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Healing conversations: developing a practical framework for clinical communication between Aboriginal communities and healthcare practitioners

Introduction

Australia, as a nation, embodies a richness in community belief systems, life perspectives and shared values stemming from a variety of historical backgrounds. Central to the Australian identity are the Aboriginal and Torres Strait Islander peoples as First Peoples and caretakers of the land many of us are privileged to call home.

Daily demonstrations of solidarity, survivorship and resilience exhibited by the Aboriginal and Torres Strait Islander community are closely entwined with ongoing marginalisation from societal structures, restricted access to basic resources and inter-generational impacts of destructive historical policy stemming from colonisation [1-3]. Colonisation, the colliding of two worlds and the meeting of different systems of knowledges and beliefs, marked the beginning of a long struggle for many Aboriginal and Torres Strait Islander peoples (hereafter Aboriginal) to reclaim individual and group identity, connection to country, family and spirit [1, 2, 4].

The combined effects of colonisation, the social determinants of health and competing belief and knowledge systems are evident in the continuing health outcome disparities between the Aboriginal and non-Aboriginal populations in Australia. Aboriginal communities are striving to maintain collective values, traditions and beliefs whilst also coping with high burdens of chronic disease, reduced life expectancies and the impacts of grief, loss and trauma [2]. Health disparities faced by the Aboriginal populations include, but are not limited to, up to an 11-year gap in expected age of death, a tripled prevalence rate of type 2 diabetes and doubled rates of tobacco smoking [5, 6].

In light of this ongoing struggle there is increasing recognition within the health community to advance and enable best practice care provision for Aboriginal peoples [7, 8]. This is on a background of international evidence demonstrating a lower quality of healthcare provision for ethnic and minority groups across the globe [9]. Leadership must be demonstrated in the health community to challenge the status quo of Aboriginal health disparities and responsibility owned and actioned [3].

In accepting the need to advance the capacity of the health system to deliver best practice care, this article is a scoping review of current evidence looking at clinical communication skills and their potential

impact on healthcare delivery for Aboriginal peoples. Given the diversity of Aboriginal communities within Australia, this review, whilst also drawing on the international literature, focuses on key concepts of Aboriginal health in South Australia, Central Australia and Western Australia. Conclusions drawn from the review and its associated research, led by an Australian Aboriginal medical academic supported by two non-Aboriginal medical practitioners with Aboriginal health expertise, will provide a guide for future work aiming to explore the utility and acceptability of a more broadly applicable framework that can be used nation-wide. The future work will draw on valuable knowledges and perspectives from both the Aboriginal and health practitioner communities to create shared solutions and a path forward.

An initial approach is outlined proposing a tailored clinical communication framework for use when working with Aboriginal peoples, accompanied by a closer look at the role of medical education in developing the communication skills of the future healthcare workforce. The ability of the healthcare workforce to enable action to better address health inequities, rather than perpetuate them, is a critical long-term goal in assuring the ongoing health of Aboriginal peoples [3]. A key stakeholder leading this charge is the Australian Medical Council who state within their accreditation requirements for medical education providers that the:

“... clinical learning environment provides students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Maori ...” [10] (p3)

What this means in practical terms for Aboriginal people’s health outcomes needs further enquiry. In order to do this, a better understanding of the meanings of the term cultural competency, what it infers and the role played by communication in this process is needed.

Culture and Competency

“The only true voyage of discovery...would be not to visit strange lands but to possess other eyes...” [11] (p657)

Whilst the concept of cultural competence is commonly espoused in healthcare and the health education literature and is often proposed as the solution to ethnic health disparities, there are limitations associated with the term ‘competence’ [12]. Despite its prominence in the conversation around Aboriginal health inequities, a clear definition of cultural competency and ways to measure it is

lacking in the literature, along with evidence to demonstrate it holds beneficial impacts on health outcomes [12-14]. It is suggested that cultural competency as a singular skill is really an unachievable goal, as it fails to recognise the ongoing learning process required to effectively care for people from different cultural backgrounds [14]. There are many variants of the term in the literature including cultural safety, security, humility and responsive which provides an indication of how educators and researchers are still seeking a more suitable descriptor [15]. For medical education providers there is a logic to building the knowledge and skills of future practitioners to work with culturally diverse patients, however the language used to denote this along with evidence to show translational impact to patient outcomes must be carefully considered [12, 14, 16].

The focus on communication skills training in medical education to explore whether a tailored clinical communication framework provides the opportunity to improve healthcare interactions between Aboriginal peoples and health practitioners, and must include recognition of the continuum of learning and the need for measurable and definable education interventions in this space [12]. Such a tailored communication framework would ideally have applications as a learning, assessment and reflective tool for training health practitioners that can be evaluated through implementation within Aboriginal communities. There is a requirement for effective interactions with Aboriginal communities to shift away from a check-list approach of knowing an individual's culture to addressing imbalances of power that exist within healthcare interactions [17]. A closer look at the integration of culture into communication provides an insight into the appropriate application of culture in the clinical context.

Culture

Commencing a journey of cultural learning and understanding, its influences on health and wellbeing, requires an understanding of what culture is and how health is defined. Developing a deeper understanding of Aboriginal health requires an acknowledgment of the diversity in Aboriginal definitions of health amongst different community groups and the limitations of the English language to effectively translate Aboriginal meanings of health [18, 19]. In recognition of local variations, the 1989 Aboriginal Health Strategy Working Group provided a collective definition that addresses core concepts of culture, social determination and role of the community in health, defining Aboriginal health as:

“... not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential

as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life" [20] (px).

As noted above, culture forms a central component of the health experience for Aboriginal peoples [20]. Whilst many definitions of culture exist, the onus is on the health practitioner to acknowledge that in regard to health, culture can influence communication, beliefs about disease and wellness in addition to values that guide health-related behaviour [21, 22]. In reviewing the literature one definition states culture to be "an accumulated pattern of values, beliefs, and behaviors shared by an identifiable group of people with a common history and verbal and nonverbal symbol systems" [23] (p16) and another the 'integrated pattern of human behaviour which includes, but is not limited to, communications languages, beliefs, values, practices, customs, rituals, roles, relationships and expected behaviours of a racial, ethnic, religious, social or political group" [13] (p253).

Often time, culture and ethnicity are used synonymously, as they can be closely related and strongly linked in particular contexts. It is salient to note that whilst populations with the same ethnic background often share a collective culture, culture can exist beyond the bounds of ethnic heritage. The presence of a collective approach to worldviews and beliefs within a community, coupled with individual-level variations, lends itself to a patient-centered approach that considers broad contextual factors adapted to suit patient needs [24].

Notable in the area of cultural learning is that the journey must begin with an understanding of the self, and the practitioners own cultural identity [25]. This can form the basis of critical self-reflection and reaffirms the complexity of suggesting cultural competence can be mastered by understanding the 'other' when our own identities and experiences of the world are constantly evolving. Critical self-reflection also lends itself to fundamental considerations of power and positioning of the health practitioner in relation to the patient [17].

Adding to the complexity here, a false dichotomy exists in health curricula between self-reflection and clinical competence, given the two are seen as inseparable entities [26]. A new framework for thinking has been called for in health curricula that challenges existing beliefs leading to a process of 'unlearning' [26]. The proposed clinical communication framework could be one answer to this call, provided it stimulates practitioners to consider their own cultural identity and positioning in relation to the environment and those around them, and the impact this has on clinical communication interactions. Extending this thinking requires a closer look at the communication process and how

communication modalities may differ between population groups who share collective worldviews and values.

Communication

Like many medical terms 'communication' has a Latin origin 'communicare' which means 'to share' [27]. In essence, communication is the act of conveying meanings from one entity or group to another through the use of verbal, non-verbal and written mediums. Intercultural communication, or communication between members of different cultural groups, explores how collective beliefs, values and worldviews influence communication discourse at a group level [23, 28].

Identifying commonalities at the population level increases the risks of inappropriate application of stereotypical characteristics at an individual level [29, 30]. It also risks representing cultures with supposedly fixed characteristics that may be in opposition with each other [31]. Effective communication requires a reflexive and critically conscious practitioner to ensure group-level knowledge of culture is appropriately applied to individuals. Despite the risks, population commonalities may provide insight to where communication mismatches can occur more broadly, enabling a reflexive practitioner to navigate ways to address this in their communication approach.

A key concept used to explain variations between different cultural groups when studying communication is individualism-collectivism [28]. Simplified, individualistic-oriented cultures place priority on the needs and goals of the individual, in contrast to collectivist cultures that weight preference to the broader needs of the entire community. Whilst no culture exhibits one set of values exclusively, where they sit on the spectrum can vary. Individuals within more collectivist cultures may purportedly give priority to the collective self over their own individual needs [28].

Western cultures can be thought of as being geared towards individualism with the presence of collective values such as individual achievement, personal development and independence [23, 31]. In contrast are the collective values of the Aboriginal population whereby community and family priorities take precedence, and a strong connection to land is maintained [32]. A simple example of where conflict may arise between the two orientations is in the agreement of management priorities, and understanding what obligations must be met in order for an individual to engage effectively in a treatment plan. Another is the distinction between Aboriginal community-controlled health service values and how these might differ to mainstream health services [31].

Another concept raised in the literature is that of high-context and low-context cultures and the relation this has to individualism-collectivism [28]. Information transfer in a high-context culture is explained to predominate both through the physical environment and the internal behaviour of the person, and less so on explicit communication approaches such as verbal and written language. In contrast, a low-context culture prefers more explicit forms of communication such as verbal exchanges, placing less emphasis on physical and symbolic methods of information sharing [33]. In general terms, collectivist oriented cultures tend towards high-context communication modalities, and the opposite for individualistic cultures [28].

The relevance of high and low-context theories to Aboriginal health is supported in research that indicates relationship building and feelings of trust between Aboriginal peoples and health practitioners extends beyond what is spoken in the clinical encounter, to how welcoming the environment is and how safe people feel in their identity [22, 34, 35]. The importance of body language when working with Aboriginal communities also supports the significance of non-verbal techniques in clinical encounters [22, 36]. This can be relevant when looking at healthcare delivery if services are designed to cater for individualism and low-context styles of communication, inadvertently marginalising collectivistic-oriented populations groups.

Reflections of group-level preferences for communication raises questions around the practical approach to addressing these within the clinical communication encounter. Strategies that may enable predominant communication styles exhibited within the community to flourish, or multiple styles to be catered for within a given environment, may be a useful step forward in enabling effective communication in the healthcare setting. The way communication skills are taught in the medical curricula can provide a platform for further inquiry to assist practitioners navigate and prepare for this delicate situation.

Communication in Medical Education

“...the delivery of medical care is fundamentally a communicative enterprise in which clinicians, patients, and (when appropriate) families discuss a patient’s health, decide on the best therapeutic action, and make plans for follow through on those decisions” [37] (p287).

The ability to communicate effectively with patients, their family and other health professionals is a required competency of medical graduates on entry to professional practice [10]. Effective communication is also linked to improved patient outcomes, satisfaction and treatment adherence [37]. A skilled communicator in the clinical setting elicits and provides essential information in a way that builds trust and empowers the patient to achieve their health goals. As each individual is unique in their needs and preferred way of communicating, practitioners are required to have a flexible approach that is responsive to the needs of the person in front of them [38].

Communication skills training is a core component of medical education and deals with a variety of communication scenarios including intercultural communication, breaking bad news, communicating with families, communicating with other healthcare professionals, discussing end of life care choices and others [37, 39, 40]. Frameworks are often tailored to specific scenarios to include clinical interviewing guides, patient-centred care guides and approaches to motivational interviewing [37, 41-43].

Communication skills require both a cognitive understanding of the required content to be addressed in the clinical encounter coupled with sound process skills in eliciting required information. Subsequently, medical curricula often categorise communication skills into these two distinct processes and the ability to integrate these is an essential part of becoming an effective health practitioner [42, 44]. Interventions to improve clinical communication skills must be mindful of the different domains that make up effective communication and how these apply to diverse clinical scenarios.

A widely used guide for teaching and learning communication skills is the Calgary-Cambridge guide to the medical interview which outlines five key steps for practitioners to undertake that integrates both process and content domains [42, 45]. The 5 steps include initiating the session, gathering information, providing structure, building the relationship and explanation and planning [42]. The Calgary-Cambridge approach to history gathering and information sharing lays the foundation for clinical communication skills in healthcare interactions and is an ideal place to start when thinking about the effectiveness of Aboriginal health communication interventions. Whilst it does not provide a platform for more specialised clinical scenarios it may offer considerations and components for adaption in these situations.

Landmark work in New Zealand has demonstrated the successful adaptation of the Calgary-Cambridge guide to create the Meihana model, which aims to assist health practitioners in their clinical interactions with Maori patients. The Meihana model draws on the analogy of the culturally significant waka haoura

(double hulled canoe) voyaging from one destination across the moana (ocean) to another, and how this relates to the journey of a Maori patient through the healthcare system [46]. As the health journey can be influenced by a range of important factors, the Meihana model integrates colonisation, marginalisation, migration and racism (along with other key components) to clarify and deepen the content of the medical history to promote implementation of best clinical practice within the Maori community [46].

Effective application of the Meihana model is guided by the Hui Process of Mihimihi (initial greeting engagement), Whakawhānaungatanga (making a connection), Kaupapa (purpose of the encounter) and Poroporoaki (closing the session) and has been shown to improve the ability of healthcare practitioners to provide more effective care when working with Maori patients [47, 48]. This innovative research provides a leading example of how established communication frameworks can be adapted to suit the needs of targeted population groups [48].

The Calgary-Cambridge guide and the Meihana model provide a foundation for improving best practice communication with Aboriginal peoples via clinical interviewing processes. Arguably many of the existing guides allow for effective communication within Aboriginal populations, however exactly what this looks like is not necessarily explicit. A key task when developing a framework tailored to meet the needs of Aboriginal Australians will be in striking the balance of applicability across the community as a collective, without compromising its utility when working with Aboriginal people from distinct cultural groups or as individuals.

Ongoing evidence of communication gaps for Aboriginal peoples in healthcare interactions warrant careful attention and evidence-based action. This action needs to be led and role-modeled from within the healthcare system in accepting the responsibility to provide meaningful healthcare to Aboriginal communities. Understanding current intricacies in achieving effective communication processes in Aboriginal health directs attention toward salient areas in need of further action.

Communication in Aboriginal Health

“People know what they do; frequently they know why they do what they do; but what they don’t know is what what they do does” [49] (p187).

There is increasing evidence which demonstrates how ineffective communication between Aboriginal patients and health professionals influences the ability of community members to make informed decisions about their health [50, 51]. Less than ideal standards of communication can be so widespread that they are sometimes seen as the norm in clinical practice [50]. Many factors are raised in the literature that contribute to current 'less than ideal' communication standards.

A relative lack of knowledge of Aboriginal history and the impacts this has on contemporary health can be a barrier to effective communication [52]. The historical, social, political and environmental context of communities influence the resources and opportunities people have access to as well as playing a role in shared meaning-making [52, 53]. The role of trust is clear when understanding the impact marginalising historical policy continues to have on Aboriginal communities [17]. A contemporary impact of these policies can be found in individuals feeling less able to advocate for their needs in a healthcare interaction [52, 53]. Experiences of disempowerment are then further compounded by the relative lack of control a patient has to determine the time, place, participants and purpose of a clinical communication encounter [50]. An individual's communication preference could add to this complex space if it leans toward a non-verbal and symbolic approach, as the spoken word may not be enough to facilitate the building of trust and rapport.

Further, differences in first spoken language are one part of the miscommunication story and this is compounded when highly specialised medical language, or 'medical jargon' is used [29, 54]. Interpreters can provide a solution to this challenge, however there is an under-utilisation of interpreters in clinical settings [50, 54], and when used, their services are not always appropriately applied to the benefit of the patient and/or their family [55]. The connection between language and identity can also influence clinical communication encounters. Appropriate and respectful integration of te reo Maori is detailed in the Meihana model signalling the importance of language in Maori health and wellbeing [46]. An innovative study that aims to measure the impacts of language reclamation on health outcomes within a South Australian Aboriginal community will provide further evidence to the role language has on empowerment, health and wellbeing [56].

Style of communication and the mode, approach and timing of information delivery is another challenge to more effective health communication when working with Aboriginal peoples [57]. Question-answer approaches may be incompatible with an Aboriginal knowledge discourse, and interrogational questioning can consolidate power imbalances [21, 50], This can result in gratuitous concurrence (repeating responses believed to be desired by the provider) [50], or 'agreeableness in the face of

authority', further compounded by direct yes/no questioning and the absence of confirming patient understanding [58].

A health practitioner working from a predominantly biomedical model can risk sidelining significant priorities held by patients [50]. The opportunities for sharing knowledge and understanding are greatly reduced when only one domain of health is explored. There is also an identified need for health information to be provided to the wider family and community to enable a more supportive environment for people when unwell [51]. Access to supplemental health resources targeted toward specific Aboriginal communities is an additional barrier, both in availability and in staff knowledge of where to access and when to use [51]. This may be one example of the intersection between collectivist and individualistic -oriented cultures whereby the role of the wider community and preferred methods of information sharing are not considered in the clinical encounter.

And lastly, time is a fundamental contributor to health communication. Time is needed to build trust and allow stories to be shared [21]. Effective use of time requires a balance of practitioner and patient needs being addressed [22]. In addition to the availability and use of time, perceptions of time within Aboriginal communities may not align with that of the health practitioner. How time is perceived varies across cultures [59]. Some Aboriginal communities embrace more circular perceptions of time in contrast to the dominant western discourse of linear time [59].

Given the complexity of the communication process and the need for interventions to work towards improved health communication, a tailored framework may better prepare practitioners to communicate more effectively with Aboriginal peoples and their community. This framework must be cognizant of the identified barriers and enablers to effective healthcare provision, providing practical solutions that can be implemented by healthcare practitioners and organisations.

A Path Forward

"Everything I do, I do with respect. Father used to say, believe in all people. It's not we and them. It's us" [60] (p8).

Addressing communication shortfalls in Aboriginal health requires the targeted building of knowledge and skills of the health care provider, guided by the values and goals of the Aboriginal community.

Building a potential framework for improved communication with Aboriginal patients in the clinical setting should begin with an understanding of the roles colonisation, racism and marginalisation have on the four domains of content, process, relational and environment. The further development of this model will be guided by Aboriginal community members, health practitioners, medical educators and medical students in two select Australian settings, drawing on both traditional knowledge and lived experiences fused with western medical knowledge and experiences to create new understandings. (Figure 1).

Though not explicit, the medical practitioner has a central role in the framework, as achieving health equity relies on the ability of the medical practitioner to communicate with people from different cultural backgrounds. Whilst a challenging task, critical reflection by medical practitioners of their own positioning in relation to each domain when working towards health equity will likely enhance the effective implementation of this process. This starts with an understanding of the self and how the practitioner's own cultural identity influences each domain, encouraging the practitioner to re-discover their own beliefs, attitudes, values and communication style and how these might complement or contest with patient care. Acknowledging personal biases and the role of ethnocentrism on interactions with others can work toward the development of a critically conscious health practitioner [21, 31, 61]. The goal of enabling health equity is centred to ground the model with the ultimate purpose of this work.

The community and patient surround the medical practitioner to guide the adaptation of the communication approach in each of the surrounding domains. Considerations of the patient cannot be done in isolation from the community, given the very definition of health for Aboriginal peoples is one that considers and is influenced by the wider community to which people belong [20]. Components of this framework may require skills and actions to be taken on by the healthcare practitioner and organisation, both prior and during the communication encounter. Actions may include recognising group-level values and preferred styles of communication, incorporating these into organisational structures and policies and then tailoring each to the individual during the communication interaction.

Given the diversity of Aboriginal communities and cultures within Australia, exploring the utility of a model within a small number of settings will guide planning for a more broadly applicable tool that can

be contextualised to local community needs. This is in recognition of the importance of place-based care; health care that is considerate of the local priorities, expectations and ways of being of the community served. [7] A focus on literature detailing knowledges from Central Australia, South Australia and North Western Australia guide the following domain considerations.

Content

Understandings of content will require an approach to clinical interviewing respectful of both Aboriginal ways of life and evidence-based medical teaching. Content considerations within a clinical communication framework might include traditional medical history-gathering and information-giving steps interwoven with appropriate questions that target core concepts of Aboriginal life.

When exploring Aboriginal worldviews, the importance of family, country, beliefs and spirituality are common threads [2, 36, 62]. In Central Australia this is outlined by Kanyini, the principle of connectedness that underpins Aboriginal life, made up of Tjurkurrpa (beliefs of creation and the right way to live), Ngara (belonging to place), Waltja (family/kinship), and Kurunpa (spirit, soul) [36, 63]. The significance of kinship roles, described as “the means by which belief and action work together in harmony” [36] (p37) are further supported by notions of family in Northwest Australian Aboriginal communities, described as “transcending the barriers of immediate blood relations” [64] (p317) to govern social and cultural exchanges as well as confirm connections to place [64]. The interconnectedness of family, place, spirituality and identity is described in Northwest Australia as Liyan;

“Liyan is the center of our being and emotions. It is a very important characteristic that forms our wellbeing, keeping us grounded in our identity and our connection to country, to our family, our community and it is linked to the way we care for ourselves and our emotions” [62] (p4).

Thus incorporating family and community structures, the impact of history, beliefs about health and wellness along with sense of belonging to place and strength of spirit will be important. In addition, including the determinants of health as identified by Aboriginal communities, such as notions of self-determination, agency, experiences of racism, opportunities to engage in cultural practices and feelings of connection to country are also relevant inclusions [64, 65]. Having a meaningful level of knowledge

of the epidemiological disease and risk burden experienced by Aboriginal peoples will also help to ensure salient medical presentations and preventative measures are communicated within the clinical encounter. This demonstrates the importance of fusing Western medical knowledges and Aboriginal knowledges to create shared understandings of health and wellbeing [60].

Process

Process considerations refer to the way in which content is delivered and received to reach a shared understanding of health and treatment pathways. This can involve reflections on approach to asking questions and accommodation of a shared dialogue [65]. Yarning has been raised as an effective communication style that is characterised by its informal, conversation qualities [22, 66]. Such approaches may work toward addressing power imbalances and making people feel more able to contribute to the communication dialogue. Effective means to achieve shared understandings could include the use of storytelling, metaphors and visual representations of health concepts, as the literature shows the utility of sharing meaning between Indigenous populations and medical practitioners/researchers [51, 66, 67]. This aligns with a high-context communication style [23].

Non-verbal skills including body language, eye contact, use of silence and deep listening are also of relevance when further developing the framework. Dadirri, or deep listening and quiet stillness, reflects an important process for some Aboriginal peoples [68]. Listening without interruption and being comfortable with silence may be an essential process component, along with open, attentive and non-confrontational body language [7, 66].

The appropriate use and integration of trained interpreters could also form a key component of this section, in recognition of the important role interpreters play as facilitators in achieving effective clinical communication. Attention to the use of audiovisual aids within the clinical communication encounter to enhance co-creation of shared understandings will also be explored as a potentially central aspect of the process domain.

Process skills can influence the quality, acceptability and outcome of clinical interactions which require attention and reflexive action as practitioners adapt their communication style to suit that of their communication partner [69, 70]. Having an understanding of ones own personal communication preferences and how these may differ to others can be the beginning point for practitioners to be more attentive to processes that might be otherwise deemed insignificant.

Relational

In order to connect with another, strong relationship building skills are required. Often in Aboriginal communities, connections are built through identifying where someone belongs, what country they identify with and who their family is. Being able to participate in this process should enhance the ability of a health practitioner to establish a stronger clinical relationship with Aboriginal patients, and work towards better understanding their contextual background. Additionally, establishing common ground between practitioners and their patients is a key process that can assist forming connections [66].

Unconditional acceptance, affirmations of the positive and providing opportunities for intervention that affirms Aboriginal life, such as collaboration with traditional healers and discussing the role of traditional medicines, hold significance in the relational domain [71]. Recognising the value of different knowledge systems and working in partnership with peoples who have expertise in areas beyond the medical domain is fundamental [72]. Collaboration with community leaders and Aboriginal professionals, including Aboriginal liaison officers, transport workers and health workers is essential to providing appropriate care. This may require a shift in how the boundaries of the clinical interview are perceived and operationalized to include inter-professional practice in preparing and engaging in clinical communication.

Gender provides another area of attention in the relation component. A potential for communication conflict may arise when discussing topics that may be seen by community as inappropriate with particular genders due to local customs and practices. [22, 73]. Understanding potential gender impacts will vary according to the local context, and having set strategies to manage this can ensure more effective communication encounters in the clinical environment.

Environment

The immediate physical environment can be symbolic to patients, influencing how a person engages in a communicative process. A welcoming environment is identified in the literature to improve engagement and feelings of safety for Aboriginal peoples, and now forms one of the standards set out by the Australian Commission on Safety and Quality for healthcare services[74]. This standard states:

The health service organisation demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander people. [74] (p3)

Further, cross-cultural interactions can be influenced by the political and organisational structure of the service in which the encounter occurs [31, 75]. Environmental considerations take these different system levels into account, requiring the practitioner to have an understanding of the nuances of the environment in which they work and the potential influence this has on the communication encounter.

Enabling patient control over where communication encounters occur may be challenging but thought needs to be given as to how to cater for this [50]. Strengths based affirmations of Aboriginal identity within the physical environment can demonstrate respect and promote attempts to build trust on the background of historical wrongs. Simple steps such as flying the Aboriginal Flag, having Aboriginal artworks and displays of commitment to Aboriginal values and priorities all contribute towards building a symbolic environment which can facilitate more effective clinical communications. Additional thoughts around how the physical environment caters to Aboriginal collective values, such as importance of family and capacity for family to be involved in the clinical encounter, are also important factors. This domain signifies the responsibility of the organisation, and its members, to ensure it actively promotes effective communication encounters rather than providing additional barriers or perpetuating less than ideal clinical environments.

Conclusion

This review marks the beginning of a research journey to develop, elaborate and test a tailored communication framework in Aboriginal health. To be effective, the framework must be appropriate to both the community served and those required to implement it, identifying the need for dual collaboration moving forward. The framework is driven by the need for health equity and provides a guide for approaching the content of clinical conversations, the way in which meanings are created and shared, the environment in which conversations take place underpinned by the salience of developing solid therapeutic relationships between the practitioner and their patient. A dedicated plan for evaluation and outcome measurement will be required in order to strengthen the translational impact this work may have on community and healthcare providers. A two-eyed seeing approach that utilises the strength of both traditional and western knowledges coming together to create new understandings,

will mark the next stages of this research inquiry to develop and refine the framework as guided by the Aboriginal and health practitioner communities [60].

Aboriginal health inequities are a multidimensional challenge that demands an equally multi-dimensional approach. In this paper, the focus has been on the factors that influence the quality of the clinical interaction with a particular interest on communication. It is proposed that a targeted framework for communication when working with Aboriginal patients may provide a platform for increased knowledge and skill of healthcare providers to meet the needs and priorities of their Aboriginal patients.

Addressing Aboriginal health disparities requires ongoing action and effort to create change, both at an individual and system level. Recognition and understanding of the role healthcare providers play in both advocating for change and shifting ways of working is essential to achieving better health outcomes from clinical interactions. When working towards health equity and the ensured wellbeing of future generations of Aboriginal communities, a long-term vision coupled with sustainable action are called for:

“When we ... get impatient for ‘results’ ... Elder Albert likes to tell us about the ash tree. Every year, the ash tree drops its seeds on the ground. Sometimes those seeds do not germinate for two, three or even four cycles of seasons. If the conditions are not right, the seeds will not germinate. Sometimes, Elder Marshall says, you have to be content to plant seeds and wait for them to germinate. You have to wait out the period of dormancy. Which we shouldn’t confuse with death. We should trust this process” [60] (p8).

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