints and general malaise some nurses detected a sense of unhappiness or loneliness and sometimes depression. Clients rarely verbalised their emotions to nurses, nor did nurses usually assess their mental health... (2005, p. 56).

Gaining informed consent in the remote setting was also a major challenge identified, with *'Clients rarely asked questions about a decision made, a specimen taken or a treatment given'* (Cramer 2005, p. 59). She concluded that it was not only language contributing to the lack of consent for decisions and procedures, but also that *'...nurses were not always able to provide an explanation to a client and obtain their consent or did not attempt to do so'* (Cramer 2005, p. 59). Making greater efforts to minimise miscommunications and facilitating communications that do not necessarily privilege English over the Indigenous client's language, may contribute to de-colonising practice. If cultural safety in health care is at all possible, then health professionals must be asked to de-colonise their practice in response to Indigenous clients.

3.6.2 Anthropological literature

In the pre-cultural safety literature, the influence of anthropologists was prominent across disciplines, particularly working in tandem with medical researchers in Australia (Thomas, 2004). In the 1970s in Australia, with the national focus turned toward health, education, and welfare of Indigenous populations, there was a concurrent growth of non-Indigenous government employees sent into the field of Indigenous service delivery. Webber (1978) was one of the more influential authors to consider that in order for non-Indigenous workers to be effective in their roles in intercultural contexts, they needed to develop an understanding of the interpersonal behaviours of Aboriginal people. Webber's research documented

interpersonal behaviours of Aboriginal people, such as looking, listening and touching mores (Webber, 1978).

Webber's findings are often quoted in other health and education literature, as a useful starting point for non-Indigenous people working in intercultural settings. Although Webber's insights may be considered to focus on the 'exotic other', he does caution non-Indigenous workers to guard against normalising their own behaviour and constructing others as not the norm and therefore possibly less acceptable (Webber, 1978). Nevertheless, Webber's work has been influential in raising awareness of potential barriers and misperceptions in intercultural communication, and it stimulated my own interest in cultural issues back in the early 1980s.

Webber's published research is reflective of the era in which it was developed, with references to 'aboriginals' (small a) and 'Europeans' (capital E). This was considered so inappropriate by one current reader of the volume used for my literature review, that the reader had gone through the book and capitalised every 'small a aboriginal' in pen. Huggins (1991) points out the implicit colonial hangover in citing texts where European, English, and Americans were always afforded the courtesy of capitalisation, whilst 'aboriginals' and other people of colour were curiously downgraded to the status of lesser nouns (Huggins, 1991). In spite of its age however, Webber's work remains a valuable introduction to intercultural communication. From a cultural safety perspective, (see 3.7.1) it also reinforces the need to extend intercultural communication beyond the cultural awareness and cultural sensitivity stages. When re-examined within a culturally safe framework, Webber's insights add significant value for newcomers and short-term health employees who may be at the cultural awareness stage in their development toward culturally safe practice.

Von Sturmer (1981) explored interpersonal relationships in his research through a description of etiquette, manners, greetings, and decision-making protocols. Eye contact for example is presented as a culturally determined behaviour that can be misinterpreted

between Indigenous and non-Indigenous Australians (Von Sturmer, 1981). This study took another anthropological approach that has been useful for those with limited preparation for working within Indigenous contexts. Again, a criticism is that the focus was on the 'other' without consideration of self. Cultural safety philosophy has sought to analyse this tendency to try to define one group as the 'norm' and any one of a different cultural background as 'the other'. Kemble (2007) sees the cultural danger in projecting a particular group as the standard by which others are measured. My main concern with this type of knowledge is the tendency for it to become almost prescriptive. It may not have been the Von Sturmer's intention but such works are often used as a 'recipe' for intercultural interactions rather than a starting point for analysis and further understanding. These examples, and other more recent researchers such as Bain (2005) position themselves within anthropological frameworks that focus on what Ramsden (2005) called the 'exotic differences' between cultural groups. As such, they are at the cultural awareness phase in which difference is identified and legitimised, but with no apparent examination of self in relation to the 'other' (see section 3.7.1).

'Exotic differences' seem to capture the attention of people working in intercultural settings for the first time. These identified differences have the potential to influence experiences either positively or negatively. Even a rudimentary awareness of difference can certainly be useful information to new nursing and medical staff starting work in Central Australian health services (Wren, 2007, personal communication). Bain (2005) believes that discussion of difference in regards to communication is not only appropriate but also necessary for understanding, yet sees certain sensitivities as possibly undermining such discussion. She blames the current political climate for somewhat impeding discussion of difference, and I agree with her that, *'In today's politically charged context, it is difficult to speak of differences'* (Bain, 2005, p. 1). It is almost as if any discussion of difference necessarily implies some negative judgement or prejudice rather than a simple articulation of what may be misunderstood or misinterpreted without this discussion.

What is interesting about Bain's work is her examination of the use of abstractions, such as *'if'* and *'when'* as well as the ways of learning. In this regard, Bain (2005) is one of the few researchers to explore the role of worldview and language in relation to Aboriginal Australians. She found that Aboriginal use of abstractions always retain a direct link with reality, whereas 'western' (sic) use often breaks links with the real (Bain 2005). Examples of this mismatch in health care settings are numerous. Saying to a client, *if you don't do this, you might lose your leg*, may mean for some Indigenous participants in the conversation that they only hear, *you will lose your leg*. When this information does not match belief however, because right now the patient feels fine, it can contribute to considerable confusion and the perception that *'white men are liars'* as suggested by Bain (2005). This confusion makes health promotion one of the biggest challenges, because of the different ways in which language is used and conceptualised.

Bain believes her research indicates most communication problems are with those whom she calls 'traditional Aboriginals', defined as someone *'...for whom an Indigenous language is their first language and who may well live on a remote community'* (Bain, 2005, p. vii). This definition presents several difficulties for me, as previously discussed in Chapter 2). I know many Indigenous Language speaking people who live in remote communities, but may not be categorised as 'traditional'. As stated previously, I do not believe the problems are solely with the people Bain deems as 'traditional' or that this definition is in fact valid. Part of the lived experience of many 'traditional' Aboriginal people today includes their experiences living under past policies in government run reserves and/or church run missions, where English was forced upon people with an active discouragement to continue speaking their own languages or living a traditional life. Another problem with Bain's labelling, is the concern that this implies communication problems do not exist for those perceived as 'non-traditional' people. There is evidence from other researchers that Indigenous people who speak only English, can be overlooked if they are having any problems communicating, *because* of the perception they are using the shared dominant language (Eades, 1995; Pauwels, 1995).

Another anthropological study by Liberman (1985) is relevant to the same geographical region in which I have undertaken this Intercultural Communication study. Although over twenty years old, Liberman's study provides an ethno-methodological analysis of interactions and is one of the seminal research studies often cited in the literature today relating specifically to Indigenous Australians. Liberman (1985) demonstrated through his research the many potential points of difference between English and Indigenous communication styles, for which either or both participants may be unaware or unprepared. Liberman (1985) uses the term *indeterminacy* to describe intercultural contacts that are full of ambiguities, half formulations and a sense of only a vague understanding of what is being communicated. Further Liberman suggests that:

... Understanding this indeterminacy – and what it is that parties do with it – is basic to knowing what is occurring in intercultural social interaction (Liberman 1985, p. 171).

Liberman's research provides valuable examples of the role of indeterminacy, technical features of Indigenous communication such as gratuitous concurrence,⁴⁸ repetition, and silences. His work is comprehensive and has contributed a major body of knowledge to the understanding of Aboriginal and non-Aboriginal communications in Central Australia from a cultural awareness perspective.

What is still missing from the literature is research that considers the stages of sensitivity and safety. It is at these stages that difference is validated, and the dominant language group reflects on the impact of their language and culture on the minority group in order to progress to a level of safety in health care communications. The Intercultural Health Care Communication study sought to examine these stages through participants' experiences, in order to move beyond an awareness of language issues to culturally safe communications.

48. Gratuitous concurrence is the tendency to say yes, irrespective of the speaker's real intentions or beliefs. The respondent prefers to agree rather than create disappointment or conflict (see 10.2).

3.7 Philosophical developments in nursing and health disciplines

Language and communication have been widely researched, eliciting extensive debates, theorising and discussion about their role and importance across various contexts. Prominent among those quoted on language and communication is the philosopher Martin Heidegger who maintained that there is a connection between language and being (Heidegger, 1977–1993). Such a position reinforces the need to examine language and language dominance within health and particularly in the field of Indigenous health, where Indigenous identity is strongly linked to language (Rigney, 2005). Hans-Georg Gadamer (1960, 1989) is another philosopher often cited for his stance on the relationship between speaking and thinking. Language shapes the way in which we think and what we can think about (Whorf, 1956). A further exploration of the philosophical literature around language and communication is provided in Chapter 4 ‘Methodology’ and again in Chapter 8 ‘Discussion’. Although there is a wealth of theoretical literature focused on communication and language, this review has mainly explored the research and theory development specifically linked to health care communications. Unlike the disciplines of education, law, linguistics and sociology, health disciplines have been less focused on the role of language and language rights until relatively recently.

In nursing education and practice for example, a long-standing philosophy of equality prevailed relatively unchallenged for some time. According to Goold and Liddle (2005) all nurses swore a duty to provide care that was irrespective of a person’s race, creed or colour. This approach to diversity among recipients of nursing care did not receive serious critique before the emergence of two key philosophical developments— transcultural nursing⁴⁹ and cultural safety. Transcultural nursing philosophy in the late 1950s was groundbreaking for its focus on cultural needs in health care. Then in the 1980s this philosophy found its own challenger in cultural safety theorists, who argued that any concept of care that was

49. Transcultural nursing – a theory of nursing that derives from anthropological perspectives of culture (see 10.2)

‘regardless of’ difference’ should instead become ‘*regardful*’ (Taylor & Guerin, 2010). In the next two sections, both transcultural nursing and cultural safety literature are reviewed.

3.7.1 Transcultural nursing

With the steady growth of nursing theorists to emerge from the professionalisation and development of nursing as a discipline, the principles of equal treatment were finally put to the test. One of the first nursing theorists to test the notion of ‘equality’ based on treating everyone the same, regardless of difference, was the pioneer of transcultural nursing practice, Madeline Leininger. Heavily influenced by anthropological roots, Leininger studied the health behaviours of various ethnic groups and arrived at a series of nursing considerations that were believed useful for providing holistic care to clients of a different ethnic background to the nurse (Leininger & McFarland, 2002). This was revolutionary for its time and raised the issue of culture as a potential barrier to receiving adequate care. Within the framework of transcultural nursing, Leininger and McFarland (2002) suggested that in order to enhance the care experience for clients from a different ethnic background, nurses should make efforts to learn various greetings and phrases, food preferences and health behaviours of the cultural groups within their care. Language in this context was given a superficial consideration only. Certainly, no critique of the role of language as a colonising strategy or power differential was considered in transcultural nursing theory.

Although Leininger has been quick to respond to any perceived criticisms of her theory, the impact of colonisation in shaping power relationships with cultural and linguistic minorities does not prominently feature in the transcultural literature. Culture within this framework, was conceptualised as a marker of difference and the focus was most often on what cultural safety proponents coined as the ‘exotic’ other (Ramsden, 2002, p 116). Racialised constructs of different populations theoretically assist nurses from the dominant culture of the health services to enhance the care experience of patients who differed in cultural background. Transcultural nursing, under Leininger’s leadership at least, seemed reluctant to develop beyond superficialities and in this regard proved inadequate for the purposes of this study.

Leininger has contributed significantly to ensuring culture is considered within health care practice. However, in hearing Leininger present at a conference in 2002, she and other devotees of transcultural approaches appeared unwilling to consider the potential of cultural safety. Instead, I felt at the time that Leininger sought to dismiss any critique offered by this new philosophy as a misunderstanding of transcultural nursing philosophy.

Whilst some authors have refined and further developed transcultural nursing theory, it remains largely an unfulfilled promise for me. Practitioners are rarely asked to examine their own role in the care experience for people who differ from them in terms of cultural and/or linguistic background. This omission is why the development of cultural safety philosophy holds such promise within the context of Central Australian health care. Instead of continuing to present superficial constructs of culture that appeared to ‘fix’ certain cultures in time, cultural safety introduced a broader and more useful definition of culture and philosophical and theoretical framework for practice.

3.7.2 Cultural safety

In the 1980s, attention to the impact of culture on health outcomes in New Zealand led to the development of a nursing philosophy that has become known as ‘cultural safety’ (Ramsden, 2002). Cultural safety sought to ensure safe and effective care of clients and communities who differ in background to the health professionals providing health care services. Several key principles of cultural safety require dominant culture health professionals to acknowledge their positions of power in a colonised context, to undertake a process of de-colonisation, and engage in dialogue with the intended recipients of their service (see also Chapter 4) (A. J. Browne et al., 2009; Eckermann, et al., 2006; Papps & Ramsden, 1996; Ramsden, 2002; Smye & Browne, 2002). Browne et al (2009, p.167) also find relevance in cultural safety’s ‘...*focus on the interrelated problems of culturalism and racialization; and a commitment to social justice as central to the social mandate of nursing*’. De-colonisation as an element of cultural safety, involves an active shaking up of power relationships and an examination of the structures and tools that reinforce the status quo (T. Edwards & Taylor,

2008; W. A. Wilson & Yellow Bird, 2005). In a context of intercultural communications, language and language use as elements of culture, take on added importance. Whoever controls the discourse potentially controls the information and ensures their own positions of power over others (Freire, 1970/1993).

In contrast to transcultural philosophy, cultural safety took a much deeper approach to the interaction between health professionals and clients, especially the experience of colonised peoples within the context of New Zealand. It arose from post-colonial theoretical foundations that prompted a growing awareness of the power differentials between nurses from the dominant cultural group and clients from a minority cultural group. It was prompted by the experience of Maori midwifery students who found that the health environment actually required them to give up aspects of their 'Maoriness' in order to participate more fully with their non-Maori colleagues (Papps & Ramsden, 1996; Ramsden, 2002). Cultural safety is a philosophy with relevance for any setting or interactions where participants differ not only on the basis of ethnicity, but in other markers of difference such as age, gender, socio-economic status, religious beliefs, and sexual orientation (Ramsden, 2002). Cultural safety was developed and promoted through nursing education, asking nurses to reflect on their personal power and cultural history, rather than continuing an uncritical imposition of their own understandings and beliefs on their patients.

Irihapeti Ramsden's thesis on cultural safety and nursing education in Aotearoa (New Zealand) remains a leading work documenting the historical development, components and responses to the philosophy within her country. Unfortunately, Ramsden passed away in 2004 taking with her a major voice in cultural safety, but certainly not a major influence. Although there is a growing body of literature on cultural safety (A. J. Browne, et al., 2009; Coup, 1996; Ramsden, 2002; Smye & Browne, 2002; Zon, et al., 2004), there remain some challenges to defining it (Anderson et al. 2003). Cultural safety starts with an acknowledgement of difference, at the initial awareness stage, moving on to sensitivity, and then the concept of safety, which is essentially determined by the recipients of care. Health professionals and health services can not declare the safety or otherwise of their care. The

client is the only one who can assess the cultural safety of care provided, making the need for effective communication between clients, practitioners and services important to the assurance of appropriate and acceptable care.

Whilst the principles of cultural safety have wider relevance than for New Zealand alone, it would be 'unsafe' and unwise to transpose the New Zealand model to Australia uncritically. One fundamental difference between the New Zealand experience and that of Australia's Indigenous peoples is the existence of a treaty, the Treaty of Waitangi, which clearly articulates the sovereignty of the first inhabitants. Another major difference is the relative homogeneity of the Maori people, with regard to language, customs and culture. Many non-Indigenous New Zealanders have learned and are exposed to Maori languages on a daily basis, through Maori owned media, school policies and enshrined legal protections. This is a different circumstance compared to the Australian context, where Indigenous Australians languages do not enjoy the same profile and legal supports.

The latest range of policy developments within Australia however, seem to have bypassed cultural safety in favour of putting a local brand on terminology and conceptualisation. A growing flurry of concepts purports to move on from cultural safety, to cultural competence (in keeping with our vocational based training) and cultural security. Grote (2008) conducted a review of literature concerning the principles and practice of cultural competence. Although I do not fully agree with Grote's (2008) description of the relationship between these approaches to culture in health care, positioning cultural safety as an element of cultural competence, she provides a comprehensive review of the literature and some of the ways in which various institutions are teaching and/or incorporating cultural perspectives into education and practice. I perceive cultural safety and cultural competence as two different philosophical approaches to culture in health care, for a number of reasons discussed further in Chapter 4.

Cultural competence is defined by citing Cross, Bazron, Dennis and Isaacs as:

...a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations' (Grote, 2008)

Cultural security as mentioned in Chapter 2 is the current (2010) framework for service delivery of the NT Department of Health & Family Services, but it is not fully articulated on the Department's web site. Cultural security apparently intends to reorient away from 'attitudes to behaviour' but it is not clarified in the Department's document whose attitudes and whose behaviour are to change and how.

It appears that superficially at least, these other frameworks fail to locate the onus of responsibility with the health services, but instead continue to construct Indigenous cultures (and therefore people) as the problem. Cultural safety locates this problem with the dominant culture, and its literature is of relevance to this study of intercultural communication because one of its key tenets calls for health professionals to engage in dialogue with their clients. Their ability and/or willingness to do so are at the heart of this study, which suggests that the dominant position of English language communications can and does affect the quality and efficacy of care provided to Indigenous clients.

3.8 Education and training in intercultural communication

Within the literature reviewed, the majority of publications have articulated recommendations for the education and training of health professionals based on research findings. A review of the literature relevant to intercultural communication strongly positions the issue as an integral part of health professionals' skill requirements (Blackford, et al., 1997; Cass, et al., 2002; Grant & Luxford, 2008; Lindström, 2008; Pauwels, 1995; Ulrey & Amason, 2001). In the numerous reports on Indigenous health in Australia, improving communication between clients and health services is usually mentioned (Australian Commonwealth Government, 2003; Government, 1991; National Aboriginal Community Controlled Health Organisation and Oxfam Australia, 2007; Wild & Anderson,

2007). Whilst widely accepted as an essential skill for health professionals, communication, and specifically intercultural communication, is given inadequate attention within Australian health curricula and during ongoing professional development (Lowell, 2001; Trudgen, 2001).

Communication however, takes place in a cultural context and cultural education is frequently mentioned as a strategy to improve health care for Indigenous Australians. Cultural safety has been identified by the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) as an appropriate strategic framework for health services that cater for Indigenous Australians (Goold & Liddle, 2005). Ramsden and other New Zealand authors provide a clearly articulated process for embedding cultural safety within that country's nursing and midwifery curricula (Papps, 2005; Ramsden, 2002, 2005; Wepa, 2005). Since the philosophy was proposed as suitable for a global context, there has been a growing body of research examining its transferability to other settings as well as making inevitable comparisons with transcultural theories (J. Anderson et al., 2003; Belfrage, 2007; JR Betancourt, Green, & Carillo, 2002; Bin-Sallik, 2003; A. J. Browne, et al., 2009; Cooney, 1994; Coup, 1996). The division between cultural safety and transcultural approaches appears to be widening rather than merging. What is less prominent in the literature is how cultural safety might be 'safely' incorporated into the Australian context and specifically into the Australian Indigenous health context (Johnstone & Kanitsaki, 2007). In particular, fundamental differences between New Zealand and Australia, culturally, politically and historically require careful consideration in shaping any educational programs for health professionals.

Intercultural communication courses are beginning to appear within the Australian context, but the availability of Indigenous content remains very limited. Searches of various key sites for Indigenous health, such as the Leaders in Indigenous Medical Education (LIME) Network (www.limenetwork.net.au) and the Australian Indigenous Healthinfonet (www.healthinfonet.ecu.edu.au) have a very small number of identified sources for

information on Indigenous communications. The key research cited is the *'Sharing True Stories'* research by Cass, et al (2006). Of concern is the growing number of 'toolkits' and checklists for intercultural communication, which are presented as part of on-line cultural competency approaches.

Several core components re-appear within the global and local research however, as suggested content for the education and training of health professionals in intercultural communications. Language awareness and language sensitivity (Irvine et al. 2006) is relevant to this study of Intercultural Health Care Communications due to factors that may prohibit learning specific Indigenous languages in the Central Australian context (see Chapters 2 and 8). As mentioned in 3.5 health professionals need to learn the skills of working with and through interpreters Pauwels (2006). The research reviewed in this chapter, along with the findings from this Intercultural Health Care Communication study, are further examined in Chapter 8 in relation to the recommendations made for education and training needs of health professionals who work with, or encounter Indigenous language speakers in their practice.

3.9 Indigenous voice

As stated in the introduction, the Australian Indigenous voice is limited to an extent by the historical reality that privileges non-Indigenous peoples' access to academic traditions, which themselves are essentially Anglo in orientation. A small, but increasing number of Indigenous people in the Australian/New Zealand context are writing about the need for decolonising practice and the social justice demands that must be met if any change to the status quo is expected (Rigney, 2004; Sherwood & Edwards, 2006; L. T. Smith, 2003). These are in concert with other Indigenous authors such as Battiste (2000) and Ermine (2007) who have called for greater examination of the impact of colonisation and ways to reclaim and recognise Indigenous voices, knowledges and world views as legitimate.

What is less apparent in the literature is how Indigenous people experience and perceive intercultural communication with English language speakers. One of the very few publications to consider the issue in Australia from an Indigenous perspective stems from the Summer Institute of Linguistics, whose publication *'Whitefella Culture'* was developed as a resource to explain non-Indigenous cultural mores (Hargrave, 1997). Although an older work, and not written by an Indigenous author necessarily, this publication nevertheless provides valuable insights for Indigenous people about the issues that perplex and confound communications and other interactions with non-Indigenous people, especially in the context of the workplace. For example, it provided scenarios from remote Indigenous communities in which the non-Indigenous employees' interactions might be misunderstood or misinterpreted (Hargrave, 1997) such as responses to time and the apparent agreement to meet at specific times. Non-Indigenous participants may interpret this 'agreement' as a commitment to meet when it may in fact simply be an example of gratuitous concurrence – a tendency to agree for the sake of harmony.

I make no claim to represent Indigenous voice, other than including the voices of Indigenous participants who agreed to assist in this study, and I am conscious of the fact that I am a non-Indigenous researcher and academic. As this research is a critical ethnography however, I can undertake to advocate on behalf of the Indigenous participants in ensuring their voices are included. My major focus however is on what health professionals and health services can do to alter the status quo and make room for all Indigenous voices to be prominent and accessible. Linguistic analyses of communication barriers and facilitators, anthropological descriptors, and even quantification of miscommunications, can all be found in the literature (Bain, 2005; Cass, et al., 2002; Edis, 1998). This area of the literature is very limited within Australia, although more is available from Indigenous people across the globe.

The perspectives of Indigenous language speakers in regard to their experiences of health care services in Central Australia, as well as more broadly in Australia, is largely missing from the literature. Locally it has been the practice to acquire feedback from Indigenous

clients orally rather than in written data collection techniques, in keeping with cultural traditions (Tranter, 2010; Wilson, 2010). This Intercultural Health Care Communication study has not claimed an Indigenous perspective, but it had provided a small opportunity for Indigenous voices to be presented, although through a non-Indigenous researcher. Nevertheless, the lack of Indigenous-led research remains problematic, in that it allows non-Indigenous health services and policy makers to pay less attention to perspectives that are not presented in *written* English - the format likely to have the greatest impact on the English-dominant culture.

3.10 Summary

Although prominent in global literature pertaining to linguistic minorities, language and intercultural communication are largely overlooked in the literature concerning Indigenous Australians. This belief emerges from both a review of the literature and my personal experience of serious and frequent communication failures between Indigenous Language clients and English Language speaking health professionals. The potential for harm due to ineffective, inappropriate or inaccessible health care communications is an issue requiring urgent investigation. While mentioned in numerous reports, communication barriers are often relegated to a single dot point that ensures intercultural communications remain inadequately addressed.

This chapter examined some of the global and local literature relevant to the study of Indigenous and English languages in health care communications. It showed some older works including selected anthropological research to be relevant for initial examination of communications involving Indigenous Language speakers. Literature that considered the colonising role of language dominance, and the relatively limited current research that examines intercultural communications in Australian Indigenous health care contexts, were also reviewed. Various theoretical frameworks were considered, including cultural competence, cultural security and transcultural nursing theory. Literature related to cultural

safety was introduced, concluding with literature linked to the training and education of health professionals relevant to the study setting. This chapter also identified gaps in the literature concerning the impact of privileging English in health care for Indigenous peoples, the role of interpreters and the influence of an Indigenous construct of shame in influencing health seeking. A further gap in the literature and the one that this study seeks to contribute to is in exploring the impact on health professionals left unprepared for the experience of intercultural communication.

The next chapter outlines the methodology underpinning this Intercultural Health Care Communication study conducted in Central Australia. It provides a rationale for the chosen methodology, which was critical ethnography. Critical ethnography has been described as ‘ethnography with a political purpose’ (J. Thomas, 1993). There was a political purpose on the part of the researcher to challenge the status quo in relation to the quality and consequences of intercultural communications in Central Australian health care services. The literature pertinent to the methodological issues of cultural safety and post-colonialism is critiqued and considered for its relevance to this study.

Chapter 4

Methodology: Challenging the status quo in Central Australian health care communications

4.1 Introduction

Most of the literature reviewed in Chapter 3 identified barriers to effective communications and serious consequences of ineffective intercultural communication involving linguistic minorities. This Intercultural Health Care Communication study chose to turn the critical lens towards the majority or dominant language group who deliver health care services in Central Australia and who are mostly English-only speakers. To gain a better understanding of the experience, attitudes and preparations of health professionals for intercultural communications, specifically involving Indigenous Language speaking clients, this study employed a critical ethnography methodology.

This chapter describes and justifies critical ethnography as the methodology chosen for the study, as well as the philosophical underpinning of cultural safety within a post-colonial theoretical framework. The rationale for selecting these particular approaches is presented, along with an overview of methodological issues encountered within this Intercultural Health Care Communication study. In this chapter various influences on decision-making for the chosen methodology are examined, including insights from decolonising methodologies outlined by Indigenous authors (Battiste, 2000; Ermine, 2007; Sherwood & Edwards, 2006; L. T. Smith, 2003). My place as the researcher within this Intercultural Health Care Communication study is also explored (Fook, 1999; Schön, 1987; L. T. Smith, 2003). Chapter 5 'Methods', discusses issues such as ethical considerations and rigour.

The methodology chosen was one that would shed light on the experiences of intercultural communication within an English dominant system primarily focusing on those who provide health care, as they may be better positioned than the clients, to affect change to the status

quo. While there may be some value derived from examining the extent of communication problems and other related events, such as clients taking own leave (TOL)⁵⁰, poor compliance and missed appointments, it was the human experience and subjective influences that were the focus of this Intercultural Health Care Communication study. My choice of methodology therefore stems from an ontological framework that views the world as *'...characterised by socio-economic and cultural inequalities, where researchers have a part to play...'* in attempting to bring about greater equality and social justice (Usher, Bryant, & Johnston, 1997). Such aims and the questions pursued in this Intercultural Health Care Communication study position the research within the critical inquiry paradigm.

4.2 Why critical ethnography?

The Central Australian health care environment is rich in its cultural composition and the interplay between the various cultures makes for a unique and challenging practice setting. Health professionals employed in the region are predominantly imported from urban and coastal Australia or internationally (See Chapter 2). The client populations are mainly Indigenous people from Central Australia, with the balance either non-Indigenous local residents, tourists from all over the world and workforces supporting the region's mining, pastoralist, hospital or government services. There is diversity within both the Indigenous populations and the mainly non-Indigenous, English-dominant health service providers in terms of culture, history and contexts. Ethnography as a methodology is concerned with description and interpretation of cultural patterns, phenomena and/or settings (O'Toole & Beckett, 2010). The context of this study within a post-colonial world and the negative associations many Indigenous people have to anthropological research, determined the need for a more inclusive approach. To choose a methodology that did not require critical examination of culture and context would ignore and perpetuate the ethnocentrism of our colonising past (Eckermann, et al., 2006; Rigney, 2002). For this reason critical ethnography,

50. Take own leave (TOL) is the term used locally to described patients who discharge themselves from health facilities against medical advice (see 10.2).

which not only describes and interprets culture but also has a political purpose (Thomas 1993) was the most appropriate methodology for this Intercultural Health Care Communication study.

Furthermore, literature reviewed in Chapter 3 focusing on the linguistic needs of Indigenous Australians within health care settings was found to be relatively scant. This apparent neglect may have its origins in our colonising past, that generated a view that Indigenous Australians were either set for extinction or would ultimately be assimilated into the dominant non-Indigenous populations (Rigney, 2002) (see also Chapter 2). While other factors were prominent in the research literature, such as health-seeking behaviours, worldviews and other cultural influences, consideration of communication issues involving Indigenous Australians was less well formulated (Watson, 2006). Issues of power, social justice, and both individual and human rights were prominent themes to be explored, suggesting the need for a more critical approach to examine existing conditions and challenge the status quo. The study's findings are later considered within a post-colonial theoretical framework that incorporates the cultural safety philosophy articulated by one of its founders and key advocates, Irihapeti Ramsden (Ramsden, 2002).

4.3 Paradigmatic context

In selecting qualitative research, within the critical inquiry paradigm, I have made certain conscious decisions and assumptions. Communication is an essential component of the human experience. The links between identity, being, and language identified by Heidegger (1962) and others, and the use of language as a mechanism of oppression and control (Freire, 1970/1993) all combine to make a persuasive argument for taking language and communication more seriously. An inability to communicate in any way has been implicated in isolation, alienation and a lack of engagement with those around us. Gadamer (1975) emphasised the need to pay attention to language use by reiterating the ideas of the 19th century philosopher Wilhelm von Humboldt, who first conceptualised languages as

representative of particular worldviews. Gadamer (1975) also acknowledged the role of historical and cultural influences in shaping worldviews and in how language is used.

Gadamer (1975) maintained that the critical influence of the context of language use has greater importance than the actual learning of a different language. In the Central Australian health care context, Indigenous Language speaking clients may use English in ways that differ from an English first language speaker. However, as Gadamer (1975) suggested, being able to converse at some level in a foreign language does not necessarily acculturate the speaker to the context, leaving room for potential misunderstandings and ineffective communications, already identified in some Australian health research (Lowell, 2001).

Quantitative research generally seeks to draw conclusions between cause and effect, often employing statistical analysis to issues under study. Communication of thoughts, feelings, knowledge and experiences on the other hand, is a subjective activity best examined within a qualitative paradigm. In the most basic of constructs, quantitative research is about numbers and qualitative is about words (Broom & Willis, 2007; O'Toole & Beckett, 2010), although increasingly these distinctions are less rigid. Of relevance to this Intercultural Health Care Communication study, an important distinction of qualitative research is the emphasis on understanding how meaning is constructed and associated with words. A qualitative paradigm was an obvious fit therefore, for a study of experiences of language dominance and intercultural communication. However, there are a number of approaches within qualitative research that could have been considered, such as phenomenology, grounded theory or participative action research. Participative action research for example, was soundly employed to identify and then develop strategies for dealing with communication barriers within a renal unit in Darwin as outlined in Chapter 3 (Cass, et al., 2002). Most of the possible qualitative approaches would have provided a perspective on the experience of intercultural communications in Central Australia. However, not all approaches would have answered the specific questions posed by this study, or have been practical for the researcher.

In seeking to explore and examine the *experience* of intercultural communications within English dominant health care communications, a decision was to be made between an interpretive approach and a critical one. For me, the choice was clear. I was not only trying to interpret the participants' experiences. I wanted to think critically about them to understand what assumptions and influences underpinned intercultural health care communications in Central Australia, and to develop critical knowledge that would lead to better outcomes for participants in health care. I wanted to expose those assumptions that have constructed the majority of communication problems as stemming from Indigenous participants, rather than from the role and practice of English-speaking health professionals. From this perspective, the description of critical inquiry as research that openly seeks to '*challenge the status quo in order to improve things for the better...*' was more relevant than an interpretive approach that would aim mainly to '*explore or describe*' (Roberts & Taylor 1999, p.123).

When asked about possible barriers to communication in this setting, one of the health professional's responses was, '*Well, **their** (Indigenous) culture to start*' (Penny, see also Chapter 6.) As with Jakamarra's opening quotation, this piece of data is included here because it typified the unexamined and throwaway comments that had pervaded discussions with people locally prior to embarking on this research. This response was the participant's superficial explanation, but one that on further examination was not what Penny really believed. This participant later articulated systemic and non-Indigenous biases as more genuine barriers than the Indigenous cultures (see 6.7). Apparent problematising of Indigenous culture by health personnel provoked my interest in critical inquiry long before commencing this Intercultural Health Care Communication study. To find such statements within the data validated for me the choice of critical inquiry as an appropriate paradigm in which to examine what was behind these sentiments.

4.3.1 Critical theory and critical social science

For health professionals to effectively use reflection on practice, it is useful to have a language that is appropriate. Theory '*organises relevant knowledge to help describe, organise or explain a phenomena*' (Roberts & Taylor, 1999). Traditional approaches were believed to overlook or make invisible some of the important power issues that served to explain certain phenomena however. It was not until some researchers determined that so called rational science did not provide a complete understanding of phenomena simply through applying scientific methods of research, that a more critical theory and critical form of science emerged. Research that purported to be objective and uncritical was no longer considered adequate for arriving at a complete understanding of human experiences.

Critical theory and critical social science are not new. They go back more than two centuries, arising from periods of social upheaval and oppression, particularly following the First World War in Europe. Critical theory is an evolving and variously defined concept. A contemporary definition offered is that critical theory is a guide to analysing matters of power, race, class, gender and other competing power interests within a society (Kincheloe & McLaren, 2002). The over-riding goal of critical social theory was to challenge existing power structures and emancipate people through knowledge (Roberts & Taylor, 1999). More recently, theorists such as Jürgen Habermas revisited critical theory and the social sciences by suggesting that research did not need to be exclusive, but could be inclusive, incorporating empiric and historical knowledge with the analytical and hermeneutic, to arrive at new critical knowledge (Roberts & Taylor 1999). The development of critical theory and critical social sciences ensured that issues of power and oppression were considered making these relevant to the Intercultural Health Care Communication study undertaken in a post-colonial Central Australian context.

Without considering critical theory and critical social science, there is a danger in choosing an ethnographic methodology simply because of culture being a prominent feature of the issue under review. Cultures are examined within this study, but not for obtaining an

anthropological picture of specific cultures. Instead, the choice of critical ethnography as distinct from anthropological ethnography emphasises a principle to examine and change practices that deny equitable access to health care or disadvantage a particular cultural group. As the participants in intercultural health care communications are usually professionals and clients, this study includes both cultural groups who themselves are enmeshed within health care systems that influence the experience and outcomes for all. In the intercultural communication context, all participants may experience power, powerlessness, and oppression (J. Anderson, et al., 2003).

4.3.2 Ontology and Epistemology

In considering an appropriate methodology researchers are compelled to consider questions about what they believe about being in the world (ontology) and how they come to know the world (epistemology). Ontology and epistemology are two aspects of research that might be said come first in influencing what questions a researcher will ask, what they want to know and how they believe they can know it (Roberts & Taylor, 1999).

My own way of knowing the world or my ontological standpoint, naturally stems from my formative years, my cultural education and my life experiences. My view on being human in a changing world has developed through an integration of theory and practice, reflection and critique. My cultural traditions demand critique rather than an unquestioning acceptance of information, although this critical view of the world has come later in life. In contrast, much of my early education was based very much on a one-way provision of information that was to be accepted unquestioningly. However, I also recognise that the ontological positions of others, including participants in the study, may or may not accord with mine.

It is also important to consider epistemological issues early in a study that includes participants from differing cultural and linguistic backgrounds. If epistemology is concerned with ways of knowing, it must be acknowledged that my own cultural traditions privilege certain ways of knowing above others. Western or European traditions place great emphasis

on ‘evidence’ or proof to justify ways of knowing. What is considered and accepted as evidence however, is not universal. Indigenous evidence has historically been regarded as less ‘credible and scientific’ than European epistemologies, in spite of their considerable seniority (Battiste, 2000; L. T. Smith, 2003). In dominant Western biomedical cultures, Indigenous ways of knowing, oral traditions, and qualitative evidence have typically been undervalued. This clash of epistemological positions forms a backdrop to the Intercultural Health Care Communication study.

In refining the issue to be studied, it might reasonably be asked why I have chosen to focus on language and intercultural communications rather than the influence of culture. One answer is that knowledge of culture is transmitted mainly via language and modes of communication. Furthermore, it is my contention that problems related to the provision of health care to Indigenous Language clients lies not in Indigenous cultures as the literature has suggested (see 3.4). In my view, the problem lies in communicating between cultural groups in order to respond more positively than problematically and the reality in which this communication takes place within potentially racist and democratically racist contexts. Individuals can study culture/cultures through observation and theorising, but may remain unwilling or unable to engage in dialogue, which is a necessary component of a cultural safety approach. With communication as a barrier, the knowledge and theorising stays largely untested and unconfirmed by the ‘other’⁵¹. Experience working with various cultural groups leads me to believe this happens with different cultural groups constructing knowledge, assumptions and beliefs in the absence of a meaningful dialogue.

According to Whorf (1956), thought is only expressed through language. In a study embracing language, communication and cultures, the literature reviewed in Chapter 3 often referred to several influential figures who speak extensively about the issues relevant to Central Australian intercultural communications. This Intercultural Health Care

51. Other – denoting individuals and groups who differ in some way from the majority group (see 10.2).

Communication study however, is not a linguistic study, but research that seeks to examine and analyse participants' experiences of communicating across cultures.

4.3.3 Methodological approach

The shift from a traditional anthropological approach that sought to observe and describe cultures, to one that also sought to critically analyse the interface between the researcher and the researched cultures, offered a more relevant and culturally safe framework for this study. Critical ethnography is a further development from traditional anthropological ethnography, described by Thomas (1993, pp.2-3) as:

... a type of reflection that examines culture, knowledge and action ... Critical ethnographers describe, analyse, and open to scrutiny otherwise hidden agendas, power centers, and assumptions that inhibit, repress, and constrain. Critical scholarship requires that commonsense assumptions be questioned.

As Manning, Van Maanen and Miller state in the introduction to Thomas' book: *'Critical ethnography emerges when members of a culture ... become reflective and ask not only "what's this?" but also "what could this be?"'* (Thomas, 1993, p. v). These and other questions help to test the commonsense assumptions made during intercultural communications.

There was frequent agreement from my local peers in response to the observably different care for Indigenous people, that things were 'different' in the Northern Territory. In looking for a suitable methodology to examine the experience of intercultural communications in Central Australian health care, I wanted to not only consider what this difference was, but what it could be. Repeatedly requiring change from Indigenous people who have already undergone enormous and rapid change, without an examination of the other side of the health care equation is to operate without all the pieces of a puzzle. Something will always be missing and the picture will be incomplete and obscured. Such a one directional response

also negates the existence of power imbalances between the dominant health systems and structures and the minorities who use health care services.

The value of using a critical ethnography approach was highlighted for me in Thomas's study of violence in prisons, which seemed relevant to the questions I had surrounding intercultural communications in Central Australian health care. Just as Thomas's participants were constructed through racially imposed stereotyping as violent prisoners, my own observations and personal experiences identified Indigenous people being labelled as non-compliant, unable or unwilling to take responsibility for their own health. By examining communication in context, a critical ethnography can be expected to do more than observe and describe (Roberts & Taylor, 1999).

Critical ethnography therefore was a further development in the field of ethnography, which provided a foundation for examining cultural issues. However, as with transcultural nursing, much of the work of ethnography relied heavily on constructs of culture as mostly fixed, something to be observed in a naturalistic manner and responded to with a new knowledge base. Critical ethnography, like cultural safety however, challenges stereotyped and racially constructed notions and examines what lies beneath interactions. Issues of racism and discrimination, power and oppression must be examined, rather than the exotic aspects of differing cultures from an anthropological perspective. In this sense, contemporary critical ethnography seeks to decolonise research (Vidich & Stanford, 2000).

The status quo within Central Australian health care, appears to be one where a particular section of the community is denied full participation through a lack of adequate attention to communication needs. The capacity to provide a culturally safe health system for Indigenous Australians requires culturally safe communications, which are limited by system inflexibility and acceptance of the status quo as unproblematic. It is not justifiable to accept that care provided to one group of people is of a lesser standard than would be accepted by and provided to members of the dominant culture.

In summary, this Intercultural Health Care Communication study required a methodology that would examine the differing cultures operating within Central Australian health care settings and critically analyse their interactions to allow issues of power, dominance and colonisation to emerge. There were enough examples from my own experiences, observations and fieldwork to realise that a quantitative approach, a qualitative interpretive methodology, or even traditional anthropological ethnography, would reveal little of the underlying issues influencing the experience of intercultural health care communications. A critical ethnography was considered the most appropriate methodology to understand the place of culture (and language as an element of culture) in influencing the political status quo of health care in Central Australia.

4.4 Insider/outsider—Emic and etic perspectives

Whilst ethnographic studies have tended to be conducted by researchers who were outsiders to the culture under examination, this Intercultural Health Care Communication study was conducted as both an insider and outsider to the cultural groups concerned. As a registered nurse and an English First Language speaker, I am an insider of sorts, possessing some understanding of the cultural context in which intercultural communications take place in Central Australia. As such my ability to interpret and understand meanings, beliefs and experiences of participants with whom I share a cultural and linguistic background may be enhanced. However, I am also an outsider to the Indigenous cultures in Central Australia. Furthermore, my understanding continues to be limited by gaps in understanding what underpins the behaviours and responses I have witnessed. I wanted a deeper, richer understanding of the experience of intercultural communications, from emic and etic perspectives, in order to make a difference for both Indigenous recipients and non-Indigenous providers of health care.

The ‘insider (emic) perspective’, implies having personal experience of a culture/ society, while the etic or ‘outsider perspective,’ suggests the perspective of a person who has not had

a personal or 'lived' experience of a particular culture/society (Young, 2005). Her interpretation of the terms *emic* and *etic*:

... also involves an interaction between this self-definition and how others perceive one's self ... While the term "others" can involve both broad concepts such as race, ethnicity, gender and social class, it also operates at more personal levels of contact ... with multiple layers (Young, 2005, p. 152).

As an insider, using Young's conceptualisation of a multi-layered self, I might identify as non-Indigenous, Anglo Australian. If asked what I do, I am a lecturer, an academic. I would probably perceive myself more as an educator than a registered nurse. The non-clinical focus of my nursing career often challenges this particular identity for some. As Young (2005) describes of herself, I might also be considered a class migrant, coming from a low socio-economic background, to a position of relative affluence.

Locally, my professional reputation at times, appears to position me as a resource for people wanting to communicate inter-culturally in the region. Both Indigenous and non-Indigenous people, health professionals and lay people have sought me out at times to assist in giving or obtaining information, across linguistic divides, even though I have no fluency in any Indigenous language. As Young (2005) explained about her concepts of self, some of these personae receive more public recognition than others.

As the researcher, I needed to acknowledge my position a member of the colonising group, which influenced my discourse and my analyses. However, I try to critically examine that position and the position of participants from my own cultural group. According to Smith (2003, p. 15) there is a need to be aware of the '*values and beliefs, practices and customs of communities, to be able to research without causing offence*'. Partnerships are needed. My own communication style also had an inevitable impact on the research, which itself became data for analysis. It was difficult to change long held habits and ways of operating even with knowledge and awareness of the ineffectiveness of some approaches. As Watson (2006)

acknowledged in his research, I too found this entrenched way of operating to be an inherent weakness in my research. However, it generated an even greater appreciation of the importance of identifying and preparing for intercultural communication in Central Australia.

Cultural baggage taken with the researcher is considered a powerful influence on the interpretation of findings and the researcher must remain alert to the informant's organisation of cultural knowledge. By employing both emic and etic perspectives within my research, I was able to '*bridge the gap*' as Young (2005, p 152) describes it, between academic theorising and the experiential, lived knowledge. With Indigenous participants, I was mindful of my role as an outsider to their culture. Rather than attempt to interpret experiences of Indigenous participants as an outsider, I focused mainly on the non-Indigenous health professionals, using the relayed experiences of Indigenous Language speakers to enhance the data obtained in a combination of insider/outsider approaches. Such a combination of perspectives gives a more complete picture of the issue under scrutiny, so there is no need to be exclusively etic or emic (Werner & Schoepfle, 1987). Watson (2006) maintains that in any ethnography the control of ethnocentrism, the tendency to view one's own culture as the norm and usually superior, should be of central concern. For this reason, I wanted to ensure reflective practice was part of my own methodology as well as incorporating decolonising strategies in my dealings with Indigenous participants. To this end I sought and responded to regular advice from critical friends and Indigenous advisors with whom I had established relationships.

4.5 Theoretical and philosophical congruence – the links between critical ethnography, post-colonialism and cultural safety

In selecting critical ethnography as a methodology, it was important that the theoretical framework and underpinning philosophy were congruent and appropriate to answer the research questions. Post-colonialism as a theoretical framework is concerned with the experiences of colonialism and their aftermath. As with many of the concepts and definitions

articulated throughout this thesis, there is ongoing debate as to their precise meaning and nature. As with cultural safety, primary health care and other concepts, post-colonialism may be a theory, a way of practice or a process (Quayson, 2000). Quayson (2000) poses a distinction between *post-colonialism* with a hyphen and *post colonialism* unhyphenated, as a usage that is gaining prominence in the literature to indicate a further development in the field. For the purposes of this study however, post-colonialism (hyphenated) is presented as a theoretical framework that is underpinned with a cultural safety philosophy, concerned with the impact of colonisation. Cultural safety is recommended by Browne (2005) and Browne et al (2009, p167) as a powerful analytical framework because of its potential to '*focus on power imbalances and inequitable social relationships in health care; the interrelated problems of culturalism and racialization; and a commitment to social justice*'.

Given the research context described in Chapter 2, the choice of a post-colonial theoretical framework might seem obvious. However, various authors hold different positions on what this terminology actually means, which suggests the need for caution. Colonisation and colonialism as terms, evoke for many a sense of something historical, pertaining to the past and largely, or not of a contemporary world. That is of course, depending upon one's life experience and position in the world.

Sykes' response to the terminology of 'post-colonialism' was sharp and challenging to the non-Indigenous researcher when she said, '*What? Post-colonialism? Have they left?*' (Smith 2003, p.24). In the Central Australian context, as previously discussed, colonisation and colonialism are anything but finished. The framework for this research is described as *post-colonialism*, which might seem to imply that colonialism is over. Sykes' response suggests that the continued dominance of non-Indigenous people in this country means that colonialism is an ongoing process. I agree that ongoing colonisation is certainly the case in Central Australia, even if different arguments can be made for other parts of the country. Colonisation as a process is defined as: '*a practice of domination, which involves the*

subjugation of one people to another ...’ (Kohn, 2008). The strategies involved in colonising any group have common principles underpinning them, including dispersal and dispossession of people, forcefully or through coercion, oppression and denial of rights and language subjugation according to Eckermann et al (2006). Language subjugation as a tool of colonisation is continued by health services that fail to adequately acknowledge the rights of all linguistic minorities to retain their own language.

Prior to the introduction of guiding principles for ethical research, investigative practices that dehumanised and colonised Indigenous Australians were common, in the pursuit of so-called scientific research. Indigenous Australians are among the most ‘studied’ group of people in the world with unique status as possibly the oldest surviving cultures (L. T. Smith, 2003; D. Thomas, 2004). The European world at the time of Australia’s colonisation was obsessed with scientific paradigms. This obsession saw Indigenous Australians positioned for a long time, as specimens rather than people (Marcus, 2005; D. Thomas, 2004). The science of anthropology with its measures and constructs of human development was largely implicated in relegating Aboriginal Australians to the bottom of an ethnocentrically constructed evolutionary ladder. Darwinism⁵² had a profound impact on the way Indigenous Australians were perceived, and worse still, researched, measured, observed and categorised. Many Indigenous Australians are still getting over the trauma of being considered as specimens rather than people, with the skulls and other remains of relatives still located in museums around the world (Marcus, 2005; D. Thomas, 2004).

Thomas (2001, p.3) describes the beginnings of Aboriginal health research in Australia as being more concerned about the *‘loss to ‘science’ should Aboriginal people become ‘extinct’...rather than on addressing Aboriginal health problems’*. According to Smith however, research still holds negative connotations for Indigenous people globally.

52. Darwinism—a theoretical construct of evolution that implied a hierarchical order to various cultures (see 10.2).

The word itself, 'research', is probably one of the dirtiest words in the indigenous world's vocabulary ... The ways in which scientific research is implicated in the worst excesses of colonialism remains a powerful remembered history for many of the world's colonised people (L. T. Smith, 2003)

The legacy of this colonising approach to research involving Indigenous people generally has elicited mistrust and reticence on the part of many Indigenous groups to being 'studied'. In turn this mistrust and reticence has led to the development of assurances and safeguards of ethical standards and specific principles for the conduct of research involving Indigenous peoples (National Health and Medical Research Council, 2003; L. T. Smith, 2003; D. Thomas, 2004). In attempting to undertake research that includes Indigenous people from Central Australia therefore, I have tried to be mindful of the close proximity of events and remembered history that still affects the lives of potential participants. Scientific research is particularly sensitive in this context, as is research that has its origins and ongoing connections to anthropological activities. This study of Intercultural Communication in Central Australian health care was also a study of the experiences and interactions of numerous cultural groups, including Indigenous health service users, the non-Indigenous health professionals, and the health services (see 2.7). Within each of these groups are the sub-cultures of different language groups, medical, nursing and other health professionals' cultural groups and the cultures implicit in government-controlled and Aboriginal-controlled health services. With so many cultures intersecting within the experiences of health care communications, and given the sensitivities and historical burden of past ethnographic research involving Indigenous people, critical ethnography and cultural safety were most appropriate. Furthermore, nurses as a professional group have also been burdened with a history of professional domination by medicine (Roberts & Taylor, 1999). Being mindful that Freire (1970) suggested those who are oppressed may also become oppressors at some point, an examination of the power relationships in the Intercultural Health Care Communication contexts of this study, was essential to uncover oppressive practices.

Within the literature, there are numerous possibilities for a philosophical framework to guide this study. According to Smith, (2003) the privileging of western scientific knowledge, and the associated text-based traditions give weight to the written word over oral traditions. This ensures orally transmitted knowledges such as those found among Indigenous Australians, are assigned lesser value by the dominant cultural group. *'Research 'through imperial eyes'* (Smith, 2003, p. 42) describes an approach that assumes Western⁵³ ideas about the most fundamental things are the only possible ideas to hold, certainly the only rational ideas, and the only ideas that can make sense of the world.

It would be just as wrong for me as a non-Indigenous researcher, to presume homogeneity of western ideals as it would to presume a lack of diversity among Indigenous ideals. For both, indeed for *all* cultures, I would suggest, there is a continuum of ideals. While some commonalities may be identified within various cultures as their 'norms', not every member holds fast to these norms at all times. As a de-colonised researcher and with values developed long before such terminology ever entered my consciousness, I am not so culturally arrogant as to assume that a singular view of ideas can make sense of the world. In fact, the joy of working in Central Australia for me has been the way in which differing worldviews and knowledges have provided a constant mental challenge to any hidden or entrenched ideas I may try to hold.

In the context of this study, I have used my own cultural traditions of research and scholarship because I do not believe I can use another's without continuing to colonise. I have however, tried to be open about my approaches, my assumptions and my rendering of the participants' stories as much as possible. In relation to communication generally, I have come to believe that Indigenous communications honed over thousands of years and across vast geographical distances, have much to offer a receptive and de-colonised non-Indigenous recipient. For myself, this implies an exchange of knowledges—not a one sided taking

53. Western is used within the cited literature to indicate non-Indigenous European and Anglo cultures (Smith, 2003).

without giving something in return. It was only when I took the time to explain my own academic tradition and to actually show an example of a thesis to some Indigenous Language participants that a shared understanding became apparent. Responses suddenly had greater purpose and importance. The importance of explaining the potential benefits of research to participants, if not directly, but indirectly, takes on added significance as an example of reciprocity. Reciprocity is not only a key feature of Indigenous relationships, but a criterion to be addressed in the application of ethical research (National Health and Medical Research Council, 2003).

Cultural safety as a philosophy has arisen within a post-colonial context and as such an acceptance of language rights are implicit in the delivery of an accessible and accessible health service. The inherent emphases on issues of power, decolonisation and self-reflection provide a valuable template against which to analyse intercultural communication. However the term post-colonialism is problematic for some who interpret ‘post’ as meaning a past event (L. T. Smith, 2003).

Ramsden (2002) in her thesis on cultural safety chose to describe her theoretical framework as ‘*neo-colonial*’, suggesting that what has occurred in contemporary times is simply a new phase of colonialism. In the Central Australian context and the Australian context more broadly, since the beginning of what is now known locally as the ‘Howard era’⁵⁴ I would argue that Australia is also experiencing a new colonialism. However, for the purposes of this study I will use the term *post-colonial* as per Browne et al. (2005) to imply events since the historical process of colonisation commenced in Australia in the late 1780s and more recently in Central Australia.

Post-colonialism as a concept is increasingly being used in the health literature to consider the broader social, historical and economic influences that shape health care services and

54. Howard era—refers to the period of government under the leadership of Australian Prime Minister John Howard 1996–2007.

systems (A. Browne, 2005). Rather than focus on individual responses, post-colonial theories require consideration of the context that shapes contemporary health services and practice. In summary, this Intercultural Health Care Communication study situated within a post-colonial context is informed by post-colonial theories, cultural safety philosophy and critical social science, which all combine to form my philosophical framework.

4.6 Philosophical underpinnings—a cultural safety approach

The philosophical underpinning this study is one of cultural safety, which allows culture to be broadly defined and does not fix culture as something static. It suggests the need for members of the dominant cultural group to undergo a process of decolonisation in order to engage in meaningful and equivalent dialogue (Papps & Ramsden, 1996; Ramsden, 2002). Derived from Indigenous health professionals, specifically Maori midwifery students, this philosophy was considered the most valuable one for my study of intercultural communication for several reasons.

Firstly, it stemmed from a colonising experience. With notable differences between the Australian and New Zealand histories of colonisation, the comparison in health outcomes for the cultural minorities of both countries suggested relevance. The Congress of Aboriginal and Torres Strait Islander Nurses of Australia (CATSIN) also identified cultural safety as a philosophical framework appropriate for consideration in Australian Indigenous contexts (Goold, et al., 2002).

Secondly, this theory sought to unsettle the status quo by requiring the dominant culture health professionals to de-colonise themselves and their practice through reflection on the power relationships inherent in health care settings. Cultural safety as it has developed over time, also allows culture to be defined as any major point of difference between the health professional and the clients for whom they provide care. This may be cultural difference due to age, gender, sexuality, religion, socio-economic status or ethnicity (Papps, 2005). As such, the principles of cultural safety cater for cultures in transition, as well as those labelled

traditional or contemporary. With no fixed definition of cultures, it differs fundamentally from the transcultural notions of cultures that can be easily described by language, food choice, dress and rituals.

Finally, the ability to illuminate the intercultural communication experience is the result of cultural safety's reorientation from examining the minority as the problem, to a focus on the impact of the dominant culture's position and privilege. Through choosing to undertake a critical ethnography underpinned by a post-colonial framework and cultural safety philosophy, I have sought to combine insider/outsider perspectives to acquire a more complete picture of the experience of intercultural communications in Central Australian health care.

My goal as a non-Indigenous researcher was not to further appropriate Indigenous knowledge and practices. My goal was to uncover the issues implicit in poor communication and not to blindly follow the traditional westernised notion of locating the deficit with Indigenous people. This study places greater emphasis on uncovering experiences, attitudes and responses of non-Indigenous health professionals. It is not acceptable to present an authoritative Indigenous voice as a non-Indigenous person, but I included Indigenous voices as a means of illuminating the experience of health professionals in Central Australia. Using Indigenous voice this way is expected in a critical ethnography.

Conventional ethnographers generally speak for their subjects...critical ethnographers, by contrast, accept an added research task of raising their voice to speak to an audience on behalf of their subjects as a means of empowering them by giving more authority to the subjects' voice (J. Thomas, 1993).

In using a decolonising theoretical underpinning for this Intercultural Health Care Communication study, I have been able to adhere to principles of cultural safety theory to reflect on my own and others positioning. By being a non-Indigenous researcher and focusing primarily on my own cultural group, I sought to reinforce this study's contention

that the privileging of English in health care is what requires examination, beyond the traditional deficit approaches that locate responsibility for ineffective intercultural communication with Indigenous Language clients.

4.7 Summary

This chapter has outlined the methodology used in this study and provided arguments for the choice of critical ethnography over other methodological approaches. The political purpose inherent in selecting a critically ethnographic methodology is described as challenging the status quo with regard to existing experiences of intercultural communications involving Australian Indigenous Language speakers. It has considered the literature related to various methodologies and presented a framework for this intercultural communication study. Post-colonialism and cultural safety are discussed in relation to their relevance as the theoretical framework and guiding philosophy respectively, which underpin this study of Intercultural Health Care Communication in Central Australia.

The following chapter outlines the methods. It includes analysis of health communications, identification of current preparations for, and attitudes towards cross-cultural communications, and how data were managed to arrive at an understanding of the experiences of communications involving Indigenous Language speakers in an English dominant health care system. Methods are described in detail, with consideration for the research setting, participant selection, ethical issues, and research rigor within a qualitative critical paradigm.

Chapter 5

Methods: The right tools for the job

5.1 Introduction

Although the issue of Intercultural Communication can be and has been examined in a variety of ways, it is the researcher's particular focus and ontological standpoints that determine which methodology will best answer their particular research questions. As outlined in Chapter 4, this Intercultural Health Care Communication study arose from a view of the world that certain cultural inequalities must be challenged. It is essentially concerned with subjective human experiences and as such draws on the critical paradigm and incorporates qualitative inquiry. Critical ethnography chosen as the methodology for this study therefore, directs the researcher to employ certain research methods.

The methodology chosen for any research inevitably influences the way in which data are collected, and is the critical potential of any study (Habermas, 1979; J. Thomas, 1993) *'Where and from whom we obtain data ultimately provides the meanings that shape the analysis'* (Thomas, 1993, p. 37). This chapter outlines what was actually done during the study of Intercultural Health Care Communications in Central Australian health care, including the methods and the relevant guiding principles for undertaking and assessing the research. It describes ethical issues, the study setting, the selection and recruitment of participants, collection and analysis of data, and research rigour, which within a qualitative methodology is variously termed fittingness and auditability (Roberts & Taylor, 1999). Figure 5 (this section) provides an overview of the methodology and methods employed in this Intercultural Health Care Communication study.

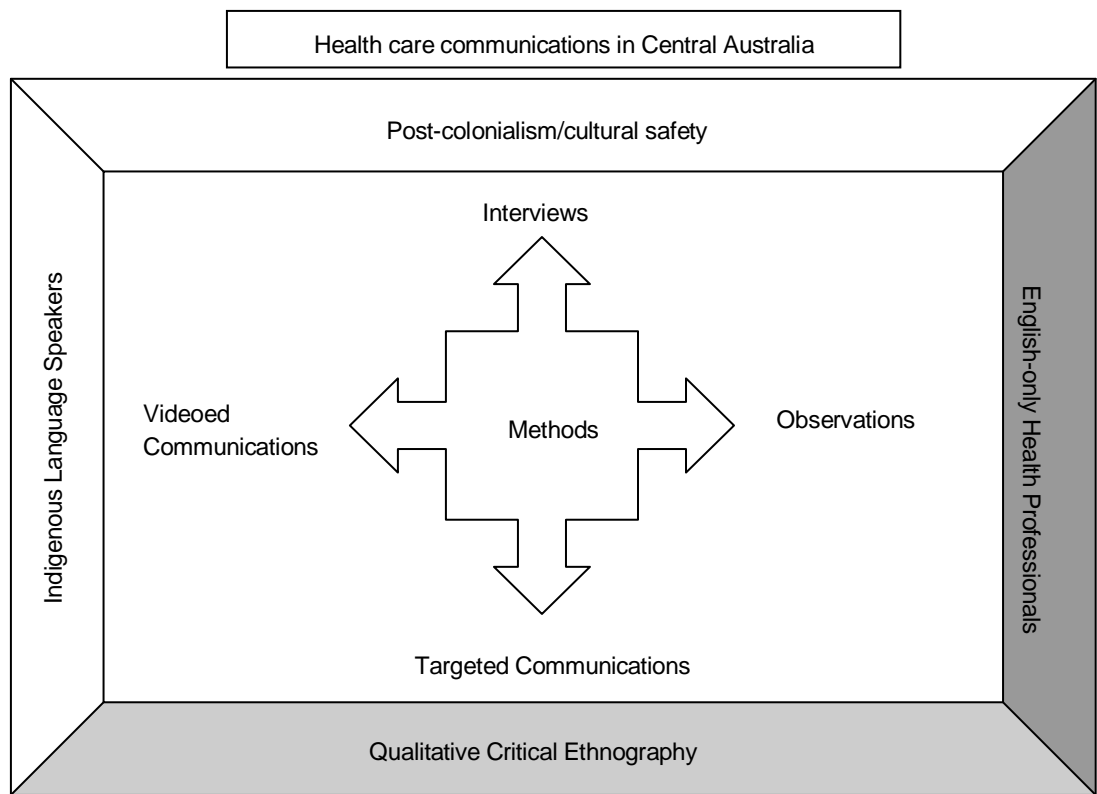


Figure 5: Overview of methodology and methods for the Intercultural Health Care Communication Study

5.2 Ethical considerations

Indigenous people have been subjected to some of the most unethical research over time, prompting the need for separate and specific ethical considerations for research in which they are participants (National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors' Committee, 2007; L. T. Smith, 2003). Given the study's location, it was important to firstly seek approval from the local Central Australian Health Research Ethics Committee (CAHREC), which includes Indigenous advisors. There seemed little point in or possibility of pursuing this study involving Indigenous participants without local support. CAHREC sought clarification over my capacity to undertake what was the committee initially thought a linguistic study. On providing further information, the proposal was accepted to be health research concerning health practice. Subsequent to making some minor amendments to the suggested approach, CAHREC approved the study (Approval No 2005.05.01, dated 30/6/05).

A request was then made to Flinders University Social and Behavioural Research Ethics Committee (SBREC). A number of changes were recommended including potential contamination of health interactions by a third party during video-taping, consent form amendments to access clients' medical records and data storage confirmation. Once these points were addressed, SBREC approval was confirmed for Project Number 3491 on April 21, 2006 (see 10.6). Access to client's medical records was later determined to be unnecessary for the purposes of this study and this was not requested of participants.

5.2.1 Ensuring anonymity and confidentiality

In a relatively small research setting, it was always going to be difficult to ensure complete anonymity of participants. Even though Central Australia is geographically vast, it is socially and professionally quite small. Anyone who knew that I was conducting research might assume that people I was with at different times and locations may have been participating in my research. However, my role locally involves a number of professional relationships.

Conducting the research over a lengthy period also provided some cover for participants so that any assumptions about who was or was not involved remained merely speculative.

Names of participants were changed, and locations removed unless they are so general as to not be linked to specific individuals. All identifiers such as place of work have been excluded where necessary. Signed consent forms have been stored in a secure filing cabinet and office. There is no recording on the signed forms to indicate which transcribed data belongs to which participants, with voice recordings, saved on a password-protected computer. Files are saved with a number identifier that is recorded with a code used to identify participants to myself only.

5.2.2 Vulnerability, power and control

In relation to the ethical conduct of this study vulnerability, power, and control have an added significance as some of the concerns inherent in intercultural communication and health care. With specific national guidelines for research involving Indigenous participants, it may be easy to assume these issues are of greater concern for the non-Indigenous researcher interacting with Indigenous participants. Indigenous specific guidelines recognise the unethical manner in which past research has been conducted and seeks to ensure the rights and dignities of Indigenous Australians are protected in current and future research practices. However, the non-Indigenous participants also warrant the same considerations of ethical treatment and vulnerabilities, power and control are also relevant for all participants in this Intercultural Health Care Communication study.

As stated, I exert no particular power over the health professionals from an employment or personal perspective. However, as a researcher, there is considerable power vested in me in relation to how I handle the data. Health professionals expressing frank views or retelling stories that may reflect poorly on their practice can be made vulnerable from an employment perspective. This required a strong trust relationship between the researcher and participants. Assurances of non-identification were very important to participants. Apart from any

specific identifiers in the data, where individuals' particular patterns of speech may have made identification easy for anyone who knew them, I have tried to break up content to minimise the risk of exposure.

As mentioned, the vulnerability of Indigenous participants is a matter of concern for ethical committees nationally and globally. Researchers in Australia are advised to consult and address the guidelines provided in '*Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander research*' (National Health and Medical Research Council, 2003). According to these Guidelines, research involving Indigenous people should show consideration of six core values identified as essential to the conduct of ethical research. These values are reciprocity, respect, equality, responsibility, survival and protection, spirit and integrity.

In response to the values of respect, equality and responsibility, it was important to make sure the consent obtained from participants was informed. The intention to use interpreters was one way of facilitating the communication of consent issues. However, as found within this Intercultural Health Care Communication Study, interpreters are not the complete solution or even always a possible solution to ensuring comprehension and agreed understanding. All reasonable steps were taken however, to ensure that participants were informed and where any doubt existed, I did not proceed with data collection.

Most Indigenous Language participants did not want to involve an interpreter, a situation that is discussed in Chapters 7 & 8. To gain informed consent in these circumstances a detailed explanation was given using plain English for Indigenous Language participants (see 10.7). The goals, possible outcomes and level of participation needed were explained directly by the researcher in most cases. One person required a translator to discuss the consent and project prior to meeting with the researcher. I was then able to reconfirm their understanding of what was being asked of them and what I was trying to achieve. A plain English script was used in conjunction with the formal required consent form, as co-

developed with an Aboriginal Liaison Officer (see 10.8). The written form was presented in conjunction with verbal explanations for Indigenous Language speakers.

For English First Language speakers, the consent form included the same information in a more formal English language style (see 10.9). All potential participants were advised of their rights to withdraw consent at any time and of the researcher's and interpreters' obligations to maintain privacy, anonymity and confidentiality. An emergency contact number was provided to all participants as recommended by the NHMRC Guidelines. The consent form outlined my identity and background as a researcher, the purpose and nature of the study, the right to refuse to participate and to withdraw at any time, the responsibilities of the researcher, the possible benefits of the study, the possible risks of participation, and measures to protect privacy as far as possible.

5.2.3 Data Storage

According to the Flinders University requirements for data storage and protection, all related materials obtained throughout this research are required to be stored on University grounds, under secure storage. Normally, this would be at the Adelaide based facility. However, I argued that locating materials some distance from the researcher would be less secure than keeping it in the secure facility of the Centre for Remote Health (CRH) located in Alice Springs. The CRH is a joint facility of Flinders and Charles Darwin Universities and as such meets the requirement for storage within Flinders University, which was agreed by SBREC in the final approval. At the conclusion of the research, it is intended that all data be kept for a minimum of seven years at the Centre for Remote Health as required by the NHMRC.

5.2.4 Non-maleficence and Beneficence

The Intercultural Health Care Communication study aimed to ensure that no physical, emotional or other harm resulted from participation and that in fact, some benefit could be gained if not directly to participants, then to their professional and or personal community. To this end, the benefits gained from enhanced intercultural communication between health

professionals and clients would impact positively on more than just local populations. Any improvements in health service delivery to Central Australian Indigenous Australians may ultimately serve the broader Indigenous and non-Indigenous communities as well. These may include improved management and care of Indigenous clients, decreased need for services as initial consultation and management is improved, enhanced access and acceptability of mainstream health services by Indigenous users, and increased retention of health personnel. Furthermore, any such improvements may also serve to enhance the cultural safety of Indigenous health personnel through improved work environments and inform curricula for the training and education of health professionals.

The researcher has an obligation to collect only data of relevance to the stated goals of the project (Patton, 2002). The formality of interviewing was often a barrier to natural discourse for both groups of participants. For the non-Indigenous participants however, familiarity with the nature of research and interviewing made this formality less of an issue than it did for some of the Indigenous participants. In addition, as confirmed through this study, the tendency of Indigenous First Language speakers to shift from one topic to another meant that at times I was privy to information that was outside the issues for which consent was obtained.

Often the start and end of the interview phase created ethical issues because Indigenous Language participants would offer up information outside the formal data collection interactions. To deal with this aspect, I revisited the consent process with participants, and explained that the topics sometimes discussed on a range of occasions were of interest to the research. I had to ask some participants if I could use my recorder over a number of occasions rather than in single sessions, with an assurance that only information relevant to intercultural health care communications would be transcribed.

For one Indigenous Language participant, quite accustomed to being interviewed within their employment, the ethical issue of returning to confirm the substance of the information was

regarded differently. For this individual, our personal relationship meant that once the ‘story’ was given to me, there was no need to check the accuracy with that participant. In fact, it was regarded as somewhat insulting, with the implication, that firstly they may not have given an accurate story or that I may have it wrong. Further use of the data was also dismissed as not requiring further consent, as this participant stressed that *‘This is your story now ... I give it to you to tell’* (Naparrula, 2007) (see also 7.7).

5.2.5 Benefits versus risk

Ethical research requires the benefits to outweigh the risks to participants. The risk to participants was relatively low as their anonymity provided protection, either from critique of their practice for the health professionals, or the potential to feel ‘shame’ for the Indigenous Language participants. However, it was acknowledged that just discussing difficulties in the experience of intercultural communication might evoke unresolved issues for participants. The opportunity to tell participants’ stories however, was usually seen as a valuable activity rather than one with any further risk.

Most health professionals stated that they welcomed the opportunity to reflect on these issues and that anything that could help improve their practice was a good thing. It was similar for the Indigenous Language participants who had a strong sense of wanting to help improve the experience for their people. Participants were advised that they could contact the researcher if they wanted to discuss any further issues or that if they needed to speak to anyone about what was raised, and that the professional employee support services were freely available. Client participants were told that their information would be used to give feedback to health services, but if they had specific concerns, I could advise them on the processes for making formal complaints if required.

In the ethics applications I assumed I would work with Indigenous Language interpreters to obtain and transcribe Indigenous Language participants’ interviews. This assumption seemed reasonable for a study looking at English in Indigenous language settings and one that Ethics

Committees had agreed would be the preferred approach. However, during data collection for both participant groups it became apparent that the use of interpreters was in itself problematic at times. To suggest the need for an interpreter to some Indigenous Language speakers elicited the response of 'shame', suggesting that I may have thought their English proficiency was poor. There were also the dilemmas of gender, family structures, and kinship restrictions that limited the value of having interpreters present. Furthermore, the function of code switching identified by Harkins (1994) meant that as one of the participants in the dialogue did not speak Language, namely the researcher, it could be considered impolite for the Indigenous Language participants to speak around me. In addition, the setting and topic suggested English was the required mode for the sake of good manners. All of this might prompt some to ask if the barriers do not support the need for Indigenous Language clients to become proficient in English. As will be discussed in the following chapters however, it also suggests strongly that the service and the English speakers need greater preparation for Indigenous communication.

The information mandated by the various Ethics Committees was in some ways a barrier to interactions with both health professionals and Indigenous Language participants. It was not until I actually showed some Indigenous Language participants a copy of another thesis that the relevance of my request became clear. The idea that I should produce a report of the size required about this issue seemed to assist with enhancing the responses and requests for information which came not in single interviews, but at opportune times over weeks with some Indigenous participants. The information sheet contained the objective of the study, an expressed plan of the project, significance of the research, and contacts for my supervisor and the relevant Ethics Committees. By way of preparation, I had conducted several meetings on hospital wards and in remote clinics, or with individuals to explain the substance of my research interest. I asked various people how best to approach participants in their particular organisation or setting and the responses differed with the setting.

Data for this study were derived from a number of sources related to the research questions (see 1.11). The English-speaking health professional interviews were perhaps the easiest to facilitate. As stated, I had visited a number of venues to explain my research interest and left information about the study. I was pleasantly surprised at the number of health professionals who immediately offered their support, suggestions and participation. There was a consensus that communication with Indigenous Language speakers was a challenge for even the most experienced staff. In fact the more experienced they were, the more interested people appeared to be, with long term personnel stating that they wanted some feedback on their approaches to communication. This sentiment was very positive, but it must also be acknowledged that the majority of participants were people who were already aware of the problem and actively wanted to improve their own and others' practice. This is a limitation of the study that some bias existed in having participants already willing to examine their practice (see 9.2).

To maintain confidentiality I followed up individuals later at a mutually agreed time. In agreed locations, either my own office or staff room or other available private space, I went through the study information, consent forms, and negotiated how to proceed with the interviewing. Using only an Interview Guide (see 10.11), I made some introductory remarks about the issue of communication being a major challenge in this setting and began by asking some demographic details, then an open ended prompt—*How do you find communicating in health care with Indigenous language speakers?* Although number of prompts were available, mostly I let participants direct the course of the interview by sharing what they felt was of importance.

5.3 Setting

The study setting, as outlined in Chapter 2 is unique geographically, historically, politically and culturally. Central Australian health care is also diverse in models of health, venues, and philosophies of care. Health services in the region cover 1 million square kilometres as

described in the introductory chapters. They comprise a mix of tertiary, community and primary health care services that are both government controlled and Aboriginal Controlled Services (ACHS). As the principle of community control is believed to facilitate more culturally safe services for Indigenous people (Central Australian Aboriginal Congress, 2004), it was necessary to include participants from community controlled settings and not just mainstream services.

Conventional ethnographies including critical ethnography, generally require the researcher to be immersed in the field for intensive periods of observation and data collection. This research context involved multiple research sites, located across vast distances. As such some of the immersion in the field was not a discrete place or period, but occurred at various times and locations, as demanded by the circumstances of the participants.

The employment settings of health professionals included a community controlled dialysis unit, a number of remote primary health care clinics, plus the paediatric, intensive care, emergency, and maternity units of a major remote hospital. Interviews were generally conducted face-to-face at the participants' employment location, with others conducted in my employment location. Indigenous participants were interviewed in their home communities, employment settings or the researcher's home, as some were people with whom I had an existing relationship.

As outlined in Chapter 2, the Central Australian environment is subject to various influences that can be geographical, historical, political or cultural in nature. For example, a political influence, which hindered some access to remote communities, occurred with this implementation of the Northern Territory Emergency Response in July 2007. These events restricted access to some communities, due to demands on accommodation by government personnel. Field observations and interviewing and other data collection was planned for but always contingent upon a range of factors, making it essential to utilise opportunistic data collection and field observations where planned events failed to eventuate. For example, the

intention to spend time in a specific remote community had to be changed due to staffing or cultural considerations. If a community was in a period of mourning, known as 'sorry business' it was not appropriate to attempt to recruit any participants at that location or time.

5.4 Participant selection

The study involved interviewing health professionals and Indigenous Language speaking clients, and then critically analysing their experiences of intercultural communications. Some observations of health care communications were also made in the field at various locations and times. Participants were identified from a range of services and models, including tertiary and remote government controlled services, Aboriginal Community Controlled Health Services, and remote primary health care clinics. Health professional participants from intensive care, emergency, midwifery and paediatric settings were recruited from the public hospital. Remote health professionals were recruited from both community and government controlled remote primary health care settings.

Although there was an intention to recruit medical officers where possible, the responses from nurses and midwives from across a range of work areas and health services quickly provided enough participants. Also as a nurse researcher conducting a critical ethnography, it was considered appropriate to recruit from my own professional and cultural group. They were also more available and more likely to be around for the length of the study than some of the medical officers. However, one medical officer did agree to be video-taped during a patient encounter in the midwifery unit and a number of medical officers were included during field observations. The absence of other health professionals, rather than being seen as a limitation, may simply highlight a gap in the research that would lend itself to further investigation of the differing groups involved in health service provision.

Indigenous Language speaking participants were from three major Central Australian language groups, Arrernte, Luritja and Pitjantjatjara. Indigenous Language speakers may speak English to varying degrees of proficiency, but a selection criterion for recruitment to

the study meant that they would have one of the Central Australian Indigenous languages as their first language (see Table 2 in 2.7.1). First language is operationally defined for the purposes of this study as a language that is actively transmitted through parents and/or grandparents and is in current use (see also 10.2).

A different approach was used to identify and recruit participants for the two main groups, the health professionals and Indigenous Language speakers. Potential health professional participants were identified by snowball or network sampling (Polit & Beck, 2004) via a series of presentations conducted within various health care venues. Having worked in the region for two decades, I was able to draw on a well-established network of health professionals who either volunteered or suggested potential participants to me. As a registered nurse myself, I chose to include only registered nurses and midwives for interviews as indicated previously. My position external to the employment setting of participants ensured that no undue influence or power to coerce participation existed.

When I raised the topic of my study with individuals and during presentations, the main response was that health professionals considered the issue of genuine importance, but one that was often overlooked in this context. Rather than attempt to find individuals known for their positive communication skills or expertise or identify anyone who experienced constant difficulties, I applied no such criteria. The main inclusion criteria was that the participant spoke English as their first and only language, was employed as a health professional in the region and was willing to be included in the Intercultural Health Care Communication study.

It was important to convey to staff the fact that they were not being sought for the study because they were either poor or highly effective communicators with Indigenous language speakers. It was not my intention to categorise anyone, but simply to ensure representation of the diversity of nursing health professionals throughout the region. I did however, deliberately exclude the growing number of health professionals who themselves speak a language other than English (LOTE). When this study commenced, the main demographic of

health staff were the monolingual non-Indigenous Australians. As the study progressed however, the workplace demographic changed considerably. Among health care workforces globally, there has been a major influx of staff from countries where English is not a primary language (Wren, 2007). Central Australia has been no exception in seeking qualified internationally mobile health professionals to fill domestic skills shortages.

I suspected that speaking and having the experience of operating in a LOTE would create a different set of issues and responses to intercultural communications with Indigenous people that may be worthy of further research at another time (see Chapter 9). Research involving nurses and other health professionals who are speakers of other languages confirms my suspicion of a different set of experiences to those who are monolingual health professionals (Blackford & Street, 2000; Kirkpatrick, 2000). As the experience of practising in an English-dominant service was under scrutiny, those who identified as English-only speaking were included in the selection criteria for health professionals. Speakers of LOTE however, were mentioned in the data by both sets of participants and are discussed in Chapter 8.

Participants in this research study were also drawn from a variety of different cultural groups. Non-Indigenous health professionals shared a common cultural background with the researcher, in relation to discipline (nursing), often ethnicity, and having English as a first and only language. The other main participant group of Indigenous Language speakers, who were also users of Central Australian health care services, came from various groups in the region. These participants were selected through purposive sampling, as people with whom I had an existing relationship (Polit & Beck, 2004, p.306). The health professionals' data was collected first. Working with this group was the easiest in terms of interaction, since I am a member of the same cultural group. Transcribing the health professionals' interviews as I went helped refine my questioning and interviewing technique and focused my questions for the Indigenous Language participants.

The intention of videotaping encounters became problematic. I did not want to record Indigenous Language clients with whom I had no previous relationship, as I would have no prior knowledge of their communications against which to assess interactions. The opportunities for matching consented health professionals with consented Indigenous Language clients, who during the research period were also in-patients, became too difficult. I did manage to obtain a video recording of two women within the midwifery ward, facilitated by an Indigenous-speaking interpreter with whom I had a long-term connection. This opportunistic event was not so much an analysis of the communications themselves, as in Cass et al.'s (2002) study, but analysis of the experience of intercultural communication. Nevertheless, it provided enough material for me to analyse and conclude that further taping would not be necessary to the objectives of this study.

5.4.1 The Participants—development of my relationships

Indigenous Australians, while diverse in languages spoken, cultural practices, histories and experiences, share a profound regard for interpersonal relationships. Harmonious relationships are central to the sense of well-being and health for many Indigenous people (Franks & Curr, 1995). In the context of research that involves Indigenous Australians, having an established relationship with participants is seen as critical to the process. Entering into research in Central Australian Indigenous setting as a relative stranger, is fraught with difficulties, and contrary to the locally accepted view that a relationship should exist before any exchange of information or knowledge is possible.

As a non-Indigenous researcher, I enjoy established personal and professional relationships with various Indigenous people in the local area. An ethical dilemma arose however, as to whether seeking participants from amongst those I knew personally, would constitute an exploitation of those relationships. However, discussions with supervisors and critical friends soon established that having an existing relationship was necessary to the conduct of any research with Indigenous people (Edwards, 2007, personal communication). It soon became apparent that rather than posing a potential for exploitation, these connections were

in fact very necessary from an Indigenous perspective. People who had positioned me within a kinship⁵⁵ category offered their assistance with this study and our existing relationships deemed their participation as appropriate. What did emerge however was the implicit understanding that the relationship was a reciprocal one. The concept of reciprocity is termed *napartji-napartji*⁵⁶ in Pitjantjatjara and Luritja languages (Franks & Curr, 1995). The implicit need for each party to give and get something in return, as in the concept of *napartji-napartji*, was clearly operating throughout this study. During the consent process, it was made clear that no financial reward or direct benefit may arise because of participation in this study, but that those who freely consented to participate may be helping to better prepare health staff to communicate with their families and other Indigenous Language speakers.

In a practical personal sense however, reciprocity was often constructed as the researcher agreeing to drive participants somewhere or to provide a meal during our interactions as an appropriate protocol for being interviewed. I also met with the Aboriginal Liaison Team manager of Alice Springs Hospital and asked for assistance with consent forms for Indigenous Language participants. Plans to translate the consent form and project information on audiotape was trialled but later abandoned. The challenge of collating these consents in each of the major language groups and the availability of the liaison team members made this step impractical within the research schedule, but it was a useful lesson for me in considering future approaches (see Chapter 8).

However, there are many issues to consider in approaching research with different cultures. Watson's (2006) critical ethnographic research conducted with Warlpiri men in Central Australia's Western Desert region raised many methodological issues in the conduct of intercultural research that resonated with my own experience. Various assumptions about the influence of gender as a barrier to accessing health care were examined in Watson's (2006) study, which involved interviews with and observations of the Warlpiri men.

55. Kinship structures are the framework for identifying how individuals are connected to one another and can include non-Indigenous people (see 10.2).

56. *Napartji-napartji*—reciprocity (see 10.3).

Watson had intended for example, to obtain data from Indigenous participants in their first language, a strategy that I also intended to employ, believing this to be the most valid way of obtaining information from speakers in their first language. For Watson, this strategy also had to be re-considered. The code-switching protocols identified by Harkins (1994) in other research was mirrored in my own and Watson's (2006) encounters. Consequently, the personal relationships that allowed us both access to participants also meant that English was the preferred communication mode for our respective Indigenous participants. Given my own linguistic limitations, and the settings in which interviews took place, the Indigenous participants in this Intercultural Health Care Communication study considered the topic as *my* issue. They chose to speak English as a sign of good manners because I was initiating the discussion. Many of the planned approaches were quickly jettisoned as differing communication styles and expectations arose to challenge my assumptions and expectations.

5.4.2 Participant details

There were twenty participants originally recruited from Central Australian health services with one Indigenous Language participant later omitted from the study due to concerns about her consent giving a final total of 19 participants (see Chapter 7): thirteen English-speaking health professionals and six Indigenous Language speaking clients (see Table 3 in 5.4.2). In seeking data related to the health professionals' experiences of intercultural communications involving Indigenous Language speaking clients, I obtained interviews with eleven nurses and midwives, employed in both government and Aboriginal controlled health services across remote, community and tertiary health levels. In addition, a medical officer and registered midwife participated in videotaped encounters, making the 13 health professionals involved in the study.

Four Indigenous Language speakers representative of three main language groups participated in face-to-face interviews, with two additional clients also agreeing to be videotaped in brief health care communications in the hospital setting. Although originally five Indigenous First Language Speakers were recruited, one participant's data (see Table 3 in 5.4.2 Nakamarra) was

excluded, as I was uncertain of Nakamarra’s level of consent, leaving an overall total of four interview participants and two video-taped participants.

Table 3: Participant details – pseudonyms used

Name	Ethnicity	Details Employment Age	Gender
HP1 (Sally) In-depth interviews	Australian	RN RM Hosp & Remote	F
HP2 (Cathy)	Australian	RAN Remote	F
HP3 (Rachel)	Australian	RN, Hospital	F
HP4 (Georgina)	Australian	RAN Remote	F
HP5 (Penny)	Australian	ICU Hospital	F
HP6 (Winny)	Australian	ICU Hospital	F
HP7 (Linda)	English	Pool RN Hospital	F
HP8 (Denise)	Australian	RN, ACHS	F
HP 9 (Tanya)	Australian	RAN ACHS	F
HP10 (Mary)	NZ	RAN Remote	F
HP11 (Stuart)	NZ	RN Hospital	M
HP 12 (Matt) Videod Interaction only	American	MO Hospital	M
HP 13 (Renee) Videod Interaction only	Australian	RM Hospital	F
Indigenous First Language Speakers	Language group	Usual residence	Gender
IFL1 (Nungarrayi)	Luritja/Pintupi	Remote	F
IFL2(Jakamarra)	Luritja	Town/remote	M
IFL3 (Ngangale)	Arrernte	Remote	F
IFL4 (Naparrula)	Arrernte	Town/remote	F
<i>IFL (Nakamarra) (Omitted from data)</i>	<i>Luritja</i>	<i>Remote</i>	<i>F</i>
IFL5 (Louise) Video Interaction only	Arrernte	Remote	F
IFL6 (Marjory) Video Interaction only	Arrernte	Remote	F

Key: HP = health professional; IFL = Indigenous First Language; RN = registered nurse; RM =registered midwife; RAN =remote area nurse; MO = medical officer; ICU = Intensive Care Unit; ACHS = Aboriginal Controlled Health Service; Remote = remote Aboriginal community; Town = Alice Springs township.

As Table 3 (in 5.4.2) illustrates, there was a strong representation within the nursing and midwifery participants, across service levels and practice settings. Indigenous Language speakers, although also small in number, provided data from three of the five major Central Australian Indigenous Language groups.

5.5 Data collection

The data collection methods employed in this Intercultural Communication Study as they relate to the research questions outlined in 1.11 and depicted in Figure 5 (in 5.1), include:

1. field observations and reflective field notes
2. in-depth interviews with English speaking health professionals to obtain a picture of their experiences of intercultural communication in Central Australian health care; the majority of data collection derived from one in-depth interview with some follow-up questions after transcribing had occurred.
3. in-depth interviews with Indigenous Language speaking clients to obtain another perspective on the experience of intercultural communications in Central Australian health care; the majority of data collection derived from one in-depth interview, with some follow-up questions after transcribing had occurred.
4. obtaining video-recordings of interactive health care communications for analysis and triangulation of data;
5. collecting examples of targeted health care communications.

Ethnography and critical ethnography in particular requires the researcher to be immersed in the setting, in particular during data collection. I have been immersed in the research setting for a number of years, having lived and worked in remote communities and within the hospital setting. My professional and personal worlds are populated with health professionals, particularly nurses and Indigenous friends and family. Without using a single venue such as the renal unit in Cass et al.'s (2002) study, a broader brush approach was more practical for my individual circumstances. I was able to gain data from a cross-section of Central Australian health services, professionals and clients, which has enhanced this critical ethnography.

5.5.1 Field observations and reflective field notes

Formal data collection using fieldwork and observations only took place from 2005 following ethics approval. Planned fieldwork included arranged visits to hospital venues, Aboriginal Controlled Health Services and remote Aboriginal health centres. Due to some of the factors mentioned in describing the research context, there was also the need to include opportunistic fieldwork. Sometimes participants would contact me to suggest an opportunity for observation.

Field notes and observations collated over the research period, mainly between 2005-2008, provided extensive data for triangulation with the semi-structured interviews and video-recordings. For example, the following extract from field notes confirms the minimal and sometimes paternalistic interaction that many linguistic minorities experience from health professionals when there is a language barrier:

FN: 1/10/07 Neuro assessment – 2 doctors one after each other, ask exactly the same questions

Speaking jargon, ... 'not high cervical compression...' talking about but not to the patient

Gets louder when speaking to the patient:

*Dr: Say yes when you feel me touching - Good girl..
talking about but not to...paternalistic manner...*

5.5.2 In-depth interviews with English speaking health professionals

Most data were obtained through qualitative interviews with health professionals and Indigenous clients. During semi-structured interviews, I sought to obtain an understanding of the experience of communicating health related issues from the perspectives of both the client and health professionals. Prompting questions were asked about the experience, the preparedness of staff for communicating with Indigenous Language clients and attitudes toward cross-cultural communications in this region (see 10.11). My approach differed from Cass et al. (2002) who examined encounters specifically for evidence of miscommunication. Instead, my study looked at the perspectives of various groups in the intercultural communication context.

I made a strategic decision to interview health professionals first. I felt that any information obtained from this group would help shape the questions or discussions with Indigenous Language participants. The difficulties of communication that are the subject of this study prompted me to tackle the more familiar first, both to hone my interviewing skills generally and to begin analysis of data that could be critiqued within my own worldview.

Interviews with health professionals were conducted in various locations, with a mind to preserving confidentiality of participants. I trialled my interview structure with a colleague to help check the process and my interviewing skills, which to be frank were poor at times. I fell into many of the same difficulties as other novice researchers. The formality of the encounter shaped by the need to present an array of forms and obtain signatures, deal with equipment, and obtain quality information changed the dynamic between participants and me, particularly those with whom I had closer personal links. With some minor modifications, that involved setting the scene and focus of my research more clearly and concisely and using shorter prompting pegs to allow the respondents to tell their stories, the quality of interviews improved.

5.5.3 Interviews with Indigenous Language speakers

It was my intention to conduct interviews with Indigenous Language people with whom I had an existing personal relationship. Relationships are fundamental to any Indigenous interactions and to approach Indigenous Language speakers, who were unknown to me, would have been highly problematic. By starting from a position of acquaintance and established connection, the interviews were facilitated more quickly than otherwise may have been possible (L. T. Smith, 2003; Watson, 2006). These relationships however, proved to be a barrier to conducting interviews in the participants' first language and the intended approach had to be modified. The intention to interview using an accredited interpreter had to be re-examined for the assumptions made about obtaining information in first language.

5.5.4 Video recordings

A final component of data collection involved identifying examples of visual communications and targeted resources believed to be culturally appropriate for use with Indigenous Language speakers. These visual communications and resources included health service signage, health promotion materials, and advertising, which supported the other data. Chapters 6, 7 and 8 contain relevant examples.

The immediate challenge was in setting up opportunities for video recording, so I had a contingency of either leaving the video with the consented participants or using observation alone if consent to be video-recorded was not forthcoming. Furthermore, video recording of health care communications was always going to be challenging, ethically, practically and culturally. For health professional participants to allow their professional interactions to be video-recorded, had certain legal implications, especially if any miscommunication occurred. For the Indigenous First Language participants, video recording was a confronting request on top of what was already believed to be (and this study confirmed) a confronting experience for many.

Research and reporting about the use of video encounters is sparse in terms of Indigenous participants. The study conducted with Yolngu patients in a renal unit by Cass et al. (2002) remains an exception (see Chapter 3). In this Intercultural Health Care Communication study, the logistics of obtaining all the requisite consents, ensuring privacy, and finding opportunities, became a greater challenge than predicted. I was able to obtain two interactions from the midwifery ward, involving a client assessment with a medical officer and a client education session with a midwife. However, I concluded that video-recorded material might not provide a valid representation of the experience of intercultural communication in Central Australia. There were too many factors influencing the encounters that made them more contrived than genuine. Analysis of the video-recordings however, provided confirmatory examples of communication styles, such as the use of silence, eye contact, non-verbal interactions, and question formats that supplemented other data and

literature. They provided visible examples of the cultural nuances of communications between English-speaking health professionals and Indigenous Language speaking clients.

5.5.5 Documents and artefacts analysed

In the Central Australian health care context there is a wealth of health-related resources, that are intended to communicate health related information to Indigenous Language speakers. This is analysed in Chapter 7. Some of the materials analysed include:

1. Signage found in Hospital, Remote, and Community settings
2. Health information materials –eg: Kanga Connect Advertising Campaign, South Australian Drug and Alcohol Health Promotion Strategy Playing cards
3. A ‘culturally appropriate’ pain assessment tool (see 10.12).

5.6 Thematic analysis applied to the data

Critical ethnography, like most other qualitative methodologies, is an evolving methodology that lends itself to a variety of data analysis approaches. As this Intercultural Health Care Communication study involved interviews with participants from differing linguistic backgrounds, a thematic analysis was considered the most appropriate method to utilise. With data derived from both English and non-English speaking participants, and as an English speaking researcher, discourse analysis would have proved problematic. Although it may have been suitable for the English-speaking participants’ data, there was already potential to misinterpret the Indigenous Language data. As I examined the data more closely, I felt my research question asking about the experience of intercultural health care communications could be answered better through thematic analysis, which is also appropriate in an ethnographic study.

5.6.1 Why thematic analysis?

Practices, rituals, and historical perspectives can all position us in language, and all can participate in making language powerful. Medical language is one such example (Foucault,

1973). Foucault (1973) believed everything is constructed in language, in the way we speak; there is a conscious choice of words used, which is tied up in notions of power. In this regard, discourse theory, which also sought to examine relations of power, colonisation, cultural safety and ethnocentrism, was highly relevant to the study. As I began to transcribe and read the data however, I was unable to analyse the discourses that crossed linguistic and personal divides accurately.

Furthermore, once data collection commenced, issues arising in the process steered my approach toward thematic analysis instead, for several reasons. The discourse used by many health professionals during interviews was somewhat incongruent with what I knew and had observed about some of the participants' practice. Participants often took on a more formal persona during interviews that was perhaps worthy of separate analysis itself. Again, being an insider, a nurse, and someone well known to many participants, responses that were not expressed in the natural discourse of other interactions stood out. Discourse analysis could have been applied, but would not have reflected some participants' intercultural communications accurately.

This study seeks to do more than just describe what is seen and heard in health care communications. Therefore, it was more helpful to uncover themes that represented major concepts or recurring ideas, as well as themes unique to individuals or what was left unmentioned. By drawing out the themes present in both sets of participants' data, a richer and more meaningful picture of the experience could emerge from shared communication encounters. Issues of place, gender, topic and relationships all influenced the encounters. There was a need to look at both parties in the encounters, not just from a linguistic point of view but also from a contextual point of view.

5.6.2 A process of thematic analysis

Thematic analysis can be undertaken by using a computer software program or equally appropriate, a manual process. After conducting the first few interviews in quick succession,

I transcribed the data myself in preparation for thematic analysis. I preferred this approach rather than asking for a transcription by another person or using a computer package, as I wanted to become very familiar with the data. More pragmatically, this research was unfunded, so this method was also a preferred option financially, and proved to be a very valuable process. Transcription gave me a strong sense of patterns and categories unfolding, so that I was also able to jettison some superfluous questions and be more focused in later interviews.

While thematic analysis has been described extensively in the literature, Aronson (1994) is one of the few authors to detail a practical approach, which I chose to follow in arriving at my findings. Aronson (1994) outlined the steps in thematic analysis clearly and these steps were applied to the data, along with suggestions from other authors such as Thomas (1993) and Braun and Clarke (2006). Transcribed interviews are examined for already classified patterns that might come from the research questions. According to Aronson (1994) the next step in thematic analysis after gaining an initial sense of the data is to identify all data that relate to the already classified patterns, which are then expounded upon and placed with the corresponding pattern (Aronson, 1994).

In my study of Intercultural Health Care Communication, the ‘already classified patterns’ Aronson refers to became headings determined by my research questions (see 1.11). As I went through each transcript, I created a file labelled as First Level Analysis, which included the words, phrases and concepts that appeared more than once both within and between the health professionals’ interviews, under the headings determined by the research questions. For example, under the question ‘Experience of Intercultural Communication, the terms *frustrating, difficult and challenging*’ came up in most interviews. I also highlighted any items not commonly expressed such as the participant response that began by suggesting their experience of intercultural communication was ‘fun’. This isolated response did appear later in other’s interviews, but not as an initial response.

The next step in thematic analysis is to combine the related patterns into sub-themes. Following this method, various interview fragments were then recorded in their broader categories in a file labelled Second Level Analysis. For example, the first level category '*frustrating, difficult and challenging*', was collapsed to a second level category 'the experience for participants'. The same process of collapsing or expanding categories continued to Third and finally Fourth Level Analysis to arrive at a set of themes (units derived from patterns) that describe the experience of intercultural communication in Central Australian health care from the perspectives of the health professionals. 10.5 shows a diagram of the four levels of data analysis.

Once themes have been constructed, Aronson (1994) then advises incorporating relevant literature to build a valid argument for choosing the themes. When interwoven with the literature, the story that develops provides the reader with a clear understanding of how the themes were derived at and the motivations of the researcher. Data analysis was completed by adapting approaches by a number of researchers (Aronson, 1994; Thomas, 1993; Braun & Clark, 2006). Most followed similar pathways for analysis, and I was able to integrate these to suit the analysis of the health professional data. Table 4 describes in detail what was involved in each phase of analysis.

Table 4: Phases of thematic analysis used in the IHCC study and adapted from Aronson, 1994; Braun & Clark, 2006; Thomas, 1993.

Phase	Description of the process
1. Becoming familiar with the data	Researcher transcribes own data – includes any notes to self, observations, initial ideas – collates direct quotes of potential significance.
2. Generating initial codes	Coding interesting features (patterns) of the data in a systematic fashion across the entire data set, collating data relevant to each code – reviewing aims and objectives of research
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme. – What picture is emerging of Intercultural communication?
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis. Link to research questions – experience, preparation, Barriers, facilitators, what is needed.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Writing the findings chapters	The final opportunity for analysis. Selection of extract examples, final analysis of selected extracts, linking analysis to the research question and literature, producing a scholarly report of the analysis.

5.6.3 Development of themes

Themes were developed as part of the process of data analysis. An initial read of the transcripts identified common experiences and expressions used to describe those experiences. In this First Level Analysis document, the initial coding process was directed in part by the opening question of the interview, that is, *what is it like communicating in health care settings in Central Australia with Indigenous Language speakers?* Clarification of ideas and meanings was generally sought at the time of interview. However, where it was not, I was able to obtain this when participants reviewed their transcripts.

Five codes were developed. The first coding process concerned the intercultural communication **experience**. The second coding considered the **consequences** of the experience. The third coding involved responses to the **preparedness** of people for communicating about health in this region, including the way in which knowledge is

transferred concerning intercultural communication. A fourth coding identified some **attitudes** toward Indigenous First Language speakers and the use of English in Central Australian health care communications, including responses to current and potential resources and personnel. The role of translators, Indigenous liaison officers and other Indigenous employees and community members as well as the discourses surrounding Indigenous clients was also examined. A final coding considered what needed to be done differently to **improve** the effectiveness and safety of communications involving Indigenous Language clients and English-only speaking staff.

Once the Second Level Analysis, the initial coding in First Level Analysis was collated into potential themes and further refined, until major themes were explicit in the Third or Fourth Level Analyses. For example, in second level analysis, a sub-theme within the pattern or code of **preparation** was ‘the penny dropped’. In subsequent analysis, the theme of ‘**unprepared and ill-equipped**’ eventually formed part of a final theme of **Power and Powerlessness**, constructed from the data set. Appendix 10.11 provides an example of one theme, drawing on each level of analysis.

As the interviews for Indigenous participants ended up being conducted in English, I applied the same approach to thematic analysis as was used for the health professionals’ data. Although the questions considered the same issues and there was a commonality of themes around the experience, consequences, preparedness, attitudes and what might be needed to improve the experience, the final themes for the Indigenous Language speakers highlighted the very personal impact of ineffective intercultural communications on health. Some additional clarification was sought and added reliance on the social and linguistic literature (Evans, 2010; Harkins, 1994) was required to ensure the accuracy of my interpretation of the Indigenous participants’ data (see Chapter 7).

This process outlined in Table 4 (in 5.6.2) generated the following major themes that help understand the experience of intercultural communication from the English-speaking health professionals' perspectives:

1. Fear, frustration and stressful – the experience
2. Individual and systemic barriers– cultural danger
3. Acceptance and complicities– continued colonisation
4. Power and powerlessness
5. Toward culturally safe intercultural communications

These themes and their sub-themes are detailed in Chapter 6. An example theme and the process used to arrive at the findings are shown in 10.5 Data analysis sample. The themes for the Indigenous Language speakers that are summarised below are presented in Chapter 7:

1. People are dying– the experience
2. Individual and systemic barriers– cultural danger
3. Acceptance and complicities– continued colonisation
4. Power and powerlessness
5. Toward culturally safe intercultural communications

5.7 Rigour of the research processes

Rigour in qualitative critical research is different to but no less important than it is in quantitative scientific research which has been somewhat privileged in European research traditions. Rigour is defined as the '*strictness in judgement and conduct which must be used to ensure that the successive steps in a project have been set out clearly and undertaken with scrupulous attention to detail*' (Roberts & Taylor, 1999). In other words, is the research methodologically sound in approach and implementation, to be considered worthy and valid

research. The use of words such as rigour and validity however, can seem incongruent with the subjective and less overtly structured nature of qualitative research, which has led to the development of paradigm specific terminology for describing rigour.

Credibility, fittingness, auditability and confirmability are the key elements of qualitative research rigor. Credibility is established within qualitative research, when 'the lived experiences described' are recognisable to participants and readers, according to Roberts and Taylor, (1999, p. 174). Fittingness implies the extent to which findings have wider meaning and relevance in contexts other than the research setting. Auditability is a major element of rigour that allows other researchers to follow clearly the methods and processes in similar investigations and arrive at comparable conclusions. A way of assessing auditability is via a clearly articulated decision-making trail that provides rationales for decisions and responses.

In Chapter 1, it was identified that reflection and reflexivity were key components of this Intercultural Health Care Communication study. Data collection processes were continually critiqued through a process of reflection and consultation with supervisors, other researchers, doctoral students and individuals with expertise in areas such as cultural safety, linguistics and qualitative research, particularly concerning data collection involving Indigenous participants. As interviews were completed, progress and outcomes were informally monitored through member checks, adding to the credibility of the study. The need for researchers to be able to deconstruct and reconstruct ideas, assumptions and long held beliefs is evident in the change of approach to using the Indigenous participants' first language with interpreters present in the encounter. Literature suggests that using interpreters for linguistic minorities is ethical and necessary, however, there is also evidence that in response to Indigenous participants it may not always be so (Lowell et al., 2005; McGrath & Phillips, 2008; Watson, 2006).

Triangulation is defined as the use of more than one method to study the same issue in order to validate the phenomenon (Roberts & Taylor, 1999). Triangulated data is considered more

valid and less subject to bias. In seeking to ensure rigour in this study of Intercultural Health Care Communication it was decided that in addition to obtaining the experiences of participants from participants themselves, that other data such as field observations, central to ethnographic research, and analysis of video-taped communications, and targeted health promotion materials, would add to the overall understanding of the phenomena.

The remote and Indigenous contexts in which this Intercultural Health Care Communication study was conducted has been described as somewhat chaotic and unregulated at times (Kelly, 2005). For those unfamiliar with the environment such uncertainty and lack of obvious systematic approaches can give an impression of a lack of routine and order. I have come to think of operating in this environment as an opportunity to hone problem-solving skills by being *strategically* reactive. Although this may seem a contradiction in terms, for me it is about being able to change direction in response to current unforeseen circumstances. Efforts to collect data, meet with key people, access communities and resources when planned, was continually challenged by unpredictability of the environment at times. The capacity to undertake opportunistic data collection when appropriate was therefore utilised to overcome the vagaries of the research setting.

5.8 Summary

This chapter has outlined the methods used to conduct the study of Intercultural Communications in health care in Central Australia. It described ethical issues, the study setting, the selection of participants, data collection, data analysis and research rigor within a qualitative methodology. It was shown that the links between methods, methodology and paradigm are overt and interdependent.

Chapter 6 presents the findings of the Intercultural Health Care Communication Study starting with the analyses of the non-Indigenous health professional participants who are the major focus of the research. Findings continue in Chapter 7 with the small, but rich data from Indigenous Language participants. In keeping with the philosophical decision to

present Indigenous voices as the first (Jakamarra, 2007) and last to be heard within this thesis there was a deliberate intent in presenting the Indigenous participants' data following the health professionals'. My first language of English often holds the last word as privileged, turning around in this sense the current position of Indigenous voices in Central Australian health care.

Chapter 6

Health professionals' findings: *It's like opening a can of worms... (Sally)*

6.1 Introduction

This study sought to describe the experience of English-speaking health professionals involved in health care communications with Indigenous Language speaking clients. For the health professional participants prior to their involvement in this study, there was a reluctance to examine the experience too closely. *'It's like opening a can of worms...'* was how an experienced remote area nurse and midwife, Sally, described reflecting on intercultural communication in her daily work. This response typified the majority of non-Indigenous participants in this Intercultural Health Care Communication study. Overall, participant responses suggest that the quality and experiences of Intercultural communications in Central Australian health care are known to be unacceptable, unpalatable and confronting, but best left unexamined for some. Indeed what do you do with the metaphorical 'can of worms' once they are released? For many of the health professionals there was a reluctance to examine the issue too deeply. This was due in part, I believe, to perceived powerlessness and sense of inadequacy in dealing with the 'wriggling mess' that often characterises communications between Indigenous language speakers and English-speaking health professionals.

This chapter reports the results of thematic analyses of the data. It considers data collected from semi-structured face-to-face interviews with health professionals in a range of settings, including those collected from the field by way of observations and collated materials. The following chapter presents data from the small cohort of Indigenous Language speakers who participated in this Intercultural Health Care Communication study.

Within this chapter, the data from health professionals are grouped within the broad categories suggested by the data analysis. Respondents' current worksite, as hospital, remote primary health care or community health service is identified to reflect the representativeness of the data, rather than suggest any direct causal relationships to responses. However, where considered worthy of further analysis and without compromising confidentiality, the setting is considered and discussed. Some respondents referred to their experiences across a variety of contexts, so may appear in more than one setting category.

6.2 Overview of main results

This Intercultural Health Care Communication study set out to answer the questions: what is the experience, what are the consequences, what preparation and attitudes exist, what are the barriers and facilitators and what might improve the experience? The health professional interviews were subjected to thematic analyses as outlined in Chapter 5. Final organisation of results in this chapter reflects the themes identified in the health professional data that provides a rich and detailed picture of a previously unexamined aspect of intercultural health care communications in Central Australia – the health professional perspective. The major themes identified include:

1. Fear, frustration and stress – the experience
2. Acceptance and complicities – continued colonisation;
3. Power and powerlessness
4. Individual and systemic barriers – cultural danger
5. Toward culturally safe intercultural communications

Within the first few interviews with health professionals, it became apparent that communication in Central Australian health care was a major issue affecting the capacity of health professionals and services to provide safe and effective care. Whilst the consequences

for the recipients of care were known to be substantial, this study also revealed the cost of flawed intercultural communication for workforces as well. Staff identified a tension between what they knew should be done in practice and what they were able to do for Indigenous language speaking clients, because of either personal or system constraints.

This finding is particularly important because few other studies have focused on or identified the impact on the individual health professional to the extent revealed in this study. While other research has acknowledged the impact of communication challenges on clients and health services (Cass, et al., 2002; Trudgen, 2001), there has been less attention paid to the personal and professional consequences for health employees who are placed in positions for which they are ill-prepared.

Prominent in the responses of health professionals were themes of power and powerlessness, of frustration, stress and a tacit acceptance of providing a lesser standard of care for Indigenous Language speakers. In short, many health professionals felt set up to fail, identifying inadequate preparation and/or support for the challenges of intercultural communication in Central Australia. This was a key finding that has not prominently featured in other Australian research to date. This study however, seemed to provide a catalyst for health professionals to reflect upon their intercultural communication skills and impact on practice, with the majority of respondents agreeing that they preferred not to examine the issue too deeply in their day to day work because of the internal conflict it might evoke. For some, as highlighted in the introduction to this chapter, it was likened to '*opening a can of worms*' (Sally, 2007) with anxiety around what any such analysis might reveal about themselves or the system in which they were agents. In addition, this noteworthy finding suggests strongly the need for a reflective model of culturally safe communications for this context that includes comprehensive education and training in intercultural communication.

Evidence of ongoing colonising practices and dominance, characterised by systemic bias and possible racism were particularly evident among respondents from government-controlled health services, although Aboriginal Controlled Health Services were not immune from these issues either. Indigenous participants also were not immune from expressing negative views toward health personnel from differing cultural groups (see 7.6). What was clear overall was that many respondents acknowledged a standard of difference that applied to Indigenous Language speakers who required language support when accessing health care. The effort to provide language support for people who were in every sense from, and of this country, was noticeably less than efforts made for the many non-English speaking visitors to the Central Australian health care. Overall, English speaking, non-Indigenous health professionals felt unprepared for intercultural health care communications involving Indigenous language speakers and vulnerable to critique of their practice.

6.3 The health professionals' data

Alice Springs Hospital is the major tertiary centre within a huge geographical region. The largest proportion of the workforce comprises registered nurses. As a registered nurse myself, I was most interested in the responses of this group to intercultural communication in Central Australia. I had frequent opportunities for observation of health care communications involving nurses and Indigenous Language clients and collated a significant amount of data on this group over a period of several years (mainly 2005–2008). Figure 6 (in 6.3) shows the various groups of health professionals who provided data for this study.

Hospital data sources included face-to-face in-depth interviews with eight registered nurses (seven female and one male), from Emergency, Intensive Care, Midwifery and Paediatrics areas of the hospital. Alice Springs Hospital is a Northern Territory Government controlled public hospital, so all hospital respondents are government employees. Table 3 (in 5.4.2). summarises participant demographics. Additional videotaped data were obtained of a male medical officer conducting a history taking of a young pregnant woman, and a midwife

conducting a brief educational session with a close-to-term pregnant woman, as two examples of intercultural communications. Both of these intercultural encounters were analysed using a simple linguistic features analysis for triangulation with other data obtained.

Within the township of Alice Springs, community health nurses work in a variety of roles including renal dialysis, women's health and child and family health. As a smaller group within the region, I have not separated the participants into those who worked in Aboriginal Controlled Health Services and those who worked in Northern Territory Health Services, due to confidentiality concerns. I have made comments or used data where the employing authority is believed to have some influence on the responses of participants, while seeking to delete information that might help identify respondents locally, such as the relevant Indigenous Language group or service type information. Two community health nurses were interviewed.

Remote health professionals also stemmed from both Aboriginal-controlled and government-controlled primary health care services. For the same concerns about confidentiality, the employing authority is only mentioned where deemed to have some relevance. A number of participants have worked across multiple sectors and organisations and provided their own comparisons in response to certain issues. For example, those who worked in Aboriginal Controlled Health Services commented on the differing expectations in some areas, in response to Indigenous language (see 6.6.3).

Five remote area nurses (RANs) were interviewed. All were female, with one employed across a state border in an Aboriginal Controlled Health Service, but still within the Central Australian region, and three who were or had worked in government primary health care services. Due to the overlap of employment experiences, the actual number interviewed in total was 11, plus 2 videotaped to provide examples of intercultural communications, providing a sample size of 13 English speaking health professionals (see Figure 6, this section).

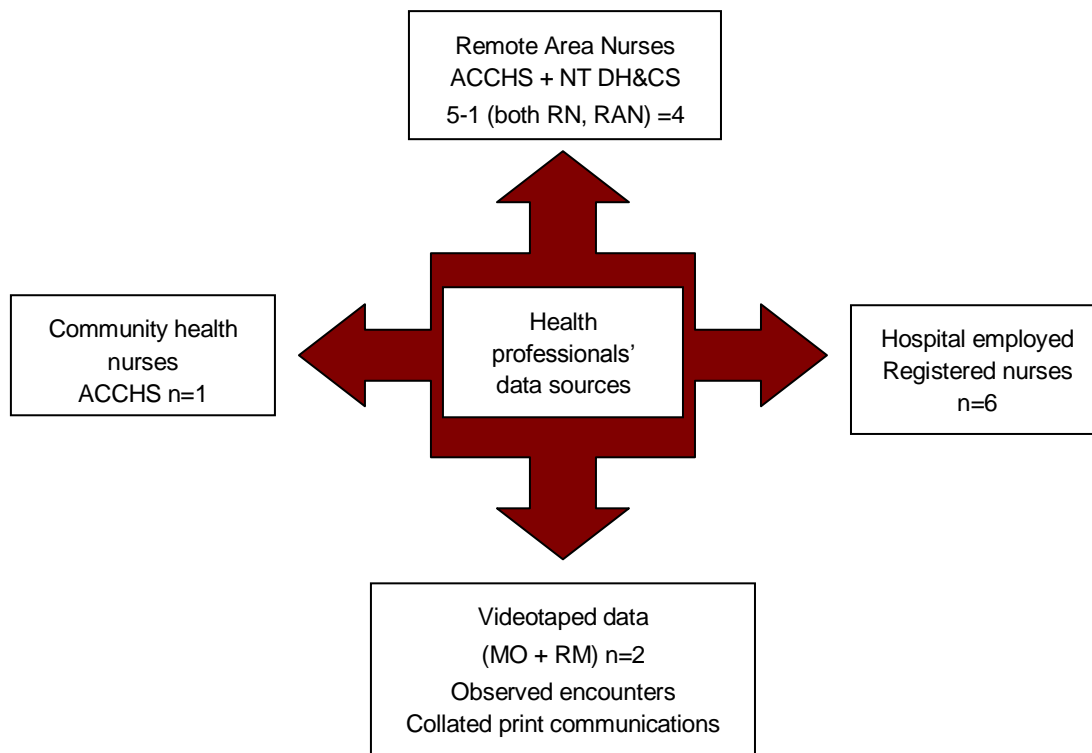


Figure 6: Health professional data sources for the IHCC study in Central Australia

The five major themes identified within the health professional data are summarised in Figure 7 in this section 6.3. Each theme had within them, several sub-themes that gave various perspectives to the overall theme. The data obtained was rich and extensive, as is the nature and value of qualitative research.

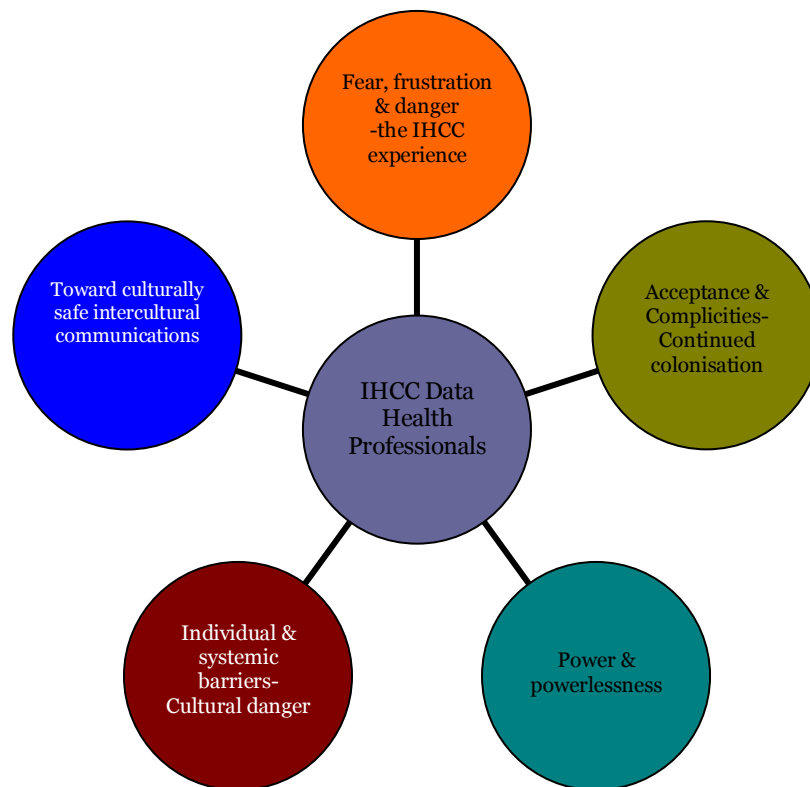


Figure 7 Summary of Health Professional Themes

6.4 Theme: Fear, frustration and stress –the IHCC experience

Within the very first examinations of the health professional data was apparent that the intercultural health care communication experience was fraught with difficulties, not only for the clients, but also for the providers of health care. Words and phrases that were repeated in successive interviews included *frustrating, difficult, challenging and stressful* when referring to the experiences of health professionals in relation to their communications with Indigenous language speaking clients. There were also expressions of fear and anxiety that health professionals may be limited in their efforts to provide the best possible care for Indigenous clients. Within the overall theme, several sub-themes were identified which recognised the consequences at various levels, - individual and system. The inherent dangers for all participants

are analysed in 6.4.1 A dangerous experience for all; 6.4.2 difficult and challenging; 6.4.3, a lack of awareness, 6.4.4 tensions and an alternate view from the main response -6.4.5 it can be fun!

6.4.1 A dangerous experience for all

Health professionals' responses reinforced to an extent the suggestion at the beginning of this thesis that people were dying because of an inability and/or unwillingness to communicate effectively with Indigenous Language speaking clients. Very experienced practitioners were frank in their admissions that poor communications in the research context put lives and practice at risk. Health professionals often mentioned the limitations to their practice that compromised care, with statements such as: *'It's a bit hit and miss really* (Georgina, Remote Area Nurse) – talking about educating clients about medication management; *'You just can't do an adequate history...'*

Literature related to linguistic minorities supports this perspective, highlighting the risk to clients (Buttow, 2010). Health professionals interviewed mostly all agreed that practice was less than acceptable with regard to Indigenous Language speakers. Apart from any admissions about their own practice, participants could all cite examples of poor practice standards among colleagues. Winny, a critical care nurse was alarmed at some of the standards of care provided to Indigenous clients: *'You see some medical officers do some horrendous things...'*, especially in relation to obtaining consent and performing procedures on clients who were not fully informed or empowered in the situation. The medical hierarchy that has historically influenced relationships between nurses and medical officers, left some participants feeling unable or unwilling to always challenge poor practice when it occurs. On the other hand, although this is what was articulated, participants observed in practice, such as Winny, would prove staunch advocates of their clients irrespective of perceived power differentials between team members, as indicated in the following observed interaction:

FN: A large group of medical students and senior medical officer crowd round a patient's bed. The medical officer is speaking to the students about the patient, but has

not made any introduction or asked the patient if they mind the students hearing about their case. Winny, steps forward and asks – cheerful manner, whilst pulling curtain around,:

'Now have these lovely people told you who they are and what they are doing today?'

Patients indicates no.

Well first we'll give you some privacy and then doctor will ask you if it's ok to show these young doctors what's happening here. Is that all right with you?

Doctor then proceeds to introduce himself and students and ask if the patient minds. Winny stays by patient throughout, quietly relaying what is being discussed in a plain English format.

Winny's seemingly light-hearted manner with the medical officers is perhaps less threatening than a direct suggestion that the doctor and students might have asked permission at the outset. She appears to use an approach of modelling preferred behaviour rather than requesting it or reminding staff. It is also an example of how Winny chooses to subvert the power relationships between doctors and nursing staff by not appearing to directly challenge the medical officers' position, while at the same time upholding her advocacy role for the patient.

6.4.2 Difficult and challenging

Health professionals irrespective of discipline, gender, service setting or length of employment most often described the experience as *difficult, challenging* and for some *frustrating*. Sally, a hospital-based midwife and previous Remote Area Nurse described the experience as follows:

I think it's really difficult, I do and ... I've been doing it for a long time and learned pieces of Language,⁵⁷ ... Then you're asking questions without waiting ... even though we know we have to wait, we get impatient and when you're in a hurry ... you want to fill the holes and it's not that you want to make things up, but in many ways you get impatient, you ... get almost suggestive of things and so you're not getting ... I think we're really deficient in it. (Sally, RN, RM Midwifery)

57. Language capitalised in text is used to mean an Indigenous language—a commonly used term in Central Australia. For example, 'She speaks Language'.

Sally seemed frustrated by what she described as her and her colleagues' own deficiencies and the lack of incentive to learn Languages. The emphasis on how long she had been working with Indigenous Language clients and was still finding it difficult was also a source of frustration. It seemed to imply an unmet expectation that time would have diminished these frustrations. She was further frustrated by the fact that even though she possessed certain knowledge about Indigenous communications, she and others in Sally's experience, became impatient and almost directive with Indigenous clients. This was attributed to the workplace itself and the busyness of work that creates such pressure, which was another theme frequently mentioned by various participants. However, even when not pressed for time, English First Language speakers were often observed responding quickly to any silences with suggestions or repeated questions as indicated in the following videoed interaction between a medical officer (MO) and young pregnant woman (Majority):

MO: So is that something you need to keep taking do you think...?

Majority: 3 second pause...looking down, Looks up - *I don't know...*

MO: (Overlapping -before reply is made) or is that finished now?

Majority: Pause...Awa (yes), that might be finished now.

This brief exchange demonstrates the English speaker's natural tendency to expect an immediate response and to re-ask or re-frame a question thought to be misunderstood. By doing so, it has become more of a suggestion than a question. It is also an example of the danger for the client of not understanding her medication regime, as this was a prophylactic medication that should be taken for the rest of the patient's life. The medical officer also seemed unaware but made a point of suggesting he would follow up with the woman about her medication.

6.4.3 A lack of awareness -*you don't realise...until you look back.*

Health professionals interviewed, were unanimous in describing the experience of intercultural communication in Central Australia, as one for which they were largely unprepared. Many suggested that they were unaware of even the need for specific

preparation, believing they were simply coming to another Australian health care setting and as such, should have no greater difficulties in communicating with clients, than in any other environment in multicultural Australia.

Georgina, a remote area nurse (RAN) of over twenty years experience, was the only person to immediately recognise the possibility for English-speaking health professionals to not even recognise when problems in communication had occurred. Others also ultimately recognised that their early interactions were very likely full of miscommunications that often went unrecognised by both parties, but Georgina identified this immediately when asked about her experience. Georgina demonstrates her use of reflection as a means of alerting her to a problem in the first instance.

*Ah well, at first it might **appear** easy ... then after a little while you realise that even though people may speak what appears to be relatively good English ... their comprehension is something different. They don't always comprehend what you've told them in English. ... well they don't **think** in English. ... you think they've understood, and then you ask them to tell you what you've said to them, what you want them to do and it's miles off! ... it's not what we talked about! (laughs) (Georgina, RAN)*

Remote Area Nurse Tanya gives an example of how hidden some of the communication issues may be to health staff, who remain unaware of what is being asked of them. She recognised the potential to miss more serious health concerns. In the study setting, Indigenous clients frequently make requests for Panadol⁵⁸ but this is not always what is actually required. The tendency of Indigenous Language speakers to make requests circuitously rather than come to the issue directly may mask other important considerations that practitioners may fail to recognise. Although focusing on common communication features of Indigenous Language speakers might be considered essentialising, research has suggested a role for language awareness within an intercultural context (Irvine and Roberts, et al, 2006). What is important from a cultural safety, post-colonial perspective is that Tanya

58. Panadol—brand name for paracetamol (acetaminophen).

and others ensure a focus on their own practice and consider the wider social influences that may lead to a reluctance to identify a major health concern in the first place. Tanya also acknowledged the likelihood that much of her early encounters with Indigenous language speakers were probably managed poorly because of her lack of awareness of local Indigenous communication features.

...the person that comes to ask for the Panadol, is it because that's how they know to ask for Panadol, that's the words they know?... if you don't have some understanding of and acceptance of ... (their language) you don't know what's going on here and you don't know to even try to find out more, ... I mean you probably do it pretty badly for the first... year to be quite honest with you. You don't realise you're doing it badly until you get more experienced and you look back on what you were doing and realise that you were doing it badly ... (Tanya, RAN)

Tanya highlights both the value of reflective practice and the constraints on novice practitioners (novice to remote practice or Indigenous health) to actually undertake such reflections while in the early stages of their new practice setting. She also provides an example of what Trudgen (2001) described as a lack of awareness of communication issues, because of the existence of communication issues – a cycle that requires better attention than it has received to date in health services in Australia.

6.4.4 Tensions

The experience of intercultural communication for the health professional participants was also characterised by tensions between personal and professional values and the reality of practice constrained by communication influences. The consequence of these tensions was believed by many to be implicated in staff turnover, job related stress and the bearing of personal burdens for less than acceptable standards of care.

*The frustration, the lack of time to be able to deal with people on an holistic level and these are nurses that really care and **want** to give full care to a patient and they can't, so these are ones that have tried for years and years and just get burnt out and that say I've had it ... (Denise, RN, ACHS)*

Denise, a registered nurse with an Aboriginal Controlled Health Service emphasised her desire to give full care and attention, and the limitations experienced in the intercultural context, by reflecting on previous hospital experiences. Rachel, a relatively new nurse, also identified the tension between knowing that practices and procedures were not implemented well, especially with issues of client consent, and being able to act as advocate for her clients. Rachel felt burdened by the knowledge that she could not always intervene when incidents occurred through her colleagues' inadequate communications with Indigenous Language Speakers.

... it makes you feel bad that loads of things like consent and treatment are done without actually informed consent ... um ... but on the other hand glad that I was in the room and I did pick it up and I was able to alleviate stress and concern and worry for this mother ... but then also concern that you can't be in every room when everything's going on and ... if it's happening once, then it's happening other places as well ... Just having that knowledge that you don't stop ... it distresses me. (Rachel, RN)

Respondents experienced a tension between what they personally felt should happen for Indigenous people, and what actually happened in health care services. They appear to bear the burden of these tensions in a very personal way, being unsure at times, scared, distressed, and conflicted about their practice. Some participants wore the weight of wanting to advocate on behalf of Indigenous clients and witnessing their clients' and their own profession's lack of power in certain contexts.

6.4.5 It can be fun!

Even though the experiences were challenging, all of the participants concluded that their experiences of intercultural communication were valued. Mary, a Remote Area Nurse, was one of the few quick to suggest the positives about her experience of intercultural communications and the value of working alongside Aboriginal Health Workers. Other participants expressed similar conclusions, when reflecting on their overall interviews, but Mary was the only one to characterise her experiences as positive from the outset.

I've enjoyed working with Indigenous People. The language thing can be quite tricky because I'm aware that English language can be their third or fourth language so it is very difficult ... for the patient ... so we get by with sign language or AHWs. We couldn't do it without them ... No ... I love it. It can be fun! (Mary, RAN)

Within this excerpt however, is another reoccurring theme, that of an acceptance of 'getting by with body language'. Several respondents mentioned the opportunity to experience Indigenous cultures through their work in Central Australia. Stuart, a registered nurse from an acute care setting, felt this was part of the appeal of working in the region:

*I think it's great from a clinical point of view, really challenging, from a cultural point of view ... **really interesting**, yeh ... really interesting. It's not easy, none of that stuff's easy ... I guess that's the good fun about it. (Stuart, RN)*

For Georgina, working in a remote Indigenous Language setting was an opportunity to gain insight into another culture that would ensure practice was more informed and the practitioner was less professionally and personally isolated. Engaging in dialogue with clients is a key cultural safety principle and Georgina suggests that this engagement is the only way to comprehend the issues underpinning health. It is also a way to decolonise, as the health professional becomes the one who changes.

... well I think the whole time people are out bush⁵⁹, they need to read historical stuff about where they are ... meet with Aboriginal people after hours, sit and talk them so they have this feeling of closeness ... and a sense of maybe belonging and then you'll find yourself talking differently and listening in a different way ... and feeling differently. (Georgina, RAN)

Georgina is a RAN who I have had considerable opportunity to observe in the field and her advice to other health professionals stems from a strongly reflective persona that has enabled

59 Out bush – vernacular for being in a remote setting

her to gain insights into Indigenous cultures and communities that are extensive. For example, in observing Georgina speaking to clients, she would rarely jump straight into a discussion of the presenting problem. Georgina would usually try to establish a connection that was unhurried and prioritised the relationship over the clinical business.

6.4.6 Summary of findings related to the communication experience

The experience of intercultural communications in Central Australian health care is characterised as culturally, professionally and personally unsafe. It is, for many health professionals, imbued with personal and professional tensions, fraught with potential to miss important information or even being unaware that miscommunication has occurred. Communications between English-speaking health professionals and Indigenous Language speakers were described as frustrating, time consuming, and often full of uncertainty. Overall, however, participants also described their experiences as challenging in a positive way and for some it could be a fun and valuable experience. The experiences of intercultural communication in Central Australian health care can cause considerable conflict for health professionals who may then choose to avoid critical reflection on their practice.

6.5 Theme: acceptance and complicities – continued colonisation

Another prominent response to be identified was the seeming acceptance by health professionals of the status quo which saw Indigenous clients subject to differing standards of care, less informed decision-making, fear and anxiety. There was a palpable discomfort among respondents in reflecting upon their own and colleagues' practices in dealing with Indigenous Language clients. The sub-themes related to this issue, include 6.5.1 'best left unexamined' – becoming complicit; and 6.5.2 It's different here.

6.5.1 Best left unexamined – becoming complicit

Health professionals interviewed frequently concluded that they and colleagues were reluctant to examine the issue of intercultural communications too closely. By not engaging too deeply

in any analysis of what was undoubtedly a major problem, protected the health professionals from any charge of knowingly failing to provide appropriate care. There was a deep sense of powerlessness to examine issues for which the respondents felt unable or unwilling to act to change as shown in the following excerpts:

Reflection on practice was something that had largely been avoided because as was previously mentioned, *'it would be like opening a can of worms'*. However, most people interviewed found the opportunity to examine the issue as beneficial and had offered examples of reflective practice that had helped them improve their practice. For example, one participant declared, *'That's fine; it's actually nice chatting about this sort of thing because it makes me think a bit more about it too.'* (Denise, RN, ACHS) Being interviewed for the study was one of the few times she and others had allowed themselves to reflect on this particular aspect of their practice.

6.5.2 Its different here

Several respondents alluded to standards that would be deemed less than acceptable elsewhere. Most felt this difference should not be an excuse for differing standards of care, whilst some respondents felt that was an inevitable consequence of the setting. For Penny, sharing information over the phone was a cause for concern in terms of maintaining client confidentiality, even though she identified that it made the Aboriginal clients *'happier'*.

I've got use to it and that's really sad ... I've got use to it. In any ... other hospital in Australia it is so confidential ... there's not a great deal of confidentiality with the Aboriginal clients ... They expect to be told on the telephone, and the more information you give them on the telephone, the ... happier the patient is and that goes against every confidentiality (principle) ... everywhere else in Australia, it just works differently here. (Penny, RN)

The balance between providing care that compares with standards elsewhere and providing care that is culturally and locally acceptable is a challenging one for health professionals. There was obvious discomfort for Penny in breaching what she perceived as a universal standard of confidentiality and what the clients' required of her. If it is accepted that it is a

different environment, then there is a natural tension in trying to apply the same practices and values applied in other parts of Australia. Remote Area Nurse Cathy, gave the example of staff who '*come with a hospital mentality*' to a remote Indigenous community and inevitably burn out because of the mismatch of values and priorities. Without a clearly articulated framework for practice, health professionals are unsure of conflicted about their practice at times.

6.6 Theme: Power and powerlessness

Health professionals identified power and power relationships as having a major role to play in the intercultural communication experience in Central Australia. These relationships were not only between the health professional and client, but between the various health disciplines and workers, the overall health services and systems and the political power within the region and the country.

6.6.1 A lack of power

The health professionals also identified experiences that might be considered examples of their own colonisation or lack of power in certain circumstances. For example, the practice of having to remain in a subservient role to others within the profession deemed to be superior in terms of their discipline, experience or level. Health professional participants identified their own or examples from their colleagues of colonising practices that caused distress at times. Colonising practices affected not only on the Indigenous clients, but also the health professionals who witnessed such events. Participants identified a feeling of powerlessness at times to intervene in the manner in which some colleagues interacted with Indigenous clients.

Winnie, a critical care nurse, felt her responsibility acutely and was concerned with the perceived differences in treatment and responses to Indigenous clients. She suggested that

Indigenous clients were less empowered than their non-Indigenous counterparts to assert their rights and have options presented to them.

It just scares me that they're not getting a full understanding of what we're doing ... you know, you give a drug, a whitefella⁶⁰ would be saying what are you doing? Oh this is your antibiotic ... and do they (Indigenous people) understand what an antibiotic is?... it scares me that they don't have the right of reply to say no, I don't want my leg off, I don't want my arm off ... is there something else they could do. I would like to think they had the options to say that ... (Winnie, RN)

Winnie did not believe Indigenous clients were empowered to make their own decisions in health services, a perspective supported in the literature (Weeramanthri, 1996). The power of health professionals to coerce or apply pressure to clients within health care encounters was reflected upon—‘... in many ways you get impatient, you ... get almost suggestive of things’ (Sally, RN, RM Midwifery). By ‘suggestive’ Sally meant that there was a tendency to direct or suggest actions to the client rather than allow the time for them to make their own decisions. Sally knew her approach was not always a culturally safe one, yet also seemed to feel disempowered by her own deficiencies in communicating with Indigenous Language speakers in her employment setting, which was often a hurried environment.

Rachel, a registered nurse, offered an example of dominance within the hospital setting in relation to gaining consent from a young mother for a procedure involving her child, that even after the interview, on discussing her example, she described the event as one which ‘haunts me still’ (Rachel [pseudonym], personal communication, May 2010). Rachel has since left the hospital setting to work in a community outreach role.

It was a doctor trying to gain consent from a mother for a child's surgery ... and, while I listened to the explanation of what the surgery was all about from the doctor and I understood completely what was going on ..., the mother was very reluctant to sign. She obviously had reservations or concerns about it, but didn't ask any questions ... but then the doctor was in a hurry and it was like, sign, sign, sign ... if you don't sign there'll be no operation ... and ... I could tell that she was still concerned and I sat down

60 Whitefella is a term referring to non-Indigenous people

with her and had a talk and found out that she actually thought, that ... her child had a boil on his head and she actually thought they were effectively going to do brain surgery and going to open up his head and she just had concerns that she signed away the right for them to cut her son open ... for things that they weren't going to do at all!

KT: What alerted you to that? What made you think there was a breakdown in communication?

Just the language that the doctor was using, it was all very medical. It was just spooled off a reel and there was no actual questions so to speak ... I mean they had questions but they really weren't questions to be answered ... it was more to please the doctor, they'd (the doctor) ask something and if he thought that he got no response, she didn't have any questions ... um and just looking at her, I knew, her facial expressions showed that she was really, really worried ... the reluctance of her to sign the form in the first place, and then I just felt like she felt like she was under pressure to do so, so ... um ...

KT: Was the doctor aware of that?

Um ... um. Neither answer is good. Cause if he was ... I don't know whether he was actually aware that he ... that she'd feel under pressure ... he should have understood because it was fairly plain to me that she was ... and so ... I just assumed that he was under time constraints, didn't want to get his superiors on the offside by wasting, in inverted commas, wasting too much time ... on what was supposed to be a simple thing like getting a consent form signed ... and um, I guess he prioritised other things above the understanding of that mother. (Rachel, RN)

Rachel identified power relationships operating in this one scenario between the doctor and mother, the doctor and his 'superiors' and possibly between herself and the doctor as she witnessed the interaction, but was reluctant to intervene at the time. Rachel chose the strategy of many nurses in relation to medical officers, of waiting until they have gone to go through information again acting as an 'interpreter' of sorts and then stepping in as advocate. This is a powerful example from the data that covers many of the themes identified throughout the health participants' responses generally and shows the very personal burden placed on health professionals to operate in a context for which they are unprepared. In a follow up interview, Rachel referred to the incident with the mother, as one which 'haunts me still'.

6.6.2 Lack of 'informed' consent

The most obvious example of the consequences of flawed intercultural communications and the powerlessness of Indigenous Language clients, was in regard to consent for medical treatments. Almost all participants expressed concern at the very dubious nature of informed consent in their workplace contexts. Informed consent in the Northern Territory requires that clients are provided with:

'appropriate, objective, truthful and understandable information about their condition and about proposed ... procedures and programs, including expected benefits, perceived risks, alternatives, costs and fees ...'... in a manner that is easily understood by the client... www.nt.gov.au, accessed September, 22nd 2010).

This issue affects not only clients, but also practitioners and health services that are vulnerable to litigation for not ensuring that consent is at all times, informed and freely and fully given as indicated by these responses from Sally and Stuart:

People go for operations and they really don't know what the consent was about. There's huge holes, so it's a big problem, yeh. (Sally, RM)

Oh yeh, for sure, it's got to ... it does worry me because, well... We put so much emphasis on informed consent on the rights to make decisions about your own health care and you can't really do that ... unless you completely understand. (Stuart, RN)

Health practitioners know consent is often inadequate to meet the legal definitions and some health staff carry the knowledge at risk to their own well-being. The client is denied options because of a lack of perceived power in the situation.

*By rights they should have **more** information ... but unfortunately I don't think we can say 40%, 60% to an Aboriginal person, and I don't mean to be rude, but I don't know that they would understand 60/40, benefit versus risk, even to get a consent, we need to fix your leg ... there is a risk with anaesthetic, you can aspirate under anaesthesia, but that doesn't ever get done ... a whitefella might say ... what are the risks associated, they listen and then say hang on a minute mate, is there something else, can I go into the hyperbaric chamber?*

An Aboriginal person just accepts that ... oh, I feel ..., hang on a minute, do you understand that this is happening? So that scares me –absolutely ...
(Winnie, RN)

Again, the health professionals in knowing that consent is of doubtful standard feel the concern strongly. Winnie also identifies the disempowerment and acceptance of Indigenous clients and notes the relative empowerment of non-Indigenous clients by comparison. Literature regarding clients in language concordant health care systems supports the notion that where language concordance exists, clients are better informed and more empowered about their treatment (E. Wilson, et al., 2005).

6.6.3 Summary of power issues

Power in a post-colonial context is of central concern. From the data presented, issues of power, powerless and dominance are both overt and covert. This section has identified that health professionals within hierarchical health systems can both exert and experience power and dominance. Evidence of unequal power relationships is found in the acceptance of a lack of informed consent for Indigenous Language speakers.

6.7 Theme: Individual and systemic barriers - cultural danger

Literature focusing on intercultural communications in health care is often full of research that has identified barriers to successful information exchanges (J Betancourt & Jacobs, 2000; Blackford, et al., 1997; Buttow, 2010). Commonly, the literature tends then to categorise barriers in terms of individual and system barriers as a useful way for considering strategies to overcome them. Similarly, in this Intercultural Health Care Communication study, findings could be seen to fall into categories of individual and system barriers. Systems however, are comprised of individuals and it becomes relatively easy to pass responsibility for problems to a nebulous entity known as a ‘health care service or system’. With this in mind, therefore, I suggest that these findings do not fit discretely into only one theme, but into many, such as the theme of acceptance and becoming complicit, for example.

The acceptance of a lesser standard for Indigenous client interactions also intersects with themes of powerlessness and systemic barriers. Health professionals may perceive acceptance of a lesser standard as reinforced by the health care services response to Indigenous clients and the wider social influences that support these responses.

6.7.1 Attitudes to Indigenous Language speakers

For a number, there was a tendency to identify clients' English language deficits as the most obvious barrier to effective communication and health care. For some, like Penny, RN, this went further to suggest the Indigenous clients' capacity to understand certain health concepts is the problem. Penny's statements to this effect were said with assurance, as if the knowledge is common about Indigenous clients and seemingly with a presumption that I might share the same perception. This is reflective of the wider social discourses identified by Browne (2005) and others (see Chapters 2 and 3). Deficit responses to Indigenous Australians abound in policies and responses that reinforce notions of superiority and inferiority.

The concept that 'Aboriginal people' simply cannot understand some matters, although tentatively expressed, is prominent in the responses of other participants and through observations and personal communications. It illustrates a commonly held view and wider social discourses that Indigenous Australians do not have capacity possessed by non-Indigenous cultures. Dominance and a construct of the Indigenous person as passive are also consistent with portrayals of Indigenous Australians. For example, '*Aboriginal people always follow*' according to Cathy. Yet in other communications, it is acknowledged that this perception might be flawed, as Indigenous clients might appear to follow or agree and then do something entirely different, which may be an example of resistance. Alternatively, it may also be yet another example of a gap in communication, where a message was thought to have been received but had in fact not been taken on by the recipient.

Denise identified the existence of negative responses to Indigenous Language clients that she found disturbing and implicated in the high staff turnover:

I've seen people being very resentful towards the Indigenous, because of that ... It's like they blame them ... and a lot of people will say, Well, why don't they learn English? Which I think is really wrong. (Denise, RN, ACCHS)

Others participants expressed their belief that Indigenous Languages are 'simple, or simplistic ... primitive and unsophisticated ...' implying notions of superiority and inferiority between English and Indigenous Languages. A number of respondents commented on the need for simple explanations of complex health issues for Indigenous Language clients and families, linking their belief to their perception of Indigenous Languages as 'simple'.

*... **their language is simple** (researcher's emphasis added) ... and when they say wiya- no, wiya is wiya and they've got the facial feature to match ... so sometimes they find that confusing, um and trying to find the words to express the complexities of..., you know, how do you explain ventilation ... I call it the wind machine, blows wind into the lungs, so you've got to find language that's not derogatory, but also simplified enough ... (Winnie, RN)*

In the absence of any real education or language awareness, health professionals may well be set up to fail and clients set to remain uninformed. Such assumptions about language likely underpin how much information is shared, how much Indigenous Language speakers are involved in decision-making processes and how much effort at a system level goes into facilitating a more equitable exchange of information.

Sally and others were concerned by the low priority given to Indigenous Languages within the system. Although not always prominent in her own mind, Sally suggested that the disparity became more apparent in the health services' and colleagues' response to other non-English speaking people from overseas.

We don't actually give a lot of weight to the fact that this is second language country, that basically most people speak English as a second language ... It only comes to the fore when someone's from Thailand, that we actually... I think interpreter services aren't used really at all ... (Sally, RM)

She began to question why the interpreter was routinely called for other language speakers, but not so routinely for Indigenous Language speakers. Sally concluded that system pressures, financial and attitudinal may in fact dissuade staff from using available resources. She finally also concluded that a lack of awareness about the **need** for interpreters might also be a factor. Sally suggested that she would like some actual evidence to assess the value of calling or not calling interpreters for Indigenous Language speakers, alluding to a concern that perhaps there is an unconsidered cost in not using them.

You are conscious of the cost of interpreter services so there's ... when it comes to Indigenous Languages ... the clientele is such a big population, so there's an understanding of well, you know, if we were getting an interpreter for everyone it would cost a fortune, whereas there's only the odd Thai speaker or Cantonese or so ... but I don't think that's an excuse. I don't think we utilise interpreter services enough ...

(if you did use them ...) You get better quality ... and actually ... it would cost the system less because in the end? You won't have the AWOLs⁶¹ who you have to readmit, because they had to go to a funeral ... you see it all the time ... (Sally, RM)

The false economies that seem to drive practice for some are understandable in the context of the overt and covert messages that health professionals are subjected to with frequency. As noted previously, the Northern Territory Government had a history of overlooking the needs of Indigenous Language speakers in the expectation that all would and should speak English well enough to 'get by'. The acceptance of the standard of speaking enough English to get by was identified in the responses of health personnel in this study and in the attitudes and beliefs of Indigenous language speakers whose self assessed competencies were somewhat flawed (see also Chapter 7).

61. AWOL—Absent without leave—discharged against medical advice. See also TOL.

6.7.2 Labelling

Health professionals were quick to recognise the impact of their communication experiences on those in their care. A common consequence was that of labelling clients for their perceived deficits, rather than reflecting on any systemic or professional deficits. Not all respondents saw this so uni-directionally, acknowledging that to some extent, the deficit was their own and due to the system in which they were employed. Both Sally and Rachel noted how the limitations of their colleagues' exchanges often resulted in labelling of the client as 'difficult historians', as the following comments illustrate:

Sally: I often read in notes 'difficult historian'.

KT: So clients are labelled as 'difficult historians?'

*Sally: It's written in the notes all the time, **all the time**... placed back on the patient all the time and it's really probably just a lack of understanding. (Sally, RM)*

KT: Is that common? (labelling clients)

Rachel: Oh yeh ... Not compliant with this, not compliant with that, ... as opposed to somebody just choosing that that's not the best path for them, whatever that be, whether that be ... not taking medication or for anybody having dialysis choosing not to have dialysis or ... loads of choices that people get termed either compliant or non-compliant, whether they're actual choices or not. Those massive communication barriers can cause negative connotations, like that, which stick and they don't just stick for that individual. Um ... I feel like everybody's pre judged before they walk through the door. (Rachel, RN)

Labelling and defining others is a powerful colonising strategy that has added weight in the context of Central Australian health care. Many Indigenous clients attending health services in Central Australia today, have been labelled and had identities imposed upon them through various government policies that continue to the present. Health professionals need to be able to reflect upon the impact and power of such labelling in order to challenge the status quo.

6.7.3 Workforce issues —‘The short termers’

Higher levels of staff turnover and challenges in recruiting to positions are a constant influence on Central Australian health workforces. The major hospital in Alice Springs experiences a regular exchange of staff who stay for short periods only—ranging from weeks, to several months. Remote health services in recent years are increasingly reliant on agency staff employed for relatively short periods as well, making the implementation of PHC programs difficult (Davey, 2010).

Some longer-term respondents noted what they saw as a change in the motivations and attitudes of staff toward Indigenous people in Central Australia. Remote Area Nurse Cathy seemed disheartened by the changing attitudes she has encountered during her lengthy employment, spanning some thirty years in the region.

To me nowadays ... ‘Aboriginals are a pain’ ... that’s the feel I get from people, the nursing staff who come for three months ... just come for, you know, I’m just getting money. They really do the long stayers a disservice because they’re really not interested ... unless they’re a nice sort of person. Any how ... They go through the place and they cause so much trouble. They create new rules, no-one’s allowed to use the washing machine, ... each one that comes though, with hospital mentality, and they come into a community and they don’t understand how difficult it is for the people living in the community, how important family is... community life is just so different. (Cathy, RAN)

Sally also pointed out the dangers of putting people straight into short term positions without adequate preparation, particularly those overseas trained nurses who may not know the historical, political and cultural contexts of Indigenous health in Australia. Sally sees this as another example of colonisation of Indigenous people, of ‘*strengthening the whip that was always there anyway ...*’

Lots of people doing three month contracts... Doctors who just don’t understand ... the fact that there’s multigenerational unemployment and social security ... that’s sort of impacting on culture ... people are coming from India now saying well, what the hell! There’s a lack of cultural understanding ... ‘these people are given everything’. That’s really

permeating our environment, creating more intolerance ... the African nurses, they don't understand all that sort of stuff ... in many ways it's just strengthening the whip that was always there anyway ... I think we all know. It's a subtle thing that has always been there. (Sally, RM)

6.7.4 Summary of individual and system barriers

Individual attitudes, assumptions, beliefs and understandings about 'the other' in intercultural encounters have been shown to influence the way in which Indigenous Language speaking clients are regarded by health professionals. For many, their beliefs and assumptions are based on untested hypotheses about Indigenous people, by non-Indigenous people. This is not to suggest that the same does not occur with Indigenous people making assumptions about others, as there is evidence of this also presented in Chapter 7. This section also identified system barriers such as workforce turnover and health services lack of preparation and resourcing for intercultural communication.

6.8 Theme: Toward culturally safe communications

As noted in 6.6 health professionals felt largely unprepared and unaware of the need for preparation to communicate with Indigenous Language clients. Trudgen (2001) has been advocating for the health professions to take the needs of Indigenous Language clients more seriously. He and others have identified a number of practical strategies to this end, including mandating Language lessons for health professionals, employing and using more accredited interpreters and developing health literacy resources (Franks & Curr, 1995; Trudgen, 2001). Not all of the strategies identified in the literature is always practical or appropriate to the Central Australian context. However, the following findings were suggested as having the potential to enhance the cultural safety of communications in health care services provided to Indigenous people.

6.8.1 Preparation – ‘it finally twigged’

The preparation of health professionals who are mostly monolingual English speakers was virtually non-existent among those interviewed for this study, with a perception that their experiences were similar for their colleagues. Most were left to learn about Indigenous communications through trial and error, to have *it finally twig, or the penny drop*⁶²! The knowledge acquired in this way was mostly unevaluated knowledge based on a colleague’s experience and/or theorising about what was occurring within intercultural health care communications involving Indigenous Language speakers. All identified the need and desire for enhanced preparation for the context of intercultural communication in Central Australian health services and the potential consequences of not having adequate preparation. Short term contracted employees and overseas-trained staff were perceived as particularly vulnerable to misunderstandings in their encounters with Indigenous Language speakers. The absence of formal programs to prepare staff and disincentives for using available resources was seen by some as institutional racism on the part of health services.

Every health professional interviewed commented on their lack of adequate preparation and even lack of awareness of the need to prepare for working with Indigenous Language speaking clients. Sally was one who had at least attempted a little preparatory study, but realised after being in the setting that this was insufficient.

... I've just done subjects looking at cross cultural ... really just pretty simple subjects through university... even in the Masters course, that one that we did was really ... it was pretty basic ... it was establishing an understanding of your culture and that you're in a different culture. And just discussions with people, and living in places where there's another language but not really a lot. I've not done any courses through IAD⁶³ or anywhere and yeh, like I've definitely read Trudgen's book.⁶⁴ I tried to think about the whole ... cultural things behind language, but probably more than a lot of people who have never been here before ... but I think when you're here for quite a while you think it's never ... never really enough. (Sally, RM)

62 Finally twig is vernacular for to realise something, similar to the phrase, have the penny drop.

63. IAD see abbreviations. Institute for Aboriginal Development in Alice Springs offers a range of IL courses.

64. Confirmed as Trudgen's *Why warriors lie down and die*—a very valuable insight into the communication issues impacting on Yolngu health.

It was of interest to note that of the 11 health professionals interviewed, several had trained in New Zealand where cultural safety is an integral part of the nursing education curriculum. Some of these participants noted that they perceived a different philosophy between New Zealand and Australian practice settings toward the issue of Indigenous languages and their importance to health and health care outcomes.

For sure, Yes, yeh ... the way the training was set up back then, they used the term cultural safety... It was a nationwide exam, on cultural safety—if you failed, you failed your whole exam ...

KT: Having come here is there a different philosophy towards working with Indigenous people?

For sure... it seems that it's more complex. So many different language groups ... maybe is the difference, I'm not sure and it's maybe not out there in the media, as much... in terms of the awareness... (Stuart, RN)

For the majority of respondents, there had been no formal preparation for the context. Denise recounted her experience of being 'orientated' to the Indigenous health environment in Central Australia:

*None, absolutely nothing ... laughs ... and funnily enough when I was orientated here, I came from a different state into this melting pot of cultural black and white, and walked into that unit and I had a preceptor and honestly I spent five days with her and she never said a word about anything that was Indigenous specific, not even on a clinical level, so it was like she was teaching me in a east coast hospital. You wouldn't have been able to tell the difference, and I remember asking her what 'palya' meant and she said **'Do what I do and just smile at them if you can't understand them ...!'***

KT: Oh. That was good advice!

***And she was my preceptor!!!** (Laughing) (Denise, RN, ACCHS)*

The 'strategy' suggested by Denise's preceptor to 'just smile at them...' is an example of the powerlessness some health professionals feel in being placed in a position for which they are unprepared. It may also be an example of democratic racism where the health professional

would like to provide good care, but is willing to accept the status quo without challenging it or their own place in reinforcing it.

A number of participants mentioned the Health Department's Aboriginal Cultural Awareness Program (ACAP) as being valuable to their understanding of issues locally, but they were aware that this formerly four-stage course had been reduced to a single day for current employees:

We had a four week orientation for RAN orientation and I think was only two days cultural component of it and I just found it fascinating. It was fantastic but it was too short. I think we need a lot more, because the culture is so foreign to us ... and it would just help with our understanding and communication ... (Mary, RAN)

Mary found it too short and suggested it should be extended. Recently (2010) there has been a call to reinstate the full ACAP program, of which I have been an invited co-facilitator for some years. Also, medical and nursing staff have approached me and Indigenous colleagues to provide more comprehensive professional development in intercultural communications (Palmer-Thompson, 2010, personal communication). The interest and demand is perhaps indicative of a growing realisation among health professionals to be better equipped for this essential element of their practice.

6.8.2 Whose deficit is it? Decolonising through re-orienting thinking

For Tanya, employed in an Aboriginal-controlled remote PHC setting, she expressed the view that the onus should be on the health professional to become better equipped, through their own effort to learn the local Indigenous language. In a remote context, there is usually a main Indigenous language associated with a specific community. However, in the community health and hospital contexts, there are multiple Indigenous languages encountered. Tanya expressed a number of times, the need for the health professional to be the one who should and could make more of an effort, reflecting on herself as the one with the deficit, in the given context.

... yeh, it's just frustrating. I think you have to make an attempt to try and learn it ... [Language] so when I worked out there, I did try and learn it and we had boards up so people would teach me a new word everyday and we'd do things like that ... (Tanya, RAN, ACHS)

Cathy, Remote Area Nurse, felt even a little effort to learn a Language would be helpful in the practice setting:

Because people relax more when they think that you're trying to understand or accept that they have another language ... which a lot of white people don't. And it breaks the ice and they're very busy teaching you how to say the words, and you just get a better rapport with people. (Cathy, RAN)

Another benefit of staff attempting to learn language was the opportunity it provided for relationship building and reversal of power relationships. This identification of power structures and a conscious effort to subvert them is also part of decolonising practice within a cultural safety approach.

6.8.3 Make the time!

The issue of time arose repeatedly from participants in relation to the experience of intercultural communications with Indigenous Language speakers. Health professionals stated that they '*... don't have time*'. Communication and care therefore *take more time* and yet the system does not provide *enough time*. Most of the responses relating to time, came from hospital employees more prominently, but were also cited concerns of community health nurses. Time was critical and having to communicate with Indigenous language speakers who took more time than other clients, lead to impatience, suggestiveness, rushing and even bullying by some health professionals toward the Indigenous clients. However it was also noted that by taking time, responses and outcomes were improved.

The issue of consent that concerned so many of the respondents was handled in an innovative way in the Aboriginal Controlled Health Services. Tanya described the use of taped scripts in the local language for specific issues.

... but as far as consent, and that, we had tapes that we played if it was for a preset thing, like if I did HIV screening, and I wanted to talk to them about HIV or syphilis or you know, one of those things, that I really needed to talk to them about it, I had a pre made tape in Language and then I would play that to them.

*It was what the tests are and why they're having it done and you know ... yeh, so we used that and if it was consent for something like, well I need you to go to Alice Springs on the plane ... and I wanted to negotiate, you know that patient negotiation stuff, then I would ask them if they'd mind if we get a health worker in ... or maybe I'd use some family that would help me, yeh.
(Tanya, RAN)*

The use of pre-prepared scripts and other resources such as visual aids and the use of narratives were also identified as facilitators of communication with Indigenous Language speakers that may actually save time through improved compliance and understanding.

6.8.4 Making use of available resources.

Although participants identified a lack of available resources, it was suggested that perceived disincentives to use what is available prevented staff from using supports that do exist. Aboriginal Liaison Officers (ALO), Aboriginal Health Workers and Interpreter Services are currently accessible in most health services in Central Australia, but they are not always utilised. The reasons for this vary from personal attitudes toward the need, the actual availability after hours, attitudes toward the time involved in engaging these resource people, versus the perceived effectiveness and the system's overt and covert responses to the need for such services. The tendency of staff to rely on family members was an issue that also came up in discussions of how practice is different in the Central Australian region. What would not be acceptable elsewhere seemed to have a level of acceptance in this context, either because of a belief that this was a culturally acceptable practice or because staff felt they had few options.

Definitely I've used Liaison but if you're on night duty you don't utilise them. There's no ALO around. You use them if there's no one around ... but you can usually find a family member who'll do that translation ... You might be on nights and you're in with a woman in labour and you don't call ... if there's some family member you can get in you do ... but essentially

you may be on your own with that woman. Then you use your pictorial resources which are great ... the flip charts are great because you can grab those ... and they'll happily sit and look through the pictures and the pictures demonstrate a lot, they speak a lot of words I suppose ... so by using that you it will help but you get by without language a lot. (Sally, RM)

The dilemma of a lack of availability of liaison officers after business hours is supported by observations from the field. During one period of my observation in the Emergency Department, I recorded the following observed incident in my field notes:

*An elderly Indigenous woman was in a cubicle waiting to be examined by a medical officer. It was late at night, very busy in the ED. A young male nurse was assigned to the old woman. He had been speaking quietly to the woman, who was in apparent discomfort and possible confusion. She was speaking in Arrernte, but no-one in the vicinity was able to understand the woman. A male medical officer suddenly entered the cubicle and tried to question the woman about her condition. His voice was raised and audible from well outside the cubicle. He started to tell the woman that she was **'bleeding from back there, so we're going to have to stick our finger in your bottom to see where it's coming from, OK.'** The woman was facing away from the medical officer and just turned briefly, saying something inaudible to me from where I was standing. The young male nurse looked at me (as we were well known to each other) and raised his eyebrows. I took this as discomfort at what we had both just witnessed, as he then went to pull the curtain around the woman. The medical officer was already pulling on a glove and asked the RN to help position the woman. The medical officer continued to say in a loud voice that he was going to **'stick my finger in your bottom now OK'**, which was followed by a very audible and English **'Hey, what you doing there?'** from the woman.*

'It's ok, it's ok, finished now ... we just had to see where that blood is coming from ok. All done.'

*The medical officer left quickly, leaving the RN to reassure and comfort the patient. I spoke with the RN who was clearly distressed at how the examination had occurred. He wanted to ask about how the incident might have been done differently, asking **'What are we supposed to do when there are no liaison after hours?'** (FN, October 2008)*

We discussed possible alternate approaches to the same scenario in the absence of available ALOs. Cultural safety as outlined is about how things are done, not what is done. Given the lack of available ALOs after hours and a gender choice at the time, the young male RN was making every effort to be respectful and discrete with the woman. The medical officer might

have followed suit and spoken in a more discrete manner, giving the woman time to comprehend what was required and why. An offer could have been made to obtain female staff for this procedure if possible.

Of the people interviewed, most respondents genuinely wanted to improve their own and their colleagues' skills in communicating with Indigenous language speakers. Rachel identified the need to better inform staff of what services are available and promote their use.

*... they should promote that they **have** an interpreting service better! They should promote the services that **are** available ... because I find often on a weekly basis, I've learned that services have been in place for a while and just didn't know, so actually having proper promotion available would be handy, so you can actually use what is available, cause if so don't use them the funding gets lost as well ... so you do need to use what's out there ...*
(Rachel, RN)

Others expressed the need for communication specialists, beyond the Liaison Officers and Interpreters, whose sole responsibility was to ensure consent was obtained appropriately and to audit and develop the communications skills of staff. The limitations of Liaison Officers and interpreters who were not trained in medical terminology and concepts were frequently acknowledged as influencing the value of these roles, most specifically in the hospital setting. Winny was particularly concerned that her own communications, learned largely on the job, had never been audited. She also made suggestions about having special communication personnel and broadening the use of consent teams so that '*we can do it better*'.

I think we need to all go to cultural safety, communication lessons ... all new doctors. We all struggle and we all try to be polite, we all try to be culturally sensitive, ... No-one's looked at us and audited us ... to say 'Win that's nice, but you were smiling your head off when you said he's going to finish (die) ...' You need a team that can go round and look at communication, look at communication incidences, and give some feedback ... Aboriginal Liaison maybe could have a special communication person in their team come round ... audit the wards and say any communication issues? (Winny, RN)

Whilst there were identified system changes that could be implemented, many of the respondents accepted that they could make small changes within their own practice. The improvements identified in the findings included organisational changes such as increasing the availability and expectation of staff to utilise Indigenous interpreters, liaison officers and health workers and other communication specialists. Facilitating Indigenous language lessons and cultural awareness education for employees was also mentioned. On a personal level health professionals need to make use of reflective practice in order to provide culturally safe communications with Indigenous Language speakers.

6.9 Summary

This chapter has provided an overview of the data provided by English-only speaking health professionals from across a range of venues, health service models and disciplines. It was shown that all participants rated communication with Indigenous Language clients as a major challenge and one for which they were and remain mostly unprepared. The costs of this gap in preparation are borne by both the clients and the staff and consequently the community at large through ineffective and sometimes harmful health service delivery. Staff knew that differing standards of care and practice existed in relation to Indigenous clients. Many either accepted these differing standards as an implicit part of the environment, an inexcusable part of the environment or an unexamined aspect of practice that few wanted to reflect upon. All identified the need for greater preparation and skills for intercultural communications with Indigenous clients.

The next chapter gives voice to the experience of Indigenous Language clients in their efforts to communicate health care needs within an English dominated system. This voice however is reflective of the experience for Indigenous Language speakers in health settings, with the respondents adapting their approach for the English-speaking researcher. It had been the intention to conduct interviews in the participants' first languages and obtain translations for analysis. Why this was not the outcome is discussed in the next chapter.

Chapter 7

Indigenous First language speakers: *my veins are aching and they don't even tell us why...* (Ngangale)

7.1 Introduction

Intercultural health care communications in Central Australia are arguably among the most challenging of any practice setting, because of the potential for ineffective or failed communication to go unrecognised. Ngangale was not alone in suggesting that much of her health care happens in a vacuum of adequate explanation and information. Her comment that her veins would ache from having blood taken, but not being told why this procedure was necessary, exemplifies the experience of all of the Indigenous participants interviewed in this study of Intercultural Health Care Communications. Yet her comment would likely surprise some health professionals who may believe they had provided an explanation for the procedure.

It must be acknowledged at the outset of this section that the interviews conducted with Indigenous Language speakers by an English Language speaker, were limited and affected by the exact same issues outlined throughout this Thesis. Certainly, the information obtained would have been of a different quality had the interviews been conducted in the first language of participants. However, participants' relationships with the researcher and confidentiality concerns meant that the participants preferred to speak directly to me, making the effort in English that I was unable to make in their first languages. Never the less, what came from this study's interviews was a rich and appreciated voice of Indigenous Language speakers that provides a mirror to the responses of English-speaking health professionals.

This chapter presents the findings of interviews with Indigenous First Language speakers, albeit conducted in English. It also highlights examples of communication issues that arose during the interviews, for both participants and me, as well as from videotaped

communications obtained from the midwifery setting and field observations. In all, four Indigenous First Language speakers were interviewed. Two additional Indigenous First Language speakers were also observed via videotaped encounters, being interviewed for a health history by a medical officer and receiving some brief health education regarding their pregnancy. In addition, field notes and observations conducted throughout the research period provide additional data.

The participants represented Arrernte, Luritja and Pintupi Language groups (see Figure 3 in 2.7.1). Kinship or classificatory names used for Indigenous participants are not the participants' actual kinship names, as an additional layer of confidentiality. The pseudonyms used therefore as shown in Table 3, (in 5.4.2) are: IFL 1 –Nungarrayi; IFL 2 – Jakamarra; IFL3- Ngangale; IFL4-Naparrula; IFL 5 Nakamarra. (Omitted from data due to concern over consent.) There was a point during interviewing that Nakamarra rose on the pretext of checking on her children nearby and didn't return. Knowing the participant well, I interpreted this to mean she was uncomfortable with the process and was uncertain. Once I put the recorder away, Nakamarra appeared more relaxed).

7.2 Overview of main results

As outlined in Chapter 6, this Intercultural Communication Study set out to answer five research questions (see 1.11). The same questions put to Indigenous Language participants sought their perspectives as health service users. The main change in question focus was concerning preparation for the experience of intercultural communication in health care. This question was reframed to ask what knowledge and preparation Indigenous Language-speaking participants thought were necessary for health professionals. The results in this chapter are organised in themes and sub-themes as per the health professional group. However, it also includes findings from my own and other's communications, videotaped encounters, field observations and health resources and targeted communications that were evaluated.

The findings outlined in this chapter share some commonalities with the health professionals' findings summarised in Chapter 6. The experience of intercultural communication in Central Australian health care was also characterised as frustrating, stressful, disempowering and inadequate for Indigenous Language speakers. However, it was also experienced as frightening and even life threatening in some instances. The maintenance of people's first language was of primary importance to health and well-being, and participants felt better about the service they received when health professionals simply acknowledged the client's language and/or made efforts to use even small amounts of Language. The use of interpreters and Liaison Officers was generally considered necessary, although some cautions were expressed about using Indigenous staff who were members of the client's community. These related to concerns about confidentiality and possible cultural restrictions on interactions between Indigenous people based on gender or kinship structures. There was also an undercurrent of possible racism or at least negative attitudes both from and toward Overseas Trained health personnel. The findings from this small sample of data were nevertheless worthy of comment as the responses were unsolicited.

Within this chapter, given the smaller number of Indigenous First Language participants, data were organised according to the themes identified. These are: 7.3 Power and powerlessness- *'the doctors don't tell them'*; 7.4 Fear and oppression – *'some people are dying...'*; 7.5 Closing the gap in intercultural communications – *talk right way*; 7.6 Cultural dangers– individual and systemic barriers; 7.7 Beginning awareness – some linguistic features. See Figure 8 Summary of Indigenous Language Speakers' Themes.

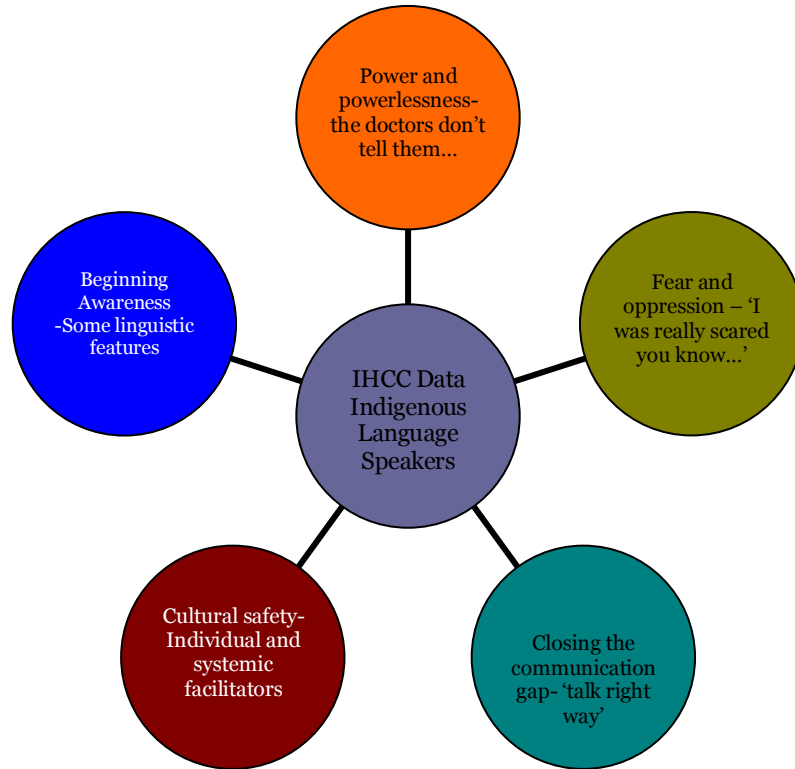


Figure 8 Summary of Indigenous Language Speakers’ Themes

7.3 Powerlessness and privilege— *‘the doctors don’t tell them ...’* (Jakamarra)

Indigenous Language speaking participants identified a sense of powerlessness as pervading their experience of communications in health care in Central Australia, as highlighted by Jakamarra’s comment that the doctors often did not tell Indigenous people what was wrong with them or at least not in a manner meaningful to them. Fear, lack of understanding and an inability to make informed choices influenced the Indigenous Language speakers’ experience of health care in Central Australia. All Indigenous Language participants revealed their belief that they receive insufficient or incomprehensible information from

health staff. The embarrassment or ‘shame’⁶⁵ felt by Language speakers who may not fully understand the words used by health professionals, is illustrated in the opening lines of this thesis and in the following excerpt from Jakamarra’s interview.

Some Aboriginal people they don’t know what’s really wrong with them. The doctors don’t tell them. They just might tell them ... you gotta have an operation, but they don’t know what for... they don’t know that doctors are really good one ... they might get frightened. They might think he doesn’t know what he’s doing. They don’t know he’s really ninti⁶⁶ one—those special doctors. They don’t know words like angiogram ... you know. And the doctors, they speak hard English, not even like plain English. We don’t know those words ... People might just go away and die because they are too frightened to have an operation, just because they don’t know ... (Jakamarra)

As shown in Jakamarra’s statements above, being frightened of the unknown consequences adds stress and impacts on compliance with medical treatments. Ngangale agreed that it is a major problem that people are uninformed about their illnesses. She identified the need for interpreters for the ‘hard English’ words that health professionals use.

*It is sometimes a problem you know because they tell their family the doctor didn’t tell me what, why I’m here and what sickness I’ve got and sometimes that really makes the family very upset ... because they’re not told what they got or why they here. That’s a big problem, not sometimes, it **is (speaker’s emphasis)** a problem for community people, like for big words we need people to interpret the language, awa,⁶⁷ like we need interpreters to interpret what the doctors are saying, what the nurse are saying ... (Ngangale)*

Ngangale also revealed that Aboriginal families talk about their experiences of health care amongst themselves and that could influence responses to seeking further treatment. She felt

65. See 10.4.

66. Ninti is Luritja for clever, knowledgeable (see 10. 3)

67. Awa = yes in Arrernte. (see 10.3)

that poor experiences of communication or health care warranted an approach from community elders⁶⁸ to speak to hospital staff.

It is you know, yes, there is problems like ... they not being treated very well in the hospital like, saying, you know, like rough things, like talking to them, not talking to them nicely, not being polite, being rude, that's what some of the families told me and I said maybe you got to get the elders to come and talk to them ... (Ngangale)

The experience of intercultural health care communication from Indigenous Language speakers' perspectives suggest it to be an uninformed, frightening experience that leaves some feeling powerless and making detrimental decisions for their health. The oral traditions of Indigenous people also contribute to ongoing fear and concerns as family members relay poor previous experiences to one another that can influence the uptake of services. It is for many Indigenous Language speakers an experience that is at odds with the efforts health professionals believe they make to overcome communication barriers.

7.4 Fear and oppression – ‘I was really scared you know...’

As identified by the health professionals, the consequences of poor intercultural communication affect people's treatments and compliance. Although health professionals may think they have given information, it is not always given in an accessible or comprehensible way, especially for those Indigenous people who may be less familiar with the environment or having grown up in ‘the bush’ as several people described themselves. Naparrula stressed the importance of feeling comfortable with her medical team and having procedures explained in a way that can be understood:

No I was really scared, you know, what that for that that really long one, the white one ... I ask him ... to go in to my lungs ... I ask him when you take to operation room, you know, that operation? No wiya,⁶⁹ wiya no anything, you

68. Elders in an Australian Indigenous community are those people who are high in status and usually age, although not exclusively. They fulfill leadership roles.

69. Wiya = Luritja for no. (see 10.3)

can watch it. They give you needle you know, make em nun (numb) ... yuwa, and I said you alright, I go with you. (Naparrula)

This quote from Naparrula highlights the difficulty of even those encounters that were anticipated to be easily understood due to the participant's self assessment of their English proficiency as good. Naparrula is an interpreter for an Aboriginal Controlled Health Service, yet there was difficulty for me in following who was giving reassurance and who was actually being quoted in this scenario. The tendency not to distinguish a change in speakers, is common among Indigenous Language speakers. A narrative is being 'played out' for the listener, who is expected to know who is meant to be speaking at a given point.

No I was really scared is Naparrula talking to me, reliving the feelings during that experience. She then switches to reporting her conversation with the doctor, asking about what the equipment is and how it will be used. There is some implied understanding that Naparrula has now asked the doctor what will happen in her operation, as in will she be asleep during the operation, even though this has not been said. She then relays the doctor's response, confirming to her that she will not be asleep, but she will be able to watch the procedure. I note the proposed change in speaker by the subtle changes in body language and facial expressions as if she is taking on the doctor's mannerisms. She will be given a needle to make her 'nun' was confirmed by me as numb. Naparrula was then reassured enough to agree to go with this doctor, because she had assessed them as being 'alright' or acceptable.

Other participants, such as Ngangale, also suggested that health professionals often instigated treatment without the client being informed or knowing what was being done, why it was being done, and what were the implications of the treatment. For example:

... so many people here, they said they come and get blood and never tell us why, my veins aching, and they not telling them why they taking it ... (Ngangale)

This experience of having procedures done to Indigenous clients with very little explanation was supported both by the health professionals' responses and by personal observations as shown by the following field notes:

The Registered Nurse (RN) continued over a period to take frequent observations, - did not interact at all with the patient, taking their arm for blood pressure assessments and placing thermometer in her ear without any verbal communication. (FN, October 2007)

It might be argued that non-Indigenous people also experience minimal interactions at times with health practitioners intent on completing specific tasks. However, there was a notable difference in interactions when health professional and clients appeared to share a common language and common cultural backgrounds. The experience of being uninformed and disempowered is continued often in the printed communications intended for Indigenous clients. Signage and other visual information may seem benign, but continue to fail to engage Indigenous clients in a meaningful way as indicated in the following section:

7.4.1 Signs and symbols

Assumptions about Indigenous Languages and Indigenous Language speakers made by English speakers influence the written and other communications used by health services. Information intended to consider the English literacy levels across the region has resulted in a plethora of resources that are highly graphic in content and described as using 'plain English'. Signage is one example of the targeted approach to communications with Indigenous people looked at in the context of this study. Most signage was largely incomprehensible to Indigenous Language speakers, even when the text could be read. The following sign from the Alice Springs Hospital is one such example:



Figure 9: Signage in Alice Springs Hospital

The sign above uses a graphic assumed to represent an abusive person as well as the presumably universal symbol for no or not allowed—the circle dissected with a line. The text however is laden with vocabulary that would pose difficulties for the majority of Indigenous Language speakers. During the study, I checked the comprehension of a range of Indigenous Language speakers concerning this sign and the symbol. One younger woman, who could read most of the words, reasonably suggested the symbol meant ‘*no shouting*’ but was unsure of the consequences of doing so. Another thought the symbol was about ‘*people with colds in their noses, not allowed, no coughing.*’ Yet another older woman who I had believed capable of reading the text surprisingly suggested that the sign meant ‘*no visitors*’.

Signage that is not developed in a culturally safe manner can also have the unintended consequence of stigmatising Indigenous people as the only ones being addressed, rather than a general instruction for all people within the health system. The consequences of this type of signage is that unless developed with input from Indigenous Language speakers, the information may be presented in a potentially offensive manner or remain uncomprehended by the readers. It is often presented in a simplistic fashion, rather than simple format that

enhances accessibility. This infantilising of communications directed toward Indigenous Australians has its origins in the wider social discourses that have shaped dominant culture responses, beliefs and attitudes.

7.5 Closing the communication gap - ‘talk right way’

Indigenous Language-speaking participants felt it was important that health staff knew how to talk the ‘right way’ to Aboriginal people. Each respondent gave examples of having been spoken to in a rude or blunt manner that was described as ‘talking rough’. On the other hand, ‘talking right way’ helps diminish fears and anxieties, and could lead to better outcomes for Indigenous clients:

Talk like gently, yuwa, slowly, ask him better way—‘Oh how are you?’ You know. You might when you talk rough way, you might think really oh this might be smart woman, I might walk away, you make me scared, you know.

KT: What do you mean?

Rough way, he might scared you know, I might think oh I don’t want this ... this not my nurse, he talking rough way to me, asking for everything. You gotta ask, sit down and ask: ‘where you from? ... I from this place ... and you got any family in your town?’ Ask him you know, ‘you got any friend ... come and sit with you?’ and ask him ... you know, ‘oh, can I have a look at you, check everything? and I said yes, you can check me, you scared from me? You talk like that you know. (Naparrula)

Naparrula also points out the importance of the polite convention of establishing rapport as an example of ‘talking right way’. This is a good example of what a culturally safe interaction could be in this setting. In most of the Central Australian languages, it is impolite to launch into speaking about the health related matter without first establishing the well-being of all participants. Again, it is probably less important to know that about polite conventions in Indigenous communications, than it is to consider that such a practice is also essential to establishing trust with the client.

Whilst there is a concern that learning about Indigenous communications could limit understanding to an essentialist construct of interactions, Naparrula's exchange also demonstrates the interchangeable nature of pronouns and tense that occurs when some Indigenous Language speakers use English, switching 'he' and 'she' and between past and current tense (see Table 5 in chapter 7). If knowledge is not simply left at this awareness stage, then health practitioners might also consider the efforts many Indigenous Language speakers make to accommodate the health services' expectation to speak English. The responsibility for potential misunderstanding should not then be the clients alone.

Ngangale felt it was important for health professionals to learn about Aboriginal people and their cultures in order to show respect.

*That's what we want, you know like if they coming they **must** respect our people that come in—they not showing respect to them. They got to learn first, so when they come in, because some non-Aboriginal people they come in and they haven't learned about Aboriginal people, in the community, so they can come and respect ... (Ngangale)*

Naparrula also stressed the importance of relationships by sharing her experience of a hospital admission in which she wanted to keep the doctor she had first met in Emergency Department. Naparrula felt that continuity was important to help allay any fears but had not understood that the hospital has different doctors for different purposes until it was explained to her that the health professionals work in teams. It was important that staff know to provide clear explanations to people like Naparrula who described herself as 'myall'⁷⁰, having grown up in the bush.

Only I tried I met him in the casualty. I come from [remote community] ... and they say me first one, you the doctor me, you bin see me the first place in Emergency room, casualty ... you gotta see me ... you my doctor ...
KT: So you just wanted the one doctor?

70. Myall – Aboriginal English term for unsophisticated, unworldly...can be derogatory

Yuwa, I want the one doctor, I don't want any doctor, you know, you know ... I said tell em you my doctor, you gotta work for me, tjukuru⁷¹ straight, don't push me to ICU ... yuwa?⁷² ...I'm scared you know.

Yuwa, yuwa and I tell him and my doctor said, don't worry. I look after you and I always come and visit every time ... you don't want that doctor from ICU, you talk to me. I'm your doctor ...and I always talk to my doctor and he always help me.

I'm happy, next round another doctor bin come, talk lovely way, not you know ...

KT: He talked a lovely way?

Yuwa, good way for me and I said hello, (he said) I'm doctor for your doctor, we work together, group, always sometimes they talk to me and I listened oh this is my doctor's group, you know working together ... and I listened.

KT: And they didn't speak too hard? They used good words that you could understand?

Yeh, yeh and I tell him, you work this area ... in emergency room ... or you not from other room, and I ask him, Yeh we'll come for this ward, we'll work this group here, these doctors. Your doctor and me, we'll work together ... we work for one company, and I listen and oh that's right ... (Naparrula)

Clearly, it made all the difference for Naparrula to understand that doctors worked in teams and communicated information to each other, and allowed her to pay attention instead of feeling anxious about being seen by different doctors. It also highlights how simple it might be to enhance the communications and compliance of Indigenous clients when time is given to providing an explanation of the system of mainstream health care.

7.5.1 Construction of 'others'

It was also evident from the data that communication issues were not restricted to those staff that spoke only English, which was not unexpected and is an issue worthy of further research given the increasing numbers of health personnel who speak a language other than English. What was surprising however, were the attitudes and responses toward overseas-trained staff

71. Tjukaruru –Luritja for straight, true

72. Yuwa? Yes? OK?

and the shifting responses this seemed to elicit between Indigenous and Anglo-Australian health personnel. Some of the health professionals encountered by IFL speakers trained in countries other than Australia, which introduced particular issues relating to preparation of staff. In fact, a recurring theme throughout both health professionals' and client participants' interviews were the unsolicited comments made about interactions involving overseas-trained health staff for whom English is also a second or other language. These unsolicited responses were not surprising based on anecdotal evidence. However, the emphasis given by both participant groups was surprising.

When first considering the research question for this study, my experience and observation of the numerous communication difficulties in health care settings primarily involved English only speakers. However, the changing demographics of the Central Australian workforce over the course of my research prompted some observations about the experience of communicating with Overseas Trained health personnel. By comparison, most felt that the English speaking non-Indigenous health professionals were actually 'friendlier' and easier to understand. Naparrula gives an example of how she felt when interacting with overseas-trained doctors.

... we don't like those ones, Chinese and ones from Africa ... they speak rough to Aboriginal people ... white nurse they alright ... they friendly ones, we can understand them alright, but not them other ones ... if I sleeping there in the bed and Chinese doctor come round and ask 'how are you?' (Spoken with intended foreign accent) what happen in you community ... or where you from?' You know. I get shy and I getting frightened and I couldn't talk to that Chinese and Indian, you know. I really get scared ... Because I only understand whitefella doctor, you know. (Naparrula)

The manner in which Naparrula 'acted out' the part of the overseas personnel, applying a 'foreign' accent, was bordering on comical, but was also disturbing in that her experience was one of fear and possibly racism. Others also identified overseas-trained personnel as being less 'friendly' toward Aboriginal people. It has been identified in the literature that people who are themselves subjected to constant racialising may themselves racialise others (Freire, 1970/93).

7.6 Cultural safety- individual and systemic facilitators

The attitude of English-speaking health professionals toward the use of Indigenous Languages was important to the participants. There was a suggestion that hearing staff make attempts to use an Indigenous Language felt *'friendlier'* and was the right way to talk to Indigenous people, as this exchange demonstrates:

*Yuwa*⁷³ *that's good, some people talking Language that was really good, you know*

KT: People like to hear the nurses try to talk Language?

*Sometimes they talking Language to me ... nyuntu*⁷⁴ *palya? [transl.you OK?] Yuwa, I'm right.*

KT: And you think that's good, some people talking Language to you?

Yuwa, that was really good you know, some people talking Language and ... some people you know, but when um like Indians you know ... they can't (under)stand. All the white sisters really good, you know they learn in hurry ... Yuwa, friendlier ... Yuwa friendlier, you can feel it. You know, oh that's good, you talking Language for me, friendly. (Naparrula)

A positive finding to come out of the interviews was the perception that non-Indigenous ('white') nurses were seemingly more open to learning and using some Language, making understanding and relationships more positive than they had previously been. It was interesting to note that this outcome was in relation to Indigenous respondents' perception of overseas-trained personnel who were considered more difficult to understand when they too spoke English as another language.

7.6.1 *We need... our language speaker to be with us* – responses to Interpreters in health care

When asked about the need for and use of interpreters within the health care settings, there were mixed responses from the IFL participants. Although all agreed on the need for interpreters, there were some differing motivations and responses to their use.

73. Yuwa, Luritja for yes. (see 10.3)

74. Nyuntu = you in Luritja. (see 10.3)

Like yes, we need hospital to get interpreters, like I do [specific Indigenous Language group] ... they need ... (other Indigenous Languages) in the hospital because they need interpreter to interpret ...

Awa⁷⁵ it is very important and it's very sad you know, because they feel very sad and they cry. We need people like our language speaker to be with us, that why we need interpreter. They want to know what disease they got ... (Ngangale)

The respondent in this instance was herself an accredited interpreter, so it was not surprising that she would see the need to involve interpreters. Others, including some of the health professionals have suggested that not all Indigenous clients are open to involving an interpreter, for cultural and personal reasons (Cass, et al., 2002). Unless the interpreter is connected appropriately via the kinship structures however, there is a concern about the interpreter being privy to the individual's private health information.

The use of family for interpreting, whilst advised against with other language speakers, is a common practice within Indigenous Language speaking settings in Central Australia. Nevertheless, Naparrula warns of the danger of using family members as interpreters when the issue may be a gender-specific or culturally sensitive one, such as sexual health. This finding highlights the need for health professionals not to assume a cultural norm such as the acceptance of other family members accessing information, but then reveals another issue in emphasising the need to stick to gender lines where possible in sharing information:

Yuwa, keep em secret ... only doctors, my doctors and me, and only my friend ...

No I don't want to see my father come and listen sit with me and my mother. Only three, my friends, my sisters, my doctors.

KT: So we need to know who the right one is for you?

And I'll go to my doctor, doctor tell me, nurse tell me, you ... which one you partner? ... I give em a name, he treat my husband too, my friends, you know, because I play around with that man and he might give me sickness, you got to treat that man and friend and boyfriend.

75. Awa = Arrernte for yes (see 10.3).

KT: Yes, that gets really tricky!

Yeh, don't talk to that families, nurse got to give it that doctor, doctor can treat em that man ...

KT: But keep it private ...

Yuwa keep it private, mens and mens, kungas,⁷⁶ kungas ... (Naparrula)

Aboriginal Liaison Officers (ALOs) were also seen to play a positive role in facilitating intercultural communications and ensuring other social and cultural needs could be met. Naparrula gives the example of how liaison officers identify issues that may be missed by non-Indigenous health personnel.

KT: Are people happy to talk to Liaison Officers?

Yeh liaison office good, good help for people. Yeh. When they can't understand.

Sometimes asking for old people you know, for pituri⁷⁷ you know, mingkulpa they call for mingkulpa, yeh..Yeh and Liaison officers know what they want. Yeh. Sometimes nurses learn you know, 'you want em mingkulpa ... pituri ... yeh?' (Naparrula)

7.6.2 Importance of own Language – *Keep that language strong...*

All IFL participants emphasised the importance of their Indigenous Languages for their sense of identity and well-being, reinforcing what has been stated in the literature. Rigney (2005) and Edwards (2005) both suggest that language is integral to well being and a sense of self. Indigenous Language speakers In Central Australia will often repeat pieces of information for emphasis.

Well Language⁷⁸ is very important because our oldies, they keep that Language strong because today our kids must learn English for our future

76. Kungas = women (Luritja) (see 10.3)

77. Pitjuri or mingkulpa is a native tobacco that is used for pain relief, appetite suppressant and more commonly now as a social habit that gives users a sense of well-being (see 10.2).

78. Language was confirmed as meaning the speaker's first language—an Indigenous language.

but our Language is very strong. If a person comes from a community that doesn't speak English very well they need somebody to interpret for them, because if our Language is gone ... we must keep our Language strong. (Ngangale)

For Ngangale, the strength of her language was repeatedly emphasised, giving weight to this point. It went to the heart of her identity and self esteem. It was felt that the attitude of health care systems toward Indigenous Language speakers had a role to play in ensuring an acceptance of language as a facilitator of health, rather than a barrier. Systems and policies that supported language choice, such as Interpreters, Liaison Officers and the availability of culturally appropriate resources were felt to be very necessary to ensuring positive health outcomes for Indigenous clients.

Encounters between English-speaking health professionals and Indigenous Language speakers were enhanced by developing awareness of and ability to reflect critically upon intercultural communications. My own interviews and the videotaped encounters also revealed insights into the experience of communicating in the study context. These insights are useful for developing strategies to deal with any arising challenges. For example, the comparison in response to silence within intercultural communications is information that once understood, allow health professionals to modify their approach for more effective interactions with Indigenous Language speakers. Rather than '*getting suggestive of things*' as Sally stated, and feeling compelled to fill in the silences that are inherent in Indigenous communications, English speaking health professionals can accommodate for silence and avoid the perception of '*speaking roughly*' or impolitely (see 7.7.3 Silence).

7.7 Beginning awareness – some linguistic features

Apart from the transcribed interviews that provided Indigenous perspectives on the experience of Indigenous Language speakers, the process of interviewing, along with my field observations, provided a rich source of some conventions of Indigenous communications.

Although not an aim of the research, the personal challenges I had whilst conducting the research, provided good examples of potential communication problems. English speakers such as myself may find these conventions challenging if we are unaware of their existence. This section presents some of the examples of Indigenous communication features that occurred in the process of intercultural communications during the research period.

7.7.1 Code Switching

As an English First Language speaker, I had planned to interview Indigenous First Language speakers in their first language and then have responses translated into English. This expectation seemed justified in light of the issues already identified as limiting the voice of Indigenous speaker, something I naturally wanted to avoid. However, this expectation was not congruent with the primary concern of Indigenous First Language speaking participants who wanted to demonstrate their polite convention of switching languages to suit the participants and contents of an exchange. I can only suggest this is what was occurring, as it became increasingly difficult to obtain information in the participants' first language, for what was regarded as 'my' story (Napaurrula).

Harkins (1994) describes the criteria of code switching, a linguistic juggling act that demonstrates the skills of multilingual speakers. I have witnessed this countless times over the years without really recognising what was going on. Harkins (1994) explains that code-switching or language choice will depend upon the subject under discussion. If the subject is considered a western medical issue, then English is the preferred mode, whilst a cultural issue would require the use of Indigenous Language. Location is another determinant influencing language choice. As most interviews occurred in either health settings or my home, it was deemed more polite for the participants to use English in my presence.

For example, Napaurrula was happy to speak with me about what she later described as 'my story'. In spite of suggesting that she might respond in her own language, we were sitting in an environment that was not her 'country' and I was the only other participant in the encounter.

The subject matter, although deemed on face value to be of more direct relevance to Indigenous First Language speakers, was something that I initiated and therefore was more appropriately discussed in English. This has implications for the role and use of interpreters in health care settings, and is discussed in Chapter 8. The ability of Indigenous Language speakers to engage in code switching should not be taken as implying that interpreters are not necessary during health care encounters. On the contrary, this polite convention has the potential to leave participants in intercultural encounters vulnerable to miscommunication and misunderstandings and is something that needs further analysis and planning to accommodate.

7.7.2 Potential for Miscommunication

While English as a language employs question formats as the most appropriate means of eliciting information, Indigenous Languages have specific protocols for obtaining information. Access to information is governed by kinship structures that determine who may or may not give or receive certain details. Making requests for Indigenous Language speakers is a circuitous process rather than the linear approach employed routinely by English language speakers. Eades (2009) provides a detailed account of Indigenous questioning styles from her research conducted in South East Queensland. Much of her accounts are mirrored in the questioning approaches and responses found in Central Australian Indigenous Languages as well. Field notes provided numerous examples of interactions that were not recognised as questions and responses within health care settings. The routine request for information from an Indigenous individual for example, is often met with silence and then a response via a third party known also as triangular communication.

7.7.3 Silence

Silence is overt and integral in Indigenous Languages from the Central Australian region. Several things influence the role of silence for Indigenous Language speakers in an intercultural context. Firstly, silence is indicative of showing a respectful consideration of a topic. Secondly, if there is a need to translate between languages there may be a lengthy pause as this process takes place internally. Alternatively, there may be a need to consider the

implications and intentions behind certain information, resulting in lengthy pauses. During the videotaping of interactions on the midwifery ward, Indigenous participants would be mostly silent throughout, prompting the English-speaking health professionals at times, to fill in silences by repeating questions. Pauses of 4 seconds were frequent throughout, which can be disconcerting to English speakers who do not often accommodate silence comfortably.

7.7.4 Gratuitous concurrence

Direct questions will often elicit an agreement response that English First Language speakers may mistake as a genuine answer, when what is occurring for the Indigenous speaker is simply the polite convention of not contradicting (Bain, 2005; Hargraves, 2001). This can be a potentially dangerous situation for participants. For example, in one of my documented interactions with a child who was experiencing obvious growth problems, the young mothers was asked if their child had eaten today or taken certain prescribed medications or nutrition supplements. The common answer given to health professionals, including on this occasion, was 'Yes'. This response may or may not have been accurate and the health professional may be challenged to work out which is correct. This convention is not deliberately misleading, but a preference to maintain harmony between participants and to provide an answer that is face-saving for the responder and pleasing to the recipient.

7.7.5 Use of Pronouns, Tenses and Repetition

When speaking in English, Indigenous Language speakers can also switch pronouns and tenses, or use repetition as a linguistic device. As documented in my field notes, it was common to hear the Indigenous First Language speakers change pronouns or use the wrong pronoun for the same person within a single sentence. For example, a woman about to deliver her first child was referred to at times as 'he' rather than 'she'. This can create confusion for the health professionals trying to obtain information about individuals.

On numerous occasions all Indigenous Language speakers provided answers in which the tense would change within the same sentence or paragraphs making it difficult for me as an EFL

speaker to be sure as to whether we were speaking about past, present or possible future events. One of the participants who seemed to do this most frequently was an interpreter for health services, raising the issue of potential miscommunications even when using an interpreter. Throughout their interviews Indigenous First Language speakers would frequently repeat phrases that contained what they felt was important information, signalling the listener that this was something significant.

7.7.6 Eye contact

As Indigenous Languages are orally/aurally transmitted, listening skills are highly developed from early childhood. Unlike English communications, there is no need to look directly at the speaker in order to show attention. Certain cultural mores also govern the use of eye contact, precluding some individuals from making direct eye contact in certain situations. Furthermore, it is considered a sign of respect when listening to a person of some perceived authority, such as health professionals, to look down while being spoken to. These conventions governing eye contact are of course context and situation specific. This is one convention however that is well known, by non-Indigenous English speakers, who often advise newcomers of what they believe is the strict requirement not to make eye contact with Indigenous people in Central Australia.

This is not so much a requirement, but a need to understand that eye contact is governed by cultural mores and is not necessarily an indicator of disinterest or a lack of comprehension if the listener is not providing eye contact at times. This aspect of communication is a good example of the limitations of transcultural theories and prescribed approaches to communications. Since peoples' life experiences and capacity for adaptation to different contexts means that whilst it is a commonly observable event, not all Indigenous Language speakers will necessarily avoid eye contact with English-speaking health professionals.

7.7.7 Non-verbal communications

Indigenous Language speakers are known to incorporate a substantial range of non-verbal communications that are not always recognisable to English Language speakers. Facial gestures and hand signals are routinely employed in local Indigenous communications. Whilst English similarly uses non-verbal communications, these are less prominent than Indigenous non-verbal communications, which are complete languages in their own right. Traditionally, non-verbal communications were used during bereavement periods and for maintaining silences during hunting and warring expeditions. Like other languages, which develop in response to new situations, contemporary Indigenous hand signals and facial gestures include signs for smoking, for being held in police custody, and for money. Health professionals who acquaint themselves with some of the common non-verbal communications can obtain more information that initially realised and avoid the perception of Indigenous people as ‘non-communicative’.

7.7.8 Triangular communication

A convention of three-way or triangular communication found in Indigenous communications allows for requests and information to be shared in polite ways. Whilst English speakers tend to expect individuals to respond on their own behalf, Indigenous cultures employ an advocacy role based on kinship structures. Information is often shared and received via another with the appropriate kinship connection. Health professionals who want to obtain permissions or provide key information may need to accept the appropriateness of communicating via a third party, so long as the client concerned has agreed to the suitability of that person.

7.7.9 Aboriginal English

Aboriginal English according to Eades (2009) is not pidgin English, but is:

the Aboriginalization of English as speakers learnt the language... by bringing into it accents, words, grammar and ways of speaking from their Aboriginal languages and those of their parents’. Importantly, Eades cautions that ‘it is both linguistically inaccurate and derogatory to use the term ‘pidgin English’ to refer to the kinds of English spoken by Aboriginal people today.

This study did not seek to focus on the majority of Aboriginal people in Australia who may have Aboriginal English as their first language, because in the Central Australian context, Indigenous Languages are more likely to be primary. However, it is important to consider even within the study setting, that Aboriginal English may be used as a second, third or other language, and can be misunderstood by English speakers who might assume a standard English use and meanings. For example, Indigenous participants did not appreciate nurses who were described as ‘cheeky’ (see 10.4). For English first language speakers, ‘cheeky’ is used often to mean rude, mischievous or naughty and is relatively mild as a descriptor of behaviour. For Indigenous people however, ‘cheeky’ has a more serious meaning and is a clear expression of unacceptable or offensive behaviour.

To conclude this section of findings on Indigenous Communications with English Language Speakers, I have summarised a comparison of linguistic features that were evident between both the English and Indigenous participants in this study (Table 5, this section). The features identified in table 5 might be considered examples of essentialising language and somewhat at odds with a cultural safety approach to intercultural communication. However, it is also the kind of first level awareness of difference that can be built upon to develop sensitivity and finally safety. It is included here with this intent. Irvine & Roberts, et al (2006) (see also Chapter 3) have identified language sensitivity as a skill that can enhance intercultural communications in health care. Having an understanding of one’s own language and/or culture, can facilitate reflection on interactions that can then be taken to the levels of sensitivity and safety.

Table 5 Summary comparison of linguistic features

Feature	Indigenous Languages	English Language
Code Switching	Multilingual Often governed by context, participants, topic & location	Monolingual Code switching within English between formal & informal, also often governed by context, participants, topic & location
Questioning	Direct questions can be considered rude, intrusive. Not always direct to person –establish rapport first. Information sharing not always individuals' right. Non-responsiveness may be polite. Third party may respond.	Direct questions accepted as best way to obtain information Best to speak directly with person. Non-responsive considered evasive.
Silence	Often integral, accepted	Usually not well accommodated Pauses help convey meaning, but prolonged silences may indicate discomfort
Gratuitous concurrence -yes responses	Accepted as polite Face Saving Promotes harmony	Only accepted for sensitive feedback Can be considered insincere or disingenuous
Pronouns	Gender indicated by context Some non-gender specific terms	Mostly gender specific
Repetition	Indicates an important issue Part of speech patterns	Seen as labouring a point
Eye contact	Aural/oral languages. Eye contact not required to show comprehension or attention. Also governed by kinship rules.	Eye contact implies comprehension and attention.
Non-verbal communications	Integral to communication Hand signals and facial gestures common	Less overt, less integrated – facial gestures sometimes subconscious. Need to be congruent with message.
Triangular communications	Polite way to make request or give information	Direct communication with individual – mediator only used for conflict or advocacy
Modified language	Aboriginal English is non standard English that is modified to sound and be executed in an Aboriginalised way. Eg: mutikayi – motor car	English is modified in context dependent situations for formality, informality.

7.8 Summary

Although a small number of Indigenous Language participants were involved in this study, they provided a rich source of data that confirmed and further illuminated the nature of intercultural communications in Central Australian health care settings. The common themes to emerge were similar to those for the health professionals. Power and powerlessness, fear, frustration, stress and lack of informed decision-making characterised Indigenous Language participants' experiences of intercultural communication in Central Australian health care. The main differences were the major consequences for the Indigenous language speakers, which had a direct and notable impact on their health and health seeking behaviours. 'Shame' was a powerful dissuader of seeking information in English for Indigenous people.

In summary, this study found that the standard of care provided to Indigenous Language speakers, including those who may use Aboriginal English, is compromised in English-dominant health services. Intercultural communication involving Indigenous Language participants is a frightening and confusing experience. The current practice of intercultural communications in Central Australian health care contexts puts lives and health at risk. Indigenous Language speakers identified certain protocols for communicating that health professionals should be taught before coming to work in Central Australia and identified the importance of being able to retain their Indigenous languages as a matter of well being. There was the perception that even small efforts to learn or use Indigenous languages would add to the comfort and well-being of Indigenous clients. There was also a negative perception of communications with health personnel who spoke English as another language, adding another layer of complexity to already frightening experiences for some.

The following chapter provides an analysis of key issues arising from the findings, and applies a post-colonial theoretical framework and cultural safety philosophy to discussing these issues. Issues of culture, power, colonisation and equity are all considered in the discussion using a critical ethnographic approach.

Chapter 8

Discussion: Culturally safe health care – does it exist, can it exist?

8.1 Introduction

This study of Intercultural Health Care Communications set out to examine the experience of communicating health care needs and information in Central Australia. It specifically sought to gain a picture of the experience for Indigenous Language speaking clients and the predominantly English-only speaking health workforce. It arose from a belief that intercultural communications in Central Australian health care settings are often poorly executed and understood. While other studies have uncovered serious consequences of flawed intercultural communications for Indigenous clients, few have considered the impact upon the health professionals at an individual level and the implications for health services to provide culturally safe care.

Key findings of the Intercultural Health Care Communications study conducted in Central Australia are discussed using a post-colonial theoretical framework that incorporates the philosophy of cultural safety. It examines the implications and relevance of the findings to broader national and global concerns. The key findings documented in chapters 6 and 7 painted a picture of Intercultural Health Care Communications in Central Australia that are high risk and have potentially harmful consequences for all participants. In summary, Indigenous Language speakers are made vulnerable by the acceptance of a less than appropriate standard of care, and health professionals are made complicit in providing care for which they are ill-prepared and unsupported. Such an untenable situation is implicated in staff turnover, stress, frustration and for the clients as well, fear.

The philosophy of cultural safety provides an appropriate template for discussing and examining intercultural health care communications in Central Australia. The Congress of

Aboriginal and Torres Strait Islander Nurses (CATSIN) and other health related groups have endorsed the relevance of the broader cultural safety principles for Indigenous Australians (Congress of Aboriginal & Torres Strait Islander Nurses CATSIN, 2002). The main principles of cultural safety include the need to:

1. engage in dialogue with consumers;
2. have consumers determine the cultural safety of a service;
3. undertake a process of de-colonising practice;
4. identify and act to address elements of institutional and individual racism and discrimination
5. undertake a process of critical self-reflection;
6. examine power differences;
7. learn about one's own culture and its impact on others.

(Ramsden, 2002; K. Taylor & Guerin, 2010)

Taking these as the main principles of a cultural safety approach, I have considered the results of this study of intercultural communications in Central Australian health care to discuss the implications arise for health services, educational institutions and health professionals. The capacity to engage in dialogue with consumers is stymied by a range of influences that are personal, professional and systemic. The opportunities for and expectation that consumers will determine the cultural safety of their health care was not evident. Furthermore, the data indicated that health professionals have little awareness of what de-colonising practice entails or might mean in an Australian health care context, especially where present policies and practices continue to colonise Indigenous Australians.

Most of the health professionals interviewed for this study were open to the idea of critical self- reflection within the confines of the study, but admitted that for the most part, the issues influencing their intercultural communications were at times too disturbing to examine deeply.

Rather than learning about their own culture and language dominance, in the study setting there was a strong focus on learning about the '*exotic other*' within various cultural awareness programs (Ramsden, 2002). Findings suggested that cultural awareness programs experienced by the research participants tended to focus exclusively on Indigenous Australians. Consequently, participants were not always aware of power differentials in their own or their organisation's delivery of health care.

In the following sections of this chapter (8.2 to 8.7), some of the major principles are considered in relation to the research findings along with their implications for intercultural communication in Central Australian health care. It concludes with a discussion of intercultural communication in a cultural safety context. The chapter is structured as follows:

8.2 Engaging in dialogue

8.3 Decolonising practice

8.4 Critical Reflection

8.5 Addressing power, privilege and whiteness

8.6 Examining own culture and its impact on others

8.7 Indigenous personnel in health care services

8.8 Summary

8.2 Engaging in dialogue

The findings of the intercultural communication study identified major barriers to engaging in effective dialogue between English-dominant health services, staff and Indigenous Language speakers. Dialogue as the term implies, requires at least two or more participants and may be at the individual level, between health professionals and clients and/or at the broader organisational level, between service providers and Indigenous Language speaking clients generally. However, this study revealed that communication in this context was often an

illusory experience leading to a range of feelings for participants including frustration, fear, stress and potentially poor health care outcomes for Indigenous Language speakers.

Health professionals interviewed seemed genuinely committed to establishing dialogue with Indigenous clients, but felt unprepared for the job. Indigenous Language speakers similarly were unprepared and often reluctant to pursue dialogue with health professionals for fear of humiliation or *shame*⁷⁹ at their inadequate English language skills. Consequently, at times Indigenous clients tried to disguise their lack of comprehension by failing to seek clarification or avoiding requests for the support of interpreters or liaison officers. This behaviour was also prominent in other research involving Indigenous Australians (Cass, et al., 2002; Lowell, 2001; McGrath & Holewa, 2007; Watson, 2006)

For health professionals to hear from Indigenous people that *'they don't even tell us what's wrong...'* as Ngangale indicated, can be upsetting both personally and professionally. In keeping with the study's methodology, this issue was relayed back to the majority of participants, although not all remain accessible since the data collection ended. This finding from Indigenous participants, along with others, has been presented at a number of local seminar presentations in the hospital and remote orientation programs during 2009 and 2010.

Health professionals interviewed were generally aware of the suggestion that clients were not always given adequate or specific information. These participants also described the numerous efforts made to explain to and seek out information from Indigenous clients. Although there was a tendency from some staff to dismiss their efforts as *'too old to let it bother'* them, or as prompting them to flippantly suggest they would *'just move on to the next'* person, this was far from what I observed. It was also not consistent with what participants ultimately revealed about the impact of their own inability to communicate, which for many health professionals was personally distressing.

79. Shame in this instance refers to the Aboriginal English meaning (see 10.2)

The influence of nursing culture, derived from military and religious origins however, is one characterised by stoicism and a tendency to ‘soldier on’ rather than overtly challenge the status quo. Added to the historical influences are the environmental and vocational aspects of practice in remote settings and it could be inferred that nurses employ protective strategies such as a level of ‘acceptance’ of the conditions in which they are practising, as just ‘*how it is...its different here...*’. Most of the health professional participants however, far from accepting their unsatisfactory conditions, internalised their concerns and sought other ways to improve the situation through trying alternative approaches and revisiting problems repeatedly with their clients. Although the sample size in this Intercultural Health Care Communication study was small, the tendency to repeatedly try other approaches with clients was perhaps more apparent with remote health staff than in the hospital settings where the relationship with clients was more transitory.

8.2.1 Well *they* never tell you do they...they never let you know!

Equally frustrating for health professionals was the perception that Indigenous language speakers did not readily volunteer information or seek clarification. Health professionals who do spend considerable time and energy in trying to convey the details of clients’ health concerns might challenge the notion that Indigenous language speakers are not told what is wrong with them. However, as Trudgen (2001) and others have indicated, it is easy to believe that communication has taken place, when in fact there is little or no comprehension on the part of Indigenous First Language speaking clients (McGrath & Holewa, 2007; Weeramanthri, 1996). The problem with recognising when or if comprehension has occurred is difficult when English-only speakers lack language sensitivity and language awareness skills (Irvine et al, 2006). In seeking to refocus attention on the health professionals as the ones best placed to make change to their practice, the study’s findings also suggest a role for Indigenous people to offer information at times. This is in keeping with communication being a shared responsibility.

In my academic practice, I use an exercise that demonstrates how individuals can convey comprehension even when little exists (Taylor, 2010 unpublished). The exercise involves asking English-speaking health professionals to complete a consent form written in German. The form's layout is recognisable for English speakers as requiring standard components such as Surname, First Name, spaces for dates that are obvious from the line, backslash, line, backslash, line pattern ie: ___/___/___. Participants in this exercise are often happy with the amount of information they can complete on the form through recognition of patterns and words and most often will sign the form without any real understanding of its content, as they wish to oblige my request. However, some people in the exercise will stop short of signing and indicate that they are unwilling to continue until they know what they are signing. This brief exercise illuminates the way in which any individual can appear compliant and functional in another language when in fact they are operating on learned responses and expectations. The link to Indigenous Language speakers soon becomes apparent with health professionals seeing clearly that it is possible to obtain 'consent' that is not necessarily informed.

However, there are strategies for testing comprehension as part of the initial assessment and history taking processes within health services (Buttow, 2010). Even when an Indigenous Language speaker is assessed as having adequate English language proficiency, there remain sound reasons for involving AHWs, ALOs or accredited Interpreters where possible. Apart from the potential for miscommunication, from a cultural safety perspective, engaging in dialogue with clients is a key tenet. Effective dialogue needs to incorporate more than verbal communications. It needs to consider the cultural nuances of communications, the non-verbal communications (see Table 5 in 7.7.9) and to ensure that dialogue occurs from an equitable power base. Dialogue also needs to account for the phenomenon of *shame* and the code-switching conventions that compel Indigenous Language speakers to make efforts to communicate in the health service's language of English, without always drawing upon resources, even where and when available. The speaker of an Indigenous Language, speaking in English, will always be at a disadvantage if dialogue within the encounter is not facilitated in a way that allows them to draw upon their first language when necessary or at the very least

have the option of language choice. In addition, dialogue is also important to help counteract individual and institutional racism and discrimination.

8.2.2 Information ‘Dumbed-Down’: superficial and minimised communications

This study found an identifiable pattern of intercultural communication employed when speaking to Indigenous clients, leading to superficial communications that were at best demeaning, and at worst were dangerous. Health professionals, in the absence of formal education about Indigenous communications, worked from sometimes-stereotyped notions about Indigenous people, their languages and their capacities to understand western medical information.

Communications in local health care settings are frequently reduced to superficial staccato utterances that ‘dumb down’ serious information. If health personnel do happen to know a few phrases of local languages, emotional concerns of Indigenous clients are frequently couched in terms of ‘big worry, little worry’ and enquiries about how someone is feeling today, become limited to ‘You good?’ or *Nyuntu palya?*⁸⁰. Sometimes however, the health professionals’ lack of awareness of the diversity of Indigenous languages leads to clients being asked for information in what is essentially another foreign language, albeit an Indigenous one as the following field notes reveal:

FN: ED, busy –all cubicles occupied. Curtains not pulled around patient. Female RN in loud voice asks male Aboriginal patient: ‘You done gunna today?’ Any gunna? (slightly louder). I know the male patient to be from an Arrernte community. He does not make a response other than to look away. Nurse repeats: ‘You been to the toilet today? Any gunna?’ Response – without looking at nurse, a discrete but audible, ‘No’.

Gunna is a Pitjantjatjara/ Luritja word for faeces. Apart from issues of simple discretion and patient comfort, this nurse was using a word from a different Indigenous language to the patient’s first language, which was Arrernte. They may have understood the word due to the

80. Nyuntu palya is Pitjantjatjara and Luritja for ‘you good?’ (see 10.3)

multilingualism of many Indigenous people, but such a lack of awareness fails to acknowledge Indigenous Australians cultural and linguistic diversity.

Pain assessment is at times limited to descriptors of *'big pain, little pain'* or efforts to relate to various faces on what is purported to be culturally appropriate a pain score chart (Fenwick & Stevens, 2004). On the pain tool used within the local hospital, the greatest pain an individual can experience, is depicted by a grizzled expression on a facial graphic and the phrase: *'Like all your bones have been broken at once'* (see 10.11). Although Fenwick was involved in developing a fore-runner to this pain tool, there was no development information with the current version. English speaking clients on the other hand use a numerical score of 1 to 10 to indicate their pain. When asked about pain assessment, staff have suggested it is preferable to use the facial graphic tool, describing it as an 'Indigenous pain tool' and more appropriate because there is a stereotyped notion that *Aboriginal people cannot use numbers or do not have understanding of numerical concepts*.

When asked about the evidence for this assumption, staff have replied that it is *well known* that Aboriginal people do not have a concept of numbers or time, because most of the languages just refer to the numbers as one, two, three or many (big mobs⁸¹ in Aboriginal English). It may be factually correct that readily translatable words for English numbers do not exist in Central Australian languages, but this does not mean that concepts of quantities, time, volume, intensity, and so on, do not exist. In fact, Indigenous kinship structures for example, are considered sophisticated and complex mathematical patterns that allow every individual to be situated within a network that is potentially infinite (Trudgen, 2001).

A rudimentary review of Indigenous Language Dictionaries available locally offer a rich selection of descriptors for pain, which would be far more clinically useful in assessing type, duration and intensity of pain (see 10.13). A resource list of common pain descriptors around wards and clinics would be useful not only to help establish rapport, but also to gauge whether

81. Mobs – Aboriginal English meaning groups of people (see 10.4).

further support is needed with communication. Minimising of communication for important situations like pain assessment, results from what Trudgen, (2001) describes metaphorically as an inability for ‘*Apple to speak to the IBM*⁸²’, without an appropriate translation tool to converse in each other’s language. However, even when resources are available this study identified numerous disincentives for utilising them, such as flawed economic considerations, perceptions of time constraints and lack of awareness of the need and availability of services.

The Intercultural Health Care Communication study’s findings also highlighted the limited attention paid to Indigenous clients’ social and emotional needs and their experiences and health professionals’ acknowledgements of discrimination, social exclusion and racism. For most practitioners, their inability to communicate on a deeper level left them reliant on physical indicators, body language and physical needs. It was apparent to health professionals that they were unable to address fully the holistic needs of Indigenous clients because of the communication barriers. The superficial or minimised nature of health care communications presents a challenge for health services in Central Australia.

8.2.3 ‘Culturally appropriate’ resources

Efforts to facilitate dialogue may be evident in the preference of health professionals to use resources that are ‘culturally appropriate’. A number of resources were examined during this study and advice sought from Indigenous Language speakers about their meaning (see Figure 9 in 7.4.1). In my experience, for resources to be effective, they need to be not only culturally relevant, but also *locally* appropriate. Resources designed for Indigenous Language speakers were generally considered appropriate if developed by or on advice from an Indigenous person, irrespective of their background in health education or other relevant communication skills.

82. Apple is a computer brand – Apple Macintosh, IBM, also a computer brand. The deliberate incompatibility of these competing systems often meant consumers had to make a choice. As both competed, it became apparent that one would lose to the dominance of the other, so suddenly tools for compatible communication were developed.

Anything with dots⁸³ or symbols was immediately recognisable as intended for an Indigenous audience, as these reflect Indigenous art and visual communications.

My intention is not to dismiss these resources as irrelevant but to caution that these inclusions alone do not necessarily enhance understanding or acceptability. One example of a resource deemed culturally appropriate for meeting the above criteria was a pack of playing cards developed in South Australia that had drug and alcohol messages on them (Aboriginal Drug and Alcohol Council (SA) Inc, undated). While they may be suitable for South Australian Indigenous contexts, the problem with this resource for Central Australian groups is that gambling in the form of card playing is a major social issue that impacts on the well-being of families. The distribution of playing cards by health services may present a mixed message in this context, as alcohol is often an accompaniment to large and prolonged card games involving Indigenous families.

Over the years, I have made the same assumptions and been involved in developing materials with and for Indigenous Language speakers, with varying levels of success. What is of concern however is the balance to be struck between making something readable and comprehensible, and keeping it age and subject appropriate. The NT Government 'Kanga Connect' television advertising campaign (www.ehealthnt.gov.au accessed 22nd September, 2010) is an example of what I believe to be an inappropriate and ineffective health communication. It supposedly targets Indigenous adults with the purpose of persuading them to consent to having their medical records stored electronically. It uses a character in a dubious kangaroo outfit, wearing an Australian slouch hat to speak to adults (presumably, as they are the only ones who can give consent). The script of the advert starts with a phrase that would immediately identify the advertisement to most Territorians, as intended for Indigenous people. *'Hey you mob⁸⁴. How would you like to have your electronic health record....'* is assumed to address Indigenous people, as *'you mob'* is an Aboriginal English term. Along with the cartoon character, the

83. Central Australian Aboriginal art is often described as 'dot painting' due to the characteristic use of fine dotting and cultural symbolism that makes up the art work.

84. Mob is an Aboriginal English term for people, generally taken to mean Indigenous people.

speech used and other images of Indigenous people interacting with white health professionals using computers leaves little doubt as to the intended audience. The implicit messages of this campaign are troubling. Firstly, that a man in a kangaroo suit and a slouch hat is an appropriate figure to capture the attention of Indigenous adults across the Territory. It seems to follow the long held view that Indigenous Australians can be ‘captivated’ by childish figures. Secondly, that Indigenous people who live in a variety of ecological areas must necessarily relate to any message with a kangaroo.

Non-Indigenous participants often identified the use of visual aids as helpful in their intercultural communications, but seemed to accept these with little critique or evaluation of their effectiveness, appropriateness and acceptability for Indigenous clients. The pain tool mentioned previously (see 10.12) is one such resource accepted locally as a culturally appropriate resource, but it is yet to be evaluated.

8.2.4 Secret English, Hard English

According to the findings of this Intercultural Health Care Communication study, if language was not ‘dumbed down’ for Indigenous people, it was inaccessible due to jargonistic medical discourses. So prominent is this approach that many Indigenous people have come to believe that English speakers have a secret language that is meant to deny information to them. This theorising by Indigenous people may be understandable, because within Indigenous communications it is a cultural norm to regard certain types of information as something to be strictly controlled and not automatically made available to all members of the community (Trudgen, 2001). The two terms used by participants in response to health communications were ‘*secret English*’ and ‘*hard English*⁸⁵’. Whilst it was usually the English language that was considered by Indigenous Language speakers to be secretive at times, one of the RANs interviewed also described the circuitous nature of Indigenous communications as like having to unravel the ‘secret’ of what was really being asked (see 6 4.3).

85. Hard English is a term used by Indigenous Language speakers to mean difficult language to comprehend due to the use of complex words rather than plain English.

Medical jargon is clearly about being very specific and unambiguous in terms of descriptions and procedures. However, medical jargon can also serve to intimidate and maintain power and control with the expert. The Nursing profession in English-speaking countries has also sought to develop discipline-specific language, in an effort to distinguish itself from medicine and as a profession with unique knowledge and skills. With the advent of the North American Nursing Diagnoses Association (NANDA), Australian Schools of Nursing also began to teach nursing-specific diagnoses that were unnecessarily jargonistic from my perspective, and certainly would qualify as 'secret' (or hard?) English if used in dialogue with Indigenous people. Technical and precise language is clearly necessary between health professionals. However, effective communication is integral to the provision of safe and effective health care practice and the role of communication in the process of caring for another cannot be understated.

Language is a major barrier not only to health but also to the very relationships needed to underpin health. This barrier also prevents an understanding of each other's worldview. The notion of health professionals and others having 'secret' English is one I first experienced personally when interacting with Aboriginal Health Workers in my clinical education role. For much of my time, I had to demystify my language of English to Indigenous Language speaking AHWs simply so they could do their job. This demystification was relatively easy given the highly visual learning styles of Indigenous colleagues (Webber, 1978). Once a pattern in the language was revealed, the AHWs were able to unlock much of the 'secret' language for themselves. A simple activity of going through medical terminology and explaining the meaning of Greek and Latin roots helped the AHWs 'translate' medical notes. For example, teaching English prefixes and suffixes such as hyper/hypo, tachy/brady, -itis, and others helped AHWs understand and predict the meaning of previously unknown medical terms. It was not that these health professionals did not conceptually know about hypertension or bronchitis, but they often did not recognise the components of English words that would help uncover their meaning. These teaching sessions also led on to discussions and complementary lessons about the structures of Indigenous languages - an example of *napartji-napartji* or reciprocity.

Reciprocity allows for the turning around of power relationships, with participants each taking turns to become learners and teachers.

This section has considered some of the factors that can influence dialogue either positively or negatively. It has suggested that dialogue as the word implies, requires an equivalent relationship, to be effective. Health professionals need to develop greater language sensitivity and awareness to be able to recognise when communications may fail. Indigenous Language speakers have come to believe that health professionals use ‘secret English’ to keep information from them and efforts must be made to enhance the accessibility of language used. Finally there is a need to evaluate communications and resources in order to stop the paternalistic dialogue and visual information most often directed toward Indigenous Language speakers.

8.3 De-colonising practice: ‘...strengthening the whip that’s always been there ...’

Decolonisation is a difficult concept for many to grasp, with descriptions and definitions being somewhat vague in the literature (see 10.2). Australian and New Zealand experiences of colonisation differ on a number of levels however. Even within Australia, the colonisation processes and impacts differed across the continent. There remains a resistance within Australia to the idea that colonising processes that could be both ‘brutal and subtle’ may continue to operate (Guerin, 2008). According to Guerin, (2008, p.1) *While many, but not all, of the brutalities have been stopped, most of the subtle effects remain.* Guerin (2008) identified various subtle colonising processes that sought to change Indigenous people’s behaviour. It may not be surprising then, that evidence of subtle and not so subtle processes was apparent within the findings of this Intercultural Health Care Communication study.

It is important therefore to consider what de-colonising practice might mean in the Central Australian setting. The literature from Australia referring to de-colonisation is relatively scant. Sherwood and Edwards (2006) describe decolonisation in Australia as a critical step in

Aboriginal health. Examples of ongoing colonisation were evident in the findings of this Intercultural Health Care Communication study. For the Indigenous participants there were distressing incidences of being spoken to 'roughly' and feeling unable to assert certain rights in an English-dominant health care system. It is important to realise that experiences of racism and discrimination can be perceived whether intended or not. For Indigenous people in Central Australia, a lack of rights has been a feature of life for many and experiences of racism and discrimination may influence perceptions of encounters with the health care services.

The internalised messages for some Indigenous people of their encounters with non-Indigenous health professionals may only reinforce feelings of ongoing colonialism, power and lack of control over their own lives. One such example of a colonising act is cited in Taylor & Guerin (2010, p.23) regarding an incident I witnessed during field observations:

FN (2008) A young boy in the paediatric ward was asking for a toy...using his local Indigenous language. The large male nurse stated at high volume... 'No, when you stop talking in Language and ask me properly in English, then I'll give it you.'

The clear message for the young boy and anyone watching was that colonisation continues and Indigenous languages are to be forgotten in favour of speaking '*properly in English*'. It was also evident who held the power in this context.

Another component of colonisation is found in the discourses used by health professionals at various times and within various settings. Discourse refers to the way subjects are discussed, revealing something of how the subjects are conceived or conceptualised by the group doing the talking. In a colonised environment, those with the power are usually in the greater control of the discourse. Although this study focused on intercultural communications, how the participants are talked about reveals something of the attitudes underlying the experience.

The dominant discourse surrounding Indigenous people and health in Australia is often one of *their* (Indigenous peoples') failure to modify behaviour, *their* failure to take on western education and health knowledge, and *their* failure to comply with western medical treatments

and advice. It is a discourse that engages in 'othering', which means locating any problems within perceived deviations from the 'norm' (Kemble, 2007). 'Othering' occurs when people treat 'others' who are different in some way from themselves as problematic because of any perceived difference (Taylor & Guerin, 2010, p. 178). The implication of 'othering' is that one's own group is preferable over the 'other'.

The discourse of Indigenous health is often negative and imbued with blame for those the dominant culture sees as problematic. A current (2009) example is provided in the following letter to the editor of a local newspaper:

'Is there any other country spending so much money on such a tiny minority, and with so miniscule positive result to show for it?...(name) should stop seeking to cast blame on governments, bureaucracy or society at large for the self-inflicted damage suffered by so many Aboriginal people. In the end we can only assist those who choose to assist themselves. (Nelson, 2009)

Central Australian media is peppered with examples of blame and accusations of failure and irresponsible behaviour. Unfortunately, health professionals rarely consider that the reasons for the lower health statuses of Indigenous people may lie with themselves and the systems in which they operate (Eckermann, et al., 2006). It is rarely acknowledged that perhaps it is the health professionals who have failed in their duty of care to inform, educate and work with Indigenous clients, or even that self-assistance is not possible for everyone in need of health care. Health professionals in turn may argue that they have been failed by the systems in which they operate and the findings of this study would support this view.

Analysis of the data from a cultural safety perspective suggests that the manner in which Indigenous clients are constructed in Central Australian health care, continues a colonising process that was assumed to be a thing of the past. Within this region, the experience and outcomes of colonial contact can still be seen in the manner people are categorised, which is another strategy of colonisation. Indigenous people are further dispersed and divided by labels of 'traditional', 'contemporary', 'urban' or 'westernised' (Bain, 2005). The historical categorisations applied to Indigenous people through various government policies remain in

usage by both Indigenous and non-Indigenous people. Terms such as ‘*half-caste, yella fella*’⁸⁶ and even more disparaging terms are still used, but with more caution in the era labelled as political correctness⁸⁷ – itself an interesting slant on what might otherwise be called displaying some sensitivity. Furthermore these terms are used by Indigenous people themselves, in an example of what might be considered evidence of successful division and conquest.

In Central Australian health care services, labelling was identified by participants as contributing to the construction of Indigenous people as deficient in most cases. Negative constructions and labelling, influence the barriers and tensions that affect intercultural communications and therefore health care. Smylie (2001, p2) offers the example from Canadian contexts of a triage nurse who identifies someone as Aboriginal and drunk due to their slow manner of speech and lengthy pauses before answering:

‘The nurse had made a prejudiced assumption about the client’s speech pattern, based on a shortage of accurate information about language patterns and a stereotyped association of alcohol abuse with Aboriginal people....’ (Smylie, 2001, p4)

This example could just as easily have come from Central Australia, where I have observed and discussed numerous incidences of stereotyping and colonising responses to Indigenous people.

Many communities west of the Stuart Highway that physically divides the Northern Territory were the major locations for missions and reserves. The first of these, was the Lutheran Mission of Hermannsburg, (Ntaria) established in 1877. This earlier contact with non-Indigenous people has resulted in the residents of Hermannsburg being described as ‘more westernised’, because of their level of English and adoption of European cultural influences to a degree. Country music, football, problems related to alcohol misuse, and less overt adherence to ceremonial activity, shape experiences in communities closer to the town of Alice Springs.

86. Half-caste – a label applied to children of mixed Anglo and Aboriginal heritage. Percentages of ‘blood’ were used to identify and categorise people (see 10.2) Yella fella is an Aboriginal English term meaning a person of mixed heritage (see 10.4)

87. Political correctness is defined as using words and behaviour that will not offend

Some label the further remote western, eastern and southern desert communities as ‘more traditional’ (Bain, 2005). These people are often given more credibility by non-Indigenous people for their so-called genuine Aboriginality, dividing people through colonially derived constructs of identity (Dodson, 2009). Within the data of this intercultural communication study, Indigenous people applied derogatory labels to themselves and others at times. Napparrula described herself as ‘*myall*⁸⁸, *grown up in the bush*’, which can be a disparaging term for ‘primitive or unsophisticated’.

More colonising strategies are found in the descriptors that further divide Indigenous people as those who perplexingly ‘*lost their culture, lost their language, or lost their identity...*’ and those who ‘*maintained their culture, language and identity*’. From a non-Indigenous perspective, Indigenous cultures are often constructed as fixed; another deficit of the supposedly less sophisticated and less evolved so-called primitive cultures. Acknowledgment of the highly adaptive and resilient cultures that have developed and changed in the face of overwhelming colonising forces, to remain staunchly Indigenous in all their inherent diversities, is rare, although it is gaining some foothold in the literature examining capacity building and social capital (Baum, 2004).

Descriptors such as *lost*, *maintained*, etc are potentially divisive and misleading. One author who presents a differing view of the response from Indigenous people to colonisation is found in the work of Ralph Folds. In his analysis of the Pintupi people of the Western Desert, Folds (2003, p.3) suggests that many societies globally are ‘*taking what they need from the west, rather than allowing themselves to be ‘westernised*’. The resilient and adaptive cultures of Indigenous people in Central Australia appear to be doing exactly this, much to the chagrin of non-Indigenous policy makers who still aspire to the goal of assimilation, only now it is called ‘New Assimilation’ (Howard, 2006). Whatever label is used, the underlying message is that one culture is superior and minority cultures must aspire to the superior culture or be doomed.

88. Myall –sometimes derogatory term for wild, unsophisticated people

Minister Brough's (2007) suggestion that Aboriginal people '*should follow the example of Greek and Italian migrants and become bilingual*' shows an alarming lack of recognition of the multilingualism of many Indigenous Australians' according to (Karvelas & Megalogenis, 2007). Not only that, but also any comparison to those who arrived as immigrants either by choice or necessity, to the position of someone indigenous to the country fails to recognise a fundamental difference. Anyone should have the right and reasonable expectation to maintain their own language in their own country. For those choosing another country as their home, it is understandably a different situation. So what is the underlying message about how Australia regards its First Peoples?

Minister Brough (2007) believed that force might be a suitable means to achieving English language proficiency among Indigenous Language speakers: '*We should be forcing, imposing, requiring- whatever term you want to use- school attendance and the basic grasp of English, mathematics, and the spoken English*'. Mr Brough said he had no figures to back up his claim of a lack of proficiency but made his conclusions after speaking to grandparents in Indigenous communities who lamented the fact that they had better English language skills than their grandchildren. This is very likely correct, but also is an example of people who were fluent in their own languages first, enabling the acquisition of English as another language.

Central Australia is a linguistically rich and diverse region as indicated in previous descriptions of the research context. During the period of past Prime Minister Howard's leadership (1997-2007+), there had been a dominant voice calling for all Australians to become proficient in English, if they wished to call Australia home (Howard, 2006). While arguments continue about the need for English language proficiency for *all* Australians, the reality is that in 2010 there remain entire populations of Indigenous Australians for whom English is not their first language. These are not people who wish to call Australia home, but people who by circumstances of history have found their own languages 'foreign' in their own country.

The provision of services and resources to help linguistically diverse people access Australian health care in relative safety suggests recognition of the right to retain one's first language. However, this is mainly extended to recent and temporary arrivals to Australia, with interpreter services available in a range of foreign languages. For Australian Indigenous language speakers however, there are notable differences in expectations and responses to their needs. An historical under-emphasis on language needs of these specific populations is evident in the demise of bilingual schooling in Indigenous communities and the relatively late development of Indigenous interpreter services nationally (Crossin, 1999; Rigney, 2004; Trudgen, 2001; Wilkins, 2008).

English Language dominance is rarely given attention in the context of health care for Indigenous Australians, with the prevailing view that all *should* and *must* speak English in the contemporary world (Karvelas & Megalogenis, 2007; Nine Yuendumu Residents, 2009). Instead, there is considerable emphasis on developing cultural awareness, sensitivity and competency among the non-Indigenous health professionals. Awareness and sensitivity are initial steps toward cultural safety, but are often the point at which many employer-run programs cease, falling short of the requirements to examine the structural and systemic issues that influence health service delivery to minority groups.

Competency is a development that at first sounds appealing. To be competent in one's communications with linguistic minorities must be a valuable skill, but my concern is that competence may not necessarily equate to safety. In my experience in remote communities, some highly skilled and fluent non-Indigenous speakers of Indigenous languages might be deemed culturally and linguistically competent, but would fail an assessment of safety on some levels. To competently speak an Indigenous language as a non-Indigenous resident of a remote Aboriginal community, can bring with it potentially exploitable power, if the accompanying elements of cultural safety are not present. Furthermore, Pon (2010) suggests that the trend toward cultural competency may in fact be taking us further away from cultural safety and swinging back toward transcultural notions of cultures.

It is not always possible or even often practical to expect non-Indigenous health professionals in the Central Australian workforce to speak an Indigenous language. It is my contention however, reinforced by Irvine et al (2006) that a greater *awareness* of the role of language in health care encounters generally and language *sensitivity* specifically, will assist health personnel to work with any linguistically diverse clients and will set them on the path to cultural safety as a result. A greater awareness and conscious acknowledgement of English's privileged status may facilitate greater awareness and conscious acknowledgement of the need to accept and respect the rights of Indigenous Language speakers in health care.

Whether one goes along with views of Brough (2007) that Aboriginal people should be 'forced' to speak English, or whether one believes in the fundamental right of people to speak their first language with appropriate support for communicating with English speakers, Aboriginal languages remain living, but vulnerable, throughout Central Australia. Health care systems and institutions that fail to accept the current reality of Indigenous language clients, participate in an ongoing colonisation of Indigenous people. Health outcomes remain poorer, costing the country financially and socially. I am not suggesting that health professionals necessarily learn an Indigenous language, but that they learn about the role of communication, and in particular language use in the provision and acceptance of health care services. Then any access to a range of complementary strategies will likely have a greater chance of success.

If, as Whorf (1956) maintained, language does indeed shape the way we think and what we can think about, then the consequences of privileging one language over another must impact on the voices and experiences of those less privileged. Knowledge of language structures, for example, can lead people to a great understanding of cultural influences. In orientation for nurses at Alice Springs Hospital, I have discussed communication issues concerning Aboriginal clients (Taylor, 2007 unpublished). One piece of information that can affect attitudes of new comers is the fact that the words '*please*' and '*thankyou*' do not exist in any of the Central Australian languages. This is because in Aboriginal kinship structures, obligations are implicit and there is no need for such words. However, there are polite ways to make

requests. Without this information, it is easy for English first language speakers to misinterpret a language issue for a lack of manners, and equally for Indigenous people to perceive rudeness on the part of the health professionals.

A second example is the place of silence in Aboriginal languages. Again, if it is known that many Aboriginal clients will deliberately pause after a question is asked, this does not have to be interpreted as a lack of interest or comprehension. It can be argued that both are cultural elements bound up in the complex kinship systems and protocols of communication. However, these small pieces of information can serve to improve the interaction immediately, as evidenced by the evaluations of these orientation sessions over a number of years (Bowyer, 2009; personal communication). The majority of health professionals in the Central Australian region do not stay long enough to develop their understanding of the complex cultural issues at play, but they can be equipped with some tools to enhance the experience for both client and professional that may be of use in intercultural communications elsewhere.

Finally, when attempting to speak about issues such as de-colonising practice there is the hurdle of Australia's unfinished business in response to our colonising past. Whilst the literature refers to *post*-colonial frameworks, others contest that colonisation has even ended (Sykes in Smith 2003). Even in the home of cultural safety, Ramsden (2002) identified major barriers to teaching Maori and non-Maori about the need to de-colonise. With regard to health care in Central Australian settings, it is obvious that *'they'* (the non-Indigenous Australians) have not left the country and predictably never will. Few if any, non-Indigenous health professionals, myself included, would consider themselves colonisers today. However, as instruments or agents of colonial structures, unexamined and unchallenged policies, processes and discourses, health professionals can indeed contribute to ongoing colonisation of Indigenous people who are reluctant to question, complain or demand their full and equitable rights to culturally safe health care. The strategies employed by Indigenous people to demonstrate their evaluation of health services is often assumed to be responsible for the high levels of clients 'taking their own leave' from the health service, or not complying with

suggested treatments. Such actions lead to a cycle of frustrations and ineffective care that underpinned by ineffective intercultural communications (Cramer, 2005, p ix). Cramer suggests that the focus on Aboriginal health status rather than the health services themselves *'has in effect deflected attention from questions most pertinent...'*

My experience in the region is that many Central Australian Indigenous people do not actually want non-Indigenous Australians to 'leave'. The problems facing remote populations today are too great to be tackled alone and having had a role in their creation, it seems only right that non-Indigenous people have role in their solution where possible. As Bob Randall expresses in 'Kanyini' – a DVD about Indigenous worldviews, *'this is all our country now...you and me together'*...but unless we can affect genuine dialogue, any shared goals will be thwarted (Randall and Hogan, 2006).

8.4 Critical Reflection: *'It's not good, is it?'*

Critical reflection is an essential component of cultural safety (Ramsden, 2002). It is also a professional competency for nurses and other health professionals in Australia (Royal College of Nursing Australia (RCNA), 2009; Northern Territory Health Professionals Board, 2010). It is contingent upon health professionals to reflect on their own practice and to ensure safe and effective health care is provided to the optimal standard possible, irrespective of context. This study of intercultural communications in Central Australian health care settings however, revealed a reluctance on the part of health professionals to examine their practice too deeply for fear of *'opening a can of worms'* as one respondent expressed it (Sally, RN, RM).

It is mandatory for health professionals, as part of their competency standards to reflect critically on not only their individual practice, but the policies and procedures that they are employed to implement. Being self-critical is not always an easy or comfortable reflection for many, as suggested in some of the health participants responses, such as Sally who said, *'yeh, its not good is it,'* and Winny, who admitted, *'it distresses me.'* Cramer, (2005, p.222) put it more imperatively by suggesting:

Where privileged health professionals ...tolerate a dual system of health care and double standards as normal for a deprived group they participate in discriminatory institutional practices. For the lives of many Aboriginal people, who as a group are already demonstrably underprivileged in every sphere, this disparity may well contribute to the most lasting deleterious consequences for their health....

What might be behind this reluctance is possibly a different but equally paralysing sense of powerlessness felt by health professionals. For many, the problems of communicating were too pervasive and confidence, practice and power were diminished by a situation for which many found themselves unprepared.

In another example of 'othering', it appears that the easier course of action for some people is to divert attention away from themselves and onto the 'other' as the source of the deficit. Locating the deficit with another is also a way of avoiding critical reflection. For example, the title of many intercultural communication articles again locates the responsibility for any perceived barriers with the Indigenous Language speakers. Walsh (1997, p.1) examines '*Cross-cultural communication problems in Aboriginal Australia*' (my emphasis added). It might be reframed to suggest that the problem does not really occur within Aboriginal Australia itself, but when Aboriginal Australians are required to communicate beyond their own communities and households. So does this make them deficient in communication within their own country? According to an article in an Adelaide newspaper in 2007:

A "TRAGIC sequence of miscommunication" led to the death of a near-blind Aboriginal elder, left alone, disoriented, with only a little water at a Northern Territory airstrip, a coronial inquest heard. The 78-year-old elder had no escort and there was no one to meet him when he arrived. (The (Adelaide) Advertiser November 15th 2007)

The failure of a health care system to exercise its duty of care that cost the life of an elderly Indigenous man hardly raised a ripple of concern in the wider community. The poignancy of a barely noticeable square of print given to this man's preventable death reflects perhaps a systemic indifference to the needs and rights of Indigenous Australians. No less acceptable in any situation, is the fact that this person was the victim of '*a tragic sequence of miscommunication*', not in a foreign country, but in his own, which highlights the lack of

adequate support and attention to the needs of Indigenous Language speakers that arises from the wider social responses to Indigenous people generally. It also serves to highlight the lack of appropriate preparation for health professionals and others involved in this tragedy. Miscommunication is not an issue that health professionals can afford to 'accept' as an inherent part of intercultural or any other practice setting. The literature reveals that being a member of a linguistic minority leaves clients vulnerable and greater attention to the needs of these populations is required (Skutnab-Kangas & Phillipson, 1995; Trudgen, 2001)

In the intercultural communication study undertaken in Central Australia, informants and other data collected, suggested there was frequent potential for, and actual incidences of equally tragic occurrences. Usually the consequences are borne by the Indigenous language speakers, but not exclusively. In relation to this thesis, both health professionals and recipients of care were asked about what they saw as the consequences of trying to communicate health care issues between English and Indigenous Language speakers. The responses had much in common. Both groups found the experience '*difficult ...frustrating...really hard...*' with the potential to have some frightening outcomes.

While other disciplines such as the legal profession have had to examine their responses to Indigenous language speakers (Johnston, 1991) the health professions have been somewhat slower to respond. An Indigenous respondent, who often helped their people with interpreting in the court system, believed that health also required similar attention (see Ngangale's comments 7.). Cramer (2005, p xii) believes that '*...practice standards in remote areas would be unacceptable in the wider community and are tacitly approved and allowed to happen in isolation by processes and omissions that are hidden from view...*' and further asks '*could a critical analysis of the whole situation make inaction indefensible?*' (Cramer 2005, p.3).

This reluctance to examine issues too deeply may point to a broader reluctance on the part of some health services to critically analyse the standards and supports provided to their workforces and clients.

8.5 Power, privilege and whiteness

The literature on 'whiteness' as a concept is increasingly of interest in examining my own and others' positions in the region. I have often found that without seeking such a position, I am inevitably elevated by my 'whiteness' as the person with authority, when in the presence of Indigenous colleagues or friends. For me, the power and privilege of whiteness and Westernisation is something I have long been made aware of in various careers and social settings. I am not an advocate of assimilation, as I believe this inevitably positions my culture above others and is essentially '*...a hidden apartheid*' (Marcus, 2006, p.5)

Power is implied in the symbols of health services, such as security for example. The hospital has a visible security presence, with security officers standing by entrances to hospital lifts for lengthy periods. There is nothing wrong with offering protection to staff and patients and my concern is not with security as such. However, the way security is utilised, targeted and importantly in the context of this study, communicated, is a problem. Identified through personal experience and observation, some security officers, whether consciously or unconsciously, extend certain privileges to non-Indigenous people that are not always extended to Indigenous people.

Most hospital wards have visiting hours that are strictly applied, or so it seems. Frequently, security guards will stop Aboriginal people seeking to visit family members before the official visiting hours. It has also been observed that at times, non-Indigenous visitors are able to discuss and explain their requirements to visit out of hours and are allowed through whilst Indigenous people are turned away without the opportunity of further discussion. The arguments for preventing family members from visiting at certain times are themselves worthy of analysis. Many staff are very welcoming and supportive of all and certainly can lay claim to the values of the hospital's mission statement. However, the justification for many of the policies applied when critically examined, may be considered examples of, if not racism, then systemic bias, power, privilege and possible whiteness.

8.6 Examining own culture and its impact on others: Cultural and linguistic awareness

Examining one's own culture is a key tenet of cultural safety and yet it is missing from Australian competency standards. Tanner, (2005, p.79) points out this critical omission in the Australian Nursing & Midwifery Council's (ANMC) Code, adding that it fails to recognise the importance of the health professional's own culture and the impact this may have on others. The majority of nurses and other health professionals in Central Australia are non-Indigenous. This ratio is reversed in the representation of Indigenous people requiring health care in the region (Department of Health and Community Services, 2009).

Ramsden's (2002) model of a culturally safe health practitioner is one who has undertaken a process of self-reflection and who knows about their own culture in order to be able to evaluate its impact on other cultures. For decades, health professionals in Australia and Central Australia in particular have been asked to undertake cultural awareness education. The Northern Territory Department of Health & Community Services has offered a cultural awareness program for employees for which I have been a co-facilitator since 1997. Cultural awareness and multiculturalism however, had always been uni-directional and largely remains Anglo Australians learning about other cultures and accepting the right to maintain culture. With little effort to explain or teach Anglo-Australian culture and even less attention to Indigenous Australian cultures, this uni-directionality became more divisive in my experience.

The assumption made by some participants that Indigenous and other cultural groups have gained an understanding of the dominant culture in Australia somehow by 'osmosis' or just being exposed to it, is also highly problematic. Naparrula's obvious lack of understanding of the way in which hospitals and medical staff function (see 7.7) is a clear example of how someone may be surrounded by a culture and yet not fully understand or be able to interpret it. A two-way cultural awareness program is not about assimilation. It is about information, and information is power. Cultural safety in health and education holds enormous potential for me, as it is the only development that does not continue to view the cultural minority as a problem

to be solved. Instead, it seeks to examine the impact of the dominant culture on that minority. In the absence of significant change to date, this single difference may be the critical one that has real potential to succeed where other approaches have failed. It must however, be embraced fully and not continue the half hearted 'tick-the-box' approaches of so many other developments.

8.7 Indigenous personnel in health care services

A common response in previous research and reports is to identify Indigenous staff as key facilitators of communication with Indigenous language speakers. In the Northern Territory, the employment of Indigenous staff across all levels of health service delivery has been a stated goal for decades, based on the premise of ensuring culturally appropriate care and communications that are more effective (Royal College of Nursing Australia). Most employment of Indigenous staff however, has often been at the lower levels of care assistants, patient service assistants, laundry, maintenance and cleaning staff. With the exception of the role of registered Aboriginal Health Workers, the proximity of Indigenous staff to client care has been historically distant.

In the Northern Territory, the registered Aboriginal Health Worker role is unique. AHWs are key professionals involved in primary health care, most often for services delivered in remote communities, with limited on-site medical support or personnel (K. A. Taylor, 1997). During 1995-6 I coordinated a pilot project to develop the role of the registered AHW in the hospital setting. In the Northern Territory, AHWs are registered with a professional board in the same way as medical officers and nurses. Unfortunately, AHWs, ALO's and Interpreters remain relatively few in number. They are generally not accessible at all hours, leaving large periods of time when non-Aboriginal staff must attempt intercultural communication without such supports. Interpreters, ALOs and AHWs are often viewed as the definitive solution to effective communication with Aboriginal clients. I would agree that they certainly have this potential,

but their roles are not without limitations. AHWs have played a pivotal role for decades, but they also suffer from a lack of role clarity, regulation and recognition.

AHWs are employed by primary health care services as a strategy to ensure that health services are not only accessible, but also culturally appropriate and acceptable to Aboriginal Australians. Nevertheless there is much controversy about what healthworkers can and should be doing. (Genat, 2006, p.xi)

These employees themselves are often the first to recognise the limitations their unique role as members of the Aboriginal communities can place on them. For many Aboriginal staff, cultural obligations may prevent their involvement with specific individuals based on gender, kinship or other factors. So much is expected of Aboriginal employees that they are often placed in culturally unsafe situations themselves, which may be implicated in the high turnover rates (Genat, 2006). Even the nature of the communication in health settings, may be highly problematic for many Aboriginal staff.

One young male ALO for example, cited the difficult position he was placed in when having to explain certain invasive procedures to an older initiated man, when he himself was still an uninitiated person. For the ALO, still considered a boy rather than a man, it was unacceptable for him to discuss the issue with the older male client. AHWs were originally chosen by their communities and as such were often selected because of their status and acceptance by all. Today, with the introduction of tertiary training institutes, anyone can apply to become an AHW based on their aptitude for educational study. Again, there is no suggestion that these AHWs have any less skill but the practical application comes into question. A young 18-year AHW trainee may not be able to communicate undesirable prognoses for example, or discuss sexual disease transmission. Furthermore, Indigenous Language clients have refused involvement of AHWs, Liaison and interpreters because of pride, or shame or embarrassment. Convinced that their language proficiency is good enough, and in line with English speaking non-Indigenous staff who are also convinced that their communication is 'good enough' to 'get by', there is under-utilisation of these roles, which requires greater scrutiny.

In a study of Indigenous patients who discharged themselves against medical advice, referred to in Alice Springs Hospital as Take Own Leave (TOL) 87% had previous admission, 73% had no understanding of their illness and 81% were unable to estimate how long they would be in hospital (Van Ersel 2009). Furthermore, 31% had expressed the urge to TOL, 33% did TOL, and 50% had TOL in last ten years (Van Ersel 2009). The costs of these statistics in terms of readmissions and more complex health problems that often result provide ample justification for greater involvement of AHWs, ALOs and Indigenous Interpreters. These roles are undeniably necessary and crucial to the provision of effective care. However, enhanced cross-cultural communication skills seem equally crucial and necessary, and not simply for one group in the relationship. Thus, while considerable emphasis has gone into developing English literacy and numeracy skills for Aboriginal staff, little has gone into preparing health staff for working effectively with these groups.

This Intercultural Health Care Communication study conducted in Central Australia identified a number of perceived barriers and actual disincentives for calling on AHWs, ALOs or interpreters, which require examination of the underlying issues. As identified by an undergraduate nurse I had supervised during a placement in the region:

I have heard a lot of health professionals comment that IPs [Indigenous People] should take responsibility for their health, and should not be readmitted to hospital for recurrent health problems that are caused by their 'ignorance'. I have not once seen an ALO brought in to explain a treatment to a patient in the four weeks I have been on the medical ward... (Taylor & Guerin, 2010 p.183)

Throughout history people of differing linguistic backgrounds have found the most practical and effective way to communicate to be through an interpreter, someone who is proficient in the language of each participant. Whilst this seems an obvious solution to the challenges of communicating there are numerous considerations relevant to interpreting between groups who hold profoundly different worldviews. As identified in the literature review (see Chapter 3), research in Australia and elsewhere has clearly identified the need for interpreting services (Buttow, 2010; Cass, et al., 2002; McGrath, 2006). Responses to Indigenous language speakers

have been very different to the services developed for Australia's growing migrant populations since the 1950s.

However, it is not only an issue for health staff. The Indigenous participants and wider community as well as health staff may need education about the need for and role of accredited interpreters. Participants of this study often preferred to communicate in English for a number of reasons, even though it was apparent at times that we were also experiencing frequent communication difficulties that could have been avoided through engagement with a qualified interpreter. Buttow (2010) identified similar barriers in relation to linguistic minority populations in health services nationally and internationally. Issues of pride or shame, an unrealistic assessment of one's own language proficiency, concerns about confidentiality, time and costs, amongst other considerations, are all implicated in the under-utilisation of Indigenous Interpreters.

8.8 Summary

Culturally safe communication requires a willingness and ability to engage in dialogue, for consumers to define the safety of services and interactions, for providers to decolonise practices, and for critical reflection to take place on one's own culture and its potential to affect others. Power is a key consideration that requires scrutiny in a post-colonial environment if the goal is to challenge the status quo. Indigenous health personnel have a role to play, in facilitating culturally safe care, but their non-Indigenous colleagues need to learn how to work effectively in partnership with Indigenous personnel. Whilst some of the positive elements exist in the data to varying degrees, this Intercultural Health Care Communication study suggests that Central Australian health services are a long way from culturally safe communications with Indigenous Language speakers.

A re-orienting of thinking has been a theme throughout this thesis. Lessard believes that intercultural communication '*... can be seen as a solution to providing quality health care as opposed to a problem*' (Smylie 2001, p. 2) However, the so-called *problem* of communicating

with Indigenous Language Speakers in Central Australian health care settings might be constructed equally and more beneficially, as an **opportunity** to improve health outcomes and service delivery. This study has added to the body of intercultural communication knowledge by revealing a concurrent impact on health staff who are ill-prepared for the experience of communicating with Indigenous health consumers. It has been shown that communication issues between English-speaking health professionals and Indigenous First Language clients are substantial and largely unexamined.

The final chapter will re-state the thesis that Intercultural Communications in Central Australian health services place clients and staff at risk of culturally unsafe care, through a lack of adequate preparation and resourcing for intercultural communication. Indigenous people are often labelled as poor historians, non-compliant, unable to understand, in need of more education or 'better' behaviour, and made personally responsible for own poor health outcomes. Furthermore, based on the findings of this intercultural communication study it is my contention that much of the problem lies in continued colonising attitudes, beliefs and practices at individual, organisation and system levels.

Chapter 9

Conclusions: Culturally Safe Intercultural Communication

9.1 Introduction

Our people are dying... because they don't understand what doctors and nurses are saying to them' (Jakamarra, 2007)

In the final chapter of this thesis, I begin by reflecting again upon the words with which it began and the experiences that provoked my exploration of intercultural health care communications in Central Australian health care settings. *Our people* for the speaker may have referred specifically to Indigenous people. However it was the same speaker who reminded me that *anangu* is not a word that distinguishes between Indigenous and non-Indigenous. *Anangu* simply means people. In that sense, it is *'our'* people who are dying, simply because Indigenous and non-Indigenous Australians, have not yet learned to communicate effectively with each other. Jakamarra's words highlighted the serious consequences of flawed intercultural communication for Indigenous people. The same quote considered now in the context of this study's findings, suggests an even greater imperative for paying attention to the needs of Indigenous language speakers within Central Australian health care settings and possibly beyond.

This Intercultural Health Care Communication (IHCC) study showed that the consequences of unsafe and/or inadequate intercultural communication affect all people either directly or indirectly, with health professionals also bearing the burden of this reality. The health of Indigenous Australians continues to be the worst of any in Australia today, and globally they are the poorest of any indigenous populations with a similar colonising history (I. Anderson et al., 2006; Australian Government Department of Families Housing Community Services and Indigenous Affairs, 2008; K. Taylor & Guerin, 2010). This statistic has been stated and

restated in reports and media until some sectors of the community have begun to accept the reality of this appalling position as the norm.

The powerlessness felt by Indigenous people within health care services, is matched by the perceived powerlessness felt by many health professionals who have expressed the belief that the ‘problem’ is too big. It is part of the historical, social, economic and political contexts which reinforce the position of dominant culture groups at the expense of minority groups who are most often blamed for their position and their desire to maintain their own cultures and identities. I say ‘perceived’ powerlessness because it is my belief that health professionals are in fact in positions of relative power and therefore able to make practice and policy changes, on both individual and system levels. In fact, I would argue that there is a professional and ethical imperative to do so when current practices may be undermining efforts to obtain optimal health for some sectors of the Australian community.

This chapter reviews the aims and research questions that were the focus of this Intercultural Health Care Communication study set in Central Australia. It considers whether the study achieved its aims of critically analysing health care communications between Indigenous First Language clients and English-speaking health professionals and outlines how it answered the research questions. In particular, it identifies barriers and/or facilitators that could ultimately improve health service delivery, practice and outcomes. This chapter also highlights the most important outcomes, reveals what has been added to the body of knowledge around intercultural communications and discusses the significance of the study overall as well as describing the study’s limitations and strengths.

The final section of this chapter presents a model of culturally safe intercultural communication for use within Central Australian health care services. The thesis concludes with recommendations for practice, education and further research that have the potential to embed culturally safe communication skills, knowledge and practice within the policies,

systems and individual mindsets of health professionals wherever they encounter Indigenous Language speaking clients in Australia.

9.1.1 Review of aims and research questions

This intercultural Health Care Communication study aimed to critically analyse the experiences of Indigenous Language and English Language participants in health care communications in Central Australia (see 1.10). The overall aim was to analyse the intercultural communication contexts of health care communications to identify barriers and/or facilitators to culturally safe communications with Indigenous First Language clients. An additional purpose was to challenge the status quo in relation to how intercultural communications occur and to develop knowledge that may improve health outcomes and facilitate culturally safe health care. Based on my personal experiences and observation I began with a notion that there were considerable dangers for all participants in the Central Australian intercultural context.

The specific research questions asked about: the experiences of both health professionals and Indigenous language clients, including what video, audio, written and/or observed communications revealed about intercultural communications; what experiences revealed about barriers and facilitators; and what preparation of health personnel and attitudes influenced Indigenous communications. Finally, the research sought to answer the question of what might be done to improve intercultural communications in Central Australian health care settings to make them culturally safe for all (see 1.11).

9.1.2 Overview of Study Conclusions

The main conclusion of this Intercultural Health Care Communication study is that health care services in Central Australia place clients and staff at risk of culturally unsafe care, through lack of adequate preparation and resourcing for intercultural communication. This lack of attention to intercultural communication contributes to the many and major communication failures. Whilst widely acknowledged by health care professionals in the region, it is an

under/unrecognised problem/issue that is either overlooked or superficially considered in policy and reports. The result is that Indigenous people are problematised, or labelled as poor historians, non-compliant, unable to understand, in need of more education and 'better' behaviour, and made personally responsible for their own poor health outcomes. Furthermore, the findings from this study indicate that much of the problem lies in persistent colonising attitudes, beliefs and practices at individual, organisational and system levels. For such attitudes, beliefs and practices to go unexamined leads to a tacit acceptance of a lesser standard of care for Indigenous clients that impact on both clients and staff.

In order to change the status quo, the onus for change needs to come from those in positions of power, even if that power is not overtly recognised at an individual level. Greater acknowledgement and attention to the issue of intercultural communication in health care services is required, both on the part of health professionals as individuals, and by health services as organisations. The effect of such changes could enhance the quality of intercultural communications in Central Australian health care and has the potential to improve health outcomes for Indigenous people generally. The findings of this study also suggest that a better-prepared and supported workforce may contribute to improved staff recruitment, retention and job satisfaction. An unexpected and significant finding of this study is that the impact of placing health professionals in intercultural communication contexts for which they are ill prepared and largely unaware of the challenges, can take a heavy toll on practitioners. This aspect has been largely unexamined in the Central Australian context prior to this Intercultural Health Care Communication study and may have implications beyond than the research setting.

Apart from the overriding principles of social justice, which demand equitable, safe and effective health care for all, greater attention to the language needs of Indigenous clients is likely to result in better intercultural communications. In turn, there may be economic and personal savings that flow from changing the status quo. The potentially transferable skills and knowledge gained from any intercultural context, including increased awareness of

communication issues generally, adds to the argument for greater attention to the preparation and experiences of health service delivery in intercultural contexts, such as Central Australia.

9.2 Study Limitations

As with most research, there are limitations to the conclusions and wider applicability of this Intercultural Health Care Communication study. To begin, this study was set in a specific geographical region that has been shown to exert particular influences over the delivery and uptake of health services (see Chapter 2). The location means that data relates to specific Indigenous language groups, which may or may not be applicable to other Indigenous language areas (see Figure 3 in 2.7.1). Neither may language issues relevant to these particular groups apply to other non-English speaking peoples. Australian Indigenous peoples have protocols around communication and information exchange that are specific and may not be of wider relevance to other groups, although some commonalities have been identified across Australia (Eades, 2009).

The participants selected for this study were mostly already known to me and therefore formed a convenience sample. However, I simply recruited participants until I reached the minimum proposed number of participants, rather than selecting specific individuals. The majority of health professionals interviewed were women (90%), which was consistent with the ratio of males to females within the Northern Territory Nursing workforce. The same situation occurred with the Indigenous participants. No commentary on gender was attempted in this study, given the gender imbalance in the participant groups. In future, however, it may be useful to consider the role of gender in relation to intercultural communications.

I remain confident that the health professionals represented a range of experience levels from various practice settings. However, it must also be acknowledged that all these participants were *already willing* to reflect on their own roles in the intercultural communication setting and to subject themselves to my critical analysis of their communications with Indigenous

clients. Some participants saw their involvement as an opportunity for reflection that they had not previously engaged in. There was no deliberate intent to identify poor examples of communications. This might suggest the magnitude of the problem to be even greater in relation to staff who were unaware of, or unconcerned about, communications with Indigenous language speakers.

As with other research, any relationship between researcher and participants may potentially lead to bias in the responses. Bias in qualitative research is accepted, acknowledged and as in this Intercultural Health Care Communication study, taken in account. Wilson (1996) in Irvine et al (2006, p432) suggested that such influences may lead to situations where '*...the respondent would give a reply that they anticipate will be favoured by the interviewer...*'. This was a possibility and did occur at times during the data collection process. However, my personal acquaintance with most of the participants allowed me to confirm or clarify responses. Watson (2006) found a similar dilemma in conducting research in an environment where he had personal relationships with participants. For me, both the Indigenous and non-Indigenous participants at times may have provided responses that they anticipated would be '*favoured by the interviewer*' and consequently avoided responses that may have reflected unfavourably upon them.

The main way such bias was managed was to assure participants that I wanted their frank and honest responses with no fear of judgement, with assurances of confidentiality, and that I did not anticipate particular responses. I was openly seeking their subjective experiences. Having the benefit of observing and knowing some of the participants, allowed me to clarify responses, by offering examples from my experience of their practice. For example, when in response to clients who discard their medications, Cathy, suggested she was 'too old to let it bother me' and that she would just move on to the next client. I was able to delve deeper with Cathy, reminding her of examples where she had gone to considerable effort to revisit medication issues with Indigenous clients, with great patience and persistence.

Indigenous participants' interviews were also analysed for possible examples of *gratuitous concurrence* – the tendency to agree in order to maintain a harmonious relationship cited by other researchers (Watson, 2006; Webber, 1978). I also sought to draw out from participants any comments that alluded to certain standpoints. I used personal knowledge and observations of health professionals' practice over time to clarify responses that seemed incongruous with my interviews with the respondents. For those that were unknown to me prior to the interviews or unobserved in practice, I followed up with any clarifications required after transcribing their interviews. For English language speakers, this might be considered as leading the participant to respond in a particular manner. However, returning transcribed interviews and asking for clarification is a well established technique in qualitative research.

For Indigenous language speakers however, I have found that 'distancing' allowed the respondents to speak more freely. Using this technique, I made statements that were seemingly unrelated to specific individuals, to avoid any perception of blame or criticism. For example, *'Some Aboriginal people are worried about being in hospital'*. Participants would often provide a response that either agreed or revealed that this statement did not apply to them, if not immediately, then at some point further in the conversation. For example, *'Yuwa, some people get frightened. I don't get frightened, because I know those doctors and nurses...'* This strategy has been confirmed in other research as an appropriate one that facilitates rather than leads Indigenous communicators. Finally, I did seek informal feedback from a locally based anthropologist, a linguist, and Indigenous colleagues and friends to ensure the accuracy of my anthropological, linguistic, and cultural assertions, even though this research was not a linguistic or anthropological study.

9.3 What has been added to the body of Intercultural Communication knowledge?

This study highlighted both individual and system barriers to culturally safe health care communications in Central Australia. Health professionals identified intercultural communication in this setting as difficult, time-consuming and challenging. Many felt

unprepared for the present reality of communicating with Indigenous language speakers and identified systemic disincentives for changing current practices. However, it was also identified that to continue the status quo left individuals at risk and practice standards compromised.

Whilst other studies have focused on the consequences of miscommunications for clients and their health outcomes, this study identified a considerable impact on the health professionals as well. Health professionals are vulnerable to the stress and burden of health care practices that are less than acceptable in this or any other context. Intercultural communication with Indigenous Language speakers is a skill for which health professionals require specialist education and on-going training in order to apply safely and effectively. Without such preparation, which must include the development of critical reflection and critical thinking, health professionals are made complicit in the delivery of a differing standard of care for Indigenous clients.

Indigenous Language speaking clients of health services also need to be equipped with skills to assert their linguistic and other rights to an equivalent standard of care. This study has shown a fear and reluctance on the part of Indigenous language speaking clients to challenge the status quo, which leaves them vulnerable to poor health and treatment outcomes. In fact, this study's participants have suggested the consequences may be potentially fatal for Indigenous clients.

Health care services have been identified in this study as responding inadequately to the needs of Indigenous Language speakers, and as deficient in preparing and supporting their employees appropriately to provide culturally safe care and communications. Untested assumptions about Indigenous people and their languages influence the manner in which health services tend to communicate with Indigenous clients. Beliefs passed on by health professionals to one another that Indigenous languages are simple, therefore communications need to be simple, may be implicated in failed health care outcomes and uptake of services through a lack of adequate information exchange.

9.3.1 Significance of this Intercultural Health Care Communication Study

A dualism in content, structure, worldviews, language and metaphors underpins this Intercultural Health Care Communication Study. It is concerned with a ‘gap’ – a concept that is in itself a dichotomous one. A gap can be a void, a negative, something missing – like the communication gap between Indigenous First Language speakers and English speakers, and the gap between Indigenous and non-Indigenous life expectancies. There is a tendency with gaps to want to ‘close’ them, from my cultural perspective at least. However, a gap can also be a positive, a way through, taking the path of least resistance, and the entrance to a new world.

The symbolism of the gap is very relevant to the Central Australian setting. The pragmatically English name for the geographical feature that stands at the entrance to Mbantwe⁸⁹ (Alice Springs) is called *the Gap or Heavitree Gap*. Traditionally, women were not permitted to pass through The Gap’ (Brooks, 1995). When the Olympic Torch relay came to Alice Springs in 2000, traditional Indigenous custodians met the group before they entered the Gap and offered them safe passage.

Similarly, this study is an effort to provide entry to proceed through the intercultural communication ‘gap’ in a culturally safe manner. I offer a way through to new understandings, meeting members of my cultural group on a journey of reflection, decolonisation, and an opportunity to engage in dialogue with Indigenous health service users. While the nation’s attention is finally focused on ‘Closing the Gap’⁹⁰ to Indigenous disadvantage and health disparities, it is timely then to consider a necessary first step in any such process is to close the intercultural communication gap between Indigenous Language speakers and English dominant health professionals.

89. Mbantwe – Arrernte people’s name for the region around the township of Alice Springs

90. Closing the Gap – see also 1.4

9.4 Towards a model of culturally safe intercultural communication

In analysing the findings of this study, a number of key areas for change at individual, organisational or health care system levels were identified. To address change at all levels, a model for intercultural communication based on cultural safety principles and reflective practice is urgently needed (see 9.4.2). The majority of health professionals in this study were cautiously willing to reflect upon their own practice, and genuinely wanted to improve their intercultural communication skills. Their desire and willingness however, would achieve little if such improvements were not embedded into the cultures of workforces and organisations across the region (Irvine, et al., 2006). Furthermore, many participants felt that there were disincentives for critically analysing health communications that might uncover potentially litigious concerns and/or colonising attitudes that would expose the health services to criticism and inertia.

Applying to this study, a post-colonial theoretical framework encompassing cultural safety, it has become evident that the experience of intercultural communications in Central Australia is problematic for all participants. When critiqued against the principles of cultural safety by clients, health services and personnel in the region were inadequately prepared in the provision of satisfactory care for Indigenous clients (see Chapter 8). The following sections discuss what is needed and then suggests a model of intercultural communication that could facilitate cultural safety for practitioners and linguistic minorities with whom they interact.

9.4.1 What is needed?

Cultural safety principles propose that the power for change lies with the health care services and personnel rather than with the minority clients. Health services need to recognise the right of all Australians to hold and maintain their first language as a universal human right (Rigney, 2002). Health care for Indigenous language speakers can be facilitated best when this ideal enshrined in policies and protocols. Research has shown that capacity in one's own language enables greater capacity to acquire a second or other language more proficiently (Evans, 2010).

Health services that wish to provide culturally safe care must ensure that language choice, language sensitivity and awareness are prominent within the ethos of the service culture (Irvine, et al., 2006).

Health professionals in this Intercultural Health Care Communication study identified major gaps in their undergraduate education and on-going professional education with regard to intercultural communication. All agreed that having had some preparatory sessions on specific Indigenous communications would have been valuable to reduce unnecessary stress and frustrations. During orientations of students and health professionals, I have been able to share some introductory sessions comparing Indigenous and English communications styles. Although risking the criticism of essentialising Indigenous communications, I see the introduction of difference as useful for engaging participants to at least begin a process of awareness, that will encourage further examination of the contexts of intercultural communications.

For example, health professionals interviewed expressed frustration over the tendency toward agreement known as gratuitous concurrence. A strategy that I have found useful to counter this gratuitous concurrence is what I have come to call 'distancing'. Making statements to Indigenous Language speakers, rather than direct questions, avoids a perception of accusation or blame. For example, suggesting to a mother that 'Some children don't like taking medicine' and allowing time for consideration before asking, 'Does X take their medicine for you?'. I have found this strategy effective in allowing participants to respond without feeling obliged to give an answer they think is desirable, because there is some distance from the direct question, by suggesting this situation may happen to others.

Informed consent was also a major concern to many of the health professional respondents. All eleven participants mentioned the issue during interviews. A remote area nurse, employed in a non-government primary health care clinic, discussed her use of locally developed Indigenous language resources that enabled understanding of the matter for which she was seeking

consent. Plain English scripts were constructed that described procedures such as Human Immuno-deficiency-Virus (HIV) testing. These were then translated into the local Language, and recorded onto audiotape, then played to clients in preparation for further discussions about treatments, procedures and options (Tanya, see Chapter 6).

Some of the hospital staff suggested that some resources in Language would be useful. Specific common phrases and words that could be posted within the hospital wards would assist staff. Such resources do already exist, but the awareness and corporate knowledge about their availability in this study was diminished by the high staff turnover. Franks and Curr (1995) in their intercultural collaboration entitled 'Keeping Company' developed a comprehensive list of common medical phrases and vocabulary in five major Indigenous languages but only some employees are familiar with this resource for the same reason as well as the diminished cultural awareness program available to staff.

Disincentives for accessing interpreters and/or Indigenous liaison and/or health workers must be removed from implied and overt messages given to staff about budgets and time pressures. The false economy of not calling in liaison officers or interpreters is demonstrated in repeated readmissions, instances of clients taking their own leave (TOL) prior to medical advice (Van Erسل, 2009) and poor health outcomes. One of the challenges to ensuring health professionals engage and utilise Aboriginal Liaison Officers and Interpreters, is the lack of role clarity and professional standing for these positions (Van Erسل, 2009).

During the ten years that I facilitated undergraduate nursing placements within Central Australia, students would often comment on how they were usually discouraged from calling on Aboriginal Liaison Officers, Aboriginal Health Workers and/or interpreters. If students are acculturated into their profession with the message that Liaison Officers and interpreters are unnecessary, or their use is not permitted, then novice nurses, without strong reflection and critical thinking abilities, may set the pattern for future practice.

Aboriginal Liaison Officers in the Northern Territory receive no formal training or special preparation. The main criteria for employment are the ability to speak one or more of the Central Australian Indigenous Languages and to possess strong written and verbal communication skills in English. This requirement places many ALOs in the position of liaising between their own cultural group and the dominant cultural group with no specific preparation for the role. Many are asked to explain policies and procedures that are as foreign to them as to the people they are supporting in the health care system.

At the time of writing, none of the liaison officers within the local hospital had been into an operating theatre. Yet it is an expected part of their role to explain what will happen to patients when they undergo an operation. This gap in the education and training of ALOs may be implicated in the reluctance of other health professionals to routinely call upon ALOs, although other factors such as economics and negative attitudes toward the value of ALO positions was also identified in this study. Aboriginal Liaison Officers must be provided with a credentialed preparation that includes medical terminology, and intercultural communication with English-speaking health professionals, if their potential within intercultural health care contexts is to be maximised.

Similarly, greater use and availability of accredited interpreter services in the region should be encouraged and promoted. Participants in this Intercultural Health Care Communication study were unaware of the availability of interpreters within the hospital setting in some instances. Health personnel also need training in the effective and appropriate use of medical interpreters when working with Indigenous Language speakers. Indigenous clients similarly need to be assured of the confidentiality provided by accredited interpreters and health employees. Encouragement to overcome their reluctance to involve such resource personnel, due to influences such as 'shame' or a flawed belief in the adequacy of one's own English proficiency, or a desire to be polite to health professionals, must also be a priority. If promoted appropriately, the message that interpreters are vital to safe and effective intercultural communications will be clear to Indigenous Language speakers.

Much of the knowledge generated and shared amongst health professionals with regard to working in Indigenous Language contexts, is transmitted through a process of acculturation to this unique workforce. It is often untested and unexamined however, as the sources of knowledge are usually other colleagues. Health professionals who aspire to provide culturally safe care to Indigenous clients must be able to engage in dialogue with them. This ability requires health professionals first being aware and sensitive to the needs and nuances of Indigenous language speakers through appropriate preparation for intercultural encounters.

9.4.2 Ways of addressing racism, discrimination and privilege

A major problem with addressing racism, discrimination and privilege lies in the nature of these phenomena. Whilst there are overt examples that are easy to identify, it is the less obvious and subtle forms that are harder to address. For many of the health participants interviewed, whilst able to identify such tendencies in others, there was a seeming lack of awareness of their own capacities for racism, discrimination and/or privilege. The assertion that the problems in communication lay with *'their culture for a start'* (Penny, 2006), were offered as authoritative and well intended explanations.

The delivery of education around racism, discrimination and privilege ranges from extreme experiential approaches such as that found in Jane Elliot's Blue Eyes/Brown Eyes workshops, to less confronting approaches that focus on set descriptions of preferred behaviours. The evidence for which approaches have the most success in changing attitudes and practices is not prominent in the literature and further research and evaluation is required. In the cultural safety experience of New Zealand, racism awareness is an integral part of the education of health professionals, along with learning about discrimination, power and privilege (Ramsden, 2002). Adherence to a cultural safety approach suggests education that allows for reflection and evaluation of practice by the recipients of care is what may have the greatest impact.

9.4.3 A model for culturally safe intercultural communications

It is apparent from this Intercultural Health Care Communication study that a model of culturally safe communications for Central Australian health care contexts is needed. Cultural safety as a philosophy and way of practising, is achieved through a three-stage process. The process begins with cultural awareness, then progresses to cultural sensitivity and finally to the stage of cultural safety (Ramsden, 2002). The principles of cultural safety include the need for reflective practice, decolonisation of practice, an understanding of one's own culture and its impact on others, a capacity to explore and acknowledge inherent power differentials.

In the Central Australian health care setting, the majority of services claim to provide health care underpinned by one of a number of culturally relevant approaches. Whilst nationally, *Cultural Respect* has been gaining some prominence, *Cultural Safety* is used in local service and position descriptions. Whilst other philosophies have been presented in this thesis, including cultural security and cultural competence (see 10.2) the core principles that locate responsibility for change with the health service and professionals themselves, offer the greatest opportunities for sustainable and genuine change. Based on the literature reviewed in Chapters 3 and 4, and an analysis of the data presented in Chapters 6 and 7, it is my belief that the same approach might also be used to develop culturally safe communications. Language awareness and language sensitivity as concepts have already been researched and found to be valuable in improving health outcomes for linguistic minorities in health settings (Irvine, et al., 2006).

The model depicted in Figure 10 (this section) outlines the element necessary to achieve culturally safe intercultural communications between Indigenous Language speakers and English-speaking health professionals. It has developed from some of the findings of participants in this Intercultural Health Care Communication study who were themselves participants in the Central Australian health care. A review of literature has also helped identify those factors required to be present in both the preparation and on-going professional development of health personnel. Organisations and training providers need to equip health

professionals with adequate education and resources to deliver safe intercultural encounters in health care settings. Language awareness and sensitivity education, reflective practice, decolonising practice, and recognition of power differences underpin the optimal intercultural health care communication experience.

9.4.4 The Model explained

Figure 10 depicts an integration of intercultural communication skill development from undergraduate level, to the orientation to health services, policy and protocols to ensure linguistic needs assessments are embedded in practice. Skill development continues through individual and health service responsibility for reflection and reflective practice, and through joint responsibility (employee and employer) for ongoing professional development. Reflection should not only be on individual practice, but as suggested by the broader influences underpinning this study, also include the wider social context of Indigenous/State relationships. Skill development should include working with and through accredited interpreters and other Indigenous Language staff as a matter of routine, where linguistic needs assessment has indicated the need for support. Finally a regular audit process be implemented for individuals and services as a whole to assess the cultural safety of intercultural communications in health care. At the centre of this integration are the key stakeholders responsible for enabling culturally safe care.

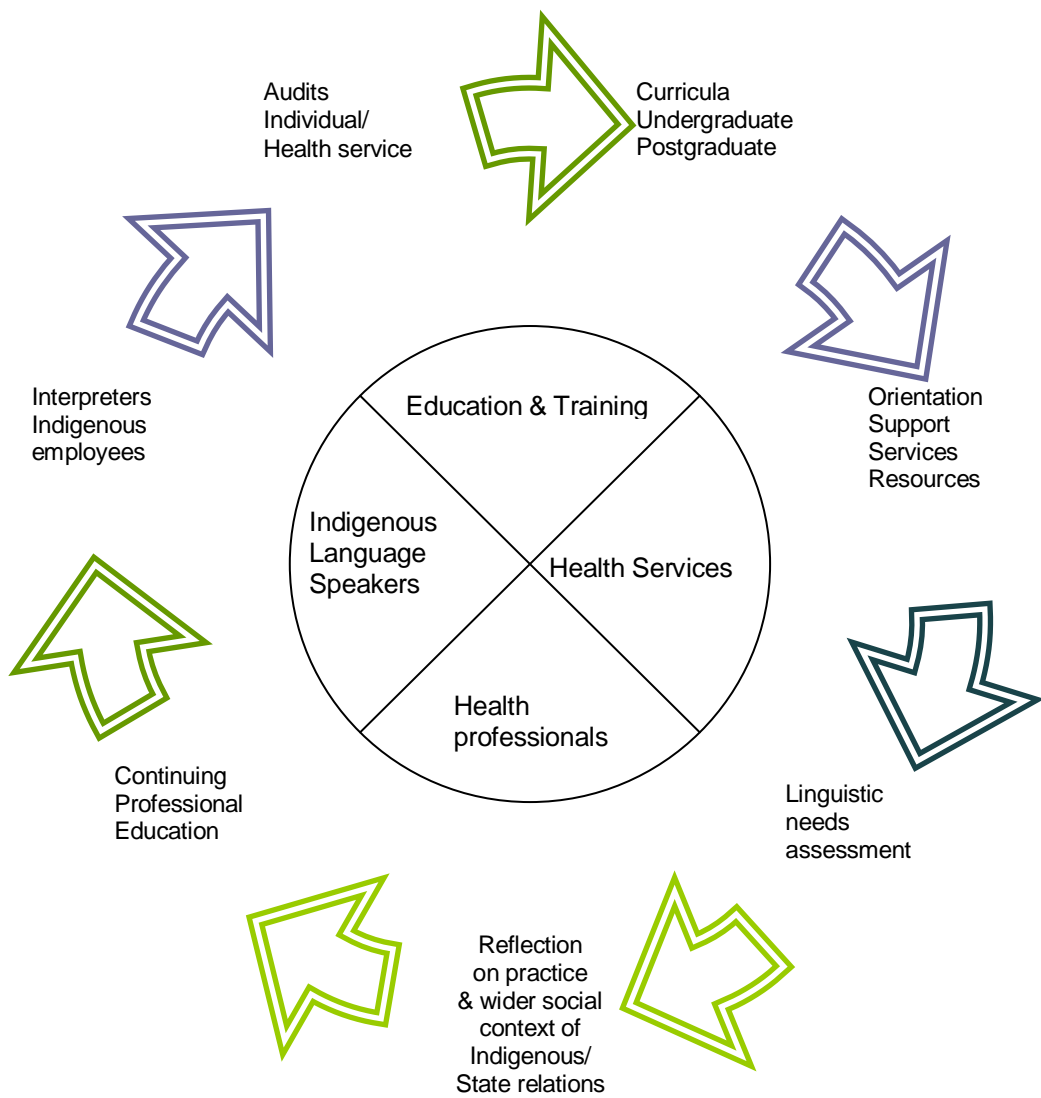


Figure 10. A model of culturally safe intercultural communication

9.5 Conclusion

Communication in health care is a key requirement for safe and effective practice. Communication that involves culturally and linguistically diverse participants is defined specifically as intercultural communication. Research globally has identified that intercultural communication is an aspect of health service delivery with the potential to impact either positively or negatively upon clients and their care (McGrath, 2006; Neulip, 2006; Skutnab-Kangas & Phillipson, 1995). In an increasingly multicultural and potentially racist world, intercultural communication skills are gaining in importance. Literature reviewed has highlighted the need for health professionals and health services to be appropriately prepared for intercultural communications in order to provide technical, ethical, legal, economical, effective and culturally safe care (Buttow, 2010; Lowell, 2001).

English is the language privileged within Australian health care systems. This is hardly surprising given that is the country's official language. However, in Australia, there is the dilemma of the original inhabitants rarely being able to obtain health care using their first language. As long as Indigenous Australians are viewed through a colonial lens with an unshakeable belief in non-Indigenous superiority, the capacity for effective communication remains limited. Any relationship with Indigenous Language speakers that continues to colonise by existing without effective communication, jeopardises the health, well-being and cultural safety, not only for clients, but also for those providing care.

In health care settings in Central Australia, non-Indigenous (western) models of health dominate, and English is an unchallenged and privileged tool of access to care. Yet Indigenous language speakers are the majority users of these same health care services in Central Australia. Slowly, almost grudgingly, health professionals have had to examine the ways in which services are delivered to Indigenous clients. While it would be nice to think this examination has arisen from a regard for lessons learnt from the past and a genuine desire to halt the painful impact of colonising practices, it seems more pragmatic factors are at play.

This pragmatism however, does not negate the individual good will and ‘good intentions’ of many non-Indigenous health professionals who genuinely want to improve their capacity to provide culturally safe care. However, ineffective health care communications are costly, personally, financially, and to the community at large.

Numerous reports have reviewed and commented on past approaches to the provision of health services to Indigenous Australians (I. Anderson, et al., 2006; Australian Government Department of Families Housing Community Services and Indigenous Affairs, 2008; Government, 1991). These reports have looked at the failure of policies, the inappropriateness of services, the lack of suitable supports, and most currently at the victims themselves. Few have looked at what this study found to be fundamental influences on all other factors, a lack of adequate preparation for, and attention to, intercultural communication between Indigenous and non-Indigenous participants. How can health professionals possibly provide appropriate health care if they cannot communicate effectively with the recipients of their care? Of course, some procedures and interventions might in certain circumstances, take place without consent, as happens when communication is not physically possible. However, effective communication in other than these circumstances is and should be possible.

Indigenous health in Australia in the early days of the twenty first century remains by any account, a national shame. Until the dominant cultural group can turn the critical lens on themselves, and their systems and structures, little if anything will change. In summary, the study reported in this thesis has described and examined the experience of intercultural communications in health care settings in Central Australia. A critical ethnography underpinned by the philosophy of cultural safety and situated within a post-colonial theoretical framework, was undertaken to address the aim and objectives of the study. The decision to interview in depth, eleven English-speaking health professionals and only four Indigenous First Language clients, was deliberate as this provided enough of a critical lens. This imbalance reflects the dominance of the researcher’s own cultural group, who are most often in privileged positions of power within intercultural healthcare encounters in Central Australia. Globally and

locally, intercultural communication is identified as a challenging and complex skill that has the potential to disadvantage linguistic minorities in terms of quality of care. The rationale for involving both groups stemmed from assumptions about supposedly culturally appropriate methods of communication used by non-Indigenous health professionals. The trend toward providing health information in specific formats for Indigenous clients in the region may be well intentioned. Some believe however, that using simplistic rather than simplified forms of English communication however, potentially contributes to a 'crisis in health care' (Trudgen, 2000; Folds, 2001). This crisis has been evident in the findings of this study, that the experience of intercultural communication for both Indigenous clients and health professionals is a culturally unsafe one.

This Intercultural Health Care Communication study adds a deeper understanding about the underlying influences and consequences of culturally unsafe communications. Health professionals were made vulnerable through inadequate preparation or support and lack of incentives to communicate safely and effectively with Indigenous language speakers in Central Australia. The findings highlighted a culture of accepting a lower standard of care, and a professional vulnerability that contributed to staff turnover and experiences of job stress. Powerlessness and lack of control for Indigenous language speaking clients contributed to their personal stress, a lack of informed consent and decision-making, negative experiences of health care. For health professionals there was a need to avoid revealing potentially unbearable truths about what really underpins intercultural communications in Central Australia.

Australia's national priority has been directed at 'Closing the Gap' in Indigenous disadvantage. Previous efforts have not achieved this national goal. There is a need to do things differently. Based on the findings of this Intercultural Health Care Communication study, I would suggest that one of the most crucial 'gaps' to be closed must be the communication gap between Indigenous Australians and English-dominant health care services and their workforces. Consequently, I have offered in this thesis, a model of culturally safe, intercultural communications for the Central Australian health care context.

Finally, in keeping with my desire for the voice of Indigenous Language speakers to have the first and last words in this thesis, I conclude with the Naparrula's reminder that this is not really a story for Indigenous people. It is *my* story to tell and therefore my responsibility to share, in order to change the status quo and seek a way through the intercultural health care communication gap between Indigenous and non-Indigenous Australians.

*Kele*⁹¹ ...**finished now... enough said.**

91. Kele is Luritja/Pintupi for finished now, that's enough also goodbye (see 10.3)

10.0 Appendices

10.1 Abbreviations

10.2 Operational definitions

10.3 Glossary of Indigenous Languages' words and phrases

10.4 Aboriginal English terms and phrases

10.5 SBREC Approval

10.6 Data Analysis sample

10.7 Letter of Introduction (English Speaking health professionals)

10.8 Letter of Introduction (Indigenous Speaking participants)

10.9 Consent Plain English for translation to Indigenous Languages

10.10 Consent form for observation of a professional activity

10.11 Interview Guide: Cross-Cultural Communication in health care

10.12 'Culturally appropriate' pain assessment tool used in Central Australian tertiary health service

10.1 Abbreviations

Aboriginal Cultural Awareness Program (<i>Kaltye-le Antherrentye</i>) (<i>Arernte for 'Teaching each other'</i>)	ACAP
Aboriginal Community Controlled Health Service	ACCHS
Aboriginal Medical Services	AMS
Aboriginal Employment and Career Development Strategy	AECDS
Aboriginal Health Workers	AHW
Indigenous Health Worker	IHW
Aboriginal Liaison Officer	ALO
Indigenous Liaison Officer	ILO
Aboriginal Research Development Services	ARDS
Alice Springs Hospital	ASH
Absent Without Leave	AWOL
Against Medical Advice	AMA
Australian Bureau of Statistics	ABS
Australian Government Department of Health and Ageing	AGDH&A
Australian Indigenous Language	AIL
Australian Nursing Council Incorporated	ANCI
Australian Standard Geographic Classification- Remoteness Areas	ASGC-RA
Australian Remoteness Indices	ARIA
Central Australian Health Research Ethics Committee	CAHREC
Central Australian Rural Practitioners' Association	CARPA
Central Australian Aboriginal Congress	CAAC Congress
Centre for Remote Health	CRH
Congress of Aboriginal and Torres Strait Islander Nurses of Australia	CATSIN
Council of Remote Area Nurses Australia (now CRANAPlus – open to all remote health professions)	CRANA
Department of Health & Families (formerly Department of Health & Community Services) (formerly Territory Health Services)	DHF DH&CS THS

English First Language	EFL
English Second Language	ESL
English-speaking health professional	ESHP
Federation of Aboriginal and Torres Strait Islander Languages	FATSIL
Indigenous First Language	IFL
Indigenous Language Speaker	ILS
Institute for Aboriginal Development	IAD
Intercultural Health Care Communication Study	IHCCS
Languages other than English	LOTE
Medical Officer District Medical Officer	MO DMO
National Health & Medical Research Council	NHMRC
Ngaanyatjarra Pitjantjatjara Yankunytjatjara	NPY
Non English Speaking Background	NESB
North American Nursing Diagnoses Association	NANDA
Northern Territory	NT
Northern Territory Department of Health & Families	NTDH&F
Northern Territory Emergency Response or Northern Territory Emergency Intervention (The Intervention)	NTER NTEI
Overseas Trained Nurses	OTN
Overseas Nurse Program	ONP
Primary Health Care	PHC
Registered Nurse	RN
Remote Area Nurse	RAN
Royal Commission into Aboriginal Deaths in Custody	RCADIC
Royal Commission on Aboriginal Peoples (Canada)	RCAP
Social and Behavioural Research Ethics Committee	SBREC
Standard Australian English	SAE

Take Own Leave	TOL
Territory Health Services	THS
Western Desert <i>Nganampa Walytja Palyanjaku Tjutaku</i> (<i>Making all our families well</i>)	WDNWPT
World Health Organisation	WHO

10.2 Operational definitions

In a study that is about language and its potential impact, one of the first challenges is ensuring that the words and terminology chosen do not contribute to their own on-going colonisation or marginalisation of specific people or groups. There are many issues related to Indigenous Australians, terminologies, definitions and single words, which carry with them historical burdens. Consensus and comfort are difficult to achieve, not only in relation to Indigenous issues, but also within my own disciplines of nursing and education and the various health cultures more generally. For the purposes of this study, and in acknowledgment that some terms used may not be acceptable to all readers or those to whom they refer, the following operational definitions apply throughout the thesis:

Aboriginal or Indigenous?

The terminology used to define Indigenous peoples in the Northern Territory and Australia generally is fraught with controversy. There appears little consensus within the literature and a great deal of changing attitudes when seeking to define populations along ethnic lines. This is in the context of a colonial history and ongoing use of categories to discriminate against specific groups. In acknowledgement of this lack of agreement, the term Indigenous has been used as this is the term currently used by governments to imply inclusion of Aboriginal and Torres Strait Islander peoples and other Islander groups recognised as the original peoples of Australia.

Aboriginal is a term applied to Indigenous Australians. It is not inclusive of the Islander populations who distinguish themselves as Torres Strait Islanders and other Islander groups. For the purposes of this study located within Central Australia, the term *Aboriginal* is used when there is a specific intention to refer to Indigenous groups of Central Australia. Further specific terminology is used where necessary to identify discrete language groups.

Aboriginal or Torres Strait Islander

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she is associated (Australian Bureau of Statistics, 2009).

Aboriginal English is the name given to the various kinds of English spoken by Aboriginal people throughout Australia. Technically, the language varieties are dialects of English. They have much in common with other varieties of Australian English, but there are distinctive features of accent, grammar, words and meanings, as well as language use (Eades, 2009).

Aboriginal Health Worker

A registered health professional of Aboriginal descent who in the Northern Territory, must hold an annual practising certificate, issued by the Aboriginal Health Worker (AHW) Registration Board. Previously this role was involved mainly in the delivery of primary health care (PHC) services in remote Aboriginal communities. Registered AHWs increasingly work within town-based community and acute hospital services as well as the PHC settings.

Aboriginal Liaison Officer

An employee of Aboriginal descent, who possesses relevant cultural knowledge and language skills, which are used to provide practical welfare support to Aboriginal clients within the health system.

Anangu

Literal meaning is 'people' (Pitjantjatjara/Luritja). Increasingly this term is being used to imply Aboriginal people, rather than all people, as was its original usage.

Arrernte (Aranda, Arrunte, Arrente)

A specific Indigenous language group or person identified as belonging to this language group, whose traditional lands are in and around Alice Springs. Spelling is subject to local preferences and historical developments, as indicated by other spellings cited.

Anmatyerre/ Anmatjere

A specific Indigenous language group or person identified as belonging to this language group, whose traditional lands are situated to the north of Alice Springs. Spelling is subject to local preferences and historical developments, as indicated by other spellings cited.

CARPA manual

Central Australian Rural Practitioners' Association (CARPA) Standard Treatment protocols for remote health care practice.

Central Australia

A geographic region, which for the purposes of this study, implies parts of the Northern Territory, South Australia, Western Australia and Queensland, as shown in Figure 1 in 2.1.

Closing the Gap

'Closing the Gap' is a national policy direction aimed at closing the disparities between Indigenous and non-Indigenous Australians in terms of life expectancy, and other disadvantage (Oxfam Australia, 2009).

Code Switching

Switching between languages and even within languages to use different forms suited to purpose, content, context and/or participants.

Colonialism

'...a practice of domination, which involves the subjugation of one people to another' (Kohn, 2008) <http://plato.stanford.edu/archives/fall2008/entries/colonialism/>, accessed September 20, 2010

Creole

'...a creole is a distinct language which has taken most of its vocabulary from another language, the lexifier, but has its own unique grammatical rules. Unlike a pidgin, however, a creole is not restricted in use, and is like any other language in its full range of functions' (Eades, 2009) <http://www.une.edu.au/langnet/definitions/aboriginal.html>, accessed September 22nd, 2010.

Cross-cultural or intercultural

Cross cultural or intercultural pertains to operating within a mixed cultural context.

Cross lingual

Operating in a context that requires communication across linguistically different groups

Country or Homelands

Countries/country used in the sense of Indigenous land connections indicates clearly defined territories, acknowledged as belonging to or being the traditional lands of specific Language groups.

Cultural Competency

...a conceptual framework to facilitate more culturally inclusive service provision
(Grote, 2008, p.7)

Cultural Respect

...a framework that promotes behavioural changes by practitioner as well as modifications to the health care systems themselves (Grote, 2008, p.12)

Cultural Safety

A philosophy of and a way of providing health care highlights the responsibility members of one culture have to ensure their interactions with members of another culture do not cause potential harm or conflict with the cultural needs of individuals or groups.

Cultural Security

...a commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. (Grote, 2008, p.11)

Democratic racism

Defined as an ideology that permits and sustain people's ability to maintain two apparently conflicting sets of values (Henry & Tator, 2007, p.15). One set of values reflects a commitment to a liberal, democratic society motivated by egalitarian values (such as those espoused in health care). Conflicting with those values are attitudes and behaviours that include negative feelings toward those who are racialised within society, and that results in differential treatment or discrimination (Browne, personal communication, 2011).

District Medical Officer

A registered medical practitioner whose responsibility is for a specific geographically defined region or health service.

Dominant Culture

The cultural group who through various processes of colonisation acquires dominance over other groups, and whose value, beliefs and world view dominate or are privileged over others. Also known in some literature as the settler or colonising culture (Edwards, 2007).

English Second Language

A language spoken and learned subsequent to one's first language.

First Language

One's own language taught from childhood, transmitted by primary carers.

First Nations /First Peoples

Identifiable nation groups or peoples acknowledged as being the original people of a region or country.

Gratuitous Concurrence

The tendency of Indigenous Language speakers to say yes irrespective of actual intentions or acceptance, most often to please the questioner or because they are perceived as being in a position of authority.

Half Caste

A term applied to people of mixed heritage, Indigenous and non-Indigenous, during the eras of Assimilation and Segregation when government policy directed that children of mixed heritage be removed from Aboriginal families in an effort to extinguish their Aboriginality. This term is still frequently used within the Central Australian region by both Indigenous and non-Indigenous, but is potentially an offensive term, imposed from within a colonial past.

Hard English

An Aboriginal English term, meaning English language that is difficult to understand, because it is too technical or context specific.

Health care communication

Any communication, verbal or non-verbal, that occurs in the context of a health care setting in the course of seeking or obtaining health care, specifically that occurring between a health professional and client.

Health in Central Australia

Health in the context of this study is generally regarded by mainstream populations to be aligned to the World Health Organisation' definition of health as :

...a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity... (World Health Organization 1978)

However, within this setting, Indigenous peoples may hold differing worldviews and define health differently.

Health literacy

The shared understanding with regards to health concepts, language and terminology— involves an ability to read, interpret and use information for health benefits (Taylor, 2008)

Health Professionals

Health professionals in Central Australia may be registered or unregistered. Registered practitioners are subject to the professional credentialing of the Northern Territory Professional Registration Boards, such as Medical Officers, Nurses, Aboriginal Health Workers, etc. Non-credentialed employees include Aboriginal Liaison Officers who may or may not possess credentialing as interpreters. Aboriginal or Indigenous Interpreters are accredited through the National Interpreter Services.

Health services

In the context of the Intercultural Communication Study, health services are taken to mean both government and Aboriginal community controlled health services. In the Central Australian region, these include Primary Health Care service, community and tertiary services.

Indigenous

See Aboriginal/Indigenous definition

indigenous

Small i indigenous pertains to being from or belonging to a specific place. Eg: Kangaroos are indigenous to Australia.

Indigenous First Language Speaker

A person of Indigenous descent, whose first language is an Indigenous one or who had primary carers (parents or grandparents) who spoke an Indigenous language as their first language.

Indigenous health definition

A locally accepted Indigenous definition that illustrates the key difference in how health is conceptualised is found in the following:

Not just the physical well-being of the individual, but the social, emotional and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life. (National Aboriginal and Islander health Organisation (NAIHO) 1982, p.2)

Indigenous Language Speaker is operationally defined as an individual who speaks an Indigenous language as their first or other language, and includes those who may speak English, but had primary carers who were Indigenous language speakers.

Intercultural is used to describe interactions that occur across linguistic and/or cultural divides. It is sometimes referred to in the literature as ‘cross-cultural’.

Kinship or classificatory names

Indigenous names that identify an individual’s place and relationship within society to others. For example, all Jakamarra will be considered brothers to anyone whose kinship name is Nakamarra.

Kinship structures or ***Skin relationships*** are the framework for identifying how individuals are connected to one another and can include non-Indigenous people. They provide more than the biological, blood connections. Kinship structures connect people through familial categories and provide the code of conduct, responsibilities and obligations individuals are expected to uphold.

Kriol

A form of Creole, spoken in the Katherine region of the Northern Territory.

Language

When capitalised within text, this term implies an Indigenous language, eg: *People still speak (an Indigenous) Language here.*

Language awareness

A person's sensitivity to and conscious awareness of the nature of language and its role in human life, (Irvine, et al., 2006)

Lingua franca

Dialect or colloquial speech

Linguicide

The deliberate destruction of languages by means of educational policy, dispersal of speakers, genocide and similar means (Mühlhäusler & Damania, 2004)

Maori

First people of country now known as New Zealand (Aotearoa)

Natives

Indigenous Australians have been referred to variously in historic literature. "Native" was in use into the mid 1970s with Native Affairs, but has gone out of current usage, as a term that has colonising connotations for Southern Hemisphere Indigenous people. The term is more often found in Northern Hemisphere literature.

Neo-colonialism

A period of continued colonialism (Ramsden, 2002).

Non-English Speaking Background

A person whose first language is other than English. For the purposes of education, this may include someone whose primary carers spoke a first language other than English as this can influence the use and proficiency of English.

Non-Indigenous (Western/ European/White)

This terminology is also subject to dispute as the diversity of Australians who are not Indigenous is significant. For myself as a non-Indigenous Australian, I find it hard to relate to the terms Western or European. Non-Indigenous may also include those whose origins are linked to other than European countries, reinforcing the difficulty of a succinct and concise terminology that reflects the appropriate level of diversity among non-Indigenous populations. However, non-Indigenous will be used within this thesis to imply the diverse group of Australians who are not Indigenous.

Northern Territory Emergency Response (NTER) was purported to be a Commonwealth Government response to a report into child abuse in remote Aboriginal communities (Altman and Hinkson, 2007). It heralded a range of repressive and discriminatory policies and actions that included the suspension of the Anti-Discrimination Act, quarantining of welfare payments, and restrictions on pornographic materials that remain available to people living outside of identified areas.

Pakeha

Maori term for non-Maori

Pitjuri

A species of native tobacco used by Aboriginal people in some regions of Central Australia.

Primary Health Care

Essential health care made universally accessible to individuals and families by means acceptable to them, through their full participation and at a cost that the community and country can afford (World Health Organisation, 2008).

Post-colonialism

Period following a colonising experience. Can also be a theoretical framework for examining issues related to the impact of colonisation on past and present populations.

Protector of Aborigines

Official state authorised positions under the Protection Act, which placed a non-Indigenous person responsible for the welfare of Aboriginal and Torres Strait Islander peoples from birth. Protectors were in place from late 1800s to mid 1900s.

Registered Nurse

Registered nurses in Australia include persons with at least a three-year training certificate, diploma or degree. Some nurses hold postgraduate qualifications. Until late 2010 registered nurses had to be registered with the state/territory registration board. From 2010 a national registration scheme came into effect. Participants in this Intercultural Health Care Communication study were interviewed prior to the national registration scheme,

<http://meteor.aihw.gov.au/content/index.phtml/itemId/327182>

Remote Area Nurse (RAN)

Registered nurses working in remote communities to provide the full range of comprehensive Primary Health Care services. These include initial emergency care, chronic diseases planning and management, community-based population health initiatives and health promotion. The role is very broad and diverse, and involves a high level of skills and knowledge over many domains of health care services,

http://www.nursing.nt.gov.au/docs/career/remote_area_nursing.pdf

Secret English

English speakers' language that some Indigenous people believe is used as a means of controlling information and excluding Indigenous people.

Terra Nullius

The concept upon which 18th century European colonial powers agreed to the seizing of lands on the basis that no obvious signs of ownership or civilisation existed, literally meaning empty land belonging to no-one.

Western Desert

Geographic and cultural region located in the Northern Territory, Western Australia and South Australia. See Figure 3 in 2.7.1 for scope of Western Desert Language groups.

Whiteness

A concept that suggests an inherent privilege for individuals in society that is related to membership of a dominant race. However, increasingly this concept is less tied to notions of race and more focused on other factors creating privilege such as socio-economic status.

Yolngu

Yolngu is the term used to denote Indigenous people traditionally associated within the region known as north-east Arnhem Land.

Yolngu matha

Indigenous languages spoken by Yolngu people

10.3 Glossary of Indigenous Languages' words and phrases

Anangu	<i>Literally people – increasingly indicates people of the Pitjantjatjara lands</i>
Anangu nganampa, ngura nganampa	<i>Our people, our country Pitjantjatjara/Luritja/Pintupi</i>
Kaltje-le Antherrentye (Arrernte)	<i>Teaching each other – Cultural Awareness Program of the NT Department of Health & Community Services</i>
Guna (Luritja/Pintupi..)	<i>Faeces</i>
Kala Kala palya, ananyina (Luritja/Pintupi)	<i>OK – implies an end to the interaction or the topic OK, that's fine, I'm going now(goodbye)</i>
Kumuntjay Kumuntjayi Kumunara (various languages and spellings)	<i>No name - used to replace the name of a person now deceased, so anyone else with the same or similar sounding name will be referred to as Kumuntjay or derivative</i>
Kunga (Luritja/Pintupi)	<i>Woman</i>
Marra, mwere, morrah	<i>Arandic words meaning 'good'</i>
Mingkulpa	<i>Indigenous species of tobacco – also known as pitjuri</i>
Myall	<i>Grown up in the bush Not worldly Can be used in a derogatory sense to mean ignorant or Unintelligent</i>
Napartji-napartji	<i>Reciprocity</i>
Napartji wangkanyi	<i>talk back and forth, talking in turn, includes question and answer.... (Bain, p.26) Pitjantjatjara</i>
Palya Pitjantjatjara/Luritja/ Pintupi	<i>word for 'good'</i>
Pika wiya Pitjantjatjara/Luritja/ Pintupi	<i>Healthy literally 'pain no'</i>
Pika Pitjantjatjara/Luritja/ Pintupi	<i>pain, sick</i>
Pina wiya Pitjantjatjara/Luritja/ Pintupi	<i>Unable to hear (comprehend) literally ears no</i>
Pitjuri	<i>Indigenous species of tobacco</i>
Tjinguru Pitjantjatjara	<i>Maybe, perhaps</i>
Tjukururu	<i>Straight, honest</i>
Uwa	<i>= yes</i>
Waltya	<i>Family</i>

Wati Wati yangupala	<i>Man</i> <i>Young man (man+ young fella)</i>
Wiya	<i>No Luritja. Pitjantjatjara, Pintupi</i>
Yuwa	<i>yes</i>

10.3.1 Central Australian Indigenous Language words and phrases to describe pain.

Pitjantjatjara/Yankunytjatjara words for pain assessment (Goddard, 2001)

<i>Pika</i>	Pain
<i>Patjani</i>	give pain
<i>Kampanyi</i>	burn, sting
<i>Wakani</i>	hurt, have sharp pain
<i>Ngalkuni</i>	feel constant pain

10.3.2 Eastern and Central Arrernte words for pain assessment (Dobson, 2001)

<i>Kwarneme</i>	ache, have a pain; give someone a sharp or strong pain
<i>Antantheme</i>	have a sharp or stabbing pain
<i>Arekurrkatye- irreme</i>	have aches and pains, aching all over
<i>Amerte ultakeme</i>	have bad stomach pains
<i>Pwerepe</i>	tender, almost unbearable (pain, injury)
<i>Rlkerte ntyeme</i>	to sting, pain, hurt
<i>Utyene</i>	painful, sore, inflamed

10.4 Aboriginal English terms and phrases

Cheeky	<i>rude or aggressive</i>
Deadly	<i>really good</i>
finish up	<i>die, pass away</i>
Gammon	<i>pretending, teasing or joking</i>
hard English	<i>English that IL speakers might find difficult to understand</i>
Mob	<i>group of people – often implies Indigenous people</i>
Myall	<i>unsophisticated</i>
secret English	<i>English that is believed to be known by some English speakers, but is thought kept away from Indigenous speakers as a means of controlling information</i>
Shame shame job too shame	<i>Profound embarrassment</i>
sorry business	<i>Mourning & associated protocols</i>
walypala (whitefella)	<i>Non-Indigenous person</i>
yella fella	<i>Indigenous person of mixed heritage</i>

10.5 Flinders University Social and Behavioural Research Ethics Committee Approval



FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Social and Behavioural Research Ethics Committee
Office of Research

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SBRE 3491

21 April 2006

Ms Kerry Taylor
Nursing & Midwifery

Dear Ms Taylor

Project 3491 **Privileging English: A critical ethnography of health care communications in Central Australia**

Further to my letter dated 31 March 2006, I am pleased to inform you that approval of the above project has been confirmed following receipt of the additional information you submitted on 12 April 2006. Approval is valid for the period of time requested and is given on the basis of information provided in the application, its attachments and the information subsequently provided.

In accordance with the undertaking you provided in the application, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion and report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

I draw to your attention the requirement of the *National Statement on Ethical Conduct in Research Involving Humans* that you submit an annual progress and/or final report to SBREC. If a report is not received beforehand, a reminder notice will be issued in twelve months' time. A copy of the report pro forma is available from the SBREC website
<http://www.flinders.edu.au/research/Office/ethics/socialbehavioural.html>.

Yours sincerely

Sandy Huxtable
Secretary
Social and Behavioural Research Ethics Committee

cc: Prof Charlotte de Crespigny, Nursing & Midwifery
Dr Jane Neil, Nursing & Midwifery

NB: If you are a scholarship holder and you receive funding for your research through the National Health & Medical Research Council please forward a copy of this letter to the Head, Higher Degree Administration and Scholarships Office, for forwarding to the NHMRC.

Location: Stuart Road, Bedford Park SA 5008

10.6 Four Level Thematic Analysis –sample

HP1 Sally
 HP2 Cathy
 HP3 Rachel
 HP 4 Georgina
 HP5 Penny
 HP6 Winny
 HP7 Linda
 HP8 Denise
 HP9 Tanya
 HP10 Mary
 HP 11 Stuart

First Level significant segments, words, phrases (Sample only – not all first level data)	Second level- categories	Third Level –Sub themes	Fourth level – Theme example
<p>End up relying more on the physical You almost give up It's not ideal... It's not good – it becomes the way you operate Doesn't make you feel good Clients labelled all the time It's very much fit into our system You get frustrated by it Feel powerless to change it A bit of apathy there Frustration Too old to let it bother me Doctor in a hurry pressure to sign Loss of choices Negative thinking – non compliance Judged before walk through the door. Not just problem with medications – its everything, all encounters Well just march on to the next one and make the same mistake... No I worry about the amount of information...assumptions made That scares me Lack of informed consent Consent just too hard Take a toll on staff Hard to nurse somebody when they're not going to communicate with you – they don't tell you they're crook Nothing is instant – you know you're going to see them again It does worry me for sure Informed consent, rights...</p>	<p>Reliance on physical tasks Poor outcomes Lower standards of care Lack of informed decision making Negative experience of health care Limitations on practice Decreased confidence Lack of time and efficiency Powerlessness – staff and clients Made complicit – uphold system Feel bad about practice and context Too hard Worry, fear, frustration</p>	<p>The experience -fear, Worry, stress... Frustration Apathy Impact on practice Impact on health professional Impact on clients Consequences for health care system</p>	<p>Fear, frustration & danger- Intercultural Health Care Communication experience-</p>

10.7 Letter of Introduction English Speaking Participants (on Flinders University letterhead)

Dear _____,

I am a lecturer with Flinders University School of Nursing & Midwifery based in Alice Springs. I am also enrolled in PhD program through Flinders University. This letter is to introduce myself to you and to seek interested volunteers to participate in research looking at the issue of 'Cross-Cultural Communication'.⁹² The full title of my proposed research is: *Privileging English: A critical ethnography of health care communications in Central Australia*⁹³.

Why I am doing this study:

I am doing this study because the main users of health services in Central Australia are Indigenous people who may not speak English as their first language. Most of the health staff employed in this area do not speak Indigenous languages. I want to analyse how communication between speakers of different languages takes place in health care settings – what helps communication and/or what problems this can cause. This study may help improve health services for Indigenous people and also help health professionals to be better prepared for working with people of different language backgrounds generally.

I am seeking your voluntary participation in this research that may involve being interviewed by me. I may also need to watch and/or video or tape record a health-care situation in which you are involved. This would take no more than one half hour for an observation and/or interview. I may need to see and talk with you up to three times during the study. The interviews and observations will be made available to you to check that the information taken from these is accurate. Some or all of the tapes and interview will be transcribed and analysed to learn about what happens in communication in health care between English speakers and those who speak an Indigenous language.

My responsibility to participants:

It is my duty to make sure that any information you give me is treated with strictest confidence and that none of the participants in this study will be identified in the thesis report or other publications. When the information is collected, the results will be published as a thesis for Flinders University. Your name will not be used in the report unless you want your name to be recorded. I will keep all details about participants separate from the interviews and other information.

I will be making a tape recording of the interview, so I will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis report or other publications. This consent will be given on the agreement between us that your name or identity is not revealed, and to make the recording available to other researchers on the same conditions (or that the recording will not be made available to any other person). It may be necessary to make the recording available to secretarial assistants and interpreters for transcription. These people will be told of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

92. Changed to intercultural communication for thesis write up. Cross-cultural seemed to be a term with which participants were more familiar at the time.

93. Title changed during write up of thesis

Voluntary Participation:

You do not have to take part in this study unless you want to. Even if you say yes and then later change your mind, as explained in the consent forms, you are always free to stop taking part in the study at any time or to choose not to answer certain questions. If you do not want to take part in this study, now or anytime later, you can say no and I will not ask any more questions. This is your right and I will respect any decision you make.

My contact details:

If you want to know more about the project or just want to contact me at any time about this project, my telephone number is: 0417 891989 or 08 89514724, fax is 08 89514777 or e-mail kerry.taylor@flinders.edu.au

Thank you for your time and help

Ms Kerry Anne Taylor
Researcher/ Lecturer
Faculty of Health Sciences
School of Nursing & Midwifery

Dr Jane Neill
Research Supervisor
Faculty of Health Sciences
School of Nursing & Midwifery

This research project has been/is to be approved by: The Central Australian Human Research Ethics Committee and the Flinders University Social and Behavioural Research Ethics Committee. If you have any concerns, complaints or other questions about this research you can contact these committees by the details shown:

Central Australian Committee on 89514700, fax 89514777, e-mail john.wakerman@flinders.edu.au

Flinders Committee on 8201-5962, fax 8201-2035, e-mail sandy.huxtable@flinders.edu.au

10.8 Letter of Introduction Indigenous Language participants (on Flinders University letterhead)

Background:

My name is Kerry Taylor. I am a lecturer with Flinders University School of Nursing & Midwifery based in Alice Springs. I am also studying at Flinders University in a course called a doctorate or PhD by research.

The area I want to research is about communication in health care in Central Australia. This research will be published in a report (called a **thesis**) as part of my university studies.

The short title of the research project is: **Cross-Cultural Communication**

The full title is:

Privileging English: A critical ethnography of health care communications in Central Australia. * (Later changed to *Intercultural Health Care Communications...*)

Why I am doing this study:

- I am doing this study because the main users of health services in Central Australia are Indigenous people who may not speak English as their first language.
- Most of the health staff in this area do not know Indigenous languages.
- I want to study how communication between speakers of different languages takes place in health care settings – what helps communication and/or what problems this can cause.
- This study may help improve health services for Indigenous people and also help health professionals to be better prepared for working with people of different language backgrounds generally.

What am I asking for: I want to ask if you will join in this research by volunteering to:

- be interviewed by me about health communications and/or
- to allow me to watch and/or video or tape record a health-care situation you are a part of (when you are talking to a non-Indigenous health worker at the clinic or hospital). This would take no more than one half hour for an observation or interview.
- I may need to see and talk with you up to three times during the study.
- I would then show you the interviews and observations so you can check that the information taken from these is accurate.
- Some or all of the tapes and interview will be transcribed (written down) and studied by me as the researcher to learn about what happens in communication in health care between English speakers and those who speak an Indigenous language.

My responsibility to people who help with this study:

- I will make sure that any information you give me is treated as confidential
- None of the people in this study will be identified in the thesis report or other publications. As explained in the consent forms, you can always stop taking part in this study at any time or choose not to answer some questions. This will not affect the care you will receive from health staff if you choose to say no.

- When the information is collected, the results will be published as a thesis for Flinders University. Your name or image will not be used in the report unless you want your name to be recorded and it does not affect the confidentiality of others. I will keep all details about participants separate from the interviews and other information.
- I want to make a tape recording of the interview, so I will ask your consent on another form (Consent Form) to:
 - record the interview,
 - use the recording or a transcription in preparing the thesis report or other publications.
- This consent will be given on the agreement between us that your name or identity is not revealed to any other researchers that are not part of this research. I may need to make the recording available to secretarial assistants and interpreters for transcription. These people will be told of the requirement that your name or identity not be revealed and that they must also promise to respect the confidentiality of the material.

Saying yes or no: Voluntary participation

- You do not have to take part in this study unless you want to.
- Even if you say yes and then later change your mind, as explained in the consent forms, you are always free to stop taking part in the study at any time or to choose not to answer certain questions.
- If you do not want to take part in this study, now or anytime later, you can say no and I will not ask any more questions. This is your right and I will respect any decision you make.

My contact details:

If you want to know more about the project or just want to talk me at any time about this project, my telephone number is: 0417 891989 or 08 89514724, fax is 08 89514777 or

e-mail kerry.taylor@flinders.edu.au

Thank you for your time and help

Ms Kerry Anne Taylor
 Researcher/ Lecturer
 Faculty of Health Sciences
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e-mail sandy.huxtable@flinders.edu.au

10.9 Consent -Plain English for translation to Indigenous Languages

(This is the negotiated text derived at with the Aboriginal Liaison Officer who provided a recording of this for use with IFL participants)

This is Kerry Taylor. She works for Flinders University in Alice Springs. She is doing a study to find out about how health workers talk to Aboriginal language speakers. Kerry has heard that some people have problems talking in English. Kerry wants to study what happens in hospital and some clinics. She wants to help teach doctors and nurses to speak properly to Aboriginal people.

If you want to help Kerry she will ask to take a little bit of video of you talking with a doctor or nurse. Only Kerry and you and the other people in the video will be allowed to see this video. Kerry will write a report (thesis) about what she learns and will show it to you. Your name will not be used in the report.

If you agree to help please sign the consent form. If you want to know more you can ask to talk to the Aboriginal Liaison Team or you can call the numbers on the form.

10.10 Consent form for observation of professional activity

I give my consent to Ms Kerry Taylor, a researcher/research student in the Faculty of Health Sciences School of Nursing & Midwifery, based at the Centre for Remote Health, Alice Springs and whose signature appears below, to record my work activities as part of a study of professional activities and role relating to communication in health care.

I give permission for the use of these data, and of other information, which I have agreed, may be obtained or requested, in the writing up of the study, subject to the following conditions:

My participation in this study is voluntary, and I understand that I may withdraw from the study at any time.

SIGNATURES

Participant.....Date.....

Researcher.....Date.....

10.11 Interview Guide: Intercultural Communication in health care

(Guide only as the interview questions may be further refined). To be read to participants, with an interpreter for Indigenous Language speakers as required. * question determined by which group participants are in.

Introductions

Confirm consent and rights.

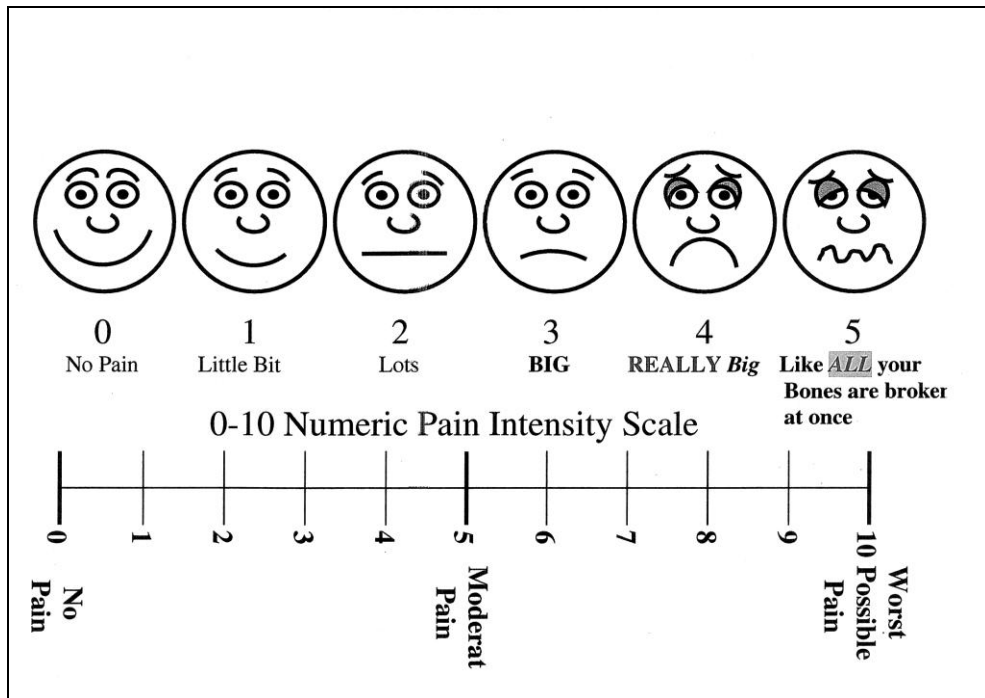
Advise about intention to record interview.

Thank you for agreeing to be interviewed for this research. This study is looking at what happens in health care communications when the health professional speaks only English and the client/patient speaks an Indigenous language as their first language. I would like to know a little bit about what it is like for you communicating in this situation. I have a few things I would like to ask about and I would be happy to hear from you what ever you think is important to this issue.

- What is your first language?
- What other languages do you speak or understand? (Health profs inclusion –English only).
- What is it like for you trying to provide/receive* health care to/as an Indigenous First Language speaker when English is the main language used?
- What has helped you to communicate with Indigenous language speakers/ English language speakers?
- What has made it difficult for you to communicate with Indigenous language speakers/ English language speakers?
- Can you give an example of a situation where you felt you were not being understood in the health care setting? How did this make you feel?
- Can you give an example of where communication worked well?
- How would you feel about using an interpreter for your health care communications?
- How do you explain thoughts, feelings or concepts that can not be easily translated to the others language?
- How would you describe your skills in communicating with Indigenous Language speakers/English language speakers?
- What experience, and or preparation if any, have you had in cross-cultural communication?
- What if anything, do you think health services need to do differently to help people communicate better in this setting?
- What, if anything, would you like to tell me about providing health care clients are mostly speakers of an Indigenous language? Or /getting your health care needs met in health services where English is the main language?

10.12 'Culturally appropriate' pain tool used in Central Australia tertiary health service

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References

- Altman, J., & Hinkson, M. (Eds.). (2007). *Coercive reconciliation: stabilise, normalise, exit Aboriginal Australia*. Melbourne: Arena Publications Association.
- Anderson, I., Crengle, S., Leialoha Kamaka, M., Chen, T., Palafax, N., & Jackson-Pulver, L. (2006). Indigenous Health in Australia, New Zealand, and the Pacific. *The Lancet*, *367*, 1775-1785.
- Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K., et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project: Toward new epistemologies of healing. *Advances in Nursing Science*, *26*(3), 196–214.
- Aronson, J. (1994). A pragmatic view of thematic analysis. *The Qualitative Report*, *2*(1).
- Australian Bureau of Statistics. (2009). *National Aboriginal and Torres Strait Islander Social Survey, 2008*. Canberra: Australian Bureau of Statistics.
- Australian Commonwealth Government. (2003). *Cultural Respect Framework*. Canberra: Australian Health and Medical Council.
- Australian Government. (2010). The Australian Health System. *About Medicare Australia* Retrieved 27 April, 2010
- Australian Government Department of Families Housing Community Services and Indigenous Affairs. (2008). *Closing the gap on Indigenous disadvantage: the challenge for Australia*. Canberra.
- Australian Government Department of Health and Ageing, & DoctorConnect. (2005). Remote area information: Introduction of the Australian Standard Geographic Classification - Remoteness Areas (ASGC-RA). *Australian Standard Geographic Classification - Remoteness Areas* Retrieved 10/4/2010, 2010, from www.health.gov.au/internet/otd/Publishing.nsf/content/RA-Intro

- Australian Indigenous HealthinfoNet. (2010). Workforce development. *Indigenous health workers* Retrieved 22/3/2010, 2010, from <http://www.healthinfo.net.ecu.edu.au>
- Bain, M. S. (2005). *'White men are liars' Another look at Aboriginal-Western interactions*. Alice Springs: Summer Institute of Linguistics Darwin Inc.
- Battiste, M. (Ed.). (2000). *Reclaiming Indigenous voice and vision*. Vancouver: University of British Columbia.
- Batty, P. (2007). *Colliding worlds: first contact in the western desert 1932–1984*. Melbourne: Museum Victoria and National Aboriginal Cultural Institute Tandanya.
- Belfrage, M. (2007). Why “culturally safe” health care? *Medical Journal of Australia*, 186(10), 537-538.
- Benavente, V. (2004). Cultural and linguistic competency assessment. *Nurse Leader*, December 2004, 25-30.
- Betancourt, J., Green, A., & Carillo, J. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*: The Commonwealth Fund.
- Betancourt, J., & Jacobs, E. (2000). Language barriers to informed consent and confidentiality: the impact on women's health. *J-Am-Med_womens-Assoc*, 55(5), 294-295.
- Bin-Sallik, M. (2003). Cultural safety: Let's name it! *The Australian Journal of Indigenous Education*, 32, 21-28.
- Blackford, J. (2003). Cultural frameworks of nursing practice, exposing a white-centric healthcare culture. *Nursing Inquiry*, 10(4), 236-244.
- Blackford, J. (2005). Equity in care for people of culturally and linguistically diverse backgrounds. *Australian Nurses Journal*, August 05.
- Blackford, J., & Street, A. (2000). Nurses of NESB working in a multicultural community. *Contemporary Nurse*, 9(1), 89-98.
- Blackford, J., Street, A., & Parson, C. (1997). Breaking down language barriers in clinical practice. *Contemporary Nurse*, 6, 15-21.

- Broom, A., & Willis, E. (2007). Competing paradigms and health research. In M. Saks & J. Allsop (Eds.), *Researching health. Qualitative, quantitative and mixed methods*. (pp. 16-31). Los Angeles: Sage Publications.
- Brown, S. (2010). Manager Western Desert Nganampa Waltja Palyanjaku Tjutuku Alice Springs.
- Browne, A. (2005). Discourses influencing nurses' perceptions of First Nations patients. *Canadian Journal of Nursing Research*, 37(4), 62–87.
- Browne, A. J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy*, 3(10), 167-179.
- Buttow, P. (2010). *Cultural issues in information exchange between health professionals and cancer patients*. Paper presented at the International Health Care Communication Conference.
- Cass, A., Lowell, A., Christie, M., Snelling, P. L., Flack, M., Marrnganyin, B., et al. (2002). Sharing true stories: improving communication between Aboriginal patients and healthcare workers. *The Medical Journal of Australia*, 176(10), 466-470.
- Central Australian Aboriginal Congress. (2004). History of Congress. Retrieved September 2009, from www.caac.org.au
- Central Australian Aboriginal Congress. (2009). from www.caac.org.au
- Cioffi, R. (2003). Communicating with culturally and linguistically diverse patients in an acute care setting: nurses' experiences. *International Journal of Nursing Studies*, 40(3), 299-306.
- Congress of Aboriginal & Torres Strait Islander Nurses CATSIN. (2002). *Getting em and keepin em': Report of the Indigenous Nursing Education Working Group*,.
- Cooney, C. (1994). A comparative analysis of transcultural nursing and cultural safety. *Nursing Praxis in New Zealand*, 9, 6-12.

- Coulehan, K., Brown, I., Christie, M., Gorham, G., Lowell, A., Marr\anyin, et al. (2005). *Sharing the true stories. Evaluating strategies to improve communication between health staff and Aboriginal patients, STAGE 2 Report*. Darwin: Cooperative Research Centre for Aboriginal Health.
- Coup, A. (1996). Cultural safety and culturally congruent care: A comparative analysis of Irihapeti Ramsden's and Madeleine Leininger's educational projects for practice. *Nursing Praxis in New Zealand*, 11, 4-11.
- Cramer, J. (2005). *Sounding the alarm*. Nedlands: UWA Press.
- Crawford, A. (1999). We can't all understand the whites' language': an analysis of monolingual health services in a multilingual society *International Journal of the Sociology of Language*, 136, 27-45.
- Crossin, T. (1999). *Aboriginals: interpreter service*. Canberra: Commonwealth Government.
- Cunningham, J. (2002). Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. *Medical Journal of Australia*, 176(2), 58-62.
- Davey, C. (2010). *Workforce Issues in Remote*. Alice Springs.
- Davidson, G., Hansford, B., & Moriarty, B. (1983). Listening to Aborigines: some communication requirements for non-Aboriginal-Aboriginal contact. *Australian Aboriginal Studies*(1).
- Dawes, B. (2001). Communicating nursing care and crossing language barriers. *AORN-J*, 73(5), 892-895.
- Department of Health and Community Services. (2008). *Aboriginal cultural security*.
- Department of Health and Community Services. (2009). *2008-2009 Annual Report*. Darwin: Northern Territory Government.
- Eades, D. (1991). Communicative strategies in Aboriginal English in language in Australia. In S. Romaine (Ed.), (pp. 84-93): Cambridge: CUP.
- Eades, D. (2009). from <http://www.une.edu.au/langnet/definitions/aboriginal.html>

- Eades, D. (Ed.). (1995). *Language in evidence: issues confronting Aboriginal and multicultural Australia*. Sydney: UNSW Press.
- Eckermann, A., Dowd, T., Chong, E., Nixon, L., Gray, R., & Johnson, S. (2006). *Binangoonj: bridging cultures in Aboriginal health* (2 ed.). Marrickville: Churchill Livingstone.
- Eckermann, A., Dowd, T., Martin, M., Nixon, L., Gray, R., & Chong, E. (1992). *Binangoonj: bridging cultures in Aboriginal health*. Armidale: University Printery, University of New England
- Edis, F. (1998). *'Just scratching the surface': miscommunication in Aboriginal health care*. Northern Territory University, Darwin.
- Edwards, P. (2005). Some survival issues. *FATSIL Federation of Aboriginal and Torres Strait Islander Languages*.
- Edwards, T., & Taylor, K. (2008). Decolonising cultural awareness. *Australian Nursing Journal*, 15(10), 31-33.
- Ermine, W. (2007). The ethical space of engagement. *Indigenous Law Journal*, 6(1), 193-203.
- Evans, N. (2010). *Dying words. Endangered languages and what they have to tell us*. Chichester, UK: Wiley-Blackwell.
- Fadiman, A. (1997). *The spirit catches you and you fall down: a Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus & Giroux.
- FATSIL. (2006). Endangered languages get a boost. *Voice of the Land*, 33, 6.
- Fenwick, C., & Stevens, J. (2004). Post operative pain experiences of Central Australian Aboriginal women. What do we understand? *Australian Journal of Rural Health*.
- Ferguson, W., & Candib, L. (2002). Culture, language and the doctor-patient relationship. *Family Medicine*, 34(353-361).
- Filmer, A. A. (2007). Bilingual belonging and the whiteness of (standard) English(es). *Qualitative Inquiry*, 13(6), 747-765.

- Fisher, D., & Weeramanthri, T. (2002). Hospital care for Aboriginals and Torres Strait Islanders: appropriateness and decision making – Why is our most needy population receiving a different type of inpatient care? [editorial]. *Medical Journal of Australia*, 176, 49-50.
- Folds, R. (2001). *Crossed purposes- the Pintupi and Australia's Indigenous policy*. Sydney: Griffin Press.
- Fook, J. (1999). Reflexivity as method. *Annual Review of Health Social Sciences*, nine, 11-20.
- Foucault, M. (1973). *The birth of the clinic: an archeology of medical perception*. London: Tavistock.
- Franks, C., & Curr, B. (Eds.). (1995). *Keeping Company: An Intercultural Conversation*. Wollongong, New South Wales: Centre for Indigenous Development Education and Research University of Wollongong
- Freire, P. (1970/1993). *Pedagogy of the oppressed*. London: Penguin Books.
- Genat, B. (2006). *Aboriginal health workers. Primary health care at the margins*. Perth: University of Western Australia Press.
- Gerrish, K., Chau, R., Sobowale, A., & Birks, E. (2004). Bridging the language barrier: the use of interpreters in primary care nursing. *Health and Social Care in the Community*, 12(5), 407-413.
- Goold, S., & Liddle, K. (2005). In Our Own Right. Black Australian Nurses' Stories Maleny: eContent Management Pty Ltd.
- Goold, S., Turale, S., Miller, M., & Usher, K. (2002). *'Gettin em n keepin em'*. Canberra: Commonwealth of Australia.
- Government, A. (1991). *Royal Commission into Aboriginal Deaths in Custody RCIADC*.
- Grant, J., & Luxford, Y. (2008). Intercultural communication in child and family health: insights from postcolonial feminist scholarship and three-body analysis. *Nursing Inquiry*, 15(4), 309–319.

- Grote, E. (2008). *Principles and practices of cultural competency: A review of the literature*.
- Gruen, R., Weeramanthri, T., & Bailie, R. (2002). Outreach and improved access to specialist services for indigenous people in remote Australia: the requirement for sustainability. *Journal of Epidemiology and Community Health*, 56, 517-521.
- Gudykunst, W., & Kim, Y. (2003). *Communicating with strangers: An approach to intercultural communication* (4 ed.). Boston: McGraw-Hill.
- Guerin, B. (2008). *Indigenous peoples: Discrimination and strategies for decolonising 'the mind'*. Paper presented at the Psychology and Indigenous Australians: Teaching, Practice and Theory Conference.
- Habermas, J. (1979). *On the logic of the social sciences*. Cambridge: Massachusetts Institute of Technology.
- Hall, B. J. (2003). *Among cultures: The challenge of communication* (Second ed.). Belmont, CA: Thomson Wadsworth.
- Hargrave, S. (1997). *Whitefella culture* (3 ed.). Darwin: Summer Institute of Linguistics. Australian Aborigines and Islanders Branch.
- Harkins, J. (1994). *Bridging two worlds: Aboriginal English and cross cultural understanding*. St Lucia: University of Queensland Press.
- Henry, F., & Tator, C. (2006). *The color of democracy: Racism in Canadian Society* (3 ed.). Toronto: Thomas Nelson.
- Hinkson, M. (2007). Introduction: in the name of the child. In J. Altman & M. Hinkson (Eds.), *Coercive reconciliation: stabilise, normalise, exit Aboriginal Australia* (pp. 1-12). Melbourne: Arena Publications Association.
- Horton, D. (Cartographer). (1996). *Aboriginal Australia*.
- Howard, J. (Producer). (2006) New plan no problem for 'fair dinkum' migrants: Howard. Radio interview
- Huggins, J. (1991). In my terms (racial annotations). *Hecate*, 17(2), 171
- Indigenous Healthinonet. (2010).

- Inglis, K. (2002). *The Stuart Case*. Melbourne: Black Inc.
- Institute of Aboriginal Development (Cartographer). *Central Australian Aboriginal Languages Distribution*.
- Institute of Medicine. (2002). *Unequal treatment: what healthcare providers need to know about racial and ethnic disparities in health care*.
- Institute of Medicine. (2009). *Race, ethnicity and language data: Standardization for health care quality improvement*. Washington.
- Irvine, F. E., Roberts, G. W., Jones, P., Spencer, L. H., Baker, C. R., & Williams, C. (2006). Communicative sensitivity in the bilingual healthcare setting: A qualitative study of language awareness. *Issues and Innovations in Nursing Practice*, 53(4), 422-434.
- Johnston, E. (1991). *Royal Commission into Aboriginal Deaths in Custody*
- Johnstone, M.-J., & Kanitsaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *Journal of Transcultural Nursing*, 18(3), 247-256.
- Kanitsaki, O. (2003). Transcultural nursing and challenging the status quo. *Contemporary Nurse, Advances in Contemporary transcultural nursing 2003*, 15(3), ppv-x.
- Karvelas, P., & Megalogenis, G. (2007). Aborigines must learn English for viable lives. *The Australian News Limited*. Retrieved from <http://www.theaustralian.news.com.au/story/0,20867,21790693-601,00.html>
- Kemble, A. (2007). *An 'other' story of Aboriginal and Torres Strait Islander health: A discourse analysis of government Aboriginal health policy*. Unpublished Honours, Flinders University, Adelaide.
- Kincheloe, J., & McLaren, P. (2002). Rethinking critical theory and qualitative research. In Y. Zou & E. Trueba (Eds.), *Ethnography and schools - qualitative approaches to the study of education* (pp. 87-138). Lanham: Rowman & Littlefield Publishers, Inc.

- Kirkpatrick, A. (2000). The disadvantaged monolingual: why English alone is not enough. *Australian Language Matters*, 8(3), 5-7.
- Kohn, M. (2008). Colonialism. *The Stanford Encyclopedia of Philosophy* Fall 2008. from <http://plato.stanford.edu/archives/fall2008/entries/colonialism/>.
- Lawrence, M. (2007). *Do you understand? How does the Aboriginal person from the remote community experience their trajectory of care for cardiac surgery at a metropolitan teaching hospital*. Flinders University, Adelaide.
- Lawrence, M., Dodd, Z., Mohor, S., de Crespigny, C., Power, C., & MacKean, L. (2009). *Improving the patient journey: Achieving positive outcomes for remote Aboriginal cardiac patients*. Darwin: Cooperative Research Centre for Aboriginal Health.
- Leininger, M. (Ed.). (1985). *Ethnography and ethnonursing: models and modes of qualitative data analysis*. Orlando: Grune & Stratton.
- Leininger, M., & McFarland, M. (2002). *Transcultural nursing concepts, theories, research & practices* (3 ed.). New York: McGraw Hill.
- Lieberman, K. (1985). The hermeneutics of intercultural communication. In H. Garfinkel (Ed.), *Understanding interaction in central Australia: an ethnomethodical study of Australian Aboriginal people* (pp. 171-215). Melbourne: Routledge & Kegan Paul.
- Lindström, N. (2008). *Intercultural communication in health care: Non-Swedish physicians in Sweden*. Unpublished Doctor of Philosophy in Linguistics, University of Gothenburg, Sweden, Gothenburg.
- Lowell, A. (2001). *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 and education research program 1998*. Darwin.
- Lowell, A., Brown, I., Marr\anyin, B., Flack, M., Christie, M., Snelling, P., et al. (2005). *Sharing the true stories, Improving communication between health staff and Aboriginal patients, STAGE 1 Report*.

- Marcus, J. (2005). *The indomitable Miss Pink: a life in anthropology*. Alice Springs: Paul Fitzsimon.
- May, S. (2005). Language rights: Moving the debate forward. *Journal of Sociolinguistics*, 9(3), 319-347.
- McCausland, R., & Levy, M. (2006). Indigenous policy and mutual obligation: shared or shifting responsibility agreements? *Australian Journal of Social Issues*, 41(3), 278-294.
- McCrinkle, M. (2006). *Intergenerational teaching*.
- McGrath, P. (2006). 'The biggest worry': research findings on pain management for Aboriginal peoples in the Northern Territory, Australia. *Rural and Remote Health*, 6(549).
- McGrath, P., & Holewa, H. (2007). End-of-life care of Aboriginal peoples in remote locations: language issues. *Australian Journal of Primary Health*, 13(1), 18-27.
- McGrath, P., & Phillips, E. (2008). Western notions of informed consent and Indigenous cultures: Australian findings at the interface. *Bioethical Inquiry*, 5, 21-31.
- Medew, J. (2009, 31 October 2009). Border politics keeps artist from clinic he helped fund. *The Age*. Retrieved from <http://www.theage.com.au/national/border-politics-keeps-artist-from-clinic-he-helped-fund-20091030-hpwf.html>
- Mills, R. (1994). Aboriginal Cultural Awareness Workshop, Territory Health Services, Hamilton Downs: October 1994.
- Mühlhäusler, P., & Damania, R. (2004). *Economic costs and benefits of Australian Indigenous languages*. Adelaide: University of Adelaide.
- Musharbash, Y. (2008). *Yuendumu everyday*. Canberra: Aboriginal Studies Press.
- Mushin, I., & Gardner, R. (2009). Silence is talk: Conversational silence in Australian Aboriginal talk-in-interaction. *Journal of Pragmatics*, 41(10), 2033-2052.
- Nathan, P., & Leichlietener, K. (1983). *Health business*. Alice Springs: Central Australian Aboriginal Congress.

- National Aboriginal Community Controlled Health Organisation and Oxfam Australia. (2007). *Close the Gap: Solutions to the Indigenous Health Crisis facing Australia: A Policy briefing paper.*
- National Archives of Australia. (2010). Governor Phillip's Instructions 25 April 1787 (UK). Retrieved 5th January 2010, from <http://www.foundingdocs.gov.au/copyright.asp>
- National Health and Medical Research Council. (2003). *Values and ethics: guidelines for ethical conduct in Aboriginal and Torres Strait Islander research.*
- National Health and Medical Research Council, Australian Research Council, & Australian Vice-Chancellors' Committee. (2007). *National statement on ethical conduct in human research.*
- Nelson, A. (2009, 10 December 2009). Comparison with Nazi Germany wrong. *Alice Springs News*, p. 12.
- Neulip. (2006). Model of intercultural communication.
- Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation. (2003). *Ngangkari Work – Anangu Way: Traditional Healers of Central Australia, Women's Council.* Alice Springs, Australia.
- Nicholson, P. (Artist). (2008). *The real Australians* [Cartoon].
- Nine Yuendumu Residents. (2009, March 24 2009). School vital to keep language. *Centralian Advocate*.
- O'Toole, J., & Beckett, D. (2010). *Educational research: creative thinking & doing:* Oxford University Press.
- Oxfam Australia. (2006). Failure on Indigenous health is our national shame. Retrieved from www.oxfam.org.au/media/article.php?id=311
- Oxfam Australia. (2009). *Close the gap: Indigenous health in crisis.*
- Palmer-Thompson, M. (2007). Aboriginal Cultural Awareness Program Coordinator. In K. Taylor (Ed.). Alice Springs.

- Papps, E. (2005). Cultural safety: daring to be different. In D. Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (pp. 20-28). North Shore: Pearson Prentice Hall.
- Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: the New Zealand experience. *International Journal for Quality in Health Care*, 8(5), 491-497.
- Patton, M. (2002). *Qualitative research & evaluation* (3 ed.). Thousand Oaks: Sage Publications.
- Pauwels, A. (1995). *Cross cultural communication in the health sciences*. Melbourne: Macmillan.
- Perkins, R., Langton, M., Atkinson, W., & et al (Eds.). (2008). *First Australians: an illustrated history* (Vol. 112). Melbourne: SBS/Miegunyah Press Series.
- Polit, D., & Beck, C. (Eds.). (2004). *Nursing research: principles and methods* (7 ed.). Philadelphia: Lippincott, Williams and Wilkins.
- Quayson, A. (2000). *Postcolonialism: theory, practice or process*. Malden: Blackwell Publishers.
- Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. Victoria University, Wellington.
- Ramsden, I. (2005). Towards cultural safety. In D. Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (pp. 2-19). North Shore: Pearson Prentice Hall.
- Randall, B., & Hogan, M. (2006). Kanyini [DVD].
- Ridgeway, A. (2002). *FATSIL Federation of Aboriginal and Torres Strait Islander Languages*, 23(6).
- Rigney, L. (2001). Intervention title: Building stronger communities: Indigenous Australian rights in education and language *Voice of the Land* 21.
- Rigney, L. (2002). *Bread versus Freedom: Treaty and stabilising Indigenous languages*. Paper presented at the National Treaty Conference.
- Rigney, L. (2004). Building stronger communities: indigenous Australian rights in education and language. *Balayi: Culture, law and colonialism*, 4, 73-82.

- Rivalland, P. (2006). *It's more than machines and medicine: they should understand there's a Yanangu Way'. Yanangu Providing their own Kidney Dialysis Services as Indigenous People from the Western Desert, Central Australia* Darwin: Western Desert Nganampa Walytja Palyantjaku Tjutaku and Cooperative Research Centre for Aboriginal Health.
- Roberts, K., & Taylor, B. (1999). *Nursing research processes: an Australian perspective*. Melbourne: Nelson Thomas Learning.
- Robinson, M., & Phillips, P. (2003). An investigation into the perceptions of primary care practitioners of their education and development needs for communicating with patients who may not be fluent in English. *Nurse Education Today*, 23, 286-298.
- Rudd, K. (2008). *Apology to Australia's Indigenous peoples*. Retrieved from www.pm.gov.au/media/Speech/2008/speech_0073.cfm.
- Schmidt, A. (1993). *The loss of Australia's Aboriginal language heritage*. Canberra: Aboriginal Studies Press.
- Schön, D. A. (1987). *Educating the reflective practitioner*. San Francisco: Jossey-Bass Publishers.
- Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Education and Counseling*, 64(1-3), 21-34.
- Sherwood, J., & Edwards, T. (2006). Decolonisation: A critical step for improving Aboriginal health. *Contemporary Nurse*, 22(2), 178-190.
- Skutnab-Kangas, T., & Phillipson, R. (Eds.). (1995). *Linguistic human rights: Overcoming linguistic discrimination*. Berlin: Mouton de Gruyter.
- Smedley, B. D., Smith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care* Washington D.C: Institute of Medicine.
- Smith, L. T. (2003). *Decolonizing methodologies: research and Indigenous Peoples*. Dunedin: Zed Books Ltd and University of Otago Press.

- Smith, S. (2006). Cross-cultural information leaflets. *Nursing Standard*, 21(4), 39-41.
- Smye, V., & Browne, A. (2002). Cultural safety and the analysis of health policy affecting Aboriginal people. *Nurse researcher*, 9(3), 42-56.
- Taylor, J., & Biddle, N. (2008). *Locations of Indigenous population change: What can we say?* Canberra: Centre for Aboriginal Economic Policy Research ANU.
- Taylor, K., & Guerin, P. (2010). *Health care and Indigenous Australians: cultural safety in practice*. Melbourne: Palgrave Macmillan.
- Taylor, K. A. (1997). *Aboriginal health workers at Alice Springs Hospital: a pilot project to evaluate alternative models of practice for AHWs*. Alice Springs: Alice Springs Hospital Territory Health Service.
- Thomas, D. (2004). *Reading doctors' writing: Race, politics and power in Indigenous health research 1870-1969*. Canberra: Aboriginal Studies Press.
- Thomas, J. (1993). *Doing critical ethnography* (Vol. 26): Sage Publications.
- Thomson, A. (1999). *The singing line*. London: Chatto & Windus.
- Thomson, N. (2005). Cultural security and related concepts: A brief summary of the literature. *HealthInfoNet*.
doi:http://archive.healthinfonet.ecu.edu.au/html/html_bulletin/bull_54/reviews/bulletin_reviews_thomson.pdf
- Toussaint, P., & Coiera, E. (2005). Supporting communication in health care. *International Journal of Medical Informatics*.
- Trudgen, R. (2001). *Why warriors lie down and die. Towards an understanding of why the Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact*. Darwin: Aboriginal Resource & Development Services Inc.
- Trudgen, R. (2005).
- Ulrey, K. L., & Amason, P. (2001). Intercultural communication between patients and health care providers: An exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Communication*, 13(4 January), 449 - 463.

- Usher, R., Bryant, I., & Johnston, R. (1997). *Adult education and the postmodern challenge. Learning beyond the limits*. London and New York: Routledge.
- Vidich, A. J., & Stanford, M. L. (2000). Qualitative methods - their history in sociology and anthropology. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (Second ed.). Thousand Oaks, California: Sage Publications Inc.
- Von Sturmer, J. (1981). Talking with Aborigines. *Australian Institute of Aboriginal Studies Newsletter*, 15(March 1981).
- Wakerman, J. (2004). Defining remote health. *The Australian Journal of Rural Health*, 12(5), 210-214.
- Walsh, M. (1993). Languages and their status in Aboriginal Australia. In M. Walsh & C. Yallop (Eds.), *Language and culture in Aboriginal Australia* (pp. 1-13). Canberra: Aboriginal Studies Press.
- Watson, C. (2006). *Warlpiri men's health seeking behaviour*. Charles Darwin University, Darwin.
- Webber, D. L. (1978). Interpersonal behaviour in relation to Aboriginal programs. *Australian Journal of Social Issues*, 13(1), 61-71.
- Weeramanthri, T. (1996). Knowledge, language and mortality: Communicating health information in Aboriginal communities in the Northern Territory. *Australian Journal of Primary Health-Interchange*, 2(2), 4-11.
- Wepa, D. (2005). Culture and ethnicity: what is the question? In D. Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (pp. 30-38). North Shore: Pearson Prentice Hall.
- Werner, O., & Schoepfle, G. (1987). *Systematic fieldwork: Foundations of ethnography and interviewing*. Newbury Park: Sage Publications.
- Whorf, B. (1956). *Language, thought and reality: selected writings of Benjamin Lee Whorf*. Cambridge: Massachusetts Institute of Technology Press.
- Wild, R., & Anderson, P. (2007). *Ampe akelyernemane meke mekarle: 'Little children are sacred'*. Darwin: Northern Territory Government.

- Wilkins, D. (2008). W(h)ither language, culture and education in remote Indigenous communities of the Northern Territory? *Australian Review of Public Affairs*.
- Wilson, E., Chen, A., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine*, 20, 800-806.
- Wilson, W. A., & Yellow Bird, M. (2005). Beginning decolonization. In W. A. Wilson & M. Yellow Bird (Eds.), *For Indigenous Eyes Only: A Decolonization Handbook*. New Mexico: School of American Research.
- Wren, S. (2007). Overseas trained nurses. Alice Springs.
- Young, J. (2005). On insiders (emic) and outsiders (etic): views of self, and othering. *Systemic Practice and Action Research*, 18(2), 151-162.
- Zon, A., Lindeman, M., Williams, A., Hayes, C., Ross, D., & Furber, M. (2004). Cultural safety in child protection: Application to the workplace environment and casework practice. *Australian Social Work*, 57(3), 288-298.