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ORIGINAL RESEARCH

Understanding experiences of Aboriginal and/or Torres Strait Islander patients at the emergency departments in Australia

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Abstract

Objectives: The present study describes the experiences of Aboriginal and/or Torres Strait Islander patients and the factors that shaped their experiences of ED visits in regional settings.

Methods: This is a qualitative descriptive study. We conducted semi-structured in-depth interviews with Aboriginal and/or Torres Strait Islander patients who used the ED services at three hospitals in New South Wales, Northern Territory and South Australia. We coded the collected data and analysed them using a thematic analysis technique.

Results: A total of 33 Aboriginal and/or Torres Strait Islander patients participated. Analyses of their experiences revealed four themes, which included: (i) patients' waiting times in ED; (ii) cultural determinants of health; (iii) treatment services; and (iv) safety, security and privacy.

Conclusions: A holistic approach and a robust hospital commitment to address cultural needs while considering overall health, social and emotional wellbeing, will enhance Aboriginal and/or Torres Strait Islander patients' satisfaction for ED visits.

Key words: *Aboriginal, Australia, emergency departments, experience, First Nations People.*

Key findings

- Issues related to waiting times, culture, treatment services along with safety, security and privacy contributed to the experiences of First Nations People in this study.
- Findings warrant a review of hospital policies and practice to address cultural determinants of health for this disadvantaged group of population.

Introduction

Aboriginal and/or Torres Strait Islander people are more likely to visit EDs specifically in very remote (50%) and remote areas (35%), although the proportion of similar visit is low in metropolitan areas (3%).[1] In 2017–2018, 6.7% of ED presentations (n = 535 000) were reported as presentations by the Indigenous people, even though they only represented 3.5% of the Australian population.[2] There is no difference in the median waiting time (19 min) between the Indigenous and non-Indigenous patients before someone attends a patient; but it is shorter for Aboriginal and/or Torres Strait Islander patients who are deemed urgent, semi-urgent and non-urgent during attendance at the EDs.[2] Similarly, there is no difference in the ED waiting times for treatment, but Aboriginal and/or Torres Strait Islander people are more likely than their non-Indigenous counterparts to leave EDs without being seen.[1]

Hospitalisation statistics are mostly non-existent as to the reasons

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for such early departures or to the experiences of Indigenous people in EDs, but prior evidence revealed that a lack of culturally appropriate services and information were key barriers to accessing health services.[2] Exploring the experiences of Aboriginal and/or Torres Strait Islander people visiting the EDs will guide relevant cultural competence training for staff and enhance experiences of cultural safety in EDs for Aboriginal and/or Torres Strait Islander patients and families. Therefore, the present study describes the experiences of Aboriginal and/or Torres Strait Islander patients during ED visits and the factors that shaped their experiences.

Methods

We selected 33 Aboriginal and/or Torres Strait Islander people from two regional settings and one urban setting for the present study in July 2020. These people used ED services of the three selected hospitals: Alice Springs Hospital in Alice Springs, Northern Territory (NT), Lyell McEwin Hospital in Elizabeth, South Australia (SA) and Shoalhaven Memorial Hospital in Nowra, New South Wales (NSW).

We included participants in the present study if they met the inclusion criteria listed in Table 1.

We recorded all interviews using an audio recorder and then transcribed them verbatim. Then we thematically analysed the de-identified transcripts, which involved identifying themes and subthemes from the coded data.[3]

Ethics approval for the present study was obtained from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) (EO129-11072019); Aboriginal Health and Medical Research Council Ethics Committee (NSW) (1544/19); The University of Wollongong and Illawarra and Shoalhaven Local Health District Health and Medical HREC (NSW) (2019/ETH13270); Central Australian Human Research Ethics Committee (CAHREC) (NT) (CA-19-3458) and Central Adelaide Local Health Network (SA) (HREC/19/CALHN/317).

Results

Aboriginal and/or Torres Strait Islander people from three local government areas in NT ($n = 11$; five males and six females), SA ($n = 10$; five males and five females) and NSW ($n = 12$; four males and eight females) participated in the present study. Participants from NT and NSW came from rural settings, whereas participants from SA came from urban settings. Age ranged from 18 to 75 years.

Qualitative findings revealed four core themes: (i) patients' waiting times in ED; (ii) cultural determinants of health; (iii) treatment services; and (iv) safety, security and privacy.

Patients' waiting times in ED

Most of the Aboriginal and/or Torres Strait Islander patients identified waiting times as an essential contributing factor influencing their experience of ED services. For example, one participant said: '*I was in a bed out in the back of ED, and we had been left there for a long time. I was sitting across from a little old lady, and no one was coming to her*'. Another one highlighted the importance of frequent check-ups and checking-in on patients instead of just waiting at the ED: '*It would be good if the nurses would do frequent check-ups instead of putting me in the room and leaving me there just waiting. Because I was alone, I was worrying, and if someone had just checked on me, I would have felt better. We know it is busy but just to even look at you, walk past and check in on you*'.

The quote also indicated that patients felt anxious and worried because of long waiting times at the ED. Many of them stated that they felt uncared for and unpleasant because of the length of waiting at the ED for varied reasons, such as test results, doctors' assessments and so forth. They felt ashamed and disturbed by such long waits and lack of care: '*She [patient] was buzzing, and I was buzzing because she needed a bedpan and she ended up wetting herself. She was so shameful, and I was shameful for her*'.

Participants noted that ED overcrowding was one reason for long waiting times. One of them said that '*overcrowding and lengthy waiting times*' triggered violence and aggression: '*I had to wait five hours for two Panadols. It was ridiculous, I was so angry*'. Furthermore, several participants reported that patients left the ED because of the long waiting times and staff's negligence: '*I walked out because of how ignorant they were to me and my wife*'.

TABLE 1. *Inclusion criteria*

Resided in urban or regional areas
Needed emergency services in the past few years
Experience of any of these situations
Elderly and had multiple chronic conditions to manage
Arrived at the ED in an ambulance
Escorted off the hospital grounds by police
Being a primary support person for people who needed care
Attended the rooms of loved ones who were dying
Needed support from the emergency mental health care team
Used English as a second language
Attended the ED and was discharged; but was re-admitted within 48 h
Travelled more than 20, 50 and 100 km to the nearest ED
Self-harmed while intoxicated

Overall, Aboriginal and/or Torres Strait Islander patients' experience of the ED waiting times produced adverse consequences such as uncertainty, anxiety, anger, and leaving ED without treatment.

Cultural determinants of health

Most of the participants voiced their concerns about the culturally inappropriate ED services for Aboriginal and/or Torres Strait Islander people in the study hospitals. Few of them highlighted that staff lacked empathy in the understanding of their feelings, culture, and the history of their culture. One participant said: '*Patients do not feel culturally safe because none of them can understand what they are saying, and they do not understand what the doctors are saying. So yeah, more Aboriginal staff; and those jobs to be respected as they should be. I also think that people working in ED need to go out to see where people live and how they live, so they lose their judgements of us and understand where we are coming from*'.

Most participants emphasised the importance of providing adequate staff interpretation services for the Aboriginal patients in the ED. For example, one of them said: '*We need more rights-based information in the ED – our right to having an interpreter and basic stuff. We should have access to an interpreter all the time*'.

Several participants indicated that some staff were arrogant and treated patients with disrespect: '*one of the nursing staff was pretty arrogant and there was no friendliness*'. Furthermore, a number of them said that they experienced racism in the ED waiting room, and cultural safety should be compulsory for all ED staff to stop patients from being '*racially profiled*'.

Treatment services

Aboriginal and/or Torres Strait Islander patients described their experience in receiving treatment and support services at the EDs. Although most of them criticised treatment and support services at the ED, some acclaimed the treatment services. For example, one participant commented on doctors' treatment: '*I went to the hospital ED for a check-up because I did not feel well. After tests, the doctors found that I was having a heart attack. The doctors were quick and acted to my needs*'.

However, several participants said that they received the wrong medical treatment provided by doctors. This was explained by one of them: '*I took my son [to the] ED because he was having some pain in the lower belly area. Once the doctor had seen him and done all the observations, she decided that he had a fungal infection, and gave me cream for my son to use for a few days until better. I was so upset about this [cream] and asked if I could see another doctor because a fungal infection will not be causing my son to be feeling sick and in this much pain. Once the other doctor came and saw my son, he did other tests and even an ultrasound, [and] the results were frightening as the other doctor was sending us home with fungal cream. My son was admitted and put on the surgery list the next morning for the removal of his appendix. The surgeon visited after surgery and advised us that he was very lucky as it was ready to burst, and there would have been some disaster*'.

Interview findings also indicated that several participants were discharged from the ED earlier than needed. For instance, an Aboriginal and/or Torres Strait Islander patient said: '*They [doctors and nurses] discharged me straight away because they needed beds. The specialist wrote me a letter to come back in, and it went on for three weeks, in and out of the emergency, and I was in a really bad condition. Finally, I got a different doctor. They scanned my abdomen for infection, and I had a massive infection. I was not going back there for the fun of it, I could hardly walk. I could not walk out when they [staff] discharged me*'.

Safety, security and privacy

Some participants regarded security guards as essential for ensuring the safety of people in the ED waiting room; others reported that their presence made them nervous, expecting surveillance and control rather than help and support. For example, one of them said: '*They [security guards] treat you like criminals… I went there [ED] on my own accord, and I said to them [security guards], "I will leave my phone and everything in my wallet and everything here, if I can just fire up a smoke. I am not going to go anywhere". And, they [security guards] still would not even let me do that, [and was treated] pretty much like I am a criminal*'.

On the other hand, one participant said how staff, including security guards, played a critical role in enhancing the security at the ED: '*… I was in the front of the emergency department, and there were already a lot of people intoxicated or under the influence there. Then, one woman came in swearing up, screaming, and making a big noise… Then, the ED staff tried to calm her down; that did not work so. Then, the security guards had to come and restrain her on the floor. The security guards finally took her away. It was terrifying*'.

The above-mentioned narratives also indicated Aboriginal and/or Torres Strait Islander patients' safety and security were vital to improving their experiences of ED services and overall satisfaction. Furthermore, participants stated that lack of privacy was a major concern in their ED experience. People preferred to wait outdoors or other areas of the hospital grounds rather than waiting in the ED rooms.

Discussion

A growing body of literature in Australia and elsewhere examined Aboriginal and/or Torres Strait Islander people's visits to the ED,[4] access to ED medical care,[5] experience of hospitalisation,[6] perceived barriers and enablers to accessing the ED services.[7] However, those studies did not provide an in-depth examination of Aboriginal and/or Torres Strait Islander patients' experience of the hospital EDs in Australia from their own

perspectives using a qualitative approach. The present study contributes to the existing literature through an in-depth qualitative analysis of their experience of the ED and factors related to their experiences from their points of view. We found that the overcrowding and lengthy waiting times, culturally inappropriate services, improper medical treatment, early discharge from ED, and insecure ED environment potentially impacted the quality of ED treatment and care services, as explained by the Aboriginal and/or Torres Strait Islander people who attended the ED settings in three selected hospitals in Australia. Furthermore, uncared and unpleasant ED services along with limited staff and resources compared to patients' demands impacted the delivery of ED treatment and care services as described by the study participants. Such findings could be explained by the findings from a systematic review, which showed that patients from ethnic minorities had to encounter intercultural care processes in hospital settings which were quite often challenging; cultural contexts of patients from such backgrounds and those of caregivers differed because of the differences in the meaning of illness, health, treatment and care.[8] Findings underscored the importance of delivering adequate and culturally appropriate treatment and services at the EDs tailored to Aboriginal and/or Torres Strait Islander people, facilitating the uninterrupted provision of treatment and care among that group of patients in Australia.

Aboriginal and/or Torres Strait Islander people's experience of long waiting times was viewed as a barrier to accessing appropriate and timely treatment and care in the EDs. Existing evidence supported that finding, which was indifferent for any patient irrespective of their Indigenous status.[7,9] Several factors contributed to the long waiting times in EDs, including limited staffing, sluggish procedures, delays in diagnosis,[10] overcrowding, inadequate availability of inpatient beds,[11] increased inpatient bed occupancy and long hospital stay.[12] The increased length of waiting times in EDs resulted in patients' adverse health outcomes and mortality.[13] Furthermore, spending longer periods in EDs could contribute to patients' feelings of anger, anxiety, boredom, and suspicion.[7,14] Findings suggested that ED administrators and managers should consider recruiting more staff to reduce patients' waiting times, develop and execute policies and strategies to improve their experiences while visiting the EDs.

The current study also found that the treatment and services in the EDs were not entirely culturally appropriate for Aboriginal and/or Torres Strait Islander patients. Such culturally inappropriate services could prevent them from visiting the EDs.[15] Evidence suggested that the Aboriginal Hospital Liaison Officers (AHLOs) provide a 'culturally sensitive link' between health providers and patients, working with and educating other staff in being culturally sensitive to the needs of Indigenous patients.[16] Engagement of AHLOs with hospital nurses can also improve their experiences.[17] Findings showed that treatment and services delivered to Aboriginal and/or Torres Strait Islander patients in ED could be improved when culturally appropriate care is provided using a holistic framework that considers the overall health, social and emotional wellbeing of the patients.[18,19] The need to incorporate social and cultural determinants of health and wellbeing for Aboriginal and/or Torres Strait Islander patients attending the EDs besides diagnosing and treating the presenting conditions is warranted.[20]

Our study was one of the very few studies exploring the experiences of Aboriginal and/or Torres Strait Islander patients on ED attendance with a specific focus on the related factors. Our sample included patients from three geographical regions who shared their experiences of attending two regional and one metropolitan hospital. Having that diversity was a strength of the present study. However, to accommodate the COVID restrictions, we had to modify the methodologies, such as training of the AHLOs for the interviews and conducting the interviews online rather than face-to-face as originally planned.

Conclusion

The current study described the Aboriginal and/or Torres Strait Islander patients' lived experience of ED attendance from their own perspectives and related factors that shaped their experiences in EDs, which included long waiting times, inadequate culturally appropriate treatment and services, uncared services in ED, limited staffing and privacy of patients, and overcrowding. Such experiences influenced the satisfaction of the Aboriginal and/or Torres Strait Islander patients in relation to treatment and services received in ED settings. A holistic approach offers a possible solution to address their cultural needs and enhance satisfaction in EDs when considering their overall health, social and emotional wellbeing. The holistic approach should dovetail robust commitment to the hospital's organisational policy and practice to embed culturally safe and appropriate care into the ED treatment and services. Such an approach may optimise Aboriginal and/or Torres Strait Islander people's experience of the treatment and services in the EDs and their feelings of culturally safe standard services.

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Competing interests

None declared.

Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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