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Journal of Medical Imaging and Radiation Sciences 49 (2018) 6-10
Journal of Medical Imaging and Radiation Sciences
Journal de l'imagerie médicale et des sciences de la radiation
www.elsevier.com/locate/jmir

Commentary

Building Foundations for Indigenous Cultural Competence: An Institution's Journey Toward "Closing the Gap"

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Introduction

According to the World Health Organisation, there are more than 370 million indigenous peoples living in more than 70 countries [1]. The First Nation peoples of these countries are substantially disadvantaged by colonisation; we are unaware of a country wherein almost all aspects of the Western perceived quality of life, including health and well-being, statistics for First Nations people are more positive than the people of the colonial power. Globally, indigenous people are marginalised with lower incomes, lower standards of education, lower life expectancy, higher rates of suicide, and generally poorer health [1].

In Australia, there are many factors that contribute to the gap between indigenous and non–indigenous health [2]. Indigenous Australians are not a single group but rather a diverse array of peoples with divergent or convergent histories, languages, traditions, and lifestyles [2]. Indigenous people represent 3% of the total population of Australia, and 78% live in metropolitan or regional areas; only 22% live remotely [2]. For Indigenous Australians, life expectancy is lower by 10 years for both men and women compared to non–Indigenous Australians, infant death rates are twice as high for indigenous people, and 67% of indigenous people live with a chronic condition with 33% having three or more chronic conditions [2]. A number of behaviours that risk health are more frequently exhibited in indigenous populations including smoking and alcohol consumption; however, the greatest social determinants of health for indigenous people relate to overcrowded housing, homelessness, lower levels of education (westernised), poorer numeracy and literacy, and lower incomes [2]. These statistics highlight a key issue; indigenous people's paradigm (square peg) does not fit the Westernised paradigm (round hole). Until recently, there has been a sense of entitlement from government to "fix the indigenous people" rather than provide services and pathways that embrace indigenous beliefs and knowledge. This is reflected in use of health services with indigenous people having 17% higher access rates to general practitioners but 39% lower use of specialist services [2], including those of Medical Radiation Science (MRS). "Closing the gap" is a strategy introduced by Federal and State governments in Australia in an effort to enhance indigenous health and well-being, education, housing, and employment. The statement "closing the gap" is itself contentious since indigenous people argue that closing implies that never gaining parity is socially and morally acceptable.

In Australia, most aspects of the reparations that are required to overcome inequity and to close the gap are not for the faint hearted with centuries of accrued pain, suffering, discrimination, and neglect to overcome. Indeed, even a best case journey to close the gap is tortuous, fraught with failures, and demanding of commitment. The journey can, however, be rich and revelatory; challenging the ways of knowing and doing ultimately illuminates those deeply motivated toward decolonising their minds. In that context, it is interesting to examine the manner by which an academic institution invests and delivers. Charles Sturt University (CSU) is regarded widely to be at the forefront of "close the gap." Indeed, a simple modification of the government vernacular for "closing the gap" policies, a strategy with key performance indicators that by their very nature do not require actual equality, to "close the gap" provides an insight into commitment and motivation toward an end point of equality. Recent evidence has identified three key characteristics valued by Indigenous Australian patients [3]:

1. Accessibility, welcoming spaces, and multiple services colocated,
2. Culturally safe care,
3. Appropriate care that is responsive to holistic needs.

While undergraduate training has little direct impact on the first, the latter two valued characteristics can be facilitated

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https://doi.org/10.1016/j.jmir.2017.12.003

through a bottom up cultural change strategy by embedded appropriate education and training for undergraduate students. The cultural shift needed by trained staff who become the next generation of practitioners and managers will also ensure that point 1 is also addressed and expected by trained staff. In Australia, CSU has the highest number of students who identify as Indigenous and proudly, the highest retention and completion rates for Indigenous students.

The *Journal of Medical Imaging and Radiation Sciences* over recent years has explored the role of image-guided therapy. Improving outcomes by tailoring treatment directed by detailed imaging insights about the pathology. This is not unlike the approaches adopted for personalised medicine that will be the theme of the 2018 special edition in the *Journal of Medical Imaging and Radiation Sciences*. Importantly, the manner in which MRS practitioners develop and apply cultural competence to enhance understanding of the social, historical, and cultural determinants of health and then apply this understanding to adapt and implement patient care/management to improve outcomes also fits that philosophy or approach; vision and insight inform intervention and outcomes to close the gap. There is no more important population in our respective national communities than our indigenous people. Here, we explore the challenges and strategies employed at CSU, generally and amongst undergraduate MRS students to drive change through education. This model has direct application to indigenous people in other countries and generally across cultural boundaries. CSU has campuses on the land of the Wiradjuri, Buripi, Nguunwal, and Eora Peoples.

The CSU Way

Traditionally, academic institutions have lacked vertical and horizontal diversity, and it has only been in recent decades that there has been a global shift to make structural changes to overcome barriers to diversity [4]. These efforts have been captured in targeted strategies for massification and diversity [4]. When considering higher education accessibility, there lies three distinct ideologies [5]:

1. Inherited merit; where access to higher education is typically merit based and, thus, linked to social factors. Inherited merit supports the traditional university environment of access based on privilege (typically: male, white, urban, upper class).
2. Equality of rights; emerged from social and political pressures to make higher education accessible to larger numbers (massification) and regardless of social standing (diversity). Gender and racial/cultural equality are the primary drivers, but merit-based entry remains an overarching barrier.
3. Equality/equity of opportunity; recognises that equality of rights does not cover equity and, indeed, equality of rights driven by merit-based entry may be particularly discriminatory for marginalised populations. At CSU, strategic direction targets equality of opportunity.

The indigenous peoples of Australia are vulnerable to discrimination with inherited merit and equality of rights structures. It is only exploring, understanding, and building scaffolding to overcome barriers to opportunity that indigenous people can move toward equity in higher education. CSU is committed to a close the gap strategy for Indigenous Australians with quality of opportunity for higher education, creating diversity in the graduate workforce, and affording consumers of those services (in this case associated with the MRSs) exposure to a culturally diverse workforce. Concurrently, cultural immersion and targeted education around the history, challenges, rights, and needs of indigenous peoples, viewed if possible through the lens of indigenous people, provides cultural competence for all graduates, infiltrating the provision of services to our indigenous people. That is, move toward equality of opportunity for MRS services.

There are challenges to achieving a close the gap outcome in higher education, in health generally and MRS specifically. A people who have been disenfranchised and had their knowledge and language banned do not find it easy to be represented at an institutional level (whether it be universities or hospitals). Institutional engagement can appear to be tokenistic, patronising, and driven by a white agenda where benevolence or exploitation manifests itself. The nature of universities, therefore, presents a challenge to embracing indigenous education since an indigenous peoples paradigm associated with pedagogy and epistemology embraces traditional knowledge and cultural practices; and these may not be engineered into typical higher education. At CSU, there is a commitment to moving indigenous knowledge from the marginalised or invisible domains to tangibly weaving indigenous perspectives through curricula.

Nonetheless, there remain challenges and barriers. The short termism of our political cycles in Western Society is quite different from peoples such as the Wiradjuri who consider their actions in the light of what effect it may have on seven generations hence. The landscape is fraught and contains the shipwrecks of many false horizons from both genuine and disingenuous intent. There is a clear need to move away from a deficit model of how indigenous people and indigenous knowledge are viewed. Indeed, there needs to be acceptance that "truth" may be one of many truths. Finally, there are scars associated with indigenous people who have been treated as experimental field work for many years and any work with indigenous peoples needs to be returned to the communities; "nothing about us without us" reflects that lack of ownership of knowledge, rather indigenous peoples provide stewardship of knowledge. There are a number of potential pitfalls in engineering, and implementing strategies aim at indigenous equality of opportunity:

1. The perception that strategies have improved "the lot" of indigenous peoples. Despite good intentions, policy makers do not always know what is best or what is actually needed (or indeed wanted). Consultation with

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