

# “The world is so white”: improving cultural safety in healthcare systems for Australian Indigenous people with rheumatic heart disease

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*The world is so white, westernised now that it's very difficult to make people understand that that's not the only way of the world.*  
(Aboriginal specialist clinician)

Acquired cardiovascular disease among young people is dominated globally by rheumatic heart disease (RHD), a condition characterised by complex disease processes requiring both medical and social action. In Australia, RHD predominantly affects Aboriginal and Torres Strait Islander people. The most accurate rates are newly revealed in an Australian data linkage study showing just how widespread RHD is among young Aboriginal and Torres Strait Islander families.<sup>1</sup> These data showing a continual trickle of new cases of the precursor condition, acute rheumatic fever (ARF), place a spotlight on challenges in preventing both conditions, including inequities within healthcare systems and broad impasses in social policy and action for affected groups. Despite extensive research efforts, there has been limited success in improving outcomes for RHD in Australia.

Two recent publications provide direction for improving care for families and communities with RHD and eradicating the conditions: *The RHD Endgame Strategy for Australia*<sup>2</sup> and the revised *Australian Guideline for RHD*.<sup>3</sup> To support their implementation, we examined the experiences and views of a range of *Aboriginal and non-Indigenous senior knowledge holders within the healthcare system*. We situated this research within a view of RHD taking place in two systems: Aboriginal and Torres Strait Islander ways

## Abstract

**Objective:** To examine the views of senior health system knowledge holders, including Aboriginal experts, regarding the spaces where elimination strategies for rheumatic heart disease take place: Aboriginal and Torres Strait Islander ways of knowing, being and doing; and biomedical healthcare models. We aimed to support the implementation of the RHD Endgame Strategy by providing some of the ‘how’.

**Methods:** In-depth interviews were undertaken with 23 participants. The design of the interview questions and analysis of the data used strengths-based approaches as directed by Aboriginal researchers.

**Results:** Given the dominance of the biomedical worldview, and the complex trajectory of RHD, there is significant tension in the intersection of worldviews. Tensions that limit productive dialogue are juxtaposed with suggestions on how to reduce tension through reflexivity, power shifting and endorsing Aboriginal leadership and governance. Evidence supported cultural safety for RHD care, prevention and elimination as the key action.

**Conclusions:** Recommendations include addressing power imbalances between dominant and minority populations throughout the health system; reform that both supports and is supported by Non-Indigenous and Aboriginal and Torres Strait Islander leadership.

**Implications for public health:** Increased understanding of and support for Indigenous leadership and cultural safety will enable implementation of the new RHD strategy.

**Key words:** rheumatic heart disease, cultural safety, Indigenous leadership, health policy

of knowing, being and doing; and Western biomedical healthcare models. Negotiating the intersection of these systems is unavoidable for people living with ARF and RHD because of the complex and lengthy disease trajectory.<sup>4</sup> The work of RHD clinicians, researchers and policy makers also takes place within this juncture.

Of concern is that conceptualisations of this intersection have implied a space where Aboriginal people are absorbed into the mainstream.<sup>5</sup> The biomedical worldview tends to be the default ‘normal’ perspective while the Aboriginal worldview, often

framed in deficit terms, frequently positions Aboriginal people in a liminal space with limited agency.<sup>6</sup> Non-Indigenous people tend not to understand or acknowledge Aboriginal worldviews and can easily become more concerned with adherence to biomedical norms and “making the culture of the Other fit or transition to the mainstream”.<sup>5</sup> Such approaches sidestep possibilities for deeper understanding and resultant changes to systems, service delivery and policy. Such changes require intentional critique and decolonising approaches.<sup>7</sup>

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## Objective

To mitigate these limitations, an emphasis on productive dialogue, which we consider synonymous with two-way learning, could generate new knowledge and new ways of working, including through Indigenous knowledge systems.<sup>8,9</sup> We define productive dialogue and two-way learning as plain, back and forth, non-polarising yarning while being receptive and valuing different ways of viewing the world. The aim of such dialogue is to encourage rigorous discussions to share ideas, experiences, and understandings while holding a stance of equality.<sup>8</sup> We use the metaphor of turbulent waters, a space where opposing currents meet that requires courage and humility to enter due to the likelihood of discomfort being experienced. Our study explores how those with an Indigenous worldview and those with a biomedical worldview employing Western healthcare models can better work together through productive dialogue to end RHD. This exploration is a qualitative component of a large health systems study examining multiple statistical data sources for RHD.<sup>1</sup>

## Methods

Given the prioritising in our research of Aboriginal ways of knowing, being and doing, critical reflexivity is needed which involves identifying the influence of researchers' sociocultural positions, assumptions and knowledge. This is central to establishing the rigour and trustworthiness of qualitative research.<sup>10</sup> Constructivist grounded theory (CGT) was therefore used to bring "reflexivity into the forefront and open a path to critical enquiry".<sup>11</sup> The contribution of two senior Aboriginal team members was important in designing the research questions and advising on the analysis, as well as encouraging reflexivity and participation in courageous conversations between team members.<sup>12</sup> The non-Indigenous researchers took a standpoint of *nhina, nhäma ga nãma* (a Yolŋu [Aboriginal] concept meaning to sit with, listen and observe)<sup>13,14</sup> to critically explore ways of being allies during the analysis. This included dialogues, paying attention to relationships, accepting philosophical discomfort and thinking critically about power dynamics, all contributing to writing with a transformative purpose.<sup>15,16</sup>

## Participants

Participants were invited from across Australia for their expertise in RHD, Aboriginal health and health systems. Selection criteria ensured participants represented a range of jurisdictions, roles (clinical, policy and social science), sex, and Indigeneity. Fifty participants were invited by email outlining the study and 23 responded and participated in interviews.

## Data collection

Interview questions reflected the Aboriginal researchers' preference for strengths-based research approaches. Dialogue undertaken in the interviews crossed service delivery, policy, and disciplines as well as culture.

After obtaining informed consent, phone interviews lasting between 30 and 90 minutes were undertaken. Participants were invited to explore:

- experiences of what works in relation to Aboriginal health in the context of RHD and why
- the function of relationships and networks as a way of working within healthcare
- Aboriginal ways of knowing, being and doing.

All interviews were fully transcribed, and all data were de-identified.

## Analysis

For the initial thematic analysis, a 'codebook' was established. To privilege an Aboriginal worldview, the codebook was developed and refined by first being applied to the Aboriginal interviews. It was then used as the basis of collaborative research team yarning,<sup>17</sup> where precedence was given to the Aboriginal researchers' views in the ongoing development of themes. Yarning continued until consensus was achieved and no new themes arose. The remainder of the interviews were analysed using this codebook, with further refining and aggregating of sub-themes into two major themes.

## Ethics

The Prince Charles Hospital Human Research Ethics Committee (HREC) provided multi-site approval for Queensland, New South Wales (NSW), Western Australia (WA), and South Australia (SA), while separate ethics was obtained for Northern Territory from the Menzies HREC. Additional ethics approval

was obtained from the Aboriginal ethics committees associated with health peak bodies in WA, SA, and NSW.

## Results

Seven of the 23 (30%) interviewees were Aboriginal and 13 (57%) were male. Seventeen interviewees had clinical health backgrounds (general practitioners, medical specialists, nurses) and four worked in policy or social science fields. Some had family experiences of RHD. Most Australian jurisdictions were represented, and many participants had experience of living in remote regions for their work. Interviewees are referred to by an interview number as well as non-Indigenous or Aboriginal, to protect anonymity. No Torres Strait Islander people were interviewed.

Themes and sub-themes are reported under two topics that can be viewed as two sides of the one coin:

1. Tensions in the intersection of worldviews that constrain productive dialogue
2. Suggestions to reduce tension and improve healthcare work at this intersection.

### *Tension at the intersection of Aboriginal and biomedical worldviews*

For some non-Indigenous participants, being able to live in a community was considered an opportunity. One non-Indigenous participant spoke of finding it stressful working in Aboriginal communities or held a sense of obligation, "I have served time" (Non-Indigenous 03). Regardless of personal experience in communities, Aboriginal participants felt they were more likely to understand Aboriginal ways of knowing, being and doing, while non-Indigenous participants acknowledged that, "it really takes years and years to evolve understandings" (Non-Indigenous 02). Insights resulting from growing up in an Aboriginal community often ran counter to commonly held biomedical perceptions, for example, regarding living in a large household, "I loved growing up in that kind of environment ... there is a certain safety and a certain element of family" (Aboriginal 17).

At a national policy level, a lack of understanding of an Aboriginal worldview causes tension resulting from a sense of non-Indigenous people defining the problems without real understanding, "What I see a

lot in Canberra is people will say Indigenous health is this issue, or whatever, and I'm like why are you saying that? You're not in our space" (Aboriginal 16).

Further unpacking of tensions is provided in the following subthemes.

#### *The impact of differences in worldview about healthcare*

Many participants observed failures resulting from 'biomedical-only' approaches that do not regard cultural difference or provide culturally appropriate care. For example:

... one of the basic tenets of Western healthcare is that individuals take responsibility for their own healthcare, and ... a lot of remote healthcare practitioners who see ... people not taking responsibility for their personal healthcare and therefore see that as something to roundly criticise (Non-Indigenous 02).

*I think that individual view of the world versus the collectivism: they're just two different ways of being. We always think about the collective* (Aboriginal 16).

Impacts from lack of understanding Aboriginal worldview can mean that:

*People won't go to a service because of a cultural safety issue. So that then affects their trajectory, and they're often presenting very late, and very unwell for something that could have been prevented years or months before* (Aboriginal 16).

In some cases, the impacts of this difference were acutely demonstrated as in the following statement from a non-Indigenous clinician reported by an Aboriginal interviewee "... we're here to treat and diagnose, we're not here to do the public health prevention stuff" (Aboriginal 16).

#### *Best approaches to RHD*

Participants discussed tensions about RHD:

*It's a very emotionally charged topic, rheumatic heart disease. So, there's a lot of scope for disagreement among people who consider themselves to be research leaders in this area* (Non-Indigenous 02).

Specifically, some participants were aware of the tension regarding the best ways to tackle RHD:

*There are scientists that really believe that the solutions lie in mechanisms they've identified at a molecular level. And how do we engage in a dialogue with people that have that as their belief system when it's so very different from how Indigenous people view themselves and view health?* (Aboriginal 15).

Lack of attention to sociological factors in relation to RHD causes frustration:

*The extent of the poverty ... you just cannot get over it, so no more biomedical is my answer ... The drivers of rheumatic heart disease are ... deeply philosophical and then it's really easy to see* (Non-Indigenous 20).

A tendency for biomedical approaches reinforces non-Indigenous interests and power:

*The problem with rheumatic heart disease, I really feel like it's owned by white people and that the academics made their whole career out of it and get grants and get prestige* (Non-Indigenous 20).

Conversely, a lack of familiarity with the biomedical worldview results in some Aboriginal patients trying to fit RHD into their knowledge systems, for example, attributing the cause to sorcery.

#### *Power differences*

Power was a source of tension, "it is really interesting where the power sits here" (Aboriginal 15). The experience of power inequity for Aboriginal participants is experienced differently compared to non-Indigenous participants where it was more a case of having awareness, in some instances also producing a vicarious trauma. Power differences are often reinforced by or attributed to knowledge differences. For example, an Aboriginal participant stated that:

*You always have this sort of creeping in of the superior non-Indigenous knowledges, which as an Indigenous person, I find really frustrating ... I'm over the white dominance of, you know, in a conversation or discussion where somehow, they know more than you* (Aboriginal 6).

In a further example, a focus on implementing continuous quality improvement (CQI) in healthcare services was referred to as a way of excluding Aboriginal leaders and practitioners, and to even be used to maintain power. Counter to the intended inclusive and participatory design of CQI one participant stated, "one of the things that we're working very hard on here is to actually try and backtrack on that CQI [process]" (Aboriginal 14).

A non-Indigenous participant presented a rational analysis of power differences,

... there are significant power imbalances. There are unintended behaviours, or maybe unconscious behaviours and structural behaviours that enforce and contribute

*to perpetuating particular modalities of behaviour which aren't conducive to better relations with Indigenous communities* (Non-Indigenous 01).

Reflections about imbalances in power can cause tension for those with power when they begin to think critically about their position:

*It's naive to suggest that that discomfort and threat isn't something being experienced by ... [medical] people coming in with degrees and qualifications and defined roles who have been for decades perceived as the experts, and all-knowing and all-controlling. What's the power imbalance and shift and the discomfort that they have to feel and work through?* (Non-Indigenous 23).

#### *Power to decide about funding*

Funding allocation illustrated one-sided power. An example was reflected by participants' awareness of Aboriginal people "living in third world conditions, and not through choice, because of different systems that aren't giving them the care and the support they need" (Indigenous 16). Anguish was keenly expressed by Aboriginal people with lived experience, such as:

*We felt sad because as an Indigenous community we were saying, "Our kids are suiciding, we need some resources". Then they give it [funding] to a mainstream service again. So, we want to hold the mainstream to account when they get those big buckets of funding. How are you helping our community? How are you improving health for our people?* (Aboriginal 16).

Given the complexities of addressing RHD, it is not surprising to find tensions about funding allocation:

*We've eradicated acute rheumatic fever and rheumatic heart disease in many parts of the world without vaccines, and focusing on vaccine development is admitting defeat ... And pulling funding away from what we know are the priorities* (Non-Indigenous 19).

Battling for system change, such as making decisions about funding, left participants feeling personally responsible, "It affects your relationship and your reputation when you say, [funding withdrawn] ... It's hard not to feel personally responsible for some of that stuff" (Non-Indigenous 23).

#### *Personal impacts*

The tension of practising in both worlds can have emotional impacts. Aboriginal participants described having to "bear the

load" whereas non-Indigenous participants could at best only share the load. This tension is markedly felt when trying to fit and maintain an Aboriginal worldview while practising in the western biomedical context. An example is the extent to which trauma is a common experience for Aboriginal people:

*The percentage of Indigenous people that have experienced severe trauma in their life, would be very high ... there's people of all ages that have endured traumatic experiences that are deeply affected by them, especially children* (Aboriginal 11).

An additional burden is imposed when trauma, such as impacts of colonisation, must be discussed with:

*... someone who doesn't understand previous trauma ... I actually find that really difficult to negotiate ... often they'll [non-Indigenous] get quite defensive around it. So, then you have to make the call as to whether you carry on that conversation in that direction. Or whether you actually just try the gently, gently approach* (Aboriginal 14).

Non-Indigenous participants spoke emotionally about their experiences of vicarious trauma and of their willingness to share the load based on empathy, "You just don't forget rheumatic heart disease because you just see what it does. It just devastates families ... it just points to that kind of cascade of failures" (Non-Indigenous 8). And, "I do have a bit of vicarious trauma ... but the people I work with have got the other [the real trauma]" (Non-Indigenous 10).

Aboriginal participants spoke of personal impacts in trying to balance work and personal life due to continually:

*... carrying a lot ... of responsibility ... sometimes in educating others and taking non-Indigenous people along a journey so that they can understand ... you're sharing a lot of personal stuff. And it has an impact, and this is unpaid work. It comes at a cost. And not just the emotional stuff, but in time as well* (Aboriginal 15).

#### Use of measured voice or silence

Aboriginal participants were more likely to use a 'measured voice' when working, due to a felt obligation to tone down their comments and be careful of non-Indigenous people's emotions, "I don't want to be critical, I would just rather they understood so they would feel better about doing a good job" (Aboriginal Int 4). Aboriginal participants, even when working at high levels, felt power differences, and sometimes a sense of invisibility within the biomedical space,

leading to them moderating how they speak to accommodate non-Indigenous people's privilege and sensitivities. Additionally, they were restrained, due to being conscious of being accountable and not to appear to speak for other Aboriginal people, "if you're speaking for yourself ... it's interpreted that you're speaking for the whole community as well" (Aboriginal 16).

#### Strategies to reduce tension and improve care.

The themes in this section describe the actions and approaches that broaden the space for productive dialogues.

##### Reflexivity as the foundation of culturally safe practice

Reflexivity while working in the intersection of worldviews was considered foundational for improving healthcare, in particular, that non-Indigenous clinicians have a responsibility to ask themselves:

*Maybe I'm part of the problem? But maybe I can also do something about it as well ... There is a power imbalance, you know, a clinician has power. They also have power to change* (Aboriginal 16).

Commitment to reflexive practice arose from non-Indigenous participants' experiences and understanding of the cultural load that Aboriginal clinicians and patients bear within the biomedical healthcare system. This was strongly associated with suggestions or actions to create system changes. Several positive examples of reflexivity were provided: listening carefully, letting community govern, and building relationships:

*Then I realised over time, what I was doing was not quite right ... I may not get the answer straight away and it's more about listening to what they tell me ... I'm learning even after doing this so many years* (Non-Indigenous 22).

*But we work in a world, in a culture where ties to each other is at the centre of life, or of society ... It's everything. And one of the key aspects of that is caring for people ... you need a good relationship with the community generally, and the clients"* (Non-Indigenous 10).

##### Willingness of non-Indigenous people to enter two-way learning relationships in work settings

A willingness to develop 'two-way' relationships can enable partnering,

reciprocal exchange and equal power to develop within work settings, "Developing ways of working that work both ways ... give immediate benefit to the community as well as research and providing healthcare" (Non-Indigenous 4). Non-Indigenous people being prepared to cross cultural boundaries, including professional boundaries, can be confronting but a willingness to do so can pave the way for advances and innovations in practice. Participants' examples were framed in emotive language borne of reflexivity. Aboriginal participants held clear views of the inherent value of relationships and that building relationships first is their way of doing business, "So, I don't think everyone fully gets that relationships aren't just about an exchange of knowledge or skills, or goods" (Aboriginal 16). From an Aboriginal point of view, "working in solidarity with" is a "shift from the concept of saviourism" (Aboriginal 15). Similarly, relationships were best prioritised over clinical work to achieve good outcomes, "I think the model of healthcare should be community development at the core. And outside is the clinical stuff" (Non-Indigenous 10).

Longevity of work placements especially aid in building trust:

*But that obviously took a lot of many years of hard work to establish that trust with families and communities. But I think this is really critical. I think that's what makes the biggest difference* (Non-Indigenous 3).

However, reciprocal relationships are challenging, requiring reflexivity, and this also holds true for organisations, "That can be a challenge for large mainstream organisations, and particularly where there's a bit of a power imbalance" (Non-Indigenous 01). And:

*If they have to really face up to having relationships with Aboriginal people, then they have to face up to the reality of life for Aboriginal people in Australia. And the history and their role in that as well. For many people, that's a very complex and challenging thing to do* (Non-Indigenous 04).

Partnerships were important across and within disciplines as well as between mainstream and community-led organisations as expressed by a participant working in policy:

*I think one of the challenges for health leaders is actually getting outside of their own immediate circle of organisations and people that they're used to working with and starting to think about things a little bit differently* (Non-Indigenous 01).

### *Creating opportunities and recognising Aboriginal leadership in healthcare systems*

Aboriginal interviewees discussed that Aboriginal leadership should be mandated in healthcare planning, governance and practice and be legitimised and given the authority as opposed to advisory roles or tokenism. "I think that Aboriginal leadership is here. I think that we're shifting from an advisory role to a leadership role" (Aboriginal 15).

Governance includes place-based and local decision-making regarding funding, as local leaders are better able to judge that "some places need more money than others" (Aboriginal 06) or that more funds may not always be required, but what is already there needs better distribution.

*So, letting the community govern what they need is really important ... whatever you put into place; it has to be underpinned by that ... A lot of the elders will say, listen to us, because we know what's needed* (Aboriginal 16).

Including the community means senior Aboriginal health leaders talking directly with senior community leaders without a non-Indigenous bureaucratic 'go-between'. Participants provided examples where recognition of community leadership enabled deep issues to be tackled:

*Some of the local Indigenous health services can demonstrate that, where they're really invested in locals, and seeing it paying off big time ... investing in local intelligence rather than importing it* (Aboriginal 06).

To guarantee sustainability, place-based decision-making needs to be embedded within policy: "You've got to put all the evidence, and then put it into a plan that goes beyond ... 10-year plans, not three ... and they've got reporting underneath". In this way, Aboriginal policy leaders are essential in ensuring the sustainability of governance decisions despite political shifts. Furthermore, for policy to be sustained and useful from the beginning, "you have to really collaborate with clinicians and people on the ground ... as policy writers we have to step back and let clinicians and community own it" (Aboriginal 16).

### *Community-level data assist governance by grassroots Aboriginal leaders*

Access to or obtaining local health data is essential for Aboriginal leaders for informed decision-making within their communities. With local data, Aboriginal leaders can better determine their local agenda: "Once the

leader knows [the data], he's not going to get consumed by it, ... Ensuring that it's on their agenda, that's all" (Aboriginal 6).

Similarly, design of data collection systems is best if informed by Aboriginal leaders, with expert assistance as they deem necessary, "And the systems need to be culturally appropriate and measure outcomes that are important and of value to the community" (Aboriginal 15).

However, it was noted that communities are not yet aware of or resourced to work with their data, "and so really a more informed conversation needs to occur around that resourcing, around creating, enabling environments. So that the data can be used in a meaningful way" (Aboriginal 15). Further effort is required in this vein, "I think some of the research that we haven't done is what does data sovereignty mean to communities" (Aboriginal 06).

### *Support for Aboriginal leadership*

Support for Aboriginal leaders was often spoken about as coming from other Aboriginal leaders, both from within their peer group and in their communities. Mentoring was considered an essential element that was not always available:

*That sort of mentorship from other Indigenous leaders is still challenging to come by. I feel that there's a really supportive community of Indigenous leaders and when we get together it's always really enriching. I usually feel really energized and ready to go back into battle* (Aboriginal 15).

Mentoring by Aboriginal leaders was built on longstanding relationships and trust generated from those relationships: "When I needed that particular bit of support without hesitation, it was there" (Aboriginal 12). Similarly, for many in clinical or academic roles, "support needs to be from other Aboriginal community leaders" (Aboriginal 11).

While agreeing with the idea of Aboriginal leadership, non-Indigenous participants were not always clear as to what this entailed or how they could support it, suggesting a lack of understanding about how leadership works in the Aboriginal context and how a person becomes a leader. Aboriginal participants indicated that support means changing mainstream ways of doing things, and making space, which may be uncomfortable for Non-Indigenous people:

*So being able to step back and say, "Yes, I'm a clinical expert, but I'm actually not a cultural expert, that Indigenous worker is, and I need to give them the space to teach me as well ..." But you know, people find that really difficult, because they're all experts ... but you're not an expert in our ways of being and knowing and doing, so be quiet; listen to what communities say* (Aboriginal 16).

Aboriginal cultural practices replicated in mainstream work scenarios can easily be misinterpreted, for instance, meeting together informally needs to be recognised as a strength:

*If a group of [Aboriginal] clinicians in a service want to come together and have a yarn over a cup of tea ... they're actually doing cultural stuff, and it's really important for their strength and their sense of self, but it needs to be allowed in a clinical context* (Aboriginal 16).

Aboriginal participants also spoke about spending time with grassroots community leaders to obtain support and this was often poorly understood by non-Indigenous people.

Aboriginal leaders felt a general sense of obligation and responsibility to assist others to understand their leadership positions despite the personal cost. They were therefore often committed to widening the space of productive dialogue: "taking non-Indigenous people along a journey so that they can understand how to work to support Indigenous people" (Aboriginal 15).

### *Innovative practice*

Implementing strategies to broaden the space of productive dialogue can result in tipping points, fundamental changes in practice. As such, one participant described a new stance of equality and empowerment for Aboriginal team members: "And then the [Aboriginal team] spend their time with the patient and then come back to say ... 'These are the issues, and we are resolving it'" (Non-Indigenous 22).

Similarly,

*... when you've got policy that's supported by action on the ground, and in a much more inclusive way of working, in so much that it's not imposed on individuals, but the solution is worked out between the various parties* (Non-Indigenous 23).

An example of innovation was allowing contracting for Aboriginal workers to fit local people's needs: "We converted those two

positions into about nine-part-time positions ... and that arrangement worked pretty well for everyone" (Aboriginal 11).

## Conclusions

The experiences and views of a broad range of experts within the health system, including Aboriginal experts, provide evidence on ways to encourage productive dialogue so that new models of healthcare can be co-designed by those impacted by RHD and those controlling the services.<sup>18</sup> While productive and transformative dialogue is constrained by tensions, it is in the negotiation of these tensions that new ways of working can emerge, while taking care not to polarise or expect Aboriginal people and culture to become subsumed into the biomedical worldview. Reflexivity that attends to power inequalities is important for generating new ways of working together.<sup>19,20</sup> That is, productive dialogue assumes engaging in respectful and honest discussions to share ideas, experiences and understandings, which may illuminate struggles at the juncture of the two knowledge systems.<sup>8</sup> Meeting in the middle, where difference is recognised and valued, and where those in the space acknowledge unequal power relations between dominant and minority populations, can be a space of freedom.<sup>21</sup> *Making the world less white and more accommodating of difference is a tipping point for change. One such approach which can aid this change is the application of cultural safety in policy, practice, and service design.*<sup>22</sup>

## Cultural safety

Aggregation of the themes pointed to culturally safe practice in all levels of the health system, such as policy and clinical practice, and in funding and programming, all of which need to be embedded into organisations as the primary pathway for improvement. Cultural safety is a broad term illuminating a way for people and organisations to engage and collaborate well in intercultural spaces. It is a comprehensive approach deeply seated in reflexivity to expose power inequalities and inequities.<sup>23</sup> As such, cultural safety is a prerequisite for effective two-way relationships and learning, and the facilitation of productive dialogue. The aim is to enable health practitioners to become adept to "work with all people who are different from them"<sup>22</sup> Cultural safety is much more than cultural awareness.

Cultural safety is not readily implemented and may even be resisted in Australia, as seen in the 2017 statement that 'the existing health safety and quality standards are insufficient to ensure culturally safe care for Indigenous patients'.<sup>24</sup> Multiple current sources explain terminology and examples of cultural safety, including hospital projects and integrating cultural safety into guidelines.<sup>25-27</sup> Our findings strongly point to cultural safety as a missing key element yet to be prioritised in all levels of healthcare that would lead to improvements for conditions such as RHD.<sup>24</sup> Enacting cultural safety would help to mitigate deepening and ongoing trauma for all involved in RHD healthcare.

Below, based on our findings, we provide some of the 'how to' for components of the Endgame Strategy that states, "The focus on healthcare design and operation will require shifts".<sup>28</sup>

## Aboriginal leadership

Cultural safety describes a practical way to make space for understanding and enabling Aboriginal leadership. Aboriginal leadership prior to colonisation was based on a cultural system with expectations and ways of knowing, being and doing that were informed by Aboriginal worldviews.<sup>29</sup> These were markedly different to non-Indigenous worldviews of leadership. Although Aboriginal leadership today is often located within a Western space, which has specific expectations, fundamentally Aboriginal leadership continues to be grounded in values and practices that are informed by knowledge systems and relationships. For many non-Indigenous people who are unfamiliar with Aboriginal culture, this can seem incomprehensible and be unrecognisable.

The changes required to legitimise and accept such leadership can best be enacted within the context of cultural safety. In supporting Aboriginal leadership, institutions must support and create the space for leaders to emerge, lead and develop in their field.<sup>25</sup> This includes allowing Aboriginal leaders to make mistakes and making sure they are financially supported to build their capacity. When non-Indigenous people stand as allies with Aboriginal leaders and are open to two-way learning as a culturally safe stance, they become supportive co-innovators with Aboriginal leaders. This can lead to the tipping points that are urgently needed in

healthcare for RHD and other conditions. Tipping points were experienced by some interviewees when some of these conditions were met such as allowing flexibility in how funds were employed locally and embedding an Aboriginal team within a large care program. Suggestions within interviews for improving RHD care aligned with the RHD Endgame Strategy, including control of how funds are spent for prevention strategies on par with vaccine development; exploring local place-based solutions that are not expected to be universally applicable; supporting local health messaging over generic messaging; and co-designing interventions and solving issues together with Aboriginal people including people affected by RHD.

## Cultural safety actions

To facilitate cultural safety being embedded and sustained within organisations despite staff turnover, our primary recommendation is to include cultural safety measures into CQI processes. These recommendations are in line with findings in similar recent research<sup>30,31</sup> but provide specific actions that broaden the cultural measures for CQI and show that work within 'turbulent waters' has been attempted. Cultural safety actions derived from the research reported in this paper are described here as measures for CQI processes for clinical services (see Box 1). The terminology and descriptions are suggestions and can be adjusted for policy, funding, and management CQI.

## Implications for public health

This study focuses on the intricacies of differences in worldview at the juncture of a healthcare system and Aboriginal ways of knowing, being and doing. Experiences of tension at the intersection of Aboriginal and biomedical worldviews are considered through different cultural lenses. Emerging from the study is the need to attend to power differentials to ensure that the socially 'dominant' move closer to the 'dominated'. The benefit of cultural safety is that it places all cultures, people and views as being valued and recognised because of shared humanity. This requires those in control of and working within health systems to examine themselves and health systems with the expectation that changes will be made to support the engagement of Aboriginal people in health and healthcare in a meaningful and

positive way that builds confidence and self-determination.

Our findings support cultural safety as the most powerful forward move within health systems that are providing healthcare for Aboriginal Australians, and especially those working in high-prevalence RHD sites. Embedding cultural safety through CQI processes would foster equality and opportunity through the world becoming “less white”. This means valuing both biomedical and Aboriginal worldviews, with each enabled to remain strongly identified in their cultures and knowledge as they collaborate to build a healthy and inclusive society.

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### Box 1: Cultural safety CQI measures.

#### 1. Reflection on stance

- Number of staff who participated in cultural safety training where self-reflection was integrated into the material covered
- Number of instances where non-Indigenous staff were reminded by self or others to reflect on their own power/privilege/opportunities and its impact on ways of working

#### 2. Aboriginal leadership

- Number of new contacts made between non-Indigenous leaders in Primary Health Care (PHC) service and local community Aboriginal leaders
- Number of new contacts made between non-Indigenous leaders in PHC service and Aboriginal leaders within the service
- Number of supportive actions initiated to facilitate growth of Aboriginal leaders in the PHC service
- Number of instances where Aboriginal leaders were supported by management and colleagues to navigate through challenges/issues/barriers

#### 3. Two-way Learning

- Number of productive dialogue sessions conducted between non-Indigenous PHC staff and local Aboriginal people (including Aboriginal staff) to do with healthcare expectations from two worldviews (Western biomedical and local cultural)

#### 4. Co-design

- Number of newly developed ways of working in local PHC service that originated from productive dialogue between Aboriginal people and non-Indigenous staff
- Number of decisions related to the nature of local data that are collected, how information is shared and used
- Number of positive health resources and messages developed together specific to the location/language group

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