Review

The power of talk and power in talk: a systematic review of Indigenous narratives of culturally safe healthcare communication

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Abstract. The study aimed to explore Indigenous narrative accounts of healthcare access within qualitative research papers, to better understand Indigenous views on culturally safe healthcare and health communication represented in that literature. A systematic literature review of peer-reviewed academic qualitative studies identified 65 papers containing Indigenous respondents' views on accessing healthcare. Analysis included all Indigenous voice (primary quotations) and author findings describing healthcare access across these studies. Healthcare communication, or 'talk', emerged as a key theme. Indigenous clients valued talk within healthcare interactions; it was essential to their experience of care, having the power to foster relationships of trust, strengthen engagement and produce positive outcomes. By mediating the power differentials between health professionals and Indigenous clients, talk could either reinforce powerlessness, through judgmental down-talk, medical jargon or withholding of talk, or empower patients with good talk, delivered on the client's level. Good talk is a critical ingredient to improving Indigenous accessibility and engagement with healthcare services, having the ability to minimise the power differentials between Indigenous clients and the healthcare system.

Introduction

I tell you, we got the best doctors in the world here...
Not talking down to us, talking to us, do you understand?
[Bond *et al.* 2012].

The profound health inequalities experienced by Aboriginal and Torres Strait Islander Australians are often attributable to social and cultural determinants of health, which extend beyond the scope of clinical health practice (Marmot 2011). The ongoing under-utilisation of healthcare services by Indigenous[A] Australians, however, suggests that health practitioners can play a critical role in closing the gap of health inequality through improving access to healthcare (Hayman *et al.* 2009; Australian Institute of Health and Welfare 2013). This requires health services that are not only physically and economically accessible, but culturally safe and acceptable, from remote to urban contexts (Scrimgeor and Scrimgeor 2007).

Over the past few decades, an agenda of 'culturally appropriate' healthcare delivery has become prominent in health workforce training, health curricula and professional accreditation standards (Phillips 2004; Eckermann *et al.* 2010; Commonwealth of Australia 2016). This has generated a broad body of theory and practice, including cultural awareness, cultural competence and cultural safety, which seek to bridge the 'cultural chasm' between Indigenous peoples and health service providers. There are concerns, however, that some of these practices, particularly those informed by cultural awareness, can produce essentialised, homogenised, stereotypical representations of 'Indigenous culture' (Downing *et al.* 2011). This avoids analysis of the culture of the healthcare system and health practitioners themselves, and risks Indigenous culture being seen as the problem (Taylor 2003; Downing *et al.* 2011; Thackrah and Thompson 2013).

[A]Although we acknowledge many Aboriginal and Torres Strait Islander Australians prefer to be acknowledged by their distinct cultural identification, the term Indigenous is used to represent the diversity of peoples included in this study.

What is known about the topic?

- There are qualitative studies on Aboriginal and Torres Strait Islander views on healthcare access and communication in specific clinical contexts, but no systematic reviews across this knowledge base.

What does this paper add?

- Talk is a critical element of healthcare, and by changing how health professionals speak with Indigenous clients, we can alter the power dynamics and cultural safety of health consultations.

Box 1.   Search strategy

Search terms

All searches used a combination of keywords, synonyms and subject headings across the following areas

Aboriginal and Torres Strait Islander Australians Aboriginal, Indigenous, Oceanic Ancestry Group [Mesh]

Health Care perspectives, cultural competency, barriers to access, patient acceptance of healthcare, access, utilisation, barriers, cultural competency, communication

Qualitative methodologies, interview, phenomological, focus group, ethnography, narrative, (semi) structured

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Health communication is one area at risk of this approach, with cultural communication publications often focusing on Indigenous communication styles (Coleman 2010), language or miscommunication (Anderson *et al.* 2008). There appear to be deeper communication barriers, however, with nearly one-third of Aboriginal survey respondents reporting experiencing racism in health settings, the majority by communication (Kelaher *et al.* 2014).

Cultural safety is a framework that may afford means to address these problems. Described by Maori nurses in New Zealand, culturally safety 'is the mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. Safety is a subjective word deliberatively chosen to give the power to the consumer' (Ramsden 2002).

There is rich, qualitative, peer-reviewed literature that explores Indigenous accounts of healthcare access, but no systematic reviews of this literature. Using the lens of cultural safety, we were curious to examine what Indigenous recipients of care had to say about their healthcare experiences. The aim of this paper was to systematically collate and examine these accounts, unpacking the themes raised and prioritised by their own voice and experience, in order to illuminate our understanding of culturally safe Indigenous healthcare communication.

Methods

Design

A systematic qualitative literature review was undertaken, which identified the peer-reviewed qualitative scientific literature featuring Aboriginal and Torres Strait Islander respondents discussing their experience of accessing healthcare. Analysis of paper findings and data was undertaken, with results concerning healthcare communication presented here.

Literature review

An evolving, non-linear literature search was undertaken of peer-reviewed sources during April 2013, aiming for exhaustion and inclusion of all applicable studies (Walsh and Downe 2005). An initial extensive PubMed database search by the first author (W. Jennings) yielded 224 results, using search terms or subject headings for: (1) Aboriginal and Torres Strait Islander Australians; (2) healthcare perspectives, cultural competency, barriers to access; and (3) qualitative methodologies (Box 1). Similar searches of Cinahl, AMI (Australian Medical Index),

Informit Rural, Informit Health Indigenous, APAIS-Health Rural and EMBASE, identified 1448 results before filtering for duplication and inclusion and exclusion criteria.

A review of included studies was undertaken by the first author, with core papers and outlying inclusion and exclusion decisions discussed with all researchers. Papers from peer-reviewed journals were included if they contained first-person qualitative data identifiably from Australian Aboriginal or Torres Strait Islander respondents discussing the experience of accessing healthcare; this included mixed-methods research papers. Respondents included Indigenous clients, family or community members and Indigenous staff. Papers were excluded if they explored only experience and knowledge of illness, rather than experience of accessing healthcare. Literature reviews and systematic reviews were not included because of duplication of primary data, however, were used to triangulate findings.

A total of 1448 initial results from the primary database searches were screened for duplicates, then assessed for inclusion criteria through sequential title, abstract and full-paper review (Fig. 1, adapted from the PRISMA Statement; Moher *et al.* 2009). In total, 65 papers were eventually included (see Table S1 of the Supplementary material), with 1998 the earliest publication year.

Data analysis

All reported findings on healthcare access, and Indigenous participants' direct quotations on healthcare access, were identified and coded using NVivo software (ver. 9, QSR International, see http://www.qsrinternational.com/products_nvivo.aspx, accessed 11 December 2017) to collate data and identify themes. Raw data were included in this analysis, promoting Indigenous voice. The first author (W. Jennings) coded all material, with co-coding of papers with key themes or outlying themes conducted by both co-authors. Repeated inductive iterations of coding and discourse led to a global thematic structure encompassing the health system, culture, history and racism, trust and the agency of Indigenous clients. Talk and healthcare communication emerged as a key secondary theme, with NVivo electronic text query of the primary quotation data from all papers revealing talk (or synonyms of talk) to be present in primary quotation data from 46 of the initial 65 included articles. Informed from the data, synonyms used for this text
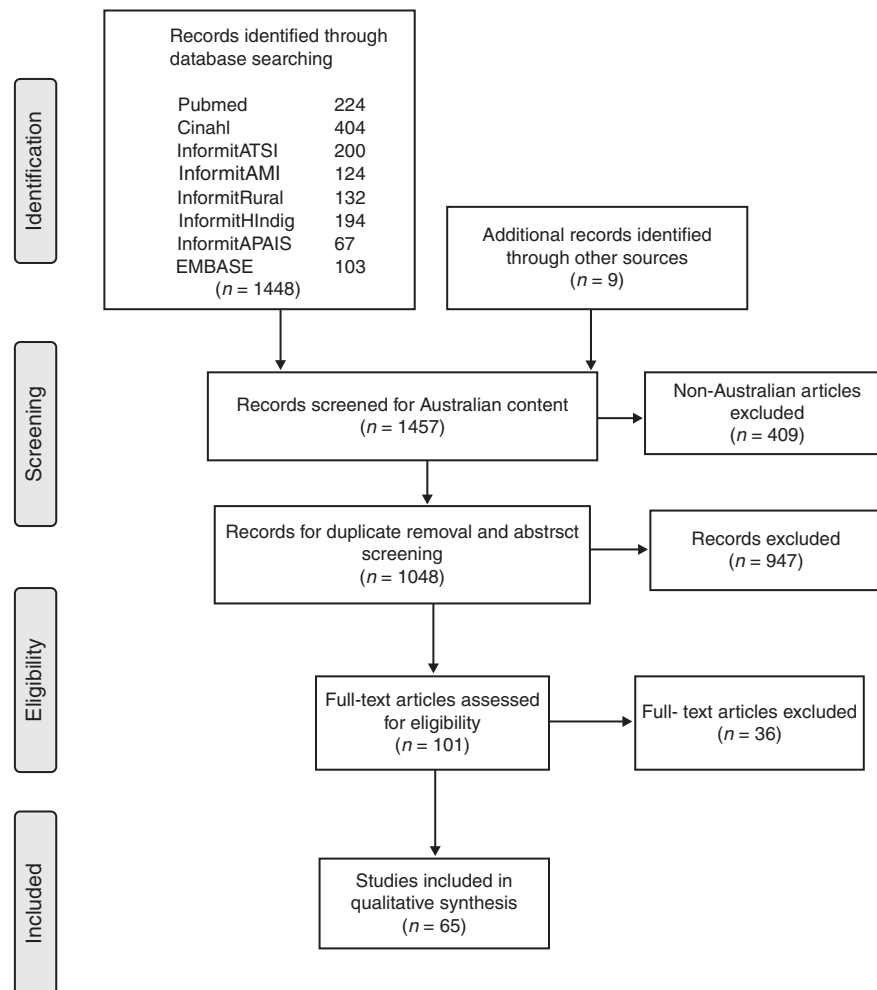
Fig. 1. Systematic review flowchart and results.

search included 'talking', 'speak', 'spoken', 'speaking', 'tell', 'told', 'telling', 'yarn', 'yarning', 'words', 'communicate', 'communication', 'grumping', 'growl' and 'growling'. These quotations featured prominently in this secondary analysis on healthcare communication featured in this publication.

The application of a cultural safety lens of prioritising Indigenous voice has been critical to this study. The second author (C. Bond), a female Indigenous researcher, provided guidance and critical feedback to the primary researcher, a non-Indigenous male general practitioner, and the third author (PH), a non-Indigenous male public health physician, aiding self-reflection on the researchers' relationship to the content and social positioning within the 'whiteness' of the health system (Eckermann *et al.* 2010). We acknowledge the essentialising possibility of this research, the presence of non-Indigenous authorship within this paper, and the potential for distortion in the [re]presentation of Indigenous voices.

Results

The importance and prominence of talk to Indigenous respondents' experience of healthcare resonated in articles across diverse clinical and geographical settings, from Sydney antenatal care

to remote Western Australia palliative care. It was essential to Indigenous peoples' experience of care and treatment, and a core mediator of culturally safe (or unsafe) healthcare.

Two key components of culturally safe healthcare communication emerged: the power of talk, and power differentials within talk. The power of talk refers to the esteem in which Indigenous respondents held talk, both individually and community-wide, with health professionals as well as with each other. This power was mediated by the power differentials experienced through talk, including talk that demeaned, diminished or disempowered (Eckermann *et al.* 2010), as well as talk that challenged or reoriented the relationships between Indigenous peoples and the health system.

Power of talk

Indigenous respondents valued talk; it was central to the experience of healthcare. They felt valued when it was shared and hurt when it was withheld. Talk between and among Indigenous clients themselves was similarly valued, influencing their relationship to health spaces, with some describing mainstream health spaces as often quiet, lonely places, preferring their health spaces to be social, talking spaces.

We share a lot. You know when we meet people we talk about things. It's like when you go into [Mainstream Health Services] you as a whiter person, you might be lucky if somebody says hello to you. If we go in and I know someone we'll have a good yarn. 'How you going with yours?', 'You got diabetes yeah. How many tablets are you on?'... And not only that, if you're a bit nervous then it calms you down, a lot of us, so there's a lot of aspects I suppose we think on a cultural basis [Client with chronic disease, Aboriginal Medical Service (AMS), Sydney/ACT] [Jowsey *et al.* 2012].

The value of talk was demonstrated in the respect and care experienced when health professionals took the time to speak with them, either personally or to the community more broadly. In country New South Wales, an elderly man expressed his surprise and delight that a group of doctors would take the time to sit down and talk with 'a boy from the mission' (Andrews *et al.* 2002). This talk, particularly in informal or social contexts beyond the usual health provider role, conveyed to Indigenous clients a sense of genuine care and compassion, fostering trusting relationships with their care provider.

They'll know this doctor's not just here to do his day's work and go home. He wants to know about us and where we're from [Cultural mentor, AMS, Sydney] [Abbott *et al.* 2014].

In contrast to the benefits of talk, the absence of talk, or perceived withholding of talk, was a commonly described discriminatory experience, as evidenced in this birthing account from NSW.

I personally noticed it. Just the general way that they [midwives] went about things with white women. I had a white woman next to me in my room, and she ... would come and check up on her, just check up on her for no reason. 'Are you okay? Do you need help, assistance, rah, rah?' And I mean, I saw other young black girls there that were being treated worse than me [Birthing mother, country NSW] [Dietsch *et al.* 2010].

Compare the experience above, however, with the empowerment inspired by the positive communication from an Indigenous midwifery program in Sydney:

They [Daruk holistic midwifery program] did give me confidence – I talk to them about something I'm worried about and they explain it in a different way and tell you how to go about it – and I feel alright then and I'll do it like that [Pregnant mother, Western Sydney] [Jan *et al.* 2004].

The power of good and bad talk in healthcare interactions to inspire different responses among Indigenous people was repeated, influencing adherence to healthcare treatment plans and whether they would continue to utilise the health service or the health professional. What was it about 'talk' that gave it such influence over Indigenous clients' healthcare decisions?

Power within talk

Talk was not simply a medium of health 'care', it was also a medium of power. When respondents discussed talk, they also highlighted the ways in which power, dominance and exclusion were exercised through talk. Withholding talk was one example, but 'being spoken down to', or health professionals 'talking down', was the most common example of this power differential. Power differentials manifested in numerous ways in healthcare communications, from overt racism to the dominance of medical culture and terminology. Indigenous clients described the importance of health professionals 'coming down to our level', citing the positive outcomes that could result. This power differential is particularly important given the positioning of the Australian health system in the colonisation and control of Indigenous peoples (Eckermann *et al.* 2010).

You do feel intimidated because you've copped it for so many years you've gone to hospitals, and they make you feel that little and make you feel like shit, that's the way that I do feel and it's left an imprint in my soul for years gone [Client with chronic illness, NSW/ACT] [Aspin *et al.* 2012].

There was no shortage of examples from Indigenous respondents where, instead of caring talk, they experienced disempowerment or exclusion through health communication. Personal racism and racist talk were perhaps the most obvious.

They say, 'we got an Abo' in last night – how many parts are you? – you're pretty for an Aboriginal' [Pregnant mother, Western Sydney] [Jan *et al.* 2004].

Racism continued to feature in Indigenous accounts of engaging with the Australian healthcare system, the effects of which were cumulative and significant. Descriptions of demeaning, abusive down-talk into the present day were evident throughout studies, most prominently in the bullying described in these birthing accounts.

...and this woman [midwife] was in her face, screaming at her. She was saying, 'Did you feed, did you bath the baby? I don't believe you. You're lying to me. Did you bath the baby?' And she was screaming at her ... all the abuse was terrible. Terrible. Jemma was like a broken woman... She left here bright and happy and looking forward to the future, and came back like an old woman, like a broken woman... It was like they were, it was designed to break [my wife] and take the baby [New father, country NSW] [Dietsch *et al.* 2010].

...I honestly thought a hospital, a maternity ward, I thought it would be full of caring, wonderful people [New father, country NSW] [Dietsch *et al.* 2010].

In addition to being demeaned, judged or spoken down to, being ignored or not trusted was recounted as disempowering experience. Common examples were respondents not being believed they weren't heavy drinkers (a repeated example) or not being believed they were in pain or labour.

...[in] the ambulance, it's the first thing they say, 'Do you drink alcohol? When was the last time?' I said to them, 'I don't drink, I have a heart condition'... When you are in casualty, the next bed is [right] there, you could just about reach over and touch the next person, but I haven't

heard them question that person about their drinking habits [Woman with disability] [Marshall *et al.* 2008].

...No, these girls haven't been believed, that they are in labour. They've just been left on the ward. Given a handover in the morning shift, it's been stated that these girls have kept other members in a four-bedroom ward awake all night ... [a vaginal examination is done and] eight centimetres and bulging forewaters... And she told me, 'They haven't believed me all night' [Aboriginal midwife, country NSW] [Dietsch *et al.* 2010].

Misbeliefs about alcohol consumption in particular were believed by respondents to have been driven by racist stereotypes. This disempowerment of not being believed, and instead treated according to racialised imaginings by their health providers, was a repeated discriminatory narrative.

Medical communication styles were a less overt but common demonstration of power by health professionals, through the use of technical biomedical jargon, or by affecting the detached professionalism and authoritarianism exerted by some health professionals, which could inspire distrust.

I can't really understand my doctors anyway ... it's all big words. It's like they just want to talk just to get the money... [Client with mental health concerns, SA] [Emden *et al.* 2005].

When I ask the doctor I don't get anything [clear information]. Have I got something else wrong [with me]? The doctors keep it a secret, they hide it. We want them to tell us plainly, 'This is the problem'. They don't talk [Renal client, NT] [Anderson *et al.* 2012].

The request for communication is clear, and the power differential is evidenced quite literally with clients describing 'big words' or 'high words', and repeatedly requesting the health professional to 'bring it down'.

[The doctors] started telling me what's going on and that. But they got a very funny way of communicating with people. When they talk to us, they need to bring it down and explain it to us [Renal client, NT] [Anderson *et al.* 2008].

Participants favoured health professionals who communicated in an informal, warm, 'yarning' manner, to demonstrate care, gain trust and share information in terms understood by both parties. One Indigenous cultural mentor did caution, however, against patronising over-simplification of language.

I found that the GP ... I don't know what he was thinking, but he was speaking to them like they were really, really stupid, and to me it was quite patronising ... they were really dumbing down their language... You need to find a balance using clinical terminology and not being patronising [Cultural mentor – Sydney] [Abbott *et al.* 2014].

Indigenous clients were conscious of the assumptions being made about them, including assumptions about their intellectual capabilities, expressed through the patronising language in the above example. This fear could inhibit Indigenous clients during communication from asking questions of their health professional.

With a lot of Aboriginal people – and I know I have done this myself – if someone is talking to you and explaining to you and they are looking at you and [you are] nodding, 'yep, yep', but really it is over your head and you are too ashamed to say, 'No, I don't understand what you are saying', because you don't want to look dumb [Aboriginal Health Worker, cancer care, WA] [Shahid *et al.* 2009].

Although this tactic of 'just saying yes' was sometimes motivated by politeness, respecting the position of power, authority or respect held by the health professional, it could also be seen as a means of resistance when the client felt too powerless to ask questions, or challenge their health professional. This disempowerment could be compounded when dealing with multiple health professionals, particularly in tertiary care contexts.

They're not used to 25 different people talking to them about the same thing and asking the same question. They can't understand why one person just doesn't ask that question and that's the end of it, they pass that information on. Yeah, so it's quite intimidating [Palliative carer, NT] [McGrath 2006].

...just having those 10 people all staring down at you like this, you know, that is intimidating enough in itself [Urban family friend, cancer care, WA] [Shahid *et al.* 2009].

'Intimidating' was the repeated description of these tertiary healthcare communication styles, highlighting the power differential. Respondents critiqued the dominating, impersonal nature of large ward rounds and the rapid-fire question-and-answer expected in a medical interview, preferring the reciprocal nature of yarning, which requires relationship building. Similarly, some respondents preferred talk over the impersonal nature of written healthcare communication such as pre-procedure checklists or health information leaflets.

Bringing it down

The harms and barriers of power differentials within healthcare communication were described repeatedly across clinical contexts. Challenging and minimising these power differentials, however, was a repeated request from Indigenous clients.

I tell you, we got the best doctors in the world here... Not talking down to us, talking to us, do you understand? This is what a black fella can't take, he can't take it when a man talks down to him. He can't take that he'll get up and say, 'Yeah, yeah, yeah,' walk out and do the same thing. But when you sit down and talk with him, talk to him, he takes notice. That's what these fellas do here honestly, I tell you the best staff in the world here... [Male, ex-smoker, Brisbane, Qld] [Bond *et al.* 2012].

With our [social worker] ... I said to her, 'before I let down my defences and connect with you, because I have to connect with you, you have to meet me on my level. You

have to come down from your big university degree level, get on the grass with me'. I said, 'we won't sit on a chair, we'll sit on the grass. If you are worried about getting your skirt dirty, well you may as well just walk out of there because it is important... You need to look into my heart' [Female, client with disability, Brisbane, Qld] [Marshall *et al.* 2008].

Whether by status ('come down to our level'), terminology ('bring it down') or physical act ('sitting down'), these were different literal representations of the same core request, from remote renal patients to clients in urban Brisbane. There was a sense of care and respect felt when health professionals were willing to minimise their power, their status, their high words, their physical position, and relate to their client with care, humility and something closer to equality.

Discussion

Indigenous patients valued talk within healthcare communication; it was essential to their experience of care, with the power to foster engagement and adherence and produce better healthcare.

This value of talk was grounded in the ability of talk to either reinforce or reconfigure the power differentials between Indigenous clients and healthcare professionals. Talk could reinforce powerlessness, through judgmental down-talk, medical jargon or withholding of talk, or empower clients with good, caring talk, delivered on the client's level.

Power differentials are inherent in medicine, with doctors using the structured 'medical voice' to maintain control of consultations (Mishler 1984), despite most complex consultations being improved by including the 'lifeworld voice', or the contextually grounded experience, of the patient (Barry *et al.* 2001). The request for health professionals to give up the detached professionalism of medical voice for the yarning, social, egalitarian lifeworld voice is not new, but is amplified in Indigenous contexts because of the sociodemographic antecedents to this power differential.

Communication between health professionals and Indigenous patients sits in the context of a government, law, police and indeed health system, acting as an apparatus of colonisation and control of Indigenous peoples (Eckermann *et al.* 2010). The taking of children, refusal of care and racially segregated wards, for instance, are documented health system examples of oppression occurring within many client's lifetimes (Forsyth 2007). This oppression continues in Indigenous health access, with barriers including insulting or humiliating health provider attitudes (Hayman *et al.* 2009), mistrust of the system, and racism (Australian Health Ministers' Advisory Council 2015), barriers which are often overlooked in health communication literature using a cultural awareness focus (Coleman 2010). The example of racism, linked to higher rates of psychological distress, is particularly prevalent, with nearly one-third of Aboriginal participants reporting experiencing racism in healthcare, including exclusion, hearing racist names and comments based on stereotypes (Kelaher *et al*. 2014), findings replicated throughout our results.

We are wary about the essentialising potential of reproducing a universal pan-Indigenous healthcare communication 'model/ framework', which can be magnified by cultural awareness frameworks (Downing *et al.* 2011; Thackrah and Thompson 2013) such as focusing on Indigenous communication styles, language or miscommunication. Such essentialised conceptions can lead to presumptions that Indigenous cultural or communication barriers aren't prominent in urban contexts (Coleman 2010). Cultural safety approaches can overcome these shortfalls, by self-reflecting on practice, listening to recipients of care, recognising power relationships and being alert to communication that demeans, diminishes or disempowers (Ramsden 2002). Whereas Indigenous communities are culturally diverse, our findings on the value of talk, and the request for health professionals to challenge and reduce power differentials within talk, were reflected across rural, remote and urban settings alike.

There is not a shared universal Indigenous culture or communication style, but there is a shared experience of encountering a healthcare system acting as an apparatus of colonisation and control (Eckermann *et al*. 2010). The request by Indigenous clients to minimise the power differential is a request for the health system to demonstrate that it has changed, that it does not wish to dominate and demean, but rather respect and care for its Indigenous clients as human beings. Health professionals should realise that something so simple as good, caring talk has the ability to reconfigure these experiences and relationships between Indigenous clients and the healthcare system.

Our focus on raw data, instead of author findings, was a modification of systematic qualitative meta-synthesis methods (Walsh and Downe 2005), a conscious decision reflecting the tenets of cultural safety by prioritising Indigenous voice. We acknowledge the risk of focusing on the 'evocative quote' (Daly 2009), valorising the direct Indigenous voice over original authors' synthesis of the total qualitative data. There is a more troublesome risk, however, when dealing with conclusions drawn from disenfranchised voice, that participants' voices become diluted through the sequential filters of selection, interview, analysis, publication and meta-synthesis. This compromise may benefit from further academic consideration.

Conclusion

Talk is a critical element of healthcare, with the potential to improve the cultural acceptability of health practice and healthcare access. By changing how health professionals speak with Indigenous clients, we can alter the power dynamics within health consultations, and reconfigure the relationship of the health system with Indigenous peoples. This may require health professionals to reflect on their own behaviours and beliefs, and their position within a health system complicit in colonisation and control over Indigenous peoples, and how their talk either reinforces, or reorientates, this position. How far these concepts have penetrated health professional awareness, training and curriculum, may benefit from further study.

This study highlights the benefits of using cultural safety as a research model for improving Indigenous accessibility to healthcare services. Through engaging in discourse with Indigenous peoples as the recipients of care, we privilege Indigenous knowledge and experiences, and acknowledge and promote their power in health communication and health

policy. We hope these methodologies find more prominence in further health services research.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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