Barnes Deborah (Orcid ID: 0000-0002-9597-3504)
Phillips Georgina Ann (Orcid ID: 0000-0002-0414-2802)
Hutton Jennie Etienne (Orcid ID: 0000-0001-7911-9546)

Working towards equity: an example of an ED project for Aboriginal and Torres Strait Islander health and cultural safety

Authors: Deborah Barnes 1, Georgina Phillips 2 3 4, Toni Mason 1, Jennie Hutton 2 4

Affiliations: 1. Aboriginal Health Unit, St. Vincent's Hospital Melbourne. 2. Emergency Department, St. Vincent's Hospital Melbourne. 3. School of Public Health and Preventative Medicine, Monash University. 4. University of Melbourne.

Corresponding author: Deborah Barnes Deborah.barnes@svha.org.au

Acknowledgement statement: We acknowledge all staff involved in this project and thank the St Vincent's Health Australia (SVHA) Inclusive Health Fund and SVHA Melbourne executive team for their support.

Conflict of interest: Dr Georgina Phillips is a section editor of Emergency Medicine Australasia.

Keywords: Equity, cultural safety, emergency department, Aboriginal, Torres Strait Islander, Indigenous

Abstract

The ED at St Vincent's Hospital Melbourne aims to provide excellent emergency care and cultural safety for Aboriginal and Torres Strait Islander peoples. High rates of people who

'Left Not Seen' and some negative experiences of care led us to improve our performance in this area. Collective desire and strong executive support generated the ED Indigenous Health Equity Working Group (IHEWG) project. This was co-led by both the ED and the Aboriginal Health Unit (AHU). A strengths-based participatory methodology and fortnightly virtual meetings were established to generate ideas for short and long term reforms. Initial outcomes have included a focus on cultural safety and trauma-informed care education. Further projects included improving identification processes, creating a welcoming waiting-room environment, and fostering strong relationships between the ED and AHU. We have begun our ED journey towards equity and excellent care for Aboriginal and Torres Strait Islander people, hoping this collaborative model will enable transformative change.

Context – The need for a new approach

Australian emergency departments (ED) can impact the inequitable healthcare access and outcomes many Aboriginal and Torres Strait Islander people experience – for better or worse[1]. There is substantial evidence that Australian EDs have contributed to inequity. For many Indigenous Australians, fear or expectation of discrimination results in active avoidance or a 'last resort' ED attendance, even when acutely unwell[2 3]. First encounters with health services are often in EDs[3], meaning experiences in EDs can define an individual's trust in the health system. This has the potential to impact both their own and their wider community's engagement with healthcare.

Despite these high stakes, EDs across Australia consistently fail to provide culturally safe care for Aboriginal and Torres Strait Islander people[2], constituting inaccessible care. Interpersonal and institutional racism in EDs remain common. In Victoria, as many as one third of Aboriginal and Torres Strait Islander people have experienced racism in a healthcare setting in the last 12 months[4]. Negative stereotyping and implicit bias have been shown to be common among ED physicians[5], and may contribute to inappropriate care for Australian Indigenous patients such as under-triage, inadequate analgesia, and misdiagnosis. Waiting for care – often without explanation of triage processes, can be traumatising, anxiety inducing, and cause shame for many[2 6]. These factors contribute to Aboriginal and Torres Strait Islander people being 1.73 times more likely to leave ED without being seen – 'Left Not Seen', than their non-Indigenous counterparts[3]. This is especially significant in the context of continued disproportionate burden of disease among Aboriginal and Torres Strait Islander

people[7 8], stark life expectancy gap of 7.8-8.6 years[8], and overrepresentation to EDs across the continent[3].

Our tertiary Melbourne ED has historically strived to provide culturally responsive care to Aboriginal and Torres Strait Islander consumers, and has taken seriously the organisational mission of caring for people facing disadvantage. Australian Indigenous people accounted for 2.74% of our ED presentations between 2016-2020, despite only being 0.50% of the Greater Melbourne population. Despite high aspirations, we continue to have combined 'Left Not Seen' and 'Left Partial Treatment' rates of 13% for Australian Indigenous people – higher than the national metropolitan averages of 9.92% for Aboriginal and Torres Strait Islander people and 5.96% for non-Indigenous people[3]. Recent feedback from local Aboriginal community members highlighted that many Aboriginal and Torres Strait Islander patients and family members currently have negative experiences in our ED. In addressing these issues, staff expressed a collective desire to do better, a belief that access to healthcare is a human right, and a desire to be guided by Aboriginal and Torres Strait Islander people's priorities. Strong Executive support, and collaboration between the ED and Aboriginal Health Unit (AHU) led to the conceptualisation of a grassroots project – the Indigenous Health Equity Working Group (IHEWG).

What we did

Theoretical framework

Our approach was informed by the principles of participatory action research and appreciative enquiry, which deliberately applies positive framing as participants are engaged to understand, reflect and act in a continuous cycle of transformative change[10, 11]. We

acknowledged our responsibility to lead and drive change, and utilised the Australasian College of Emergency Medicine (ACEM)[12] and our organisation's Reconciliation Action Plans[13], and findings of the 'Traumatology Talks' report[2] into cultural safety in Australian EDs to set priorities. We aimed to embed reconciliation as core ED business.

We approached this project conscientious of negative discourses surrounding Aboriginal health and EDs, and actively countered these with a strengths-based approach. Firstly, we believe that ED staff want to be culturally competent and provide equitable healthcare, but are constrained by structural workplace barriers including time-based performance indicators, limited cultural education, and rigid hospital processes that exemplify Western conceptualisations of health. Secondly, we reject the all too common deficit narrative that problematizes Aboriginal and Torres Strait Islander people, framing persistent disparities as a consequence of individual decision-making. Instead, we acknowledge that the health and social hardships faced by many are legacies of colonisation, dispossession, and inter-generational trauma, and are compounded by ongoing racism. Explicitly articulating these fundamental attitudes has enabled individual staff and the ED as a whole to begin critical self-reflection. A constructive discourse has emerged whereby the ED has taken responsibility for its role in inequitable access, and has taken the initiative to improve.

The Working Group

The IHEWG was founded and primarily led by an ED consultant, with co-leadership and collaboration by the AHU. The project was funded through an internal grants scheme for a 6-month pilot phase. Key aims included establishing the IHEWG as a sustainable and ongoing project, increasing staff cultural competency, improving cultural safety and experiences of care for all Aboriginal and Torres Strait Islander people – including staff, improving

consistency of excellent emergency care provision, and establishing strong links with the AHU. The IHEWG commenced in the context of several existing projects addressing the high Australian Indigenous 'Left not Seen' rates, as an organisational performance indicator priority. These included a mixed methods study on 'Left not Seen' events, a service-wide 'cultural safety audit', and internal improvement projects to improve identification of and cultural safety for Aboriginal and Torres Strait Islander people. The IHEWG aimed to promote awareness, support, and ownership of these projects within the ED.

An open invitation was extended to all ED staff, resulting in a broad membership encompassing all professional craft groups and levels of seniority. This included members of the ED leadership, nursing, medical, clerical, security, and mental health teams, as well as members from the hospital's 'continuous improvement' team. The IHEWG held virtual fortnightly meetings that became a forum for learning, discussion, debate, and brainstorming of innovative solutions to complex problems. Expert guest speakers – including Aboriginal and Torres Strait Islander academics, ED leaders from other organisations,[7] and researchers in implicit bias, presented at meetings to prompt candid discussion of barriers within our ED. Discussion was also facilitated through use of case studies and sharing of personal experiences. Smaller focused action groups formed as specific action areas were identified, allowing the IEHWG meetings to maintain a broader agenda. The wider ED staff cohort was engaged through a goal-setting survey, which invited all staff to express their vision for the future and to identify specific needs.

What we have achieved so far

The IHEWG's work remains underway, which in itself marks the success of the primary pilot aim – to create a sustainable working group. Many achievements such as raising awareness of inequity and sparking passion and interest are hard to measure, but have been significant both within the ED and across the organisation - following the opportunity to present our methodology internally. Initial efforts have focused on the following areas.

- *Relationships:* The collaborative approach and shared vision of equity has nurtured an authentic relationship between the ED and AHU that exceeds the scope of the IHEWG alone and will be foundational to future work. Inviting Aboriginal leadership in ED reform represents a step toward the self-determination of Aboriginal and Torres Strait Islander people being realised in mainstream services.
- *Education:* ED staff collectively identified the need for cultural safety education. AHU resourcing, and turnover and volume of staff make provision of targeted cultural safety education challenging. To fill this gap, medical and nursing staff were encouraged to complete ACEM's Indigenous Health and Cultural Competency Program[14], and an intranet page was established with practical resources including video recordings, best-practice guidelines, and journal articles. Topics include local Aboriginal culture, cultural safety, the Social and Emotional Wellbeing model of care, and trauma-informed care. The page has been shared widely across the hospital as a well-curated collection of resources.
- *A welcoming waiting room:* The waiting room is being refurbished with local Aboriginal artwork, and a 'Wominjeka'- Woi Wurrung for 'welcome', sign that acknowledges traditional owners and welcomes all Aboriginal and Torres Strait Islander people. Plain-English information regarding ED processes and expected wait times will be displayed on screens. All Aboriginal and Torres Strait Islander patients in the waiting room will be assessed and investigations initiated by a senior doctor-

nurse team. This expands the remit of an existing process. The IHEWG has successfully secured funding for a nurse to follow up 'Left Not Seen' patients from priority patient groups, and support them to access an appropriate health service.

- *Accurate identification:* Although required to ask all people whether they identify as Aboriginal and/or Torres Strait Islander, clerical staff noted that this is done inconsistently and often incorrectly. Limited education around why and how to ask this question, and fear of causing offence were barriers. Targeted education addressing specific knowledge deficits was implemented using a peer-education model, utilising clerical staff to support and teach each other. The pace and patient turnover in ED is such that even when someone identifies, clinical staff are often unaware the person they are caring for is Aboriginal and/or Torres Strait Islander. An Aboriginal-designed motif will be incorporated into the patient administration IT system's main display, to assist rapid identification.

Lessons learnt

The pilot phase of the IHEWG has brought as many lessons as successes, explored in Box 1. Continual reflection through our action research methodology will ensure sustainability as the project transitions to becoming part of our ED's business as usual.

Key lessons so far
• A ***participatory, ground-up methodology*** has been integral to continued engagement of multi-disciplinary staff of varying seniority, allowed traditional ED hierarchies to breakdown, and promoted shared ownership of reform. • ***Meeting regularly*** has enabled functional relationships to flourish. • ***Virtual meetings,*** due to Covid-19, have constrained the openness of some discussions. However, it has allowed broader participation by shift workers.

- ***Paid time*** has been essential to build and maintain momentum, and health services must be willing to invest in this. Management support for dedicated staff time over the long term will be fundamental to ongoing success. Lack of funded 'non-clinical' time for security and environmental services staff has restricted their participation.
- ***Individual and institutional racism cannot be ignored.*** We took a sensitive yet direct approach to addressing racism when it arose. Although mainstream discourse increasingly acknowledges that colonial legacies of disempowerment and trauma contribute to health disparity, these events are often presented as being in the distant past, not as occurring today[15]. This allows many in non-Indigenous society to ignore their own complicity in individual and institutional racism, adding immense complexity to building consensus regarding reforms. Addressing these issues remains an ongoing challenge for the IHEWG.
- ***Sustainable and transformational change takes time***. Current health disparities are a result of centuries of institutionalised racism, and measures such as 'Left not Seen' are unlikely to change rapidly. Sustained hospital and ED executive leadership investment will be required to support transformational change.
- Engaging with and becoming cognisant of complex issues can lead to a perception of things becoming worse. **S*trong support systems*** to avoid burnout will be key long-term.
- ***Risks to Aboriginal staff.*** AHU staff are accountable to both their local community and the hospital, which can result in unresolvable tension and stress. High expectations in the context of limited staff resources, ensure that burnout remains a substantial risk.

- ***All are responsible***. ED staff must all gain culturally safe practice and cannot rely on continuous clinical AHU presence. The IHEWG members can become cultural safety champions to support 'whole of ED' transformation. Our ED owns the responsibility to better understand and resolve all issues (that can be controlled) to improve Aboriginal patient experiences.

So what?

The IHEWG has demonstrated that a strengths-based and ground-up participatory model can create momentum to tackle complex systemic issues that contribute to inequity. Although issues of implicit bias and institutional racism are complex and deeply entrenched, straight-forward initial steps can subvert power imbalances and improve experiences of care. These include becoming better informed, creating a welcoming environment, building relationships and prioritising Aboriginal and Torres Strait Islander voices. By piloting a process towards achieving equity within our ED, we have built foundations for long-term change that have potential far-reaching implications. Our next challenges will be examining the functionality of our model of care for Aboriginal and Torres Strait Islander people, establishing relationships with local Aboriginal community external to the hospital, addressing implicit bias and racist stereotypes, and maintaining the momentum for change. In light of the urgent need to address inequity for Aboriginal and Torres Strait Islands people, we believe it is imperative for other EDs to embark on similar journeys.

References

1 Preisz P, Priesz P. Supporting black lives 'mattering' with flexible health care. J Paediatr Child Health. 2020 Dec;56(12):1848-1850. Available from: https://onlinelibrary-wiley-com.virtual.anu.edu.au/doi/full/10.1111/jpc.15128 doi: 10.1111/jpc.15128

2 Arabena K, Somerville E, Penny L, Dashwood R, Bloxsome S, Warrior K, Pratt K, Lankin M, Kenny K, Rahman A. Traumatology Talks: Black wounds, white stitches. Melbourne: KCT Publishing; 2021[10 July 2021]. 134p. Available from: https://acem.org.au/getmedia/18897d91-4449-4d5f-9ec2-4f7c2b9ec23b/TraumatologyTalks_ACEM_Report_FINAL

3 Lim JC, Harrison G, Raos M, Moore K. Characteristics of Aboriginal and Torres Strait Islander peoples attending Australian emergency departments. Emerg Med Australas. 2021 Aug;33(4):672-678. Available from https://onlinelibrary-wiley-com.virtual.anu.edu.au/doi/full/10.1111/1742-6723.13701

4 Kelaher M, Ferdinand A, Paradies Y. Experiencing racism in health care: the mental health impacts for Victorian Aboriginal communities. Med J Aust. 2014 Jul;201(1):44-47. Available from: https://onlinelibrary-wiley-com.virtual.anu.edu.au/doi/full/10.5694/mja13.10503 doi: 10.5694/mja13.10503

5 Quigley A, Hutton J, Phillips G, Dreise D, Mason T, Garvey G, Paradies Y. Review article: Implicit bias towards Aboriginal and Torres Strait Islander patients within Australian emergency departments. Emerg Med Australas. 2021 Feb;33(1):9-18. Available from: https://onlinelibrary-wiley-com.virtual.anu.edu.au/doi/full/10.1111/1742-6723.13691 doi: 10.1111/1742-6723.13691

6 Australian Commission on Safety and Quality in Health Care. Understanding leave events for Aboriginal and Torres Strait Islander peoples and other Australians from health service organisations: A Systematic Literature Review. 2020 [cited 10 July 2021]. 33p. Available from: https://www.safetyandquality.gov.au/sites/default/files/2020-07/understanding_leave_events_for_aboriginal_and_torres_strait_islander_people.pdf

7 Priesz P, Preisz A, Daley S, Jazayeri J. 'Dalarinji': A flexible clinic, belonging to and for the Aboriginal people, in an Australian emergency department. Emerg Med Australas. 2021 Jul. doi: 10.1111/1742-6723.13833

8 Australian Institute of Health and Welfare. Indigenous life expectancy and deaths. Canberra: Australian Institute of Health and Welfare; 2020. [cited 10 July 2019]. Available from: https://www.aihw.gov.au/reports/australias-health/indigenous-life-expectancy-and-deaths

9 Australian Bureau of Statistics. 2016 Census QuickStats. Canberra ACT: Australian Bureau of Statistics; 2021 [cited 18 February 2022]. Available from: https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/2GMEL?opendocument

10 Koshy E, Koshy V, Waterman H. Action research in healthcare. Sage; 2010.

11 Bushe G. Appreciative Inquiry. Theory and critique. In, Boje, D. Burnes, B. & Hassard J (eds.) The Routledge companion to organizational change. Oxford. Routledge; 2011. P 87-103

12 Australasian College for Emergency Medicine. Australasian College for Emergency Medicine Innovate Reconciliation Action Plan September 2019-August 2021. West Melbourne VIC: Australasian College for Emergency Medicine; 2019 [cited 18 February 2022]. Available from: https://acem.org.au/getmedia/1703e425-e501-4748-8421-1a9a0e1ffcd6/ACEM_RAP_2019-2021

13 St Vincent's Health Australia. St Vincent's Health Australia Stretch Reconciliation Action Plan August 2020 – August 2023. Australia: St Vincent's Health Australia; 2020 [cited 18 February 2022]. Available from: https://www.svha.org.au/ArticleDocuments/3007/SVHA_RAP_2020.pdf.aspx?embed=y

14 Australasian College for Emergency Medicine. Indigenous Health and Cultural Competency Program. West Melbourne VIC: Australasian College for Emergency Medicine; 2021 [cited 18 February 2022]. Available from: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Indigenous-Health-and-Cultural-Competency.aspx

15 Herring S, Spangaro J, Lauw M, McNamara L. The intersection of trauma, racism and cultural competence in effecting work with Aboriginal people: waiting for trust. Aust. Soc. Work. 2013 Mar:66(1):104-117. doi: 10.1080/0312407X.2012.697566