Collaborative Voices: Ongoing Reflections on Cultural Competency and the Health Care of Australian Indigenous People

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Abstract

The issue of cultural competency in health care continues to be a priority in Australia for health and human services professionals. Cultural competence in caring for Aboriginal and Torres Strait Islander peoples is of increasing interest, and is a priority in closing the gap in health disparities between Indigenous and non-Indigenous Australians. Through a collaborative conversation, the authors draw on a case study, personal experience and the literature to highlight some of the issues associated with employing culturally appropriate, culturally safe and culturally competent approaches when caring for Aboriginal and Torres Strait Islander peoples. The intent of this article is to encourage discussion on the topic of cultural competency, and to challenge health professionals and academics to think and act on racism, colonialism, historical circumstances and the political, social, economic, and geographical realms in which we live and work, and which all impact on cultural competency.

Introduction

The terms ‘culturally appropriate’, ‘cultural safety’ and ‘cultural competency’ are used to describe approaches to health service delivery for Aboriginal and Torres Strait Islander people. Over the past 20 years, we have seen substantial growth and emphasis on programs designed to increase cultural awareness of employees so that they might be able to provide care, support and treatment to Aboriginal and Torres Strait Islander peoples in a way that is culturally appropriate, culturally safe and culturally competent. There are mixed views about such training, and equally mixed experiences.

In this paper, we explore some of the literature about cultural competence and, in keeping with the theme of this special edition of the journal, we explore our thoughts as Aboriginal women, health professionals and researchers in relation to the terms ‘culturally appropriate’, ‘cultural safety’ and ‘cultural competency’. We do this through a discussion format as this gives us the capacity to engage with one another and express our thoughts in first person narratives, thus owning our own voices and ideas. Through our narratives, this paper will demonstrate the everyday reality for Aboriginal and Torres
Strait Islander people who access health care and who work within the health arena.

Please note that, within this article, BF refers to Bronwyn Fredericks and MT refers to Marlene Thompson. Where the text is silent in terms of the speaking voice, this implies that both Bronwyn and Marlene collaborated and therefore authorship is shared.

Beginning our dialogue and setting the scene

Bronwyn Fredericks (BF): I am a Murri woman from South-East Queensland. I grew up in Inala and the Ipswich area. My family have always lived on the south side of the Brisbane River and in the Ipswich region which is where we are historically and ancestrally from. My partner is a Kuku Yalanji man from North Queensland. I’ve lived in Brisbane, Melbourne, Rockhampton and other places. I’ve been working in health and human services for most of my adult life and have worked as a Project Officer, Manager, Chief Executive Officer, Teacher, Educator and Researcher. I’ve also been involved in community-based organisations for all of my adult life. I was the Chairperson of the Bidgerdii Aboriginal and Torres Strait Islander Health Service for nine years, Secretary of another organisation for about five years and on a number of other boards. I know I got this from my mother, because as from as far back as I can remember, she was also on committees. I have a number of qualifications and I try to use these in my work with other Aboriginal and Torres Strait Islander people and in our ongoing struggle.

Marlene Thompson (MT): I am a Koori Woman of the Yuin Nation. I come from a small community, a former mission called Jerrinjla, situated on the Crookhaven River on the South Coast of New South Wales. I am married to an Aboriginal and Torres Strait Islander man, a Gudang man, who is a Traditional Owner of the land on the Tip of Cape York. I have lived in the Torres Strait, Cairns and Rockhampton in Queensland. I have also lived in Sydney and Nowra in New South Wales, and worked in regional centres in a range of roles. I currently live in Cairns, North Queensland. I have worked as an Indigenous Health Worker/Educator, Diabetes Educator, Project Officer, and am now a Koori Researcher. I have worked in health since 1997. I have facilitated and coordinated various community health development, heath promotion and education programs; developed, implemented and evaluated health programs designed on clinically sound evidenced-based models; represented Indigenous people in forums; and I am one of the few Aboriginal people in Australia who is qualified as a Diabetes Educator.

BF: In terms of the work you undertake, what do you understand as ‘culturally appropriate’, ‘culturally safe’ or ‘cultural competency’?

MT: The terms ‘culturally appropriate’, ‘culturally safe’ and ‘cultural competency’ are extremely important to me. From my world view, the three concepts differ in terms of their application. These differences are important to acknowledge and fully understand. From my personal experience of working
in the health system, I find that sometimes people use these terms as what I call 'buzz words'. At times, I find that the terms are bandied around like some sort of tick and flick exam that can be easily passed. People do a one or two day cultural training course to be 'culturally aware'. There is more to the story, and much more to be learnt that cannot be taught sitting in a two day workshop.

MT: In order to provide information for those who are reading this article, I want to share a case study that illustrates the elements of 'culturally appropriate', 'culturally safe' and 'cultural competence'.

An Indigenous Male was a patient in the regional hospital. Both he and his wife are Indigenous Health Workers who had worked in their community for more than 10 years. In the hospital there were very few male nurses; the majority of nurses were female. During his lengthy stay in the hospital, conflict arose. The patient became quite agitated and would not converse openly with the female nurses. From the nursing staff’s point of view, he continued to be non-compliant and would not allow the female nurses to attend to particular components of his health care. What was going on? The wife and husband tried to explain to the nursing staff how they would like his treatment to be received, and there was an obvious breakdown in communication somewhere. Questions needed to be asked around the lack of understanding and on whose part?

As stated, both the patient and his wife are Indigenous Health Workers. Both are very well qualified with many years of practical health experience between them. The male patient became agitated when he felt that the female nurses were entering an area of health care practice that was uncomfortable for him, such as assisting him with bathing. The patient was not allowed to leave his bed for two weeks in order to recover and, therefore, needed to be bathed and needed assistance with toileting. His wife was the only person that he would allow to enter within this highly private realm and undertake such support tasks.

Many heated discussions took place, and his wife took on the role of negotiator between the patient and the nursing staff (an informal liaison type of role). At times, the patient disengaged from discussions and rarely spoke to the nursing staff.

It was not until a formal complaint was made to the hospital by the patient’s wife about the persistence of the nursing staff in trying to bathe him that the nursing staff began to realise the seriousness of the issue. They came to understand what discomfort he had in receiving health care from them and the issues that were present in terms of him receiving care. In the patient’s view, his cultural protocols of men’s and women’s business were being breached. The frustrating part of this for the patient and his wife was that each time a change of staff took place (with each shift change) they were forced to go through it all again with a different staff member.
This is a real case study. Often, Indigenous people in receipt of health care can be labelled as non-compliant, or they abscond and are then spoken of in a derogatory way for going ‘walkabout’. This type of absconding has nothing to do with the cultural practices associated with ‘walkabout’. Sometimes, it is not because people are unconcerned with their health; it can be the way in which the service is delivered. In this case, a female nurse may have thought she would not be fulfilling her duties if she did not attend to the male patient. However, the male patient was verbal in responses stating that his wife would be able to attend to his needs. All he required were items such as a towel and a basin with warm water. The patient and his wife felt disempowered because they felt their requests, no matter how subtle, were not being acknowledged. Nor did they feel respected for their work experience and knowledge about health care as highly experienced health workers. After the complaint was made, the patient’s time at the hospital was less uncomfortable. The nursing staff knew what duties they could assist with, and what his wife would attend to.

The questions that come from this case are: Why did it get to the point of the patient and his wife having to make a formal complaint about the health care received? Why didn’t the staff hear both the patient’s and his wife’s requests?

BF: What stands out in the case study you shared is the lack of understanding of the cultural realms of men’s and women’s business. It’s also clear that we, as Aboriginal people, adhere to these gendered domains even when we have experience and a professional working knowledge of health care practices and our own health care needs. As a health worker of 10 years, the male patient knew what needed to take place in terms of his health needs. But this didn’t mean that he was not vibrantly committed to ensuring that his cultural needs as an Aboriginal man were met. In staying steadfast to his cultural needs and ensuring that they were met, his health care needs were affected.

**Cultural appropriateness**

According to Thomas (2002: 2), cultural appropriateness is “the delivery of programmes and services so that they are consistent with the communication styles, meaning systems and social network of clients, or programme participants, and other stakeholders”. In Australia over the years, the words ‘culturally appropriate’ have become embodied with a sub-set of connected meanings associated with Indigenous health. For example, one can draw on ‘culturally appropriate approaches’ when working with Indigenous people, or a service can be described as ‘culturally appropriate’ or ‘culturally inappropriate’ for Indigenous people.

Cross-cultural awareness has been employed as a strategy within workplaces, in an attempt to create health and human service environments that are more culturally appropriate to Aboriginal and Torres Strait Islander
people (Fredericks 2006). This includes appropriateness for Indigenous people as co-workers or as the clients that those workplaces serve (including via programs or direct service delivery). Underpinning the cultural appropriateness training, according to Young (1999: 205), is the concept that if workers know more, they will be more tolerant of other cultures and make adjustments to their behaviour at work.

One difficulty with cross-cultural training is knowing how to measure or evaluate it in terms of whether it alters behaviour or services. A Western Australian Department of Health document states that “Cultural Awareness as a public policy has been in vogue for more than 25 years, yet Aboriginal people continue to portray health services as alienating and uncomfortable” (n.d.: 12). Phillips (2005) asserts that cultural awareness could stigmatise Indigenous people and Indigenous health issues, and therefore result in culturally inappropriate health service delivery. That is, cultural awareness training could result in behaviours which, in fact, work in ways that work in opposition to what was intended.

BF: Simply creating awareness or making something culturally appropriate does not bring about the structural changes needed and a true recognition of Indigenous rights. Neither does it involve reflecting on the positioning of non-Indigenous people by non-Indigenous people. It does not mean that participants will look at their own subjective identity in relation to the social order. Cultural awareness training focuses the lens on Indigenous people as being under-serviced, needy and problematic to non-Indigenous people to some degree because their efforts to service us have failed. If more people become more cross-culturally aware, or more culturally appropriate, what change will it bring for Indigenous peoples aside from services and programs that we are already entitled to and that fit within Australian society’s bureaucratic structures? Cultural awareness training does not mean that we, as Indigenous peoples, will be any healthier – as Indigenous people and as defined by Indigenous people. It does not mean that we will be exercising our rights, roles and responsibilities as Indigenous peoples nor that non-Indigenous people will be exploring how they acquired their privileged positioning within Australia and moving to redress their positioning. From my perspective, more focus is needed on the role of non-Indigenous people in their societal positioning and our positioning as Indigenous peoples, and structural change within the health system, including at the interface of patient care.

MT: Culturally appropriate service provision, from my point of view, is when a service is delivered in a manner that is mutually respected by all parties. By saying mutually respected, I mean that when a service is delivered, there is reciprocal respect by the service provider who accepts Indigenous cultural protocols. In the above case study, the nursing staff were ‘culturally unaware’ of the patient’s unease at the possibility of having a female nurse bathe him. After the complaint was lodged and discussion took place about what his wife could assist with, the patient’s time in hospital improved. The staff became more open to hearing what the patient and his wife would say and were more
attentive to his needs; the patient and his wife felt more at ease and were able to move forward with his recovery.

BF: Other words or terminologies might be drawn on here too in relation to the example given by Marlene. Some of these other terms are ‘cultural sensitivity’, ‘cultural security’, ‘cultural awareness’, ‘cultural respect’, ‘cultural safety’ and ‘cultural competency’. It is to cultural safety that we now turn.

Cultural safety

From the literature, it is very clear to us that Maori woman Irihapeti Ramsden was the first person to put forward a model of cultural safety when she articulated Maori dissatisfaction with nursing education and care of Maori (see Ramsden 2001; 2000; 1997; 1996; 1992; 1990). The work of Ramsden was later drawn upon by Australian groups, institutions and individuals (Bin-Sallik 2003). Questions remain, though, as to whether people need to be ready to explore their own subjectivity in relation to care giving. What can they do when they realise the unequal power relationships that are invested in health systems and structures that maintain the dominance of non-Indigenous people? Can cultural safety be measured or evaluated as to whether it has made a difference?

BF: I see cultural safety as extending beyond cultural awareness programs which essentially teach non-Indigenous people about us (see Fredericks 2006; 2008). Cultural safety seeks to engage workers in their own feelings of safety in how health care is delivered, and requires non-Indigenous people to reflect on their own cultural identity and understand the impact of this cultural identity on their professional practice.

MT: Cultural safety to me denotes services that are delivered in a form that is non-discriminative and without underlying or indirect racism. From an Indigenous perspective, it is the ability to receive health care, which is our basic human right, without the fear of retribution or as a consequence of our ethnicity. It is what makes us as Indigenous people unique (Bin-Sallik 2003); it is what makes us who we are.

BF: In essence it is about one’s own subjectivity, one’s own positioning, and coming to understand that in relation to how we interact and relate to other people in a range of settings and environments. In health care, everyone therefore needs to recognise how their cultural, ethnic, gender and religious backgrounds influence their perceptions, understandings and decision-making in relation to those that they are caring for. Drawing on the work of Anderson et al (2003), cultural safety should challenge people to examine their own biases, opinions and the perceptions they have of others, along with the unequal power relations constructed within the health care system they work within. While we understand that this is so and that universities are taking steps to critically teach health professionals to do this, one has to wonder why situations like the one Marlene has shared still happen if people are taking on board what they have been taught.
MT: Let’s revisit the case study. The male patient and his wife are both Indigenous. Their worldviews are similar. Throughout the course of treatment and the angst and frustration they experienced, their cultural safety was diminished (Bin-Sallik 2003). Instead of empowering and enabling the patient and his wife, the opposite occurred; both the patient and his wife felt disempowered and disenabled. As a result of what they experienced, and through their experience of the health system, they were able to raise their concerns through the appropriate formal compliant mechanisms within the hospital. They obviously knew how to take the matter further to rectify the situation. What would happen to someone who didn’t have the experience that this male patient and his wife had?

**Cultural competence**

Cultural competence, as defined by Campinha-Bacote et al (1996: 59), is a process in which the health service provider or carer “continually strives to achieve the ability to effectively work within the cultural context of an individual, family, or community from a diverse cultural/ethnic background”. Since their definition includes the words ‘continually strives’, we take it to mean that the process is on-going and that an individual or service can continue to make improvements and grow in proficiency in cultural competency. Campinha-Bacote’s work (1999) outlines that cultural competence includes: learning to value and understand other cultures (cultural awareness), acquiring basic cultural knowledge about other cultures (cultural knowledge), the ability to apply cultural knowledge in patient health care (cultural skills), developing experience through cross-cultural interactions (cultural encounters), and having the motivation to pursue all of the above. The model put forward by Campinha-Bacote (1999) focuses on the individual, and is useful when reflecting on individual interactions and patterns of behaviour within health care settings. Other models and frameworks have been put forward to address organisational and systems level levels (see for example, Bauer 1993; Brach and Fraser 2000).

MT: To me, cultural competency is a personal journey. At an individual level, a person cannot gain cultural competency by participating in a workshop or learning from a book. To be culturally competent is the result of being culturally aware, delivering culturally appropriate services, and ensuring those services are culturally safe in a way that clients accept. Thus, you become culturally competent over time. I believe that the only way competence can be demonstrated is by experience and learning with the community in the community. This is much the same as the education system that is competency based. Therefore, to be culturally competent there is a learning process which includes the community.

MT: Again, revisiting the case study, the nursing staff became more aware of the needs of the male patient in order for his recovery to be stress free. Nursing staff may have become ‘culturally competent’ in male and female cultural care needs because they learned first hand, albeit in an ad hoc
process, what cultural needs the male Aboriginal patient required. However, in a large regional hospital, one could have assumed the staff would have already been culturally competent given the high proportion of Indigenous patients at that hospital. In Indigenous culture, hearing and listening are two different things. A person can listen but not necessarily hear what is said. The angst and frustration for the patient could have been avoided if the staff had listened and heard what he and his wife were saying.

BF: I want to link the case study back to the cultural competency literature and some of the work being done by Indigenous scholars. Campinha-Bacote’s (1999) model outlines that cultural competence includes cultural awareness, cultural knowledge, cultural skills, cultural encounters, and having the motivation to pursue these things. I have often wondered how this takes place. I will explain why I have difficulty with this. The works of Atkinson, Taylor and Walter (2010) and Walter (2007; 2009) clearly demonstrate that Indigenous and non-Indigenous people live and work within very different social, economic and geographical realms. Walter (2009) highlights that the workforce is segregated in terms of occupational type and employment sector, and that more Indigenous people are employed in the public sector and at lower decision-making and management levels. Therefore, even as workers within the health system, Indigenous people are more likely to be health workers, liaison officers and administration officers, while non- Indigenous people are more likely to be doctors, nurses, managers and high level policy officers. In their work, Atkinson, Taylor and Walter (2010) demonstrate that people who are more educated, more likely to be engaged in higher paid jobs and more likely to be in positions that can influence policy, systems and decisions are more likely to be non-Indigenous and to live in suburbs with few or no Aboriginal and Torres Strait Islander people. Thus, the on-going historical, social, economic and political racialisation and marginalisation of Indigenous peoples continues, as it did in Australia’s colonial past. In other words, the people more likely to be engaged in decision-making within health care settings (including decisions about patients and in health care policy that relates to Indigenous people) are more likely than not to be non-Indigenous and to have very little opportunity to engage with Aboriginal and Torres Strait Islander people outside of work or in arenas where there is no supervisory, coach or ‘boss’ role (Atkinson, Taylor and Walter 2010). In addition, if they are within the same socio-economic and social grouping as their parents, then it is feasible that they also had little or no opportunity for engagement with Aboriginal people when they were growing up (Atkinson, Taylor and Walter 2010).

Questions about developing cultural competence

BF: I would like to propose a number of questions to encourage deeper dialogue between Indigenous people, health professionals and academics. These include:

• How can health professionals develop cultural skills and actively participate in cultural encounters when the Indigenous people they have
had contact with are via a supervisory relationship or as a patient receiving care?

- How can Australian university staff teach cultural competency when their relationships with Indigenous people are probably also based on the same set of distant relationships that their students have with Indigenous people, and possibly also involve the same levels of segregation in their lives (Atkinson, Taylor and Walter 2010), and when the majority of them are non-Indigenous?

Sometimes, Indigenous people may be invited to speak to students as guest lecturers or as community members to share their stories. But in these instances, Indigenous people are offered the role of ‘informant’ (Khan 2005: 2025) or ‘targeted resource’ (Gareau 2003: 197), and provide legitimacy and advantage to the university and the non-Indigenous people who perhaps co-ordinate the subject. Depending on how this is handled, it can have either a positive outcome or result in us as Indigenous people servicing non-Indigenous academics in the same way that Indigenous people were required to service non-Indigenous people in colonial history (Huggins 1989; Rintoul 1993). As Moreton-Robinson (2008: 86) explains, placing us in such a service relationship also positions our Aboriginality “as an epistemological possession to service what it is not”. I am aware of a number of Indigenous people who are highly selective about what lecture or speaker invitations they accept, as they believe that the preparation time and the delivering of such talks diverts their attention from their own and their community’s priorities toward the priorities of the dominant society.

- How can health and human service professionals develop cultural competency skills within this context and intertwine them with a patient-centred approach (Saha, Arbelaez and Cooper 2003) to care for Aboriginal and Torres Strait Islander people and bring about improved health outcomes (Epstein and Street 2007; Mead and Bower 2002)?

- How can health and human service professionals develop along the path to proficiency in cultural competency without assuming the roles of ‘goodwill’ and ‘benevolence’ or being seen as ‘special for doing so’? This may sound harsh to some, but there are numbers of non-Indigenous people who are awarded kudos, credibility and seen as honourable for their work (Lampert 2003) in Indigenous health or for assisting and caring for Indigenous people. I am referring to health and human service professionals and academics, and I will also say that the awarding is done by mostly non-Indigenous people (and sometimes by Indigenous people). Generally, if the motives or behaviours of awards are questioned, Indigenous people are given a justification of how ‘honourable’ or ‘special’ the person, people or organisation is, or that they were ‘only trying to…’. In the process of this justification, sometimes Indigenous people come off looking ungrateful (or being told we are ungrateful). These types of statements, and others of goodwill and benevolence, mask the power differentials (Hage 1998; Riggs 2004) and deny the truth of Indigenous poverty and dispossession and non-
Indigenous privilege. Riggs’s (2004) work on whiteness and benevolence is useful for providing a context about why some non-Indigenous people are seen as ‘good white people’ and are given personal and institutional legitimisation for helping Indigenous people or advocating for Indigenous people, even if Indigenous people don’t agree or aren’t empowered by the activities of the ‘good white people’.

MT: Hopefully these questions will stimulate debate amongst nurses, practitioners, policy makers and academics about how to develop cultural competency within the every day. They are questions for people to ask of themselves as they work within cross-cultural environments or when contemplating working within cross-cultural environments. The answers might vary depending on where one works, the context of the exchange and where people are along the cultural competency journey. Nevertheless, this does not mean that these questions should not be asked.

**Conclusion**

The intent of this article was to foster discussion on the topic of cultural competency and to challenge health professionals and academics to think and act on racism, colonialism, historical circumstances and the political, social, economic and geographical realms in which we live and work and which impact on cultural competency. We have done this through a collaborative conversation drawing on a case study, personal experience and the literature to highlight some of the issues associated with employing culturally appropriate, culturally safe and culturally competent approaches when caring for Aboriginal and Torres Strait Islander peoples. In using a collaborative conversation as a means to discuss the issues, we have moved from the object to the subject and have been able to gain a form of liberated voice (Hooks 1989). We believe that a key challenge is to encourage this deepening of dialogue to bring about change in the future, and we encourage others to do likewise so that cultural competency incorporates strategies that can act on racism, colonialism, historical circumstances and the political, social, economic and geographical realms in which we live and work.
References


