August 2020

**Ethics in Clinical Triaging Frameworks:**

**Aboriginal and Torres Strait Islander Peoples**

## Background

The Australian Indigenous Doctors' Association (AIDA) is the peak body representing Aboriginal and Torres Strait Islander medical students and doctors in Australia. AIDA's membership includes doctors across a wide and growing range of medical specialities. Our purpose is to contribute to equitable health and life outcomes, and the cultural wellbeing of Aboriginal and Torres Strait Islander Peoples. We do this by striving to reach population parity of Indigenous medical students and doctors and supporting a culturally safe healthcare system.

AIDA shares the deep sorrow of First Nations' communities and other communities marginalised around the world who have suffered inordinate illness and loss of lives during the COVID-19 pandemic. The mortality rates are sad reminders of persisting and pervasive injustice around the world.

In responding to the COVID-19 pandemic AIDA members discussed the persistent issues of inequality, inequitable access to resources and services, disproportionate burden of illness and social disadvantage experienced by Aboriginal and Torres Strait Islander peoples.

Pandemics can bring system failures into sharp focus. Early in the pandemic period, AIDA was made aware of two cases of Aboriginal people experiencing racism in the health system.[i] These reports were of grave concern for AIDA and highlighted the need for Governments to urgently address the social and cultural determinants of Aboriginal and Torres Strait Islander health.

Aboriginal and Torres Strait Islander peoples have advocated to Governments and health services for many years to embed initiatives and accountability mechanisms to support a culturally safe health system. We now see commitment to cultural safety reflected in health policy documents at Federal, State and local levels. However, ongoing attempts to meet the health targets for Aboriginal and Torres Strait Islander people have largely been unmet. An important lesson from the COVID-19 pandemic therefore needs to be to urgently act on this commitment in times of crises.

## Purpose

It is vital that clinical triaging frameworks developed to assist clinicians' decision making during times of crises recognise cultural bias and embed cultural safety as a core principle. This paper aims to address ways in which such frameworks can address the ongoing inequitable health outcomes experienced by Aboriginal and Torres Strait Islander peoples.

## Understanding Racism in the Health Sector

AIDA's 2017 policy statement, 'Racism in Australia's health system'[ii] includes the following definition of racism

*"racism can be defined as organised systems within societies that cause avoidable and unfair inequalities in power, resources, capacities and opportunities across racial or ethnic groups."[iii]*

Racism manifests in beliefs, stereotypes, prejudices and discrimination. It may be institutional and systemic. It can occur on an interpersonal level. In any case, it can be internalised by those who suffer its consequences. All forms of racism impact the health of Aboriginal and Torres Strait Islander peoples.

Institutionalised racism within health services influences access, not only to medical facilities and services but also to information, resources, influence and representation.

During COVID-19, incidents of unnecessary suffering and injustice were caused by inconsistent identification of Aboriginal and Torres Strait Islander people by health services. Outright denial of services to Aboriginal and Torres Strait Islander people who sought testing and care was also raised by our members[iv].

Clinical triaging frameworks, pandemic plans and institutional policies that underpin health service response are developed by practitioners, clinicians and other decision-makers. Few Aboriginal and Torres Islander patients are in a position to inform and influence those decisions. Clinicians must recognise and address this disparity through firm commitment to understanding unconscious bias and a commitment to equity.

**Cultural Safety to Ensure Patient Safety**

The Australian Health Practitioner Regulation Agency has outlined its commitment to "*achieve patient safety for Aboriginal and Torres Strait Islander peoples as the norm*" through the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025. In this strategy, the following definition is included:

*"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.*

*Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."*

The following principles inform the definition of cultural safety in the AHPRA National Scheme:[v]

- *Prioritising the Council of Australian Government's goal to deliver healthcare free of racism, supported by the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.*

- *Improved health service provision supported by the Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health.*

- *Provision of a rights-based approach to healthcare supported by the United Nation's Declaration on the Rights of Indigenous Peoples[vi]*

- *Ongoing commitment to learning, education and training.*

The AHPRA Strategy outlines the following steps for health practitioners to ensure that practices are culturally safety and respectful. These can guide pandemic responses. They are:

*"Acknowledge colonisation and systemic racism, social, cultural, behaviour and economic factors which impact individual and community health*

*Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism*

*Recognise the importance of self-determined decision marking, partnership and collaboration in healthcare which is driven by the individual, family and community*

> *Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torre Strait Islander people and colleagues".*

**Aboriginal and Torres Strait Islander Health Expertise**

Historical reports and evidence indicate that prior to colonisation, Aboriginal people led fit and healthy lifestyles. Colonisation and the resulting dispossession has had a devastating impact on our health. But our cultural values and holistic health practices continue today.

There are over 140 Aboriginal community-controlled health organisations in Australia founded on Aboriginal and Torres Strait cultural values and models of holistic care.[vii]

Indigenous leaders were very aware of the disproportionate damage that the H1N1 virus had on communities in the Top End in 2009, with hospitalisation rates higher than those reported elsewhere in Australia and overseas.[viii] In anticipation of the COVID-19 pandemic, local Aboriginal health services led the way in preparing and caring for their communities.[ix] They did so in an environment of gross inequity. Remote communities do not have access to high level medical services. Many health units are unable to care for the anticipated need. Urgent evacuation to an intensive care unit (ICU) in a major centre would be difficult or unlikely. The loss of the fly-in fly-out workforce further compromised health and mental health services during isolation. Pre-existing failure by governments to address workforce issues has potentially catastrophic consequences. The only hope for survival has been absolute isolation.

Long-term investment in local skills, employment opportunities, health and social infrastructure is overdue. Many Aboriginal peoples were encouraged to return to traditional homelands. This was only possible for Aboriginal peoples who have been successful in their fight to retain traditional land. Furthermore, as highlighted by Aboriginal and Torres Strait Islander Social Justice Commissioner, Ms June Oscar OA, the "prevailing policy position for several decades has been to systematically under-invest in, and to close down, homeland communities."[x] In some places, people returned to areas with no water and electricity, let alone adequate access to phone and broadband and appropriate health and social infrastructure.

Testing whole communities to avoid early spread of COVID-19 may have been possible but was not offered. Communities were not sufficiently supported to screen widely, protect and support our people. Leadership by Aboriginal and Torres Strait Islander organisations meant that our peoples have apparently been tested sufficiently for quarantine purposes during the crisis.

In a number of jurisdictions with far less monetary resources, Aboriginal and Torres Strait Islander communities have been quicker to respond and better prepared than some State Governments.[xi] Local communities have planned, prepared and introduced measures to mitigate the underfunding of Aboriginal communities and the community-controlled health sector. But the capacity of these organisations is always limited by overstretched and inadequate staffing and funding. The exemplary work done by many in the first months of the COVID-19 crisis may be potentially unsustainable without more substantial support.

Aboriginal and Torres Strait Islander clinicians, growing in numbers and represented across diverse specialties, have played key roles during COVID-19, caring for patients on the frontline, advocating for appropriate planning and response on behalf of their patients and contributing to appropriate messaging to instil calm as trusted clinicians in their communities. In all decisions COVID related, an Indigenous governance component must be involved in addressing the power imbalance.

Local Aboriginal and Torres Strait Islander community experts and clinicians will better understand and properly consider the diverse contexts of Aboriginal and Torres Strait Islander peoples, identifying appropriate responses and strategies.

**Self-Determination and Effective Partnerships – Learning from Closing the Gap**

Despite a bipartisan commitment for over a decade by Governments, most Closing the Gap targets have not been achieved.  In 2019 the Federal Government committed to an historic agreement and a shared partnership with the Coalition of Aboriginal and Torres Strait Islander Peak Organisations, to which AIDA is proud to be a member.[xii]

In order to ensure culturally safe frameworks health services must be respected and empowered, so that Aboriginal and Torres Strait Islander communities are supported and resourced to lead decision-making that affects them at all levels of health planning, including pandemic responses.

**Understanding cultural bias in concepts of 'best value'**

The University of Sydney's Health Ethics Paper notes that "when resources are scarce, the primary obligation is to ensure that 'best value' is gained where we possibly can from the expenditure of that resource".[xiii]

Examples of essential resources that we can expect to be limited during pandemics will include access to Intensive Care Units (ICU), ventilators, clinical expertise, personal protective equipment (PPE), diagnostics, medications and vaccines.

Resource allocation decisions necessarily involve ethical considerations within a values framework. Choices that are made, including doing nothing, will impact on, and may even end, people's lives. The main ethical issue in resource allocation is ensuring that any decisions that we make are fair or just.

Frameworks developed to apply a triaging system do so with the intention to apply equal human value for all.

The continued inequitable health outcomes of Aboriginal and Torres Strait Islander peoples within Australia reflects a system that is not fair or just and potentially devalues the lives of Aboriginal and Torres Strait Islander people.  At the national level the lack of allocated resources and consequent inequity for remote locations is even greater. Redressing this must be a priority for all governments.

**Systemic Exclusion through Simplistic Algorithms**

Medical ethicists have noted that "in high-pressure situations, clinical triaging systems are likely to be simplistic such as algorithms based on the age of the patient and any health conditions. This approach systematically discriminates against disadvantaged groups including the elderly and those with underlying health conditions".[xiv]

Compared with the dominant Australian culture, Elders and older people hold unique authority as cultural knowledge holders within Aboriginal and Torres Strait Islander communities. They are intrinsic to the social and ethical fabric of our communities.

The First Peoples' Disability Network of Australia has further warned of the issues of disability and racial inequality in healthcare delivery and the significant risk that people with a disability may not be provided health care resources in times of scarcity.[xv]

The Sequential Organ Failure Assessment (SOFA) and Paediatric Logistic Organ Dysfunction 2 (PELOD-2) are tools that measure the likelihood of survival of individuals with particular conditions. These predictive values can serve as adjuvants to care and decision making for both health professionals and the families of patients. If used as a triage tool however, in determining who gets access to critical care in times of demand, such tools will inevitably exclude members of those populations that are disproportionately impacted by ill health.

This is because the surrogate markers used to determine the likelihood of survivability will be poorer at 'base-line' as a consequence of the impacts of conditions such as hypertension and type-2 diabetes. The social determinants of health for these conditions ensure that the exclusions will be of many First Peoples, disabled people, homeless people and other marginalised groups, not because of individual prejudices in the health care decision makers, but because of the ways in which racism[xvi] and poverty drive ill health. The result of such measures reflects systemic violence directed at those populations.

**Rethinking the Clinical Aims of Clinical Triage Decision Making**

The first aim of clinical practice outlined in the University of Sydney paper is "to work with patients to deliver appropriate health care in response to their needs."[xvii]

This raises the ongoing issue of appropriate identification of Aboriginal and Torres Strait Islander people in health service delivery. Under-identification creates profound gaps in the provision of targeted services and policies for Aboriginal and Torres Strait Islander patients.[xviii]

Where there is an inadequate process of identification of Aboriginal and Torres Strait Islander patients, poor management, poor presentation rates, unchallenged racism, unconscious bias and poor understanding of holistic care requirements, needs of Aboriginal and Torres Strait Islander patients will not be met. Health services must understand that lack of consideration of the harm caused to individual Aboriginal and Torres Strait Islander peoples through denial of service and/or poor care will damage relationships with communities and impact health outcomes in the present and long-term.

The second aim of clinical practice articulated in the University of Sydney paper is to ensure continuity of a sustainable health care and public health system. Implicit in this aim is a view that the current system is worth sustaining. As outlined earlier the current system requires significant change to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

The third clinical aim articulated is to "promote the maintenance of trust in the health system." Aboriginal and Torres Strait Islander people can have low levels of trust in the health system. Trust needs to be established, and greatly improved, not maintained.

The fourth aim is "where appropriate conduct research and innovation to improve patient care." Research with Aboriginal and Torres Strait Islander peoples needs to be driven by community priorities, and appropriate ethics must be employed.[xix] Holistic models of care and the innovative responses by Aboriginal communities within these parameters can guide and inspire efforts to improve patient care and health outcomes.

**Recommendations**

AIDA makes the following recommendations for Clinical Triaging Frameworks

1. **Prioritising Aboriginal and Torres Strait Islander Peoples**

Lower presentation rates and a higher probability of poorer care provide a further rationale to elevate Aboriginal and Torres Strait Islander peoples in a clinical triaging model. Health Service delivery must be led by local Aboriginal and Torres Strait Islander communities in developing their response. Where necessary communities themselves should be appropriately resourced and supported to discuss issues and prepare their positions.

2. **Respecting Complexity**

Aboriginal and Torres Strait Islander communities, families and individuals are diverse; historically, geographically, socially and culturally.

Relationships between health institutions and Aboriginal and Torres Strait Islander communities will vary depending on historical factors, experiences of individual community members and the level of commitment demonstrated by Health Services to ensure that they are culturally safe.

A universal clinical triaging framework is not appropriate. Health Services must be guided by local Aboriginal and Torres Strait Islander community leadership and involvement. This contribution needs to be appropriately resourced.

Individuals, families and communities must also have the private opportunity to deliberate and decide on factors important to them which may include deciding on appropriate representation and leadership, upholding and balancing cultural laws, expectations and responsibilities with Aboriginal and Torres Strait Islander population survival, among other issues.

### 3. Ongoing Review

Review mechanisms need to be established with local health services and local communities to monitor implementation and adjust as necessary.

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*AIDA acknowledges the contributions and guidance of its members and associates in the development of this paper.*

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