The Winston Churchill Memorial Trust of Australia

Report by Eileen Van Iersel

2008 Churchill Fellow

Research to compare the differences between Cultural and Communication Barriers within a Health Setting.

I understand that the Churchill Trust may publish this report, either in hard copy or on the Internet or both, and consent to such publication.

I indemnify the Churchill Trust against any loss, costs or damages it may suffer arising out of claim or proceedings made against the Trust in respect of or arising out of the publication of any report submitted to the Trust and which the Trust places on a website for access over the internet.

I also warrant that my final report is original and does not infringe the copyright of any person, or contain anything which is, or the incorporation of which into the Final Report is, actionable for defamation, a breach of any privacy law or obligation, breach of confidence, contempt of court, passing-off or contravention of any other private right or of any law.

Signed ………………………………. Dated …………………………..
INDEX

INTRODUCTION 3

EXECUTIVE SUMMARY 4

BACKGROUND 5

CULTURAL SAFETY 6

COMMUNICATION BARRIERS 7-9

CULTURAL BARRIERS 10-11

CONCLUSION 12

RECOMMENDATIONS 13

CENTRAL AUSTRALIAN GEOGRAPHICAL MAP 14
(Attachment)
INTRODUCTION

Aboriginal culture is one of the oldest surviving cultures of the world, made up of hundreds of language groups within Australia. The various socio-economic factors that contribute to poor health rates amongst Aboriginal people are similar to other indigenous nationalities that have little or no access to appropriate health, housing, education and employment services.

The national population of Aboriginal and Torres Strait Islander in Australian people is approximately 2.5%, the lower percentage of the population nationally. The mortality rates amongst Aboriginal people remain 15-20 years less than non-Aboriginal people, an indication that Aboriginal health has not improved greatly.

While Aboriginal people make up the lower percentage of the total population in Australia, they continue to make up the higher percentage of patient bed days in hospitals. As an example the Alice Springs Hospital patient bed days occupied by Aboriginal people can be anything between 80-85% on an annual basis.

The Alice Springs Hospital is unique in regards to its geographical location, providing acute health care services to approx. 100 million sq hectares and 15 Aboriginal languages.

The Winston Churchill fellowship was used to undertake a comparison in New Zealand (Cultural Safety models), the US (medical interpreters) and Canada (Indigenous access to mainstream health care services).

Acknowledgements

I extend my appreciation to the Churchill Trust and the opportunity that allowed me to travel overseas to experience the multiculturalists of the countries I visited.

Thank you to Vicki Taylor, General Manager of the Alice Springs Hospital who supported my study and acknowledged the importance of this topic as the NT Department of Health and Families roll-out the Cultural Security policy in 2009. And most importantly, to my family who at times found it difficult when they needed me the most, but understood that I had to take advantage of this unique opportunity.
EXECUTIVE SUMMARY

Eileen Van Iersel
Manager Aboriginal Support Services –
Alice Springs Hospital PO Box 2271
Alice Springs NT 0871
eileen.vaniersel@nt.gov.au

Project Description

Fellowship travel was undertaken between 3rd November 2008 – 11 December 2008 to compare Communication and Cultural Barriers for Indigenous and minority groups in three different countries within a Health Setting.

The aim of the fellowship was to compare cultural safety models and communication strategies in hospitals where there is a high population of non-English speaking people living in English speaking countries where there are diverse health needs; and where there is a large population of minority groups, (that includes refugees and migrants)

This comparison study highlighted the need for more resources to be developed to improve communication and reduce cultural barriers to ensure people can receive Culturally Secure Health-care services.

Highlights:

Meeting Naida Glavish, Chief Maori Adviser – Auckland, New Zealand
Attending the Maori health workforce workshop – Auckland, New Zealand
Experiencing a traditional Maori Welcome (Nau mai)
Working alongside Izobel Aroacha and Medical Interpreters at the Cambridge Health Alliance and with Oscar Aroacha at the Boston Medical Centre.
Darcy Jagodzinsky, Senior Coordinator. Inuit Health Canada, Alberta Region and meeting Gloria Letendre, Bigstone Cree Nation and Anne Bird, Paul Band First Nations Reserve
Tania Thomas, Deputy Health Complaints Commissioner, Auckland New Zealand.

Implementation and Dissemination of learning’s in Australia:

- Presenting my learning’s at local and national conferences/audiences Australasian College of Surgeons, Alice Springs August 2009
- As on-line facilitator for Cultural Awareness learning modules, Australasian College of Surgeons. (April/May 2009)
- Medical staff orientations/presentations
- Reinforcing the values of Cultural Security during the implementation of the NT Health & Families Cultural Security policy.
BACKGROUND

In Australia the impact of colonisation of Aboriginal people resulted in the loss of land, culture, language and spiritual well-being and have economically and socially marginalised and exposed Aboriginal people to new diseases, a similar effect that occurred with the people of the ‘First Nations’ and the ‘Maori’.

Colonisation around the world has also resulted in an inability for the Aboriginal people of that land to access health care services, education, employment and housing the key contributing factors that continue to prevent Aboriginal people from living long healthy lives and in some instances, culture and language were irretrievably lost.

The Alice Springs hospital is a 180 bed hospital and provides health care services to a remote Central Australian geographical region that covers approximately 1.6 million sq kilometres. (Map attached)

In this region there are approximately 22 Aboriginal languages spoken.

Most Central Australian Aboriginal people speak English as a second, third or fourth language, live in some of the remotest communities in Australia and have to drive 3-6 hours on corrugated dirt roads to access health care services.

The Alice Springs Hospital is also a specialist teaching hospital and a high number of medical staff are either overseas trained or have not had experience working in a remote and diverse region with Aboriginal people who live semi-traditional lifestyles.

Communication and cultural barriers prevent people who speak English as a second or third language from receiving a full understanding of their health issues, giving proper informed consent, and receiving health-care services that are culturally appropriate.

I visited hospitals and health care services throughout Auckland New Zealand, Boston in USA and Edmonton Canada.

8th – 17th November 2008 - Auckland, New Zealand
18th November 2008- 27th November 2008 - Boston Mass, USA
‘Reflection Break’
1st December -6th December 2008 - Edmonton, Canada

Standing outside the Maori Cultural Healing Centre with (L-R) Naida Glavish- Chief Maori Adviser, Tania Thomas, Deputy Commissioner Health & Disabilities Complaints Commission, me & staff member.
CULTURAL SAFETY

This comparative research was done in locations where there are minority populations and where issues around language and culture have an impact on people’s health and well-being.

Minority groups are usually immigrants, lower income earners, lower on the socio-economic scale. Have poorer health, education, housing and access to health care services.

The Alice Springs Hospital based their Cultural Safety practice on the New Zealand model.

While there maybe several interpretations of Cultural Safety, the origin of the term Cultural Safety was first introduced in New Zealand, when a first year nursing student was attending a training day in Christchurch, she had been listening carefully to the talk and to the language being used. Finally she rose to her feet and said that legal safety, ethical safety, safe-practice/clinical base and a safe knowledge base were all very well to expect from graduate nurses, ‘but what about cultural safety’?

The presenter, a very experienced Maori nurse, gave this some serious thought and considered what this young graduate had just said.

While the term Cultural Safety can have several interpretations, the meaning that fits into a health care service is ‘an environment that is welcoming and does not discriminate against ones race, religion or cultural beliefs and language, a place where one can receive services in a safe environment where they don’t feel discriminated against just because their beliefs or language are different’.

Cultural safety can also include making changes to the work system to ensure people feel comfortable when entering a health-care service; it’s about systematic change and could include employing more frontline staff who is from the same language/cultural group as the majority of your clients.

This diagram illustrates clients and staff working together to provide a culturally safe environment.
COMMUNICATION BARRIERS

Cultural diversity exists amongst the minority groups worldwide; there are many similarities between the Indigenous peoples. These people go through the process of adjustment and adaptation, living in a diversity of situations, often on the lower socio-economical scale and includes poverty.

For many of these groups they are limited to their choice of health care providers and have to access the public health system; this creates a multitude of different languages and ethnic groups congregating in one hospital.

As an example the Boston public medical centre caters to a large number of multi-lingual people. The number of referrals for interpreters in one year demonstrates the high need of requests for medical interpreters, however these figures do not determine if these referrals were for in-patients only;

Spanish 43%  Polish 3%
Haitian French 16%  Somali 2%
Cape Verdian 9%  Arabic/Kurdish 2%
Portuguese 6%  Albanian 2%
Vietnamese 5%  Ethiopian 2%
Chinese 3%  Russian 1%
Bosnian 1%  Other 5%

2008 – Spanish was the language in high demand (43%) compared to Haitian French (16%) which was the most used language for the Boston Hospital.

In the Boston medical centre and Cambridge Health Alliance, Interpreters are medically trained and have an understanding of medical terminology to ensure medical information is translated and the information is done in a culturally safe way, compared to the Alice Springs hospital where the Aboriginal Liaison Officers are nationally accredited interpreters, provide cultural brokerage services and do not have access to medical terminology training.

Minority groups can experience ‘Culture Shock’ and will impede the way they receive or give information. At times withdrawing and not interacting with others, to overcome this problem, many Interpreters will provide a cultural brokerage service to ensure the Doctor/patient interaction does not delay the passage of information. Organisations risk management strategies need to address these issues.

While accompanying several medically trained interpreters at the Cambridge Health Alliance in Boston, I was able to see first-hand how the referral was made, to the actual consultation between doctor and patient.

It was interesting to note a few medical practitioners directing their questions at the interpreter and would not involve the patient nor have direct eye contact. This could be due to cultural sensitivity and eye contact may be considered offensive but it highlights the need for medical staff to be trained in the use of interpreters, so they are mindful of how complex this type of interaction can be. Trust and respect are two important points to be aware of when interacting with someone from another language group.
It is also important to note that not all patients that speak a language other than English will want an interpreter and would prefer to have a family member or friend, interpret for them.

Good communication strategies include the structuring of questions and will enable staff to determine if the patient requires an interpreter, and in an ideal situation staff would not ask direct questions, instead would ask a patient “What language do you speak at home”?

Medical interpreters working at the Cambridge Health Alliance, experience situations where a patient may waiver their rights to an interpreter because they do not want someone outside their cultural group to know their private business, or that interpreter is known to them outside of the hospital.

To avoid any repercussion the interpreters will have the patient sign a waiver form and include the reasons why the interpreter was declined. This is signed by patient and staff and included in the patient’s notes.

It is essential that patients are informed of interpreter’s expertise such as fluency in language, medical knowledge and terminology that hospital based interpreters hold and should be explained to patients prior to patient waiving their rights to an interpreter.

Patients must also understand that family and friends may not understand medical terminology and can prevent them from receiving a consultation where they are able to ask questions. There are doctors that will take time to use pictorials and other visual aids to assist the patient to have a full understanding of what is being said.

Communication flow – Urban and Remote

In Edmonton I was privileged to meet two women of the First Nations, they explained the lack of information flow from doctors in Central City hospitals to the remote health care services resulting in people being referred to as non-compliant when they return to their communities.

People are then stereo-typed and labelled as a burden on society. This leads to low self esteem and self worth.

This is similar to how communication problems occur within Central Australia given the vastness of the geographical region it services and the number of different languages and cultural practices within that area.

Information needs to flow between health care service providers so that there is a continuity of care and patients are well-informed.

The way information is relayed is an important aspect of communication, and unless there is effective communication, can result in a patient’s inability to understand medical advice and comply with medical treatment.

While Medical staff, want to be able to diagnose in order to treat the patient, communication barriers can prevent effective information and may result in the patient failing to inform doctor of important family and medical history.
Most hospitals have access to Interpreter services, whether they are hospital based or accessed through an interpreter service. At times a delay in an interpreter presenting to referral should not mean the consultation proceed, staff need to determine if the consultation can be delayed until an interpreter arrives so that important information can be properly extracted from the patient.

At medical services throughout the USA video interpreting units are used for various reasons to assist with interpreting requests. While there are language barriers, there are also patients that communicate through signage.

Where there may be problems accessing an interpreter who speaks a particular language, or the interpreter is of the wrong gender and can not interpret face-to-face one of these units can be used. The interpreter is based at an interpreter service and communicates through this unit.

Using hospital based interpreters or medical interpreters when a patient arrives at hospital will identify problems that may present at a later stage of medical treatment and will assist in the identifying information on past medical history, family contact details and other important information.

Communication is also complicated when a non-English speaking patient is not confident in asking questions. Interpreters can be used to support patients concerns and can influence the Doctors behaviour.

**CULTURAL BARRIERS**

Cultural barriers can also prevent a patient from receiving a full course of health care treatment. My study reinforced reasons Aboriginal people Take Own Leave (abscond) from hospitals and health-care services.

At times patients are scared and don’t understand why they are there and what medical treatment is being given. A long stay in hospital that is not environmentally or culturally friendly can lead to patients leaving before medical treatment is completed.

It also involves Health care staff understanding that minority groups have common elements that are strongly rooted in the family and extended family.

Aboriginal Australians, Maori from New Zealand and people of the First Nations in Canada has similar cultural elements. Kinship is formed based on language groups, biological and kinship systems that are formed through ‘cultural connections’ (ceremonies) and a particular area in the country.

**Some of the common cultural issues are:**

- Appropriate communication
- Avoidance relationships
- Touching of certain body parts
- Birthing practices
- Gender issues
- Death and burial
- Grievance of past practices
Cultural misunderstandings can prevent medical staff from making a full assessment. If a man is uncomfortable with having a female interpreter or doctor, he will not communicate, as this is not acceptable and inappropriate in his culture and vice versa with female patients.

Many cultural groups have common avoidance issues and ceremonial laws.

In Central Australia, avoidance relationships amongst Aboriginal Australian people is usually when a mother-in-law and a son-in-law cannot speak or have any eye contact with each other and a brother and sister cannot play together after he has been to men’s business, (usually between the ages of 13 – 16) as he is then considered a man.

This creates a multitude of problems when a hospital policy may state that a person under the age of 16 years old is considered a child, yet under his custom, he is in fact a young man. Is this young person going to be admitted to the paediatric ward or to an adult ward and how is it determined if he should be admitted to an adult ward or to a children’s ward?

A common theme that happens in other countries where there are a large population of minority groups is when patients admitted without understanding why they are being admitted can also create problems that may present during the hospital stay and for reasons that could have been resolved prior to admittance.

It can vary from wanting a family member to ‘stay’ in the room with patient or they don’t want to be in the same room as a person from another language group because there may be a cultural or religious issue.

Patients who speak English as a second language may present as shy or withdrawn. They could be afraid because they simply don’t understand why they are in hospital receiving medical treatment or their treatment is against their cultural beliefs.

Aboriginal and minority groups may be afraid to stay in hospital on their own and want a family member to remain with them. This person may be from a small and remote community or village, or it may be their first hospital admission. The hospital environment may be unfamiliar to them and can be put into a mixed ward that includes different gender, cultural and/or language mix.

There could be cultural elements in the way information is relayed, certain terminology, how the room is set up, who is part of the discussions, and gender. Interpreters play an important role in health services, not only as interpreters but the other important role as a ‘Cultural Broker’.

Not all patients will agree to an interpreter because they may:
- Know each other outside of hospital and want information kept private
- May believe the Interpreter will tell others about the patients health issues
- Be culturally inappropriate for that particular interpreter to translate, even if they speak the same language – avoidance issues

In Central Australia people who are biologically related may not be able to translate for one another because of ‘Ceremonial Reasons’.
Stories shared with me.

“There are not enough trained hospital staff who are fluent in multi-lingual languages and are able to treat patients in a culturally safe way just by having the key fundamental expertise such as; fluency in language, medical knowledge and terminology and cultural safety”.

“A Doctor who thought he was pretty good in the Spanish language was treating an elderly Spanish man who spoke very little English. The Dr decided against calling an interpreter and decided his fluency in Spanish was good enough and proceeded to explain his diagnosis in Spanish. Later in the day the elderly man’s son arrived to visit him. The elderly man said to his son, “You need to take me home because I am going to die. My heart is burnt out” His son was very concerned because he had not been informed of this from the hospital. He asked the Dr to be paged. The Dr arrived and the son explained what his father had said. The Dr looking confused explained that he informed his father he had heart burn”. The elderly man thought his heart had burnt out as this is how the Dr had interpreted it.

A woman that speaks Pitjatantjara (An Australian Aboriginal language) as her first language being informed she needs to sign on the dotted line on this form (Consent) because the doctor needs to amputate part of her leg today because the infection has spread. Interpreter had to intervene and inform the medical staff that it isn’t acceptable for the patient to have the operation without a family meeting being held so that family are aware of the operation procedures and to give their consent.

A young Portuguese lady preparing for the birth of her baby, cultural considerations ignored. She became stressed and resulted in medical staff being concerned for her and her unborn child. An interpreter was called and after discussing her concerns, was able to negotiate how staff could meet the patients cultural needs that was mutually agreed upon

“Competency is not separate from communication skills; it’s not a trade off”!
William Oster, MD Professor of Medicine
CONCLUSION

During my study overseas, it became apparent that it didn’t matter where I travelled or what language was spoken when visiting the various Organisations, common barriers exist.

Many hospitals already recognise the disparities in health care delivery and have included ‘best practice’ tools that includes Cross-Cultural awareness training for all staff, however we need to recognise teaching hospitals have a high turnover of staff who may have a different working culture and English as a second language.

- Cultural and communication barriers are over arching and errors are more likely to occur when language and cultural barriers exist between patient and their health-care provider and can contribute to an adverse event.

- Some hospitals may treat very few patients from the minority groups so may not have issues around inequalities and therefore not believe it important to change its working culture or systems. Changing the attitude of hospitals will depend on their Risk Management Strategies and if it includes a patient that was ‘culturally at risk’.

- My overseas travel reinforced the need for hospitals to include cultural safety mechanisms into their quality improvement and risk management policies.

- The comparative study revealed common attributes of Indigenous people is, when communication or cultural barriers exist, patients will ‘vote with their feet’, this means a patient will walk out of the hospital without notifying medical staff.

The terminology used in the Alice Springs Hospital is Take Own Leave (TOL) or Abscond. This is different to ‘Discharge against Medical Advice’. Discharge against medical advice’ is when a discussion takes place between medical staff and patient signs a form stating they take full responsibility for their health once they leave the hospital.

There are times when it is simply a life or death situation and operations are performed without a patient’s consent, but where the procedure/operation can be delayed until family can arrive, should be considered.

Reasons for communication barriers are complex. Addressing communication barriers should be an important component of an organisations risk management strategy and accreditation regulations.

For long-term sustainability in mainstream services, there needs to be more than the ‘cultural awareness’ programs.

The problem with cultural awareness today is staff lack cultural competency and the only way forward is to understand the past practices and develop cultural security policies and improve the health-care work culture.
RECOMMENDATIONS

• Medical services to include communication and cultural safety strategies in their risk management strategies and accreditation regulations.

• Strategies developed for on-going cultural security training for staff and to include visiting specialists and locums.

• Systemic changes to include resources that are readily available for patients that speak English as a second language.

• Medical services to include the development of culturally appropriate infrastructure, better coordination of available services to allow greater flexibility in service delivery.

• Medical staff to be competent in Cultural Security and have an understanding of the patient’s language and cultural/religious beliefs before commencing a consultation.

• The structures of buildings need to be considered when building or redeveloping, to improve Aboriginal people’s access to a culturally safe environment, and can result in Aboriginal people not feeling intimidated.
To assist in locating a language area refer to the key below which shows the colour and shape of the areas.