How do you decide? Experiences and influences promoting best practice and engagement in Aboriginal Health.

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Abstract

This thesis explores the role of the practitioner on Aboriginal health outcomes, by examining influential factors on the decision-making process and engagement in this field. This topic became an interest after working as a medical student and junior medical practitioner, where differences in the decision-making process for Aboriginal peoples were experienced.

International and local studies have explored the role of the practitioner in maintaining ethnic health disparities. Proposed ways in which providers do this include; the decision-making process, implicit and explicit beliefs about patients, feelings toward and expectations of patients, practitioner interpretation of symptoms and interpersonal behaviour. Setting characteristics such as time and respect for diversity are also key factors that play a role in this field.

A qualitative approach to the topic was implemented, using semi-structured interviews with 16 medical practitioners from the Perth Metropolitan region and the Kimberley region. Participants had a diverse range of clinical expertise and experience. Interview data was transcribed and analysed using thematic networks.

The interview analysis found that unequal treatment and institutionalised racism play a role in health disparities experienced by Aboriginal people, which were also influenced by key setting factors such as time, staff, case-load and resource availability. The importance of communication was highlighted when looking at the need for patient-centred care as a way to work towards improved health outcomes for Aboriginal peoples. Having accurate representations of patient reality in addition to minimising negative perceptions of adherence was found to be a critical aspect potentially impacting health outcomes. The acceptance of the normalisation of poor health resulting from immersion and reduced resource allocation is an area in need of attention if Aboriginal health outcomes are to see an improvement.
Aboriginal health is a dynamic field encompassing people with unique contexts, realities and ways of life. Having an understanding of the broader issues relating to Aboriginal health, and implementing this in a patient-centred context, was viewed to be the key in providing effective healthcare to Aboriginal peoples. Core notions of self-determination and patient empowerment were found in this research. Medical practitioners hold the responsibility to enable their patients right to health; working closely with Aboriginal patients, empowering them in decision-making processes and realising their individual priorities is a step toward equitable health in our society.
Table of Contents

Table of Contents ............................................................................................................................................ 4

Chapter 1 - Introduction ................................................................................................................................. 8
  1.1 If ... our patient was Caucasian .............................................................. ........................................... 8
  1.2 Health Disparities ......................................................................................... 9
  1.3 Respect for Diversity .............................................................. ............................................................... 10
  1.4 Clinical Decision-Making ......................................................................... 11
  1.5 Engagement ............................................................................................. 12
  1.6 Parliament has allowed the passage of racially discriminatory legislation .......... 13
  1.7 We have enough diabetics ......................................................................... 15
  1.8 My Family Background ........................................................................... 18
  1.9 Thesis Outline ......................................................................................... 19

Chapter 2 – Scope of the Literature .............................................................................................................. 21
  2.1 Evidence of ethnic health disparities ........................................................... 22
  2.2 Practitioner Contribution to Ethnic Health Disparities ................................. 25
    Practitioner clinical decision-making ............................................................... 26
    Practitioner Implicit and Explicit Beliefs, feelings toward, and expectations of patients
    associated with Ethnicity .................................................................................. 28
    Practitioner Interpretation of Symptoms .......................................................... 33
    Practitioner interpersonal behaviour ............................................................... 34
  2.3 Setting Factors .......................................................................................... 36
  2.4 Respect for Diversity ................................................................................ 37
  2.5 Conclusion .................................................................................................. 39

Chapter 3 – Methods, Methodology and Participants ..................................................................................... 40
  3.1 Research methodology ........................................................................... 40
    Theoretical Framework .................................................................................. 41
  3.2 Research Participants .............................................................................. 41
  3.3 Data Collection ........................................................................................ 43
  3.4 Thematic Analysis .................................................................................... 45
  3.5 Ethical Considerations ............................................................................. 47
  3.6 Rigour ....................................................................................................... 48
  3.7 Limitations ............................................................................................... 49

Chapter 4 - Results and Analysis .................................................................................................................. 51
  4.1 The naming of the un-nameable ................................................................ 51
  4.2 Oh my, what have I been doing! ................................................................. 54
    You can take the horse to the pond but you can’t make it drink ................... 56
  4.3 It’s just that group mentality ..................................................................... 60
    You need more Aboriginal people ............................................................... 61

Chapter 5 - ... ones that are a little bit bad, there’s just not the time .......................... 64
  5.1 Setting Characteristics ............................................................................. 64
    Time is not important ... the outcome is important ...................................... 65
    Understanding community, and how everyone is connected ... it takes time ... 68
  5.2 Influence of the Self on Engagement ........................................................ 70
    I come from a background where I haven’t been upper class ..................... 71
  5.3 We don’t understand their culture ............................................................ 76
  5.4 The role of the self on decision-making in Aboriginal health ....................... 81
    There’s this perception of the doctor that they’re wise ............................... 84
    We try to be very selective ... if they are Aboriginal ................................... 86
  5.4 Shifting the goalposts .............................................................................. 88
Is it worth treating? ............................................................................................................. 91
It's a bit of an easy way out ................................................................................................. 95
5.5 Not losing hope ........................................................................................................... 96

Chapter 6 - ... who is the individual in front of you ....................................................... 99
6.1 ... the patient is the decision-maker ......................................................................... 102
Creating change for the long-term .................................................................................... 104
6.2 Factors promoting engagement in Aboriginal health ................................................. 106
... that solidity of understanding ....................................................................................... 106

Chapter 7 – Shifting the gaze ......................................................................................... 110
7.1 Participants ................................................................................................................... 110
7.2 Unequal Treatment and Institutionalised Racism ....................................................... 112
7.3 Importance of communication .................................................................................... 116
7.4 Notions of Adherence ................................................................................................. 119
7.5 Role of the self and conflicting realities .................................................................... 121
7.6 Normalisation of poor health ..................................................................................... 124
7.7 Patient centred care and respect for diversity as the key to improvement ............... 127

Chapter 8 - Conclusion and Future Directions ............................................................... 130
References ....................................................................................................................... 135

Appendices ....................................................................................................................... 147
Appendix I ......................................................................................................................... 147
Appendix II ....................................................................................................................... 150
Appendix III ..................................................................................................................... 151
Appendix IV ..................................................................................................................... 154
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All kids need is a little help, a little hope, and someone who believes in them

Earvin ‘Magic’ Johnson

This thesis does not contain work that I have published, nor work under review for publication.

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Chapter 1 - Introduction

I don't think it's necessarily any different to your basic approach to ethical medicine, so respect for autonomy, make sure that what you do is helping, make sure nothing you do is hurting, make sure what you do is equitable and accountable. They are sort of my five, ethics principles. And if you apply that in every patient, that's fine. But so often I discover that just on a day-to-day basis in the ward round that the doctors I work with, even senior consultants, breach those horrifically. And it would be, really, sort of, two or three times a month I almost have to take my colleagues aside and say 'yes I know Aboriginal patients have worse health outcomes, but by denying them access to X, Y and Z, that's really unacceptable.'

Study participant

1.1 If ... our patient was Caucasian ...

In contemporary society, the Australian Aboriginal population experience a wide range of health inequities. This project will explore beyond the statistics of health inequities, and consider the role of the practitioner in Aboriginal health outcomes by looking at influences on best practice and engagement in this field.

An Aboriginal male born today can expect to live 10 years less than his fellow non-Aboriginal Australian. (Australian Bureau of Statistics 2013) He is more likely to smoke, at higher risk of chronic disease, and is less likely to be referred for treatment options such as renal transplantation. (Australian Institute of Health and Welfare 2011)

Throughout my medical education I had an awareness of the disparities suffered by Aboriginal people, however the reality of this issue struck me as a fifth year medical student. At this time I had the opportunity to care for neonates on a
paediatric rotation. Holding a newborn Aboriginal male, it hit me that we, as a society, held expectations for his life that were completely unacceptable. Expectations that had been pre-written before he had even the opportunity to take his first steps, and ponder his first choices in life.

A number of factors contribute to health inequities suffered by Aboriginal peoples. (Australian Institute of Health and Welfare 2011) It is important to acknowledge the historical context of our community, and the ongoing role this has on health outcomes. Dispossession and displacement from land, forced separation of families, loss of cultural traditions and practices, oppression and marginalisation from society. The legacy of past policy and colonisation impacts the health of current and future generations of Aboriginal people.

Australia’s history is intertwined with ways of living in contemporary society, and is associated with current poor socioeconomic indicators commonly experienced by Aboriginal peoples. Substandard housing provision and infrastructure, overcrowding, low income, poor diet, reduced access to services. These are all recognised contributors to current health outcomes. (Australian Institute of Health and Welfare 2011)

In conjunction with historical context and socioeconomic indicators, other recognised potential contributors to health disparities worldwide range from organisations, administrative bodies, health practitioners and, to a somewhat lesser extent, patients themselves. (Smedley, Stith et al. 2009)

Next in this chapter I will provide further background to this enquiry, outlining current health disparities that exist between Aboriginal and non-Aboriginal populations.

1.2 Health Disparities

Most recent data on life expectancy show Aboriginal females are expected to live to 73.7 years, 9.5 years less than non-Aboriginal females and Aboriginal males
have a life expectancy of 69.1 years, 10.6 years lower than non-Aboriginal males. (Australian Bureau of Statistics 2013) Aboriginal peoples suffer from end stage kidney disease (ESKD) at 8 times the rate compared to the non-Aboriginal population. (Australian Institute of Health and Welfare 2011) Aboriginal people are 3.3 times more likely to have diabetes or high blood sugar levels compared to non-Aboriginal people. (Australian Bureau of Statistics 2013)

Disparities are not limited to health conditions, but are found in risk factors for disease and decisions regarding choice of treatment. Aboriginal people are 2.3 times more likely to smoke than non-Aboriginal people. (Australian Bureau of Statistics 2013) Aboriginal patients suffering a myocardial infarction are less likely to receive a revascularisation procedure than non-Aboriginal patients. (Randall, Jorm et al. 2013) Evidence of these disparities provides a picture of the gap in health outcomes that we currently face as a community.

Disparities in health outcomes between population groups are not unique to the Australian community. Minoritised groups worldwide experience poorer health outcomes and lower quality health care provision when compared to their majority population counterparts. (Smedley, Stith et al. 2009)

As variability in health outcomes of different populations within similar environments occur worldwide, research is looking at the role of the provider more closely. (Van Ryn and Fu 2003, Larson, Gillies et al. 2007, Van Ryn, Burgess et al. 2011) Key provider factors are discussed in the literature that are theorised to improve Aboriginal health outcomes. The following section will provide an introduction to health practitioner preparation to work with Aboriginal peoples and communities, notions of best practice implementation and how these then link to the broader topic of respect for diversity.

1.3 Respect for Diversity
As Australian health professionals, we have a responsibility to strive for the best possible health outcomes for the most disadvantaged group in our community. This can be achieved through the implementation of best practice when working with Aboriginal patients, practising in a manner that respects diversity and engaging with the Aboriginal community in terms of medical practice and community advocacy.

Appropriate healthcare for peoples of diverse backgrounds has been described to be moving away from a checklist approach targeting a person's ethnic background, toward a critical assessment of power imbalances between patients and service providers. (Peiris, Brown et al. 2008) Practitioner education in Aboriginal health facilitates the provision of appropriate and respectful health care. (Ewen, Paul et al. 2012)

The delivery of Aboriginal health education varies between medical training institutions, at both the undergraduate and postgraduate level. (Lawson, Armstrong et al. 2007) Further, the diversity of the current medical profession means our healthcare system has practitioners who have grown up and trained in medicine overseas, within environments that have their own unique histories, cultures and contexts.

Currently, there is a lack of evidence that explores the role of diversity training on patient outcomes. (Ewen, Paul et al. 2012) Whilst it is beyond the reach of this enquiry to look directly at patient outcomes, I aim to gain a sense of how practitioners’ educational experiences influence best practice and engagement in this field, which are likely to play a role in patient outcomes. As best practice implementation is a core concept in this enquiry, the clinical decision-making process is of particular relevance.

**1.4 Clinical Decision-Making**
Best practice in essence refers to good quality medical care. The need to promote best practice in Aboriginal health has been acknowledged and addressed. In 2011, the Chair of the Australian Medical Association (AMA) Indigenous Health Taskforce stated at the launch of the AMA Indigenous Health report card:

> The first step is to be clear about what is involved in providing 'best practice' high quality and accessible primary health care for Aboriginal and Torres Strait Islander peoples.

(Steve Hambleton 2011)

The impact of the self on decision-making has been widely researched in the literature, suggesting that personal attitudes and previous experiences play a role in continuing health disparities. (Van Ryn, Burgess et al. 2011) Whilst normative decision-making models in health exist, ongoing disparities suggest variability in their use. This variability is one potential aspect of how the practitioner may influence health outcomes for Aboriginal peoples.

### 1.5 Engagement

Providing care and advocating for the needs of another is an important role of the medical practitioner. Engagement has been acknowledged to be key to quality healthcare provision. (Durey, Thompson et al. 2012)

Engagement is a broad and subjective term. It can be applied to individual medical practitioners, health service providers, organisations and communities. Referring to the definition of health from the 1989 National Aboriginal Health Strategy, it is evident medical practitioners need to move beyond practicing only a provider role to improve health outcomes for Aboriginal peoples.

'Health' to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease or incapacity.
Engagement in Aboriginal health is not limited to clinical interactions with patients, but encompasses participation in history, advocacy and policy. 

(\textit{National Aboriginal Health Strategy Working Group 1989, Commissioner Elliott Johnston 1991}) Whilst the need for effective engagement of health professionals in this field appears obvious, ongoing health disparities suggest this need is not being met.

Respect for diversity, best practice implementation and engagement are each connected and are examples of good medical practice. They are reflected throughout the code of conduct for doctors in Australia, for example:

\begin{quote}
Good medical practice is patient-centred. It involves doctors understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.
\end{quote}

(Australian Medical Council 2014, p. 6)

\section*{1.6 Parliament has allowed the passage of racially discriminatory legislation}

My interest in clinical decision-making and engagement in Aboriginal health come from experiences both as an Aboriginal community member and Aboriginal medical professional. The experiences I describe provide an insight into myself as a researcher, and the motivations behind this enquiry. In qualitative research, to have a good understanding of our research, it is important to have an equally good understanding of ourselves. (\textit{Elliott, Fischer et al. 1999}) This transparency intends to provide an understanding of my
perspectives of this research area, which contribute to the findings presented later in the thesis.

As a medical student and junior medical practitioner, I witnessed health disparities affecting the Aboriginal population first hand. I recall working on a paediatric ward caring for a young patient suffering with florid Sydenham’s Chorea, a movement disorder associated with Acute Rheumatic Fever. So profound was the young patient’s chorea that it was complicated by severe weight loss. Due to difficulty in feeding and swallowing, our patient was fed through a nasogastric tube for a period of time. Rheumatic fever is a medical condition that reflects poor socioeconomic conditions, and is virtually non-existent in the non-Aboriginal Australian community. (Lawrence, Carapetis et al. 2013) It is a preventable disease that can have serious complications when not treated appropriately (Lawrence, Carapetis et al. 2013) and provides an example of the inequities in health that contemporary society should address.

Aboriginal peoples in Australia suffer a high burden of renal disease. The impact of end stage kidney disease, and the implications accompanying haemodialysis treatment were evident when I was working in the Kimberley region of Western Australia. Elders having to leave country, often permanently, for what was to be end-stage treatment has lasting effects on the individual and family left behind. The importance of looking beyond the patient and their disease to family, social and cultural factors was reinforced as a training medical practitioner.

During my second year of studying medicine, I had the opportunity in my mid-semester break to participate in work experience in the Office of Aboriginal and Torres Strait Islander Health (OATSIH). This was in 2007 when the Northern Territory Emergency Response was introduced. (Brown, Brown et al. 2007, O’Mara 2010) The exposure to high level decision-making and its impact was an eye-opening experience, and introduced me to the powerful role of policy in medicine. It also revealed the relative absence of power and voice for peoples both in the community and in government departments directly involved with the response. This was an uncomfortable experience for me.
The high level of decision-making that shaped the Emergency Response, which aimed to target health disparities, arguably worsened them. (O’Mara 2010) It appeared whilst purportedly providing services and support to Aboriginal communities, the policy was simultaneously promoting marginalization and disempowerment of Aboriginal peoples. (O’Mara 2010) I was curious to know if personal experiences and influences of key decision-makers toward the Aboriginal community shaped how this policy was developed and implemented. The decision-making process of this response received ongoing criticism, for example:

Further, the legislation covering the NT intervention places unparalleled control of Indigenous affairs in the hands of the Minister (or his designated delegate), and is largely discretionary and, in critical elements, poorly defined. Unfortunately, we also bear witness to a moment in time when Parliament has allowed the passage of racially discriminatory legislation.

(Brown, Brown et al 2007, p. 622)

Whilst it is beyond the reach of this study to explore policy making in Aboriginal health, I draw on this experience as it highlights the importance of decision-making at all levels on health outcomes. It provides an indication of how influences on the decision-making process can potentially have significant effects on the health of our community.

1.7 We have enough diabetics

Another key experience was when I was a medical student in a remote community near Fitzroy Crossing that involved a patient with a random blood sugar level of 11, a level elevated enough to diagnose diabetes mellitus. On informing a health staff member of this test they replied:

... that’s not too bad for here. We have enough diabetics, stop finding more.
I remain intrigued as to the reasoning behind this statement. Had a previous experience influenced this healthcare worker to change how they managed patients? If so, how does the healthcare system harness those experiences and provide workers with strategies to ensure they work consistently with best practice guidelines? Do best practice guidelines need to be altered for different population groups? This experience raises the question of the normalisation of health disparities in our community, and whether this impacts the decision-making process in medicine.

The opportunity to work in a rural town towards the end of my medical training resulted in an experience with an Aboriginal man being cared for by a local organisation, who presented to the local clinic with seizures. After discussion with the General Practitioner (GP), it was concluded that his seizures were a result of alcohol withdrawal, despite the patient and the organisation explaining he had not consumed alcohol in weeks, and his symptoms had commenced recently. The seizures continued, and were further investigated upon the arrival of another GP. It was discovered a recently introduced antipsychotic medication was causing the seizures, and on its withdrawal they subsequently stopped. On reflecting on this case I wondered why there was a difference in decision-making regarding exploring the cause of the seizures. What is the role of past experiences and time/resource availability in decision-making processes?

A further clinical experience that led me to consider the importance of clinical decision-making occurred in the Emergency Department of a small town, involving a patient suffering with acute abdominal pain. The usual standard of investigation for this presentation that I followed is to exclude the potentially fatal condition of pancreatitis. However, I was ordered by one of my supervisors to not test for this. The reasons I was given (I had already taken the blood for the test) were that we were in a regional town, our patient was Aboriginal, in addition to the use and availability of pathology resources overnight. The assumption being made by the more senior practitioner was that our patient was likely suffering gastritis. On further discussion it was stated that we would have performed that test:
... if we were in Adelaide and our patient was Caucasian.

These experiences made me start to consider what influences decision-makers and what affects how they decide? To what extent do our own personal attitudes and experiences impact on our clinical decision-making processes, and what is the subsequent impact on patient outcomes? Does our community normalise health disparities, and does this decrease our vigilance to identify and address them? Is our capacity to implement best practice influenced by the structure and availability of resources in the organisation of which we work? It is these questions that have led me into this research project.

In addition to decision-making, I wish to share some personal experiences in education and respect for diversity. I have always held a strong interest in Aboriginal health, and contribute this to my family, who are my role models in advocating for equity. Further, I was brought up with a strong sense of identity and awareness of the challenges facing the Aboriginal community. Throughout medical school I sought out learning experiences that would further my knowledge in Aboriginal health.

I undertook an Aboriginal Health Specialisation course as part of my medical degree, which assisted in gaining a deeper insight into Australian history and important landmark events for the Aboriginal community. I gained exposure to Aboriginal community organisations and training initiatives. I also came to work and engage with people having an influence in Aboriginal health, education and advocacy, expanding my network of role models and providing motivation to continue working in this area. I found these learning experiences invaluable to my knowledge and willingness to engage further in Aboriginal health.

During my sixth year in medical school, I travelled to a large regional centre for my final year medical elective. My interest in Aboriginal health took me to work with the Baker IDI Heart and Diabetes institute. During my time with Baker I had the opportunity to visit many local areas and town camps, guided by a local
Aboriginal Health Worker. This experience gave me an insight into the historical context of the area, along with issues faced by the Aboriginal population regarding living conditions, impact of the Intervention and access to services.

I returned the next year to work at the regional hospital and was intrigued by the minimal cultural orientation that was provided to the new intake of medical practitioners. I was grateful for the opportunity to have experienced the reality of the living conditions and issues faced by the local Aboriginal people the year before, and felt that this would have been useful again as an intern for myself and fellow colleagues.

On reflection I became curious about how other medical practitioners view Aboriginal health education and what their experiences are.

1.8 My Family Background

My family are of the Gija people in Halls Creek, in the Northern Kimberley of Western Australia. Growing up, our Aboriginality was embraced. My grandmother was a strong Aboriginal woman who was a member of the stolen generation and as a child she was removed from her family and taken to Moola Bulla mission. At the mission she was raised alongside other children who were also removed from their families. This was a very traumatic experience for my grandmother, and the legacy of this trauma remains with my family today.

At Moola Bulla mission my grandmother received a Western education and life-skills that enabled her to step between traditional and western cultures. Even though the removal from her family was, and remained, a traumatic experience, she would tell her children that something good always came out of a bad situation. These experiences were the good she took out of being removed from her family’s care. Later she was faced with the choice to either have her children removed from her care, or forego any ties that linked her to her traditional lifestyle or Aboriginality. As a result my mother was raised in a non-traditional
environment and many cultural practices were not passed on. This was a heavy
sacrifice, but necessary in order for my family to remain together. As stated by
Charles Perkins:

We know we cannot live in the past, but the past lives within us

(Deadly Vibe 2004)

The historical context of my family, and the Aboriginal community, is important
in health. An acknowledgement and understanding of historical events that have
resulted in trauma and loss of identity is essential when working with Aboriginal
people.

Historical events were traumatic and accompany a sense of loss, however they
highlight the strength and resilience of the Aboriginal community. Every human
being has their own strengths and weakness unique to them. With recognition of
our own and others strengths, we can address our weaknesses in an attempt to
provide a better future for the coming generations of Aboriginal people.

1.9 Thesis Outline

This thesis is structured into eight chapters; Introduction (1), Review of the
Literature (2), Methodology and Methods (3), Results and Analysis (4-6),
Discussion (7) and finally, Conclusion (8).

Throughout this thesis I use the terminology Aboriginal peoples when referring
to Australia’s first nation peoples. This is the preferred term of reference within
Western Australia, in recognition that Aboriginal people are the original
inhabitants of this state. (Government of Western Australia Department of
Health 2015)
Chapter two will present an exploratory review of the literature that provides an opportunity to explore current literature on decision-making in health, with a focus on ethnic health disparities.
Chapter 2 – Scope of the Literature

The practice of medicine is commonly described as a combination of both science and art. This is a way of relating the humanistic component of medicine; the personal aspect an individual brings to their everyday work as a medical practitioner. The impact and significance of practitioner experiences and attitudes on decision-making has been a recently researched phenomenon in the literature. (Carroll, Wiener et al. 1982, Greenwald, McGhee et al. 1998, Patel, Kaufman et al. 2002)

An overview of current international ethnic health disparities begins this review, to provide grounds for the proposal of practitioner contribution to these disparities. Possible causal mechanisms for this contribution are then explored, followed by the influential role of structural processes and setting characteristics on practitioner decision-making. This allows for the context of decision-making processes to be accounted for. Also introduced in the review is the need for health services to respect patient diversity, in addition to a critique of the terminology used to discuss this concept currently. Throughout the scope of the literature, various research methodologies are encountered; consideration of these methodologies has informed the design and implementation of this thesis.

The online databases Medline and Google Scholar were searched using a combination of key terms: ‘clinical decision-making’, ‘bias’, ‘ethnic health disparities’, ‘Aboriginal health’, ‘cultural awareness’ and ‘implicit association test’. A ‘snowballing’ effect of pursuing references of references was utilised to enhance discovery of relevant papers. (Jalali and Wohlin 2012) Further, papers were identified via ongoing perusal of Aboriginal health forums including the National Aboriginal Community Controlled Health Organisation (NACCHO), Leaders in Indigenous Medical Education (LIME) and the Indigenous Health infonet.

It is important to note that there are limitations and connotations associated with the descriptive terms found in the literature. The terminology used in some
of the research related to ethnic health disparities and decision-making frequently uses descriptive terms such as ‘black’ and ‘white’. Reasons for this include the large proportion of American based studies in the literature and the ongoing difficulty, both scientific and social, in agreeing upon more appropriate descriptors. (Bhopal and Donaldson 1998) Such labelling techniques in health research have received strong criticism, as they categorises diverse population groups together and lack definition and recognition of cultural variations that may exist within the descriptors. (Bhopal and Donaldson 1998) It is argued that researchers should clearly and accurately define their target and comparison population. (Bhopal and Donaldson 1998) This allows for clarity regarding the heterogeneity and origins of both populations, and discourages ethnic stereotyping. (Bhopal and Donaldson 1998)

In this thesis the particular descriptors in a cited study are used, this should not be seen as an endorsement of such binary and simplistic terminology. Rather, it reflects the lack of appropriate definition and description behind these labels. Their use in this review is a way to minimise inaccurate perception of what these descriptors are referencing.

2.1 Evidence of ethnic health disparities

Eliminating health disparities between population groups has become a priority across the globe. As discussed previously numerous health disparities exist between Aboriginal and non-Aboriginal Australians. Internationally there is a 20-year difference in life expectancy between the most and least advantaged population groups in the United States. (Marmot 2005) The implications of ethnic health disparities are significant. For example, if the health disparities were eliminated then 100,000 African Americans would no longer die prematurely. (Fiscella, Franks et al. 2002) Further, disparities are present in education, employment and other socioeconomic indicators, factors that all contribute to health and wellbeing. American Indians and Alaskan Natives have been shown to be twice as likely to be poor, unemployed or to not have a tertiary
degree compared to the general American population. (Castor, Smyser et al. 2006) A better understanding of the potential role medical practitioners’ play in contributing to disparities may assist in working towards achieving an equitable Australian community.

Observational studies in Australia and New Zealand reveal substantial health inequity. The incidence of end stage renal disease (ESRD) is highest among Australian Aboriginal and Maori populations. (McDonald and Russ 2003) The proportion of patients receiving dialysis who had been waitlisted at least once for a renal transplant was lower in the Indigenous groups; 31% for Australian Aboriginal patients, 35% for Maori patients compared with 59% for non-Indigenous patients. (McDonald and Russ 2003) These differences existed despite accounting for the presence of co-morbidities, age and gender. (McDonald and Russ 2003)

In New Zealand between 1997 and 2001, the rate for Caesarean section among Maori women was observed to be 15%, compared to 24% for non-Maori women. (Harris, Robson et al. 2007) The reduced Caesarean section rates persist after adjusting for deprivation (socioeconomic status) and other relevant clinical factors. As the Maori population suffer a high burden of health issues, there is argument that they should be receiving higher rates of obstetric intervention, not less. (Harris, Robson et al. 2007) Proposed explanatory factors for this lower rate of intervention include patient factors; preferences, requests and expectations, and provider factors; provider practice, access to information and preferred management. (Harris, Robson et al. 2007)

In a General Practice setting, researchers found the average patient consultation length to be 13.7 minutes for Maori patients compared with 15.1 minutes for non-Maori patients, despite an equal distribution of illness severity. (Crengle, Lay-Yee et al. 2005) Of patients with a new or existing diagnosis of chronic obstructive airways disease (COAD), Maori patients were less likely to receive a respiratory drug prescription than non-Maori patients (62.6% compared to 71% respectively). (Crengle, Lay-Yee et al. 2005)
In Australia, Aboriginal patients with lung cancer have been found to be 35% less likely to receive active treatment (chemotherapy, radiotherapy or surgery) when compared to non-Aboriginal patients with lung cancer. (Coory, Green et al. 2008) This disparity in treatment remained after adjusting for cancer histology subtype, stage of diagnosis and comorbidities. (Coory, Green et al. 2008) Rates of surgical treatment for non-small cell lung cancer in different ethnic groups in America has shown that, using the language of the authors, there is a 12.7% difference in treatment rates favouring ‘white’ patients when compared to ‘black’ patients. (Bach, Cramer et al. 1999) The five-year survival rate for ‘black’ patients was also found to be 7.7% lower when compared to their study counterparts. (Aboriginal and Torres Strait Islander Social Justice Commissioner 1995) African American patients were likely refused care in an Emergency Department compared to ‘white’ patients, according to one American study. (Lowe, Chhaya et al. 2001)

Whilst these observational studies provide a large evidence base of ethnic disparities in health that suggest a practitioner role, these approaches are limited by the inability to definitively explain why such disparities occur, and subsequently what can be done to minimise them. (Bach, Cramer et al. 1999) Assumptions vary from the problem stemming from the medical practitioner making decisions subject to particular bias and attitudes, to the patient being non-adherent with recommended treatment, having different treatment preferences or having restricted access to services. (Bach, Cramer et al. 1999, Condon, Barnes et al. 2005, Harris, Robson et al. 2007, Coory, Green et al. 2008) Without a clear understanding of the reasoning behind clinical decision-making, it is difficult to attribute health disparities to practitioner decision-making processes. (Harris, Robson et al. 2007) The following section looks at literature that considers the evidence relating to practitioner contribution to ethnic health disparities.
2.2 Practitioner Contribution to Ethnic Health Disparities

The complexity of clinical decision-making processes is revealed in the literature, and is demonstrated in the diagram below. This diagram is an updated causal hypothesis of the potential practitioner contribution to health disparities, developed by American researchers Van Ryn and colleagues. (Van Ryn 2002, Burgess, Van Ryn et al. 2006, Van Ryn, Burgess et al. 2011) Whilst the hypothesis has been developed in an American context, the concepts are relevant in further understanding this topic at a broader level.

The causal hypothesis proposes that practitioner’s beliefs about patients, interpretation of symptoms and interpersonal behaviour affect both clinical decision-making processes and patient behaviour. (Van Ryn 2002, Burgess, Van Ryn et al. 2006, Van Ryn, Burgess et al. 2011) This hypothesis identifies the role of setting characteristics, clinical resources and clinician characteristics on practitioner contribution to health disparities. (Burgess, Van Ryn et al. 2006, Van Ryn, Burgess et al. 2011)
Practitioner clinical decision-making

Several methods have been used to reveal the processes where clinical reasoning and decision-making can contribute to health disparities. Hypothetical clinical scenarios have revealed disparities in decision-making in the United States, through the use of pre-recorded video interviews with patients suffering chest pain of differing demographical features. (Schulman, Berlin et al. 1999) Medical practitioners viewed the interviews and then completed a survey. Analysis of the surveys revealed that ethnicity and gender of the patient were significant factors in predicting referral for cardiac catheterisation, with women and 'blacks' being 40% less likely to be referred for cardiac catheterisation compared to men and 'whites' respectively. (Schulman, Berlin et al. 1999) The odds of ‘black’ women being referred for this procedure were 60% lower when compared to ‘white’ men. (Schulman, Berlin et al. 1999) This is consistent with population studies that have found ‘black’ women are half as likely to receive a cardiac
catheterisation procedure than ‘white’ men. (Giles, Anda et al. 1995, Schulman, Berlin et al. 1999) After adjusting for symptoms the findings remained significant, indicating the difference in referral rates was not due to variations in clinical presentation. (Schulman, Berlin et al. 1999)

Scenario studies have provided evidence of factors other than ethnicity influencing physician decision-making. (Tamayo - Sarver, Dawson et al. 2003) In this study, Emergency Physicians from across the Unites States participated in three hypothetical clinical scenarios where opioid analgesia was indicated. Each scenario specified a different patient ethnicity, with randomly selected scenarios providing explicit detail of socioeconomic indicators. (Tamayo - Sarver, Dawson et al. 2003) Analysis of the results showed that the decision to prescribe opioids was not related to patient ethnicity but rather, description of favourable socioeconomic indicators resulted in a very small but significant increase in opioid prescription for two out of the three scenarios. (Tamayo - Sarver, Dawson et al. 2003)

In 2004, Australian nephrologists participated in a survey exploring their recommendations for renal transplant for 15 randomly generated case scenarios with differing patient characteristics. (Cass, Cunningham et al. 2007) Patients who were young, of normal weight and considered to be adherent with treatment were more likely to be recommended for transplant compared to those who smoke, have diabetes or have heart disease. (Cass, Cunningham et al. 2007) No differences in recommendations based on ethnicity or gender was found. (Cass, Cunningham et al. 2007)

Limitations of scenario studies include the inability to provide a deeper understanding of what influences the clinical reasoning that leads to differing decisions being made, and what subsequent impact this has on health outcomes. (Van Ryn and Fu 2003, Peabody, Luck et al. 2004) Also, decisions made in scenario studies do not necessarily reflect those made in real life clinical practice. (Bogart, Catz et al. 2001, Cass, Cunningham et al. 2007, Sabin, Rivara et al. 2008). The practitioner-patient interaction, which is a critical component of
the decision-making process, remains unexplored. (Tamayo - Sarver, Dawson et al. 2003, Aberegg and Terry 2004) Referring back to Van Ryn’s hypothesis, the preceding factors that may influence decision-making (beliefs, interpretations) are not accounted for in this approach. Studies that explore these additional factors broaden the understanding of decision-making influences.

**Practitioner Implicit and Explicit Beliefs, feelings toward, and expectations of patients associated with Ethnicity**

Differences in decision-making processes resulting from practitioner beliefs about patients is explored in the literature. Looking closer at practitioner beliefs is the consideration of how practitioner social cognition through the use of bias and stereotypes can influence decision-making. The social cognitive process can be described as the way in which people make sense of themselves and those around them. (Beer and Ochsner 2006) It is a cognitive adaptation making daily life more manageable through the use of categorisation and generalisation techniques. (Van Ryn and Fu 2003) Stereotypes, for example, are a method in which people can simplify the amount of cognitive processing that is needed to undertake, allowing the remaining cognitive resources to be used elsewhere. (Van Ryn and Fu 2003)

Furthering our understanding of the role of cognition on decision-making is the dual cognitive theory which proposes that people have two learning and memory systems that interconnect with each other; slow learning and fast binding (also described as controlled and automatic processes). (Smith and DeCoster 2000, Burgess, Fu et al. 2004, Burgess 2010) The slow learning system is used quickly, effortlessly and often unconsciously to minimise cognitive processing (i.e. stereotypes). The fast binding system is engaged in situations that require hard thinking and a great deal of cognitive effort, such as a patient with a complex medical presentation. (Smith and DeCoster 2000, Burgess, Fu et al. 2004) The fast-binding system is only engaged when there are sufficient cognitive resources available to do so: adequate time, workload, minimal
interruptions, and minimal fatigue. (Smith and DeCoster 2000, Burgess, Fu et al. 2004) Note structure and/or environment can also play a role on workload, time and fatigue.

An American longitudinal study which considered the management of HIV positive patients found that women, injecting drug users and minority groups were less likely to receive highly active antiretroviral treatment (HAART) compared to men, men who have sex with men and ‘whites’. (Shapiro, Morton et al. 1999) Following on from this observational study, medical practitioners participated in hypothetical clinical scenarios with differing patient demographics (past injecting drug use, gender, ethnicity) that explored practitioner’s preferences regarding 1) treating the patient and 2) their thoughts regarding adherence to treatment. (Bogart, Catz et al. 2001) It was found that practitioners perceived both men and women who had contracted HIV through injecting drug use to be less adherent to treatment, with African American men less adherent than ‘white’ men. (Bogart, Catz et al. 2001)

As mentioned, an aspect of the social cognitive process explored in the literature is bias. Bias can exist in both explicit and implicit forms.(Burgess, Fu et al. 2004, Blair, Steiner et al. 2011, Cooper, Roter et al. 2012) With increasing recognition of the importance of equity, equality and reconciliation, explicit bias can be viewed as socially unacceptable. As a consequence, researching this accurately can be difficult if people are reluctant to report viewpoints deemed unacceptable in their practice. To address this, research has focused on implicit bias, referring to an unintentional viewpoint that a person may hold, of which they are consciously unaware. (Haider, Sexton et al. 2011)

As implicit bias has unintentional characteristics, quantifying and assessing its presence and impact can be difficult. The Implicit Association Test (IAT) was developed to assist with revealing and understanding the presence and implications of implicit bias. (Greenwald, McGhee et al. 1998) The IAT is a computer-based test that is focused on the automatic evaluation that underlies an implicit attitude. (Greenwald, McGhee et al. 1998, Olson and Fazio 2003, Blair,
In the literature, the IAT has demonstrated implicit attitudes of compliance to be associated with ‘white’ patient race. (Cooper, Roter et al. 2012) Exposing the presence of implicit attitudes toward ethnic groups raises the question; to what extent do these attitudes impact on decision-making, and potentially, patient outcomes?

To address this question, the IAT has been used to assess implicit bias against recommendations for thrombolysis in ‘black’ and ‘white’ patients presenting to the emergency department with acute coronary syndrome. (Green, Pallin et al. 2007) Explicit bias was assessed in internal medicine and emergency medicine practitioners using a survey conducted in Atlanta and Boston. No difference in the perceived cooperation of patient groups with management plans was found; a socially expected result. (Green, Pallin et al. 2007) The study results did reveal through the use of the IAT an implicit viewpoint amongst practitioners that ‘black’ patients were uncooperative with treatment. (Green, Pallin et al. 2007) The study also concluded that as the implicit preference toward ‘white’ patients increased, so did the likelihood that such patients would receive thrombolysis treatment and their study counterparts would not. (Green, Pallin et al. 2007) This suggests that patient access to medical treatment can be influenced by medical practitioner perceptions of their cooperation with recommended treatment, which may stem from assumptions based on ethnicity. The difference in researching explicit and implicit bias is clear, as viewpoints regarding patient cooperation that were explicitly denied by practitioners become evident in the IAT.

As demonstrated in Van Ryn’s table above, practitioner beliefs and perceptions not only influence decision-making, but also impact patient cognition and behaviour. (Van Ryn, Burgess et al. 2011) Studies utilising the IAT have displayed this impact when paired with audio-recorded patient interviews and a survey, exploring the effect of implicit racial attitudes on communication and patient experience with their doctors. (Cooper, Roter et al. 2012) Negative implicit attitudes towards ‘black’ patients are shown to be associated with low levels of patient trust and confidence toward their doctor, and lower levels of
patient-centred dialogue. (Cooper, Roter et al. 2012) This reveals how providers have the potential to not only influence treatment and management outcomes directly, but to influence help-seekers view of themselves, future expectations of care and health related behaviours. (Van Ryn and Fu 2003).

IAT results could be interpreted to imply that implicit bias influences medical decision-making, which may contribute to ethnic health disparities. However, whilst the IAT is the most widely used tool when researching implicit bias, its validity and use has been challenged. (McFarland and Crouch 2002, Brunel, Tietje et al. 2004) It is argued that the IAT assumes prejudice equals discrimination, without considering that discrimination may have causes other than prejudicial beliefs. (Brendl, Markman et al. 2001) The case of ‘English’ versus ‘Australian’ names is used to illustrate this. It is proposed that an individual could be deemed prejudiced if they hold 1) a negative evaluation towards ‘English’ names, 2) a positive evaluation of ‘Australian’ names with no evaluation of ‘English’ names, 3) stronger, positive associations towards ‘Australian’ names than ‘English’ with no negative evaluations toward either and 4) low familiarity with ‘English’ names with no held attitudes towards these. (Brendl, Markman et al. 2001) This argument uses the explanation that an individual can possibly favour one concept over another, in the absence of a negative association toward the unfavoured concept. (Brendl, Markman et al. 2001, Brunel, Tietje et al. 2004) Using this explanation, a supposed prejudicial IAT result could be found in an individual who holds no biased viewpoints towards a certain group. This makes identifying a supposed prejudicial belief with the IAT ineffective in predicting discriminatory behaviour, particularly in the absence of further investigation and information. (Brendl, Markman et al. 2001)

Another interpretation of the IAT is that rather than predicting racial prejudice, participants are identifying concepts belonging to an in-group versus an out-group. (van Ravenzwaaij, van der Maas et al. 2011) A Dutch study explored this hypothesis using racially charged out-group names (in this example, Moroccan) and racially neutral out-group names (Finnish) against the same in-group
Similar responses to the Finnish and Moroccan names were found, indicating the IAT was identifying between ‘in’ and ‘out’ groups as opposed to racial prejudices toward these. (van Ravenzwaaij, van der Maas et al. 2011) Thus, the potential exists for IAT results to be confounded by cognitive factors, which is further supported by the observation of changing IAT results being associated with increasing age. (McFarland and Crouch 2002, De Houwer, Teige-Mocigemba et al. 2009) Thus, caution is required in the use of this tool due to the potential for confounding factors to influence the results.

There are alternative research tools of use in this area. A recent Australian study utilised qualitative methods to consider the notion of practitioner beliefs of non-compliance and its influence on decision-making regarding kidney transplant referral in Aboriginal patients. (Anderson, Devitt et al. 2012) This research builds on the previously described study in this field that utilised hypothetical clinical scenarios. (Cass, Cunningham et al. 2007) Drawing on semi-structured interviews with nineteen nephrologists, researchers explored the views and experiences regarding transplant referral and non-compliance with Aboriginal patients. (Anderson, Devitt et al. 2012)

It should be noted that the term compliance itself has been critiqued and is not recommended, as it holds negative connotations for patients and suggests yielding or submission. (Vermeire, Hearnshaw et al. 2001) The use of ‘adherence’ is favoured over compliance, as it reduces the impression of power attribution to the practitioner within the patient-practitioner interaction. (Humphery, Weeramanthri et al. 2001, Vermeire, Hearnshaw et al. 2001) The term compliance is used in this thesis when directly related to a study utilising this term, or to direct study participant quotes later in the results section.

Returning to the kidney transplant study, there was a tendency for nephrologists to rely on assumptions about patient adherence when considering referral for transplant. These assumptions are likely to disadvantage Aboriginal patient referral rates. (Anderson, Devitt et al. 2012) Whilst non-compliance was a listed
contraindication in the majority of referral guidelines, it lacked clear definition. (Anderson, Devitt et al. 2012) Further, it was found that pre-transplant compliance was viewed as a predictor of post-transplant compliance, without clear evidence to support this assumption, particularly as the management regime of dialysis is quite different to that of post-transplant care. (Anderson, Devitt et al. 2012) Non-compliance with dialysis was also associated with generalised perceptions regarding social and cultural factors, commonly resulting in Aboriginal patients being pre-judged as high-risk for kidney transplant. (Anderson, Devitt et al. 2012) This provides another example of how notions of adherence may influence clinical decision-making, and potentially, patient outcomes.

There is considerable evidence supporting the understanding that practitioner beliefs and perceptions of patients can influence health care and health outcomes, impacting on decision-making processes and patient behaviour. Looking more closely at decision-making and patient behaviour reveals the influence of practitioner interpretation of symptoms and interpersonal behaviour, as significant factors in relation to how health practitioners contribute to health disparities

**Practitioner Interpretation of Symptoms**

It can be argued that the interpretation of symptoms is one way that practitioners contribute to and maintain health disparities. This has been explored in the literature predominantly in the field of mental health. (Pavkov, Lewis et al. 1989, Bhui K, Bhugra et al. 2001, Roy and Balaratnasingam 2010) A study from the United States looking into disparities in schizophrenia diagnosis between ‘black’, ‘white’ and ‘other’ populations revealed ethnicity to be a significant predictor of diagnosis. (Pavkov, Lewis et al. 1989) These findings were independent of clinical status, suggesting diagnostic criteria were not implemented appropriately in ‘black’ patients. (Pavkov, Lewis et al. 1989) Whilst the suggestion that being ‘black’ is a significant predictor of receiving a
schizophrenia diagnosis, why this is the case remains unclear. (Pavkov, Lewis et al. 1989)

Australian Aboriginal patients with autism are commonly misdiagnosed as having schizophrenia. (Roy and Balaratnasingam 2010) The potential for incorrect diagnosis of this disorder within the Aboriginal population, is thought to be due to potential communication and cultural barriers causing a misinterpretation of symptoms. (Roy and Balaratnasingam 2010) Despite similar prevalence of mental disorders in the United Kingdom between patients of English and Punjabi heritage, English-identifying patients have been found to be more likely to receive a correct diagnosis of psychiatric or mixed pathology compared to Punjabi-identifying patients. (Bhui K, Bhugra et al. 2001) Punjabi-identifying patients with mental disorders were assessed more often as having a subclinical disorder or physical and somatic disorder, suggesting practitioner interpretation of symptoms may vary with patient ethnicity. (Bhui K, Bhugra et al. 2001) The authors also commented on the possibility of Punjabi-identifying patients being less likely to express emotional distress in a recognisable manner to practitioners. (Bhui K, Bhugra et al. 2001)

These studies contribute to understandings of the role played by medical practitioners in maintaining health disparities via the way symptoms are interpreted. Practitioner feelings, beliefs and attitudes towards patients are also key contributors here, with particular reference to the style of practitioner interaction.

**Practitioner interpersonal behaviour**

The nature of interaction between practitioners and their patients, including questions asked, content of interaction, and personal factors such as warmth and style can be described as practitioner interpersonal behaviour. (Van Ryn 2002) Negative implicit attitudes held by practitioners toward patients have been
associated with lower levels of patient-centred dialogue, an essential component of patient-centred care. (Van Ryn, Burgess et al. 2011)

Exploring decision-making style and patient involvement has shown that minority patients experience less participatory style consultations / interactions when compared to non-minority patients. (Kaplan, Gandek et al. 1995) A higher level of perceived participation was found to be associated with better self-reported health. (Kaplan, Gandek et al. 1995) This suggests a variation in interpersonal behaviour of the practitioner, resulting in varying levels of patient-centred care and perceived patient outcomes according to patient’s position in society. (Kaplan, Gandek et al. 1995)

A qualitative study exploring patient-practitioner interactions from Aboriginal patient perspectives in Canada has shown that interpersonal characteristics are key factors in effective management. (Towle, Godolphin et al. 2006) From patient perspectives, having an understanding of history and establishing trust by getting to know themselves and their community were preferred interpersonal characteristics associated with positive health encounters. However, it needs to be acknowledged that it takes time to do this effectively. (Towle, Godolphin et al. 2006) Similarly, in Australia, barriers to accessing healthcare have been in Aboriginal settings where staff are perceived to be uncaring, unfriendly, talking down to clients and displaying body language resulting in people feeling unwelcome. This behaviour tended to discourage health service attendance. (Hayman, White et al. 2009)

This section has provided an insight into the role of the self in medical practice, outlining potential causative mechanisms where practitioners can contribute to and maintain ethnic health disparities. This complex process is influenced by multiple factors, including the environment in which health care services are provided. (Smith and DeCoster 2000, Towle, Godolphin et al. 2006) The following section will examine this concept more closely with a particular focus on the role of setting characteristics in clinical decision-making processes.
2.3 Setting Factors

Decision-making is not a cognitive process occurring in isolation, it is a part of a paradigm of political, ethical, legal and socioeconomic structures. (Dowie and Elstein 1988, Bucknall 2003) The setting and structural context in which a decision is being made plays an influential role. (Bucknall 2003) This context includes institutional values, such as respect for diversity, in combination with logistics such as time availability, workload and resource allocation. (Bucknall 2003, Van Ryn, Burgess et al. 2011)

Respect for diversity within health services refers to how structures and attitudes toward patient diversity are addressed within those respected organisations. (Van Ryn, Burgess et al. 2011) The importance of culturally familiar, welcoming environments for Aboriginal patients is recognised in the literature. (Hayman, White et al. 2009) Strategies promoting this include employment of Indigenous staff and having culturally appropriate waiting rooms.

The Australian healthcare system has been described as failing Aboriginal peoples at a fundamental level. (Durey, Thompson et al. 2012) Tertiary health services focused around a Western biomedical model of health provided in a metropolitan environment act as barriers to healthcare for regional Aboriginal communities. (Durey, Thompson et al. 2012) These services are difficult to access readily and can result in cross-cultural misunderstandings of health. (Durey, Thompson et al. 2012)

Returning to social cognition, parts of our learning and memory systems that only engage with sufficient cognitive resources emphasises the significance of environment on decision-making. This is of particular relevance to medical practitioners who frequently make decisions in a stressful, time-limited, sometimes chaotic environment allowing minimal room for error. (Smedley, Stith et al. 2009) Further, studies have found that with sufficient cognitive resources and practice, individuals with a high motivation to control personal
prejudice can be successful in reducing the impact of implicit bias. (Van Ryn, Burgess et al. 2011)

Looking at the concept of time, structures that place emphasis on quick turnover of patients in hospitals can reduce the opportunity to provide comprehensive health advice and make follow-up arrangements and further compromises patient care. (Durey, Thompson et al. 2012) On an organisational level, an Australian qualitative study exploring setting factors found chronic staff shortages in Aboriginal Medical Services impacted on practitioner ability to provide best practice care, and contributed to staff burnout. (Peiris, Brown et al. 2012)

2.4 Respect for Diversity

A variety of terminology is used in the literature to describe health services that provide best practice care to patients from diverse cultural backgrounds. These include, cultural competence, cultural awareness, cultural safety, cultural responsiveness, cultural security and cultural sensitivity. (Manderson and Allotey 2003, Papadopoulos, Tilki et al. 2004, Durey 2010) There appears to be a lack of clarity to what these terms mean, and subsequently how they can be achieved and evaluated. (Papadopoulos, Tilki et al. 2004) Regardless of the definition, the need for health services to be able to provide best practice care to patients from diverse backgrounds is critical. (Papadopoulos, Tilki et al. 2004) This thesis refers to health services being respectful of diversity, turning the emphasis of ‘culture’ towards ‘diversity’, removing any confusion or assumptions practitioners may have about how ‘culture’ can be defined and measured.

A health service respectful of diversity has been defined as one that meets the needs of minority groups, regardless of their ethnic background. (Peiris, Brown et al. 2008) This supports the use of the term ‘respect for diversity’ as opposed to ‘culturally safe’, as the need for recognition of vulnerability and power imbalances extends beyond cultural traditions. This definition may go against
initial thoughts that healthcare respectful of diversity is dependent on the cultural characteristics of the individual. Rather, service provision should not be a checklist approach based on patient ethnicity, but one that acknowledges power imbalances in health interactions between Aboriginal patients and non-Aboriginal practitioners. (Peiris, Brown et al. 2008) Indigenous people are sensitive to power imbalances in their interactions with healthcare services for a number of reasons. (Peiris, Brown et al. 2008) In an Australian context, this can be attributed to our historical context, dominance of the biomedical model of health and the view that non-adherence to health advice are causes of poor health outcomes. (Peiris, Brown et al. 2008)

Providing diversity training in medical curricula is a proposed method to reduce ethnic health disparities, though not favoured everywhere. A survey of American cardiologists regarding health disparities found that whilst 34% of respondents agreed disparities exist, patient factors were thought to have an equal or larger role in comparison to provider or system factors. (Lurie, Fremont et al. 2005) Less than 30% believed increasing provider awareness about disparities and improving respect for diversity would be of any use. (Lurie, Fremont et al. 2005)

In Australia, there is the assumption that inclusion of Aboriginal health education will result in better-prepared medical practitioners, which in turn will promote good patient outcomes. This assumption is yet to be grounded in research evidence regarding improvement in patient outcomes. (Ewen, Paul et al. 2012) A qualitative study involving Aboriginal Community Controlled Health Services, community members, and overseas trained doctors, supported this idea. It was identified when working in Aboriginal health settings that cultural orientation is critical to achieving respect for diversity. (Gilles, Wakerman et al. 2008) Without knowledge of diversity and how this influences health, best practice care may be more difficult to implement.

Aboriginal health education has been shown to favourably influence medical students’ preparedness to work with and engage in Aboriginal health. (Paul, Carr et al. 2006) Similarly, West Australian school teachers who had undertaken
Aboriginal studies regarded themselves to be knowledgeable about Aboriginal history and current issues. (Zubrick, Lawrence et al. 2004) Participation also enhanced their enjoyment of teaching Aboriginal studies and Aboriginal students. (Zubrick, Lawrence et al. 2004) Further research is needed to explore whether shifts in self-perception are in time reflected in daily work. A significant gap in the literature exists evaluating the impact of diversity training strategies on patient outcomes. (Durey 2010, Ewen, Paul et al. 2012)

2.5 Conclusion

This review of the literature demonstrates the potential of the provider to contribute toward and maintain ethnic health disparities. The decision-making process is a key component of this hypothesis, and can be subject to different influences relating to both practitioner and setting characteristics.

Whilst it is uncomfortable to suggest that those working to eliminate health disparities may play a role in their perpetuation, the ongoing existence of inequitable outcomes needs to be addressed from all angles. Understanding of the role of practitioner beliefs, attitudes, interpersonal style and interpretation of symptoms, particularly in an Australian context, is a current area in need of further enquiry.

In accompaniment to practitioner characteristics is the role of the setting. A key solution to health disparities in the Australian community is the notion of service provision that is respectful of patient diversity. This applies to both the individual practitioner and the overall setting of health care provision. Structures that embrace and respect diversity in addition to recognising the need for prepared practitioners are important.

The next chapter will provide more detail on the methodology and methods that are implemented to gain insight into the role of the practitioner when working in Aboriginal health contexts.
Chapter 3 – Methods, Methodology and Participants

3.1 Research methodology

This study utilises predominantly a qualitative interview approach in addition to a survey. The epistemology of qualitative research differs significantly from quantitative methods. (Denzin 2009) The difference adds strength to the research by considering the topic from two different epistemological viewpoints. (Curry, Nembhard et al. 2009)

[Quantitative research] theories provide a general picture of trends, associations and relationships, but they do not tell us about the processes that people experience, why they responded as they did, the context in which they responded, and their deeper thoughts and behaviour that governed their responses.

(Creswell 2012, p. 48)

The use of a mixed method approach has been discussed in the literature, with the recognised need for research to move beyond merely identifying ethnic disparities in health towards methodologies that can provide a better understanding of the processes behind why disparities occur and what can be done to minimise them. (Van Ryn and Fu 2003) The multifactorial nature of this complex issue requires research designs that can accommodate for this, addressing core issues within relevant environmental and cultural contexts. (Klein, Orasanu et al. 1993, Van Ryn and Fu 2003, Peabody, Luck et al. 2004) Qualitative research methodologies are useful in exploring social issues from a human perspective. (Liamputtong 2013) The lived experience of individuals is valuable, and can provide a deep insight into the various influences experienced by practitioners when looking at decision-making and engagement in Aboriginal health.
Theoretical Framework

For the qualitative component of this enquiry, a phenomenology framework is used which allows for the exploration of the ‘lived’ experiences of individuals or groups in relation to a certain phenomenon. (Liamputtong 2013) An individual’s reality is influenced by the world in which they live, an idea that is embraced in this approach. (Lopez and Willis 2004) Within the phenomenology framework, this study closely adheres to hermeneutic theory, an interpretive rather than a descriptive based approach. (Lindseth and Norberg 2004, Lopez and Willis 2004) Hermeneutics moves deeper when exploring lived experiences to finding meaning embedded within the data. (Lopez and Willis 2004) The idea of ‘bracketing’ is frequently addressed in regards to phenomenology frameworks. (Lopez and Willis 2004, Starks and Trinidad 2007) Bracketing refers to the setting aside of preconceived ideas and knowledge of the researcher, in an attempt to hear and view participants shared stories with an open mind. (Starks and Trinidad 2007)

Advocates for hermeneutic approaches to research argue that bracketing is a concept impossible to achieve, and discuss the personal knowledge of the researcher is both useful and necessary in order to conduct quality studies in this framework. (Lopez and Willis 2004) I have chosen to address this issue by making my own personal experiences and views transparent throughout this enquiry, clarifying my perspective when interpreting the results. This has led to a ‘fusion of horizons’, whereby the findings of the enquiry are bound by both the participants and me. (Lopez and Willis 2004)

3.2 Research Participants

The participant group for this research project included registered medical practitioners working in tertiary hospitals, urban and rural Aboriginal Medical Services and regional hospitals. Given the constraints of masters’ level research, other health practitioners including nurses and allied health workers were not invited to participate in the interviews. I acknowledge that their views and experiences could provide an invaluable contribution to studies in this field.
Purposeful, criterion sampling was implemented, as practitioners were required to be registered with the medical board, and to be working in either the Perth Metropolitan or Kimberley regions. (Lapan, Quartaroli et al. 2011) This was to ensure that they had experience with notions of clinical decision-making and engagement.

No restrictions on age, gender or location of training were included in the sample criteria. This sampling method was implemented in order to allow for a diversity of views, experiences and backgrounds to be included within the study. A maximum range of 15-20 participants was pre-defined in the planning stages, to maintain a manageable sample size for the scope and nature of this study. 16 medical professionals took part in this study.

Seven participants were from the Perth Metropolitan region and nine from the Kimberley region. Given the nature of the medical workforce, study participants had varied experiences in work environments (both geographically and organisationally). To provide an example, one of the Kimberley study participants had just relocated from a metropolitan General Practice, giving them experience in two locations and two organisations.

There were an equal number of both female and male participants in this study. No participants identified as Aboriginal or Torres Strait Islander. The majority of study participants completed their medical training in Australia, however only half received targeted Aboriginal health training as an undergraduate. An increase in the levels of postgraduate training in Aboriginal health was found in the survey, which could reflect both the increased awareness of the need for this form of education and the environment in which participants are currently practicing.

Study participants were at different stages of their medical careers, with seven participants identifying as consultants in their respective fields. Participants were distributed across general practice, medical specialties, emergency medicine and others such as public health and medical education. Three participants identified two current areas of practice. The majority of participants identified Aboriginal Medical Services as their current practice location.
It was found that the majority of participants feel either very confident or confident in their ability to manage Aboriginal patients. No participant felt unconfident managing Aboriginal patients. The general answer amongst study participants was that poor health was an expectation at least sometimes within the medical profession, with only one participant disagreeing with this statement.

The concept of sample size in qualitative studies differs significantly from quantitative methods. With the absence of numerical data, focus shifts away from statistical significance toward saturation of key themes in the data from the interviews. (Guest, Bunce et al. 2006) On reflection, data saturation was obtained quite early throughout the interview process. The sample size of 16 in this study is consistent with recommendations in the literature for phenomenology studies, which range from six to 25 depending on the purpose and intent of the research. (Guest, Bunce et al. 2006)

In regards to recruitment, I established contact with the leaders of each organisation involved, who subsequently advised me of appropriate methods to recruit participants. Recruitment then proceeded in a snowballing fashion once appropriate contacts were provided. Potential participants were contacted via email and in person as directed by the organisation leaders. Each participant was provided with an information sheet and asked to provide written and verbal consent prior to conducting the interviews.

The participant information sheet and consent form can be found in Appendix I and II.

3.3 Data Collection

Data was collected in the form of semi-structured interviews with participants, along with a demographic survey. The survey was designed to establish baseline information regarding the participants and their views on Aboriginal health. The survey instrument (see Appendix III) was implemented for its ease and time-efficiency obtaining data such as age, gender and location of training.
The survey questions regarding confidence managing Aboriginal patients and expectations of the medical community served as an introduction to the interview discussion. These responses also gave some initial understanding of participant’s viewpoints of these topics. Cognisant that the number of practitioners interviewed was relatively small as is the number actively working in Aboriginal health contexts I have taken particular care in the presentation of the demographical data, to ensure participants remain unidentifiable.

The semi-structured interview is a useful tool in exploring the experiences of individuals beyond the limitations of surveys and scenario representations, and is commonly used in qualitative research enquiries. (Boyce and Neale 2006, Liamputtong 2013) Interviews were conducted using open-ended questions focusing around four key themes in Aboriginal health: experiences, engagement, education and clinical-decision making. Participants were given the choice to not answer particular question/s if they wished. At one participant’s request, the final part of their interview was not audio-recorded or included in the thesis.

Any particular topic participants wished to elaborate or expand on was accommodated within the study design. As a result of this flexibility, interview times ranged from approximately 20 minutes to one hour, depending on the time demands of the participant and the level of discussion they wished to have.

Interviews were conducted in person at locations most convenient for the participants. I travelled to each site where participants were located, both metropolitan and regional, to conduct the interviews. Each interview was audio-recorded using a portable handheld recorder. One interview was performed in two sections, fifteen minutes apart to accommodate for the needs of that participant. All other interviews were done in one episode. Each interview was successfully audio-recorded. All interviews with the exception of one were transcribed verbatim to text from the audio recordings using the transcription software ‘Express Scribe’. I conducted and transcribed each interview, allowing for deep immersion in the data. The transcribed interviews were analysed thematically as described below.
In preparing the results and analysis section, direct quotes from the interview transcripts are provided to enhance the richness and quality of results presented. For readability purposes, filler words such as ‘um’, ‘uh’, ‘like’ and duplicated words were transcribed but not included in the presentation of results. Each participant was offered a copy of the transcription to ensure that what was transcribed accurately reflected the interview. Of the transcripts that were provided to participants, there were no objections.

One semi-structured interview was excluded from the results and analysis process. The interview participant whose discussion was excluded wished to elaborate on topics beyond the structure of the interview, and core questions and themes were not addressed. Survey results from this participant have been included in data analysis.

### 3.4 Thematic Analysis

Data analysis in qualitative research is an interpretive process described as the ‘decontextualisation and recontextualisation’ of results. (Starks and Trinidad 2007) This essentially refers to the separation of textual data into separate concepts, which are then grouped together to tell a story of the phenomenon explored. (Starks and Trinidad 2007) The analysis process of this enquiry is consistent with phenomenology frameworks, where description moves beyond identifying core concepts, looking for embedded meaning within the descriptions. (Lindseth and Norberg 2004, Lopez and Willis 2004)

Textual data from the interviews were analysed using the process of thematic networks. (Attride-Stirling 2001) A diagrammatical representation of a thematic network is found below, as depicted by Attride-Stirling.
After each interview was transcribed to text, basic themes were identified within the data. For ease of analysis, each basic theme was labelled with the interview number (for example #8 to indicate interview 8). The number of basic themes varied for each interview, ranging from 10 to 20 basic themes per transcript.

Once basic themes were identified, they were grouped based on shared commonalities into organising themes. For example, similar basic themes were grouped together into the organising theme:

Factors promoting engagement in Aboriginal health

Once identified, organising themes were further grouped into six global themes forming the basis of the results chapter. For example, the above organising theme formed the global theme with other related organising themes:
How to implement best practice in Aboriginal health

Below is a schematic illustration of the analysis process.

![Schematic illustration of analysis process]

Important in data analysis is to distinguish between observations and interpretations of observations. (Sofaer 2002) To clarify, the basic themes are direct observations from the transcript text, which were then classified into organising and global themes based on my interpretation of the observations. The results section will present the global themes, using direct quotes from transcripts to support the findings.

### 3.5 Ethical Considerations

This research study received ethics approval from the University of Western Australian Human Research Ethics Committee (RA/4/1/6868) and the Western Australian Aboriginal Health Ethics Committee (#554).
The development and implementation of this research project was influenced by the guiding principles of ethical research in Aboriginal health.
- Survival and protection
- Responsibility
- Equality
- Respect, spirit, integrity
- Reciprocity

Written community support for this research study was gained from Aboriginal health organisations in both the Kimberley and Perth Metropolitan Region. In addition, verbal support was obtained from a Tertiary Health Service provider in the Perth Metropolitan region. These organisations provided valuable input into the design and implementation of this enquiry, to ensure it was done respectfully, and of a high standard to benefit the community.

In the respect for autonomy, informed consent was obtained from participants in both written and verbal forms. No participants requested they be omitted from the study.

A resource list was provided to each participant detailing where they could source further information on Aboriginal Health topics, and social and emotional support if necessary. The resource list provided to participants can be found in Appendix IV.

3.6 Rigour

Rigour in qualitative research revolves around the understanding that interpretive findings are based on the political, social and environmental context in which the research is done. (Lincoln and Guba 1986) This is somewhat contrasted against the goal of obtaining objective, unbiased ‘true’ findings sought after in positivist approaches to knowledge. (Lincoln and Guba 1986) When it comes to human experience, the idea that there is no single truth challenges the application of rigour to qualitative approaches.
Three elements have been proposed to establish the trustworthiness of qualitative research findings. (Barusch, Gringeri et al. 2011)

- Credibility
- Transferability
- Confirmability

Enhancing credibility, I conducted all of the semi-structured interviews. This allowed for me to gain a deep immersion of the collective experiences of participants over the course of data collection. Participants were provided the opportunity to access their interview transcript to ensure accuracy of interview representation.

In relation to transferability, the results section utilises direct quotes from textual data to illustrate meaning and is provided in context. This allows readers to make the judgement as to whether the thesis findings can be transferred to aspects of their daily life or practice. An outline of participant demographics and geographical location assist in the contextualisation of results. The diversity of participant demographics may impact transferability by exploring the topic from a range of backgrounds and contexts that readers and other health professionals may find elements of similarity to. (Lincoln and Guba 1986)

The transparent insight into me as a researcher and the methodology utilised in this enquiry aims to contribute to the confirmability of this study. Clarity of processes regarding data collection and interpretation allow for accountability of results obtained. (Barusch, Gringeri et al. 2011) The use of direct participant quotes gives an understanding of where meaning was drawn from the interviews.

### 3.7 Limitations

The use of the semi-structured interview has limitations in that what people say may not necessarily reflect true events or true opinions. I acknowledge this limitation but am unable to address this given the scope and constraints of a Masters degree research project. That said, this is an area that provides the opportunity for further exploration via future research, which could utilise
observational and quantitative research methods to further enhance the validity of the interview findings.

As the leaders of participating organisations provided contacts for recruitment of participants, there is the potential for selection bias to impact on the thesis findings. Further, medical professionals who did not wish to be involved in the study may have viewpoints and perspectives not addressed in this thesis. Having outlined the research topic and context and methods implemented to explore the topic, I now move on to present the findings of this research enquiry.
Chapter 4 - Results and Analysis

In this chapter I present the findings from the thematic analysis of the interviews, beginning with experiences shared by participants regarding unequal treatment of Aboriginal people in the healthcare system. A common thread throughout the interviews was a commentary about adherence and communication as a foil for unequal treatment. Unequal treatment may be the consequence of institutionalised racism meaning the structures, policies, practices and norms that result in differential access to services and opportunities in society based on race. (Jones 2002, Smedley, Stith et al. 2009) It is a multifactorial concept involving contributions from individual behaviours, health structures and policies and practices carried out within the healthcare system. (Larson, Gillies et al. 2007)

4.1 The naming of the un-nameable

... only in the raising of important questions and the naming of the un-nameable that we will be able to focus our tremendous personal and intellectual resources on a system so powerful and pervasive that the majority ... are still in denial about its very existence.

(Jones 2002, p. 7)

As stated in the above quote, an important step in addressing health disparities involves identifying the presence of institutionalised racism in the healthcare system, however uncomfortable a topic it may be. Because, as the opening quote to the thesis states:

... two or three times a month I almost have to take my colleagues aside and say 'yes I know Aboriginal patients have worse health outcomes, but by denying them access to X, Y and Z, that's really unacceptable.'

Study participant

This participant's experience encapsulates the concept of institutionalised racism, where access to health opportunities become restricted due to the expectation of 'worse health outcomes'. As evident in the survey results, this is not uncommon;
with fifteen out of sixteen participants agreeing this expectation occurs within the medical community. Unequal treatment of Aboriginal people was flagged to be a common observation in the interviews.

And a few other, there’s been lots. It’s just depressing to talk about these examples but there’s lots of times that I can tell they wouldn’t have treated a non-Aboriginal person the same way.

Study participant

This statement is consistent with findings elsewhere, with one study reporting 70% of Aboriginal participants had experienced negative treatment based on their ethnicity. (Paradies and Cunningham 2009) Despite the suggested high rates of racism, only a small number of study participants shared direct observations or experiences of unequal treatment. Two participants related specific examples of unequal treatment in regards to referral times and hospital admission. This supports the contention that Aboriginal people can experience differential access to services and opportunities based on their ethnicity. The reluctance to discuss this uncomfortable issue is clear in the first example, with the second revealing feelings of frustration and disbelief at its occurrence.

... referring to the hospital and stuff, if you’re referring a Caucasian person they get seen quicker than an Aboriginal person ... don’t know what’s going on there ...

Study participant

I’ve had an 18 year old refused, they refused to admit my 18 year old patient, because she had taken her own leave the week before. So I found that really awful, because it wouldn’t happen to a non-Aboriginal person.

Study participant

These experiences further our understanding of the challenges Aboriginal patients face in accessing healthcare opportunities and resources, and the possible ‘symbolic violence’ that can be experienced within these interactions. Symbolic
violence is described as ways of thinking and acting that are accepted without criticism, allowing underlying power imbalances between groups to remain hidden. (Durey 2010) The term violence is used, as it is the act of leading to constraint of individuals, and symbolic, for the indirect and implicit nature in which it presents. (Durey 2010) Differences between power and violence lie in the potential to escape the effects of such interactions. (Foucault 1982) It could be argued the more that is known about such relations, the more likely their impact can be realised and minimised within the healthcare system.

Individuals can find themselves in various complex power relations. (Foucault 1982) When the effects of these power relations are adverse, struggles to minimise these are experienced. (Foucault 1982) Poor health as a result of power relations in medicine is an obvious example. This struggle raises the question of the effect a change in power would have on the medical practitioner, and whether this too would result in further struggle from them. Foucault reflects on this:

In effect, between a relationship of power and a strategy of struggle, there is a reciprocal appeal, a perpetual linking and a perpetual reversal.

(Foucault 1982, p. 794)

Perceived negative attitudes toward service provision and resource allocation for Aboriginal patients were noted in the interviews. The second participant quote is a reflection on historical service provision issues in Australia, when access to renal dialysis was very restricted.

... we can't say this is what you should have but if you can't afford it go and die in the corner. How do we make sure that people get what they need so that the best care can happen?

Study participant

... in the first bed was a 35 year old Aboriginal lady from the Kimberley who had been on dialysis for a month with apparently end stage diabetic renal failure. So I
said 'Wow that’s tragically young so what’s the plan? And they said ‘well, she’s a Kimberley Aboriginal’. And I said ‘So?’
‘Well we offer dialysis until she wants to go home’ And I said ‘well what happens when she goes home?’
‘Well there is no dialysis beyond a 300 kilometre radius from … Perth.’
So I said ‘you mean, she can stay dialysing here away from her family or she can go home and die? I don’t find that an acceptable ethical choice!’

Study participant

In these comments the participants reveal perceived attitudes toward resource allocation and service provision, which exemplify the deep structural influences on health that exist for Aboriginal communities. That said, it must be acknowledged that progress has been made in recent times regarding service provision for patients suffering with end-stage renal failure. (Kneipp, Murray et al. 2004) Community dialysis centres are enabling access to life-saving medical treatment whilst allowing many people the opportunity to fulfil family and cultural obligations. (Kneipp, Murray et al. 2004) This progress is a positive move in addressing and minimising the impact of undesirable attitudes toward resource allocation in Aboriginal communities.

4.2 Oh my, what have I been doing!

... it’s different how you deal with the non-Aboriginal Australians to how you would deal with the Aboriginal Australians, more in way of communication.

Study participant

Effective communication skills have been identified as the cornerstone of best practice decision-making in healthcare, because without them, it is difficult to develop shared understandings, limiting ability to meet patient priorities for health and the achievement of good outcomes. (Cass, Lowell et al. 2002, Ha and Longnecker 2010) Communication skills can be related back to practitioner interpersonal style discussed in Chapter two. The opening quote reveals how a perception of diverse language and cultural backgrounds may lead to potential
barriers to communicating with Aboriginal people. Further, some use the perception of communication issues as an excuse to not even try:

And the (specialty) surgeon came to see her, and basically said 'I don't even know if she knows, understands anything, I don't know if I should be doing this surgery... I can't communicate with this patient'. And so he said 'I don't even know if she knows she could die from this surgery'. So I said to the surgeon 'look she understands, she has come down, she understands, you can talk to her. You just need to sit down and talk to her', and he's like 'well you just go and talk to her' ...

Study participant

This situation provides an alternate perspective of institutionalised racism, where constructed and real communication barriers can lead to differential access to services. Or, as highlighted above, limited attempts by a practitioner to ensure informed consent. This is further complicated by hierarchy and power differences within the health system, in addition to negative attitudes toward a patient's capability to engage in informed communication, as expressed in the interviews. The participant sharing the above experience with a surgeon went on to comment:

... the intern and I felt we'd really trying to being advocating for this patient, when the surgeons didn't want to talk to her... There was two parts that affected me. And the first was communication in tertiary hospitals. And it's really difficult and people who haven't experienced ... don't often have the skills to communicate with [Aboriginal] people. But then you know we could communicate with her but we obviously didn't have the expertise of a (specialty) surgeon to make a decision ...

Study participant

This apparent reluctance to communicate with Aboriginal patients in tertiary health settings inevitably has an influence on health outcomes. It provides an example of symbolic violence, referred to earlier, in which the structure of the health setting allows for episodes of poor communication to occur without being addressed. One participant described Aboriginal people as 'generally quite shy' and possibly 'uneducated' and as a consequence it can be 'difficult to get a history'.

...
This is another form of symbolic violence, where perceptions impact toward attempts at communication.

Participants gave examples of how episodes of poor communication are not always intentional or due to a lack of motivation from the practitioner to engage. A participant mentioned how despite efforts, their attempts at effective communication were unsuccessful, and took time to be realised.

... I was talking and dealing with a patient with a kidney transplant and I used to go and spend ten, fifteen minutes every day explaining about the transplant ... and after one week she asked me, after she's received her kidney transplant ... ‘you always use that word transplant. What does that mean?’ ... that’s when it struck me ... I’m not communicating ... it is for us an eye-opening experience. ‘Oh my, what have I been doing’!

Study participant

This demonstrates how less than ideal communication, even with the best intent, can contribute to ongoing health disparities. Further, it shows the ability of participants to reflect on their practice and identify areas for improvement in their approach to communication. Communication has also been shown to play a role in patient adherence (Ha and Longnecker 2010), a recurring theme in the interviews.

You can take the horse to the pond but you can't make it drink

Compliance is definitely a problem. I can tell you 40% of the Indigenous patients, you can take the horse to the pond but you can’t make it drink.

Study participant

As a medical student the term compliance was deemed politically incorrect, holding negative perceptions and connotations for both practitioners and patients. As already discussed, there is a current shift toward the use of the term adherence to minimise perceptions of power imbalances between patients and practitioners. (Humphery, Weeramanthri et al. 2001) Challenging the acceptability of the term compliance are causes of non-adherence now being realised as not being
dependent on patient behaviour and motivation for their health (see Chapter two). (Harrington, Thomas et al. 2006) Rather, it is understood to be a result of health system structures and their ability to facilitate appropriate and accessible service provision. (Harrington, Thomas et al. 2006) To sum up, patient adherence is more a consequence of health service provider behaviour, and less from the motivation of the individual patient. Despite this shift in understanding, the term ‘compliance’ was encountered numerous times by different participants in this study. For example,

... very compliant and very proud of her daughter ...

Study participant

... they are compliant because that is the way I deal with them ...

Study participant

The same issues the compliance, not spending time ...

Study participant

The negative overtones accompanying these statements made by participants are disconcerting, particularly as the majority of participants work in settings with a relatively high or high proportion of Aboriginal peoples. The presence of these overtones supports the argument in favour of using adherence over compliance, as perceived attitudes presented in the interviews hint toward subtle perceptions of power of medical practitioners in regards to Aboriginal patients. It also indicates an area of practice that requires better understanding from health service providers, posing issues of power imbalance and ways to minimise this. At times the globalising commentary on Aboriginal people as patients was quite striking. As one participant revealed:

... How violent they are, how non-compliant they are, how rude they are ... we should not lose our poise.

Study participant
It should be noted that such strong negative stereotypical perceptions of Aboriginal patients held by a health practitioner working closely with Aboriginal people does not necessarily reflect the views of most. This study cannot comment on the full impact of such perceptions on patient health, however the presence of these perceptions identifies a significant underlying issue and an area for future work.

Continuing the thread of adherence, the impact of health service accessibility was another area that emerged during the interviews. Whilst working in the Goldfields in WA, a participant observed how the location and setting of a health service can influence access for patients. The language used in this observation is another example of the use of less than ideal terms of reference.

I knew there were lots of Aboriginal patients coming ... that none of them would see me when I was in the hospital. So, I found there was an Aboriginal Medical Service, so I went down and talked to them, I set up a clinic there. So I did a morning clinic at the Aboriginal Medical Service, and my afternoon clinic, and it was Black and White! In the morning it was Black, in the afternoon it was White. The White people wouldn’t go to the AMS, and the Black people did not want to go to the hospital.

Study participant

This reflection provides insight into the impact health service acceptability and ways of working can have on Aboriginal patient’s opportunity for health, as shown by the preference for patients to access health care at the Aboriginal Medical Service (AMS). It outlines how service provision in an appropriate environment can improve patient accessibility. It raises the question, had the above participant not provided the service at the local AMS, would patients not wanting to access that service be deemed non-adherent? It is a good example of practitioner flexibility in seeking out solutions to improve access to health for Aboriginal patients. The potential to be innovative with service provision to communities to allow for maximum participation is recognised as a useful quality in a service provider. This is supported by the following Royal Commission into Aboriginal Deaths in Custody (RCIADIC) excerpt:
When structures and organisational formats are imposed and thrust upon Aboriginal people, there is no sense of ownership developed. Such things tend to come from outside Aboriginal considerations and initiatives ... there needs to be control and sensitivity to enable delivery and participation. Without these dynamics being put in train, there will be repetition of past patterns of rejection, failure and resistance. Contracting, involving, supporting and resourcing Aboriginal community controlled organisations, offers the best opportunity to get some of the crucial matters about progress and achievement right.

(Commissioner Elliott Johnston 1991)

Limited accessibility of health services not only impact patient opportunity for better health outcomes, but also the medical community’s perception of Aboriginal patients’ motivation for health, and adherence. A participant captured this in the following:

Some of it is self-fulfilled. Aboriginal people particularly don't like going to hospital. And then if you’ve got an experience wherever you meet with bureaucracy that people ignore you or, talk at you or don't talk to you at all, it becomes this self-fulfilling, they don't want to come and then the doctors say ‘Oh but they are non-compliant!’

Study participant

There is a need for service providers to think broadly when faced with notions of non-adherence. Improved practitioner understanding of adherence and what influences patient behaviour is apparent from interview discussions. Referring back to the 1989 National Aboriginal Health Strategy definition of health, professionals need to embrace a wider role that enables patients to determine their own health. If a patient is displaying behaviour perceived as non-adherent, it is the responsibility of the practitioner to recognise their role in facilitating and prolonging that behaviour, not the patient. The relationship between communication and engagement and adherence was noted by one of the practitioners interviewed:
... it's a little bit hard to make a connection so I try quite hard to ... And then I guess also plenty of negative experiences where, despite trying that I feel like I haven't effectively connected ... people maybe don't want to take your advice about what you think is important and you wonder perhaps if I got better connection, they might have taken that advice.

Study participant

This represents a shift away from placing the responsibility of non-adherence onto the patient, with the practitioner exploring the role of their communication on patient health. The acknowledgement of who should own the responsibility for adherence was captured in the following comment:

... have to get practitioners beyond that notion of people like this don’t do very well because people won’t take their pills or they will not come back for a follow-up, or they won’t listen. How do we get practitioners to understand that it’s their obligation and they are contributors to less than ideal care? The less than ideal care doesn’t sit with people not taking advice. It sits with both the practitioner and the client ... the obligation is more on the practitioner to be able to develop the relationship and the understanding ...

Study participant

4.3 It’s just that group mentality

The preceding section considered the importance of communication and perceptions of adherence as indicators of unequal treatment. Another issue that arose from the interviews was that unacceptable behaviour is relatively commonplace in health settings. Those participants who discussed this indicated their frustration at its occurrence. The following comments from one participant relay the potential struggle practitioners may face in speaking out against unequal treatment of patients in an organisational setting.
It's just that group mentality. Everyone just expects that's how it'll go... and nobody, even if there's a few people because you see some people feeling a bit uncomfortable with things, but they don't call it because as a group they are all OK with it.

Study participant

And I ran back ... to tell the sisters ... and the midwife was kicking [the Aboriginal patients family] out ... it was really confronting but the whole ward supported that behaviour. And I was really shocked by it. And I’m less shocked now but I’m angry still when it happens ...

Study participant

The process of apparent acceptance of particular behaviours over time was a recurrent theme in the interviews. Awareness of the different forms of institutionalised racism and its expression provides service providers with a framework that can begin to address differential treatment. This could work toward reducing the impact unacceptable behaviours may have on health outcomes.

You need more Aboriginal people

In the interviews participants went beyond sharing their views and experiences related to institutionalised racism, but also offered potential solutions they thought may counter or reverse these behaviours in health organisations. Two participants offered resolutions to unequal treatment focused on partnership with Aboriginal peoples.

I think you need more Aboriginal people at every level. And obviously that’s hard and there’s not an overnight solution. But I think it’s much harder to do those things if there’s an Aboriginal person in staff. And we’ve got one Aboriginal [staff member], and things don’t happen quite the same ... So I think that's the way, that’s the ultimate thing that we want ... is to have a place with lots of Aboriginal people and lots of Aboriginal health staff. And then ... that uncomfortableness that [non-Aboriginal staff] felt and then got over it, they wouldn’t be able to get over it quite so easy.
... the best way you can work is in a team with Aboriginal Health Workers. And where that exists, you have better outcomes for patient care.

The relevance of the health provider in promoting unequal treatment is again found in these views. That said, the suggestions could be interpreted as placing the responsibility on Aboriginal people to address this. As stated, there is no ‘overnight’ solution, and all health professionals need to be able to critically reflect on themselves and their own responsibility for any unequal treatment displayed in their respective institution.

The apparent difficulty targeting differential treatment was also mentioned in the interviews. There was a tendency toward equal treatment, even in offered examples of unequal treatment regarding intravenous (IV) drug therapy. This may be explained as a cultural aspect of the medical profession whereby practitioners are reluctant to critically reflect on issues of equality and equity. Automatic tendencies toward equal treatment may not always be the best option, as differential treatment can, under certain circumstances, embrace best practice.

It shouldn’t really make any difference really, if you look after them. Actually, I haven’t actually thought about this. I suppose normally the culture difference, probably if you can get IV, probably should use IV, that was before anyway ... for me, it doesn’t make any difference. It should be the same. I can’t say physically for Aboriginals whether you would treat this person different. Should be treated the same.

Here the issues of equity and equality are under consideration. Further the quote provides an example of polarising language when referring to Aboriginal peoples. Using terms such as ‘them’ and ‘Aboriginals’ is a subtle example of power and separation of the practitioner in reference to Aboriginal peoples. Examples of
similar polarising language can be found in many participant statements in this results chapter, indicating the relatively common nature of ongoing implicit power relations and bias within medical practitioners.

This chapter has provided some insight into the presence and consequences of unequal treatment within the medical system, with particular reference to communication, the notion of adherence, and differential access to resources, services and opportunities for health.

The importance of communication and adherence, whilst introduced here, will be revisited in the next chapters, strengthening their importance in the realms of Aboriginal health. Throughout the next chapter, structural and personal influences on decision-making process are explored, providing understanding of why decision-making can be different in Aboriginal health, and how this relates to best practice implementation.
Chapter 5 - ... ones that are a little bit bad, there’s just not the time ...

In this chapter I consider the relevance of setting characteristics including time and practitioner connectedness. Then the influence of the practitioner as an individual is explored in regards to engagement and decision-making in Aboriginal health.

5.1 Setting Characteristics

The burden of disease in the Aboriginal population is well known. As outlined in Chapter one, disparities in health outcomes are demonstrated by high rates of chronic disease, mortality and risk factor prevalence. The high disease burden has implications when considering a medical practitioner’s ability to provide ongoing care in a time-limited environment.

... and the ones that are a little bit bad, there’s just not the time in the clinic day to be able to ... sort it all out ... if you were in private city practice, you would get [the patient] back in right away and sort it all out ...

Study participant

... so much of the health service is directed toward trying to provide the best service for as many people as possible .... It's great that anyone can come in on any day and hopefully be seen, but then when you add in staff pressures and everything else it's not always quite as easy as telling someone to come back next week ...

Study participant

The above quotes deepen our understanding of the causation of unequal treatment in health, particularly as the first experience reflects how the situation would be different in another setting. It is important to recognise that unequal treatment is not always a result of the practitioner, but can be secondary to the structural and contextual constraints placed upon the practitioner’s ability to perform in a best practice manner. The second participant comment conveys the perception of how
structural limitations hinder the ability to develop a good understanding of health, further supported in the following comments.

As a doctor, you’re always like right I’ve got this sort of time to do this, and you’ve got a lot going on in the day and sometimes it’s hard to just take a step back and be like right well, I’m not going to be able to sort this problem out in a fifteen minute appointment ... if you could just sit down for five hours, you probably could really help ... sometimes physically you don’t actually have that time because you’ve got all these other people to see ... So I think that’s a barrier ... time availability.

Study participant

... in another setting you might go ‘oh this is something we should look at, here’s your blood form, come back and see me in a couple of weeks’. Is it something that you’re ... right we are going to bleed you today and we are going to start this plan, sort of throwing everything at this person in one go ... as much as it’s great that you’re taking your opportunities, I don’t think it contributes to a better understanding of health ...

Study participant

Setting structures that do not facilitate equal access to resources and health opportunities as compared to those in different environments, with the same health goal (primary healthcare provision for example), will inevitably fail to obtain equal health outcomes for their patients. This highlights the need for resource allocation and funding to match the needs of the community served, and for services to be delivered that meet these needs effectively. Effective models of service delivery were raised in the interviews.

Time is not important ... the outcome is important

The design and implementation of Aboriginal Medical Services (AMS) reflect the needs of the community, enabled by the core principle of community control and self-determination. (Alford 2014) Aboriginal Medical Services are structured to allow for greater time availability for patient care. This is achieved by removing
financial constraints to practice time, flexible appointment systems in conjunction with a multidisciplinary health team approach within the service. The effectiveness of this design in achieving better health outcomes was raised in the interviews.

Time factor. See, in a mainstream practice what happens is the time factor is very important, ... here, time is not important, it is eventually the wellbeing and what we do to the patient is important. The outcome is important. So it takes a lot of time and dedication.

Study participant

I think that the values of an AMS ... they are run by Aboriginal people so ... they are trying to think about values of the community, and what the community wants. So I think that's really good and important. It's a good way of delivering healthcare, because there's ... funding so we can spend more time with patients ...

Study participant

These observations demonstrate how Aboriginal Medical Services are responding to the needs and priorities of the community in which they serve. They offer a good model of service delivery for other organisations engaging in healthcare provision to Aboriginal communities.

Given the diversity in historical, political and cultural contexts in contemporary society, a claim could be made that a similar diversity needs to be displayed in service provision. The structure of health services was identified by some participants as impacting on health professional ways of working and patient acceptability. Examples included hospital environments clashing with community culture, and technological requirements impacting on patient-doctor rapport building.

... it's a hard thing that the way we run, it's about scheduling follow-up appointments and doing things by appointments and structured ... So I think there's just a clash between those two cultures, it was good working in the Aboriginal Health Service because they could go and pick people up who did have
appointments, and I can see how that worked better for Indigenous people, but the hospital can’t run like that ...

Study participant

Trying to tick the boxes that the government requires, tick the boxes that the health service requires but still do the best by your patient. And sometimes ... they can be slightly at odds ... I feel like you do spend time doing tick boxes that require you to stare a computer ... while your patient's sitting there. It can really impact your relationship.

Study participant

Participants advised that the setting of the AMS does make a difference to the way they practice, supporting the proposal that these structures work toward achieving best health outcomes for Aboriginal communities.

The culture of an AMS and the setting of that and obviously the people that run it makes a difference to the way we treat things.

Study participant

Participants referred to setting factors that impact on their ability to engage in best practice care. In particular, staff availability and practitioner shortages were identified as ongoing issues in the health system.

... we need to increase that doctor to patient ratio, where actually you have less number of client but better quality care. The best model of care. That's what I hope to see in the future.

Study participant

... just staffing levels, in general ... there's a lot of short staffed ... that makes it hard as well.

Study participant
Recall systems and administrative processes were also noted to both assist and limit health care provision in respective organisations. The second quote below conveying criticism of structures that are perceived to take on too much responsibility for patients reveals contested notions of equity and autonomy within medical culture.

... adequate recall systems is something that we are always battling with ... so when I did do the 6 months in private you hit recall and then the nurse calls them and calls them and then they come back in ... those frustrations sometimes when you spend all of your afternoon instead of seeing your patients you end up trying to organize administer which in different organisations, is done by somebody else.

Study participant

So in general I’m very thankful for our very robust recall system ... the robust recall system is very good. But I guess the criticism of it is are we taking too much responsibility for people’s health when perhaps they should be taking more responsibility.

Study participant

**Understanding community, and how everyone is connected ... it takes time**

The importance of time in establishing connections with community and building understandings was a recurrent issue in the interviews. Having a good understanding of Aboriginal communities and their context was considered to influence the ongoing engagement of practitioners in this field, something that requires time to develop. The following quotes identify how building connections with Aboriginal peoples supports engagement, however, the time that is required to do this could be perceived as discouraging medical practitioners from engaging in this area.
I think understanding community, and how everyone is connected is really important. And it takes time. And then it’s hard to leave when you’ve got the understanding. That’s where I’m at now.

Study participant

I think the main discouragement is just that it takes more time. I think you just do need to give a bit more time ... And because they can initially be a bit less feedback from an Aboriginal person so, it can be a bit harder to tell at the beginning if you are getting anywhere or not. So, if you are in a bit of a hurry, might be easy to give up quickly.

Study participant

There are a number of ways that Aboriginal Medical Services, controlled by the community, begin to address structural limitations to health and health care issues. Firstly, the community members who receive the service have a say in how it is implemented and setting the priorities that have to be met. The need for the medical profession to recognise the importance of community control and not struggle against it was stated clearly by one interviewee.

I guess … organisational structure, that’s often a barrier because it’s very different to mainstream medicine. And [doctors] struggle, and they want to be in control, and that’s not appropriate. And they need to be able to let go of that control.

Study participant

The above comment highlights the idea of power relationships having reciprocal appeal as proposed by Foucault, whereby doctors struggle to maintain their position of power, even if it goes against the notion of empowerment of Aboriginal peoples.

In this section the importance of time has been considered not only as a reflection on the level of health needs within the Aboriginal population, but also of importance in relation to structural issues which impact on the ability of
practitioners to address health priorities effectively. In finding out more about engagement, the role of the self was another issue that arose in the interviews.

5.2 Influence of the Self on Engagement

... depends on the personality. Some people they don’t like dealing with the Aboriginal clients, but personally I feel it’s really great, and it’s really challenging, and I am happy with what I am doing.

Study participant

In the interviews, participants identified personality to be a key factor for practitioner engagement in Aboriginal health. There was the perception that practitioner personality and personal prejudices could result in some discomfort with Aboriginal health, leading to limited engagement within this area. Some went as far as to identify prejudice as the following quote reveals.

It’s personalities. Some people don’t like people. Its intrinsic prejudice, some people don’t like certain sorts of people.

Study participant

Emerging from the interviews was the suggestion that a personality correlate could provide further insight into the personal characteristics of people working in Aboriginal health. This suggests the possibility of common practitioner characteristics for those working in this field. This becomes more relevant with the connection between practitioner personality and the effectiveness of patient-doctor communication and development of rapport. As discussed earlier, effective communication is critical in good clinical interactions. (Ha and Longnecker 2010) One participant provided their observation of how practitioner interpersonal style can influence patient satisfaction and behaviour.

I think that some doctor’s personality is to be more direct and more task-oriented. I think that’s not a fault but it does make it harder to deal with Aboriginal patients.
When exploring how personality influences practitioner interpersonal style, it becomes evident how factors that play a role in shaping our personality eventually play a role in our daily life as practitioners. Factors that were discussed in the interviews include practitioner upbringing, values, attitudes and context.

**I come from a background where I haven’t been upper class**

Practitioner characteristics are of considerable importance as they can play a role in provider contribution to health disparities. (Van Ryn and Fu 2003) Particular characteristics of relevance here include explicit and implicit attitudes about patients, which can be influenced by personal values. (Van Ryn, Burgess et al. 2011) This was recognised by one participant who stated:

… we all put our personal context and values onto the people we see whether we mean to or not. In some way, I don’t think overtly but just even in the not understanding the different cultures of your patient. Or the different values of your patient. You might put your own values, they might just be what’s on your mind rather than theirs.

**Study participant**

Given the contention that practitioners can implicitly project their own values onto their patients, it is useful to consider how having compatible contexts and values with Aboriginal patients can positively influence engagement. There is a diversity of belief systems and values in contemporary Australia, reflecting the multicultural community in which we live. With such diversity comes the potential for incompatible beliefs and values to be displayed between the practitioner and the patient, which may pose difficulties in clinical interactions. For example,

You can get two doctors, they might have the same knowledge but you can’t get the same personality between the two … patient doctor relationship sometimes didn’t go well, not because the doctor is not actually good in terms of the health and medicine, but probably the message misunderstood by the patients.
The point that this participant makes so well is that regardless of practitioner skill and knowledge base, achievement of desired patient outcomes can be limited if the doctor-patient interaction is suboptimal. This reinforces the significance of good communication in clinical settings, and the potential impact this can have on patient’s overall health. Provided that compatible contexts and values influence patient-doctor communication and interaction, one could argue that if a clinical interaction did not go well, a patient could simply seek another doctor. The difficulty for patients is the relative lack of opportunity to do this in an area with limited numbers of practitioners.

... every doctor has a different approach. And the one thing that you learn going through general practice is because you do something differently to another person doesn’t mean that you’re wrong. It makes you different doctors, and ideally patients get to choose because you have more than one doctor. But especially in regional areas you don’t always get to choose a doctor, you’re stuck with someone. Normally patients and doctors find each other by having the context and values and attitudes being compatible in broader populations.

Extending the discussion around the influence of personal factors in Aboriginal health are perceptions of the medical community toward this area.

I think maybe there’s that mentality for some people that it’s so bad you can’t fix it, so maybe that’s why some people don’t want to work in Aboriginal health ...

Practitioner perceptions of Aboriginal health were raised as barriers to engagement. Such perceptions include notions of managing Aboriginal patients, and working in this area to be challenging. It was observed by some participants how such perceptions might be unfairly applied to the Aboriginal community, with similar challenges occurring in mainstream medical practices.
I think many doctors consider this job as challenging ... maybe because of this stereotype about the Aboriginal people, which I found is not correct. The stereotype that being difficult patients, and many drunks ... lot of negativity ... There is some difficult patients, as I think they have in the mainstream.

Study participant

Perceptions of fear and lack of prestige associated with Aboriginal health were described as potential barriers to engagement. Adding to negative perceptions was the potential association of Aboriginal health with rural health, which was seen as a discouraging factor.

I think people are often discouraged because they perhaps fear Aboriginal health a little bit. Like it is too hard, and often Aboriginal health can be rural health, which can sort of scare people a little bit.

Study participant

I think some of the things are what they bring with them. So some kind of, stereotypes and judgements but also probably, what the medical profession thinks of people who work in community and in Aboriginal health. I know I sometimes get perceived as some kind of bleeding heart or something ... I think that’s a barrier in a way because it’s not perceived very well ... it’s not seen as a prestigious thing to do.

Study participant

Looking closer at the notion of prestige, participants discussed how career development and financial gain were not viewed as core motivating factors for people working in Aboriginal health. This supports the importance of the values and beliefs held by practitioners.

I think from observing people ... it seemed to be a really eclectic group of people ... who’d had really interesting past careers in medicine and they seemed to be a little bit outside the box ... they did seem to perhaps have less emphasis on career.
development and money and perhaps a little bit more of an emphasis on maybe some more social justice type things.

Study participant

... I think the encouragement for people to work up here is ... I guess it’s more of an altruistic, wanting to close the gap ...

Study participant

The importance of values, beliefs, personality and upbringing on engagement in Aboriginal health contribute to who we are in the world that we live in. This is further complicated by the potential for the world to be viewed differently by different people. The concept of reality was a recurring thread within the interviews.

The construction of our own reality has been proposed to be a combination of a wide number of factors including history, culture, resources and social structure. (Mol 1999, Montero 2002) Practitioner perceptions of reality were thought to influence the health of Aboriginal peoples. It was understood in the interviews that an inaccurate representation of the reality for Aboriginal communities and individuals could be a barrier to engagement in this area.

People have maybe had negative experiences or friends or their family might have had a negative experience and that creates the reality... for them rather that ... closer reflection of reality for most Aboriginal people, and Aboriginal non-Aboriginal interactions.

Study participant

Exploring the factors that construct our reality helps to demonstrate how the reality of an Aboriginal person may differ significantly from that of a non-Aboriginal person. The impacts of colonisation, historical policy, marginalisation; and how these play an ongoing role in the daily lives of Aboriginal people are a few examples. Different realities were described as potential barriers when engaging in clinical decision-making and providing care for Aboriginal patients.
The main barriers I think are a disconnect between the practitioners reality and Indigenous peoples reality.

Study participant

... we do often get things back from Perth for example, from maybe a cardiologist or someone who clearly has no concept of what Aboriginal family structure ... might involve.

Study participant

Providing additional evidence of the difference in perceived realities of individuals, one participant described experiencing a different reality to be a confronting process for them.

It was really shocking to me ... in the wonderful country Australia how my lovely privileged north shore Sydney lifestyle was just so different from a footy field that was strewn with broken flagons, where heads were split open every single day that I was sewing together. These tragic lives with, as far as I could see, no hope of getting out of them.

Study participant

This perspective is an example of how within one environment the experiences of reality can be quite different. Having an understanding of another individual's reality and the challenges they may experience refers back to the core notion of respect for diversity. Here, factors contributing to power imbalances between patients and providers become a priority. The view that lives are 'tragic' with 'no hope' could be interpreted to be patronising or offensive to the Aboriginal community whom are living with intergenerational effects of colonisation. Another participant reflected on their changing understanding of reality for Aboriginal patients, which when not properly achieved, could be a potential barrier to providing best practice care.

... thinking back to when I was ... in Perth in hospitals, I was quite nervous of Indigenous people from remote communities because they didn't talk much and I
felt like I had no idea what world they were going back to. So there was just that baseline barrier ... I’m not nervous of that ... anymore.

Study participant

Whilst the above descriptions detail significant differences in perceptions of reality, participants also accounted a similarity in issues and ways of life between Aboriginal communities and populations in other countries. The resemblance struck one participant on their first interaction with an Aboriginal patient.

...that’s when I first met an Indigenous, or an Australian Aboriginal patient. For me it was a striking resemblance that I had ... when I treated patients back home. That in [country] it was supposed to be, a developing country...

Study participant

Health similarities between Aboriginal populations and people from developing worlds mirror parallels observed regarding poverty between Aboriginal Australians and the developing world. (Altman 2004) Given Australia is a developed nation these are confronting observations, depicting the ongoing marginalisation Aboriginal peoples experience in the community.

Individual characteristics relating to engagement and understanding of reality impact on health outcomes for Aboriginal peoples. The need for improved awareness of the reality and relevant contexts of Aboriginal peoples was considered throughout the interviews.

5.3 We don’t understand their culture

Participants identified the need for medical practitioners, and the health system overall, to have a greater respect for patient diversity within the Aboriginal community. In the following quotes note the wide variety of terminology used to describe this core principle, further supporting current literature explaining the lack of an agreed understanding of what these terms mean and how they can be
achieved and evaluated. (Manderson and Allotey 2003, Papadopoulos, Tilki et al. 2004)

... we don’t understand their culture completely. And that holds true for any other culture as well ... we lack cultural awareness. As much as we think we know we don’t know fully.

Study participant

To be very frank with you, culturally competent care looking into the diverse needs of the patient.

Study participant

These comments relay a collective view for better inclusion of respect for diversity in the medical field. The view of how a deep understanding of patient diversity is required, moving beyond current knowledge, was another issue mentioned in the interviews. This conveys how gaining an understanding of diversity can be an ongoing process, reflecting the dynamic nature of Aboriginal communities, cultures and ways of life. Participants noted that the need for diversity training spanned across the disciplines and experience of clinicians, and that there should be no end to the learning process.

I think it’s an ongoing thing, it never ends. It’s not like you have had enough. You have never had enough ... even at a consultant level ... there is a lot you don’t know. You think you know because you’ve just worked a certain way and that’s worked in the past so you presume that it is but it’s not the best, I think we should have some targeted learning at whatever level of your career.

Study participant

... It’s like we deal with the problems differently to the metropolitan patients. I don’t know I’ve never really thought about it before. I guess we get all our medical teaching in medical school and then we kind of forget about it ... I think it’s important.
The statement of practitioners avoiding presumptions about past practices being the only way embraces the change needed to attain a more equitable society. Ongoing recognition of important issues that require modification in the structure of the health setting will arguably promote better patient wellbeing.

The second participant statement detailing how teaching occurs in medical school and is then ‘forgotten’ illustrates the prospective for training initiatives to be introduced for practitioners. Particularly as participants noted a better understanding of diversity was an area they would like ongoing learning in. The potential for such learning to lessen the likelihood of stereotypical assumptions being made was commented on.

I would like to actually know a bit more about the history. I know there are different dialects so I’d like to know how different ... tribes behave, and what are their cultural ... because we group them all into one big pot, which is not true. So I would like to have a bit more education on that.

... maybe a little bit on the beliefs and the culture, not so much on the routine things, but their beliefs, and what they think we can do for them.

The above participant remarks show how even practitioners confident in Aboriginal health still want to build on their learning and knowledge in this area. Time is mentioned as a potential limiting factor to this process, which may suggest the value placed on diversity training in the health sector.

The need for all medical practitioners to have exposure to Aboriginal people and culture was frequently expressed. The experience with fellow colleagues who described zero exposure to, or interaction with the Aboriginal community was commented on. This again highlights the relative separation that continues to exist.
between Aboriginal and non-Aboriginal communities. The need for practitioners to have an understanding and an awareness of Aboriginal people and culture is essential in addressing the continuation of this relative separation.

... if you’re not exposed and you do your training in a totally different environment because we have seen that ... people from Melbourne when they came over to Perth to do some training ... they said to me, ‘oh, this is the first time I’m actually seeing a real Aboriginal’

Study participant

I think I come from a position of being perhaps quite ignorant about Aboriginal people and Aboriginal culture, so I guess the more experience I have in meeting people... helps me understand people a bit more and, hopefully that affects what I do.

Study participant

Drawing links between how conflicting patient and practitioner realities can influence both engagement and decision-making in health, and the need for Aboriginal health education and exposure to facilitate better understandings, is the following participant stance. There is a voiced need for the provision of an alternate view to how Aboriginal people's reality is perceived. The potential for this alternate perception to enhance practitioner engagement is communicated in the following:

... things that encourage engagement are being able to provide an alternative experience and an alternative view ... if people haven’t been through a fairly comprehensive Aboriginal health education ... then they don’t necessarily have the alternative view that is portrayed in popular culture, and the media. So if we use the majority of peoples experience to be based on the mythology of the front page of the West Australian it’s really hard for people to have a different view ... it’s about trying to get a ... alternative understanding that might challenge the myths and stereotypes that they’ve grown up with. And that means you have to get engagement in Aboriginal history and culture and practice in a real form rather than a fictionalised ... way
Adding to the discussion of the need for viewpoints and experiences to be understood, were participant reflections on the impact of learning about the Stolen Generations. Especially, the Aborigines Act 1905 in WA which was designed to assimilate Aboriginal people into mainstream society resulting in ongoing intergenerational effects on Aboriginal individuals and families, and the social and emotional wellbeing of the community as a whole. (Wilkie 1997) Some of the participants reflected in the interviews how learning about the Stolen Generations had a significant impact on them, such that it influenced their engagement in the field of Aboriginal health.

... I remember we had somebody come in who was stolen generation come and talk to us. And it was the first time out of all of my schooling, it's such a failure of the school system... and maybe it’s changed now, I don’t know but I never had that experience before. And it really quite moved me... I can distinctly remember that. I think that’s probably what made me decide to go on this path...

And I met the lecturer, and for the first time I am hearing about the stolen generation. I, I can’t forget the lecturer when she tried to discuss this issue, and she start to cry, this Aboriginal lady. So this really affected me.

The quote detailing a participant’s first exposure to Australian historical events that have impacted the Aboriginal community occurring in medical school outline how past events continue to lack proper widespread recognition and understanding. There are ongoing efforts in today’s society to address this, with advocacy for recognition of Aboriginal peoples in the Australian constitution being one example.

An additional complexity adding to the historical legacy of trauma and marginalisation suffered is the burden of disease experienced by Aboriginal communities. Understanding the amount of trauma and grief Aboriginal people
and communities face on a regular basis highlights features of strength and resilience. This was considered by one of the practitioners interviewed who commented on how an understanding of this grief is necessary in order to work more effectively with Aboriginal patients.

... again same for all patients but in particular for Aboriginal patients ... they've just got so much ... grief that I have never had to deal with. I remember my grandparents passing away, but you've got all these people who constantly have their aunties or cousins or people being very unwell or people passing away. So you might come in and growl at them for ... not taking their diabetes tablets ... but really they've just got all of this other kind of stuff to deal with.

Study participant

The following section will focus on the process of clinical decision-making and the influence of the individual on this process.

5.4 The role of the self on decision-making in Aboriginal health

Causal mechanisms for health service provider's contribution to health disparities include practitioner beliefs, feelings and expectations towards patients, together with their interpersonal behaviour and interpretation of symptoms. (Van Ryn, Burgess et al. 2011) Similar to the above discussion on engagement, an individual’s personal characteristics were reasoned by participants to play a role in clinical decision-making given the subjectivity and variability that can be found within the practice of medicine. Even when there are guidelines to assist better practice these can be subjected to interpretation, which can often rely on the individual characteristics of the decision-maker.

... your practice is always going to be influenced by other stuff that's happened, other patients that you've seen. I think also your own attitudes or upbringing ...

Even within strict guidelines there are so many grey areas in medicine ...

Study participant
My guideline says I should give Amoxycillin 25mg/kg bd, but I don’t really think that’s necessary so even how you are implementing that guideline and you’re explaining it to the patient is influenced by your attitudes.

Study participant

This example is consistent with Van Rynn et al’s hypothesis of how practitioner interpersonal behaviour impacts on patient care. (Van Ryn, Burgess et al. 2011) Practitioner expectations and assumptions were acknowledged by participants as having a key role in clinical decision-making processes especially in relation to patient outcomes, behaviours and priorities. Some participants’ noted how their assumptions regarding patient behaviour guided their treatment decisions, and how these may not always be accurate. The example of an assumption regarding Aboriginal people suffering with diabetes quote confirms the presence of assumptive processes in healthcare provision.

I don’t think a lot of [Aboriginal patients] understand the consequences of what would happen. Particularly diabetics, some ... don’t look after their diabetes. Whether they really don’t care or they just don’t know that they could lose a limb or could die. I know the message has got to be fairly simple.

Study participant

The interviews displayed the struggle practitioners experience when trying to implement the perceived best approach to care without restricting access to opportunities that might be offered to other patients not subject to these assumptions. The above participants’ perception of Aboriginal people suffering with diabetes provides an idea of how management options may be different based on the view that ‘they really don’t care’. These are supporting examples to how assumptions about adherence and patient behaviour play a part in decision-making in Aboriginal health.

An important consideration when thinking about assumptions is whether they result in the attainment of best health outcomes. Whilst it is difficult to argue that all assumptions result in poor outcomes, the importance in recognising and
limiting personal assumptions about patient preferences for treatment was mentioned in the interviews. Particularly when, in the following quote, it moves beyond simple antibiotic treatment to a higher level of medical intervention.

You have to try and not make assumptions about what treatment people might want ... Like assuming whether someone wants dialysis or not. Sometimes you think old and pain, comorbidities and stuff, surely you don’t want dialysis ... And sometimes you get it wrong and that’s really bad ... we’ve got to revert to just having the people you’re treating as the decision-maker, and not changing that because they are Aboriginal.

Study participant

This observation provides an example of a clinicians assumptions potentially being at odds with a patient’s preferred treatment. Whilst assumptions may improve patient outcomes, they also have the potential to limit access to medical resources and conflict with patient ideas and priorities for health care. Assumptions can also be at odds with the right of the patient to be the decision-maker in their own health. The right to self-determination has also been recognised internationally. The 1978 Declaration of Alma Ata places self-determination as a core component of primary health care. (World Health Organization 1978)

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

(World Health Organisation 1978 p. 2)

A deeper understanding of the source of assumptions that limit the potential for patients to determine their own health is a starting point for future interventions that could provide potential solutions and strategies to address them.

Giving further examples of the source of assumptions, a participant mentioned that in other non-Aboriginal health contexts, they tend towards “this is what I think you
should do and expect the patient to do it”, noting how in other environments adherence is commonly assumed and therefore plays a lesser role in decision-making. That said, it could be argued that notions of adherence can play a positive role in this situation, as the practitioner is acutely aware of the impact of patient behaviour. Two participants provide examples below of how having a good understanding of patients can influence decision-making:

... is there too much other stuff going on that’s going to mean that kid’s not going to get that antibiotic. So you’re better off giving an injection now, what do you know about where they are living, who is looking after them … what’s the access to follow-up going to be. If they have come all the way into town today to see you, and they can’t come back for a month ...

Study participant

So is this someone who’s going to come back in if they get worse? Is it someone who’s going to be able to take medications that you are suggesting? Is it realistic? I don’t think it’s realistic to ask many people to be taking an antibiotic four times a day for ten days. I know I can’t take an antibiotics four times a day!

Study participant

These statements show the influence of patient behaviour and context on decision-making. It is difficult to judge whether the above perceptions of adherence and access to services accurately reflect patient context or are based on assumptions. The comment regarding a participant’s own likely non-adherence to antibiotic treatment reinforces the need to ensure health related advice is targeted toward the individual, rather than basing them on assumptions, for example relating to ethnicity.

There’s this perception of the doctor that they’re wise

Given the frequency that assumptions have been mentioned in the interviews it is useful to explore the origins, drivers and factors that reinforce them. The impact of past experiences on current approaches to care was one issue raised in the
interviews. In particular, past experiences with Aboriginal patients engaging in perceived non-adherent behaviour was considered to play a key role in decision-making. Such assumptions are used to rationalise the behaviour of the practitioner, behaviour that could be viewed as paternalistic and/or discriminatory. As two participants commented:

... that sort of thing where people go ‘oh they're not going to come back I can’t really be bothered’, or ‘last time I gave them the medications they didn’t take them so I’m not going to’.

Study participant

I guess I’ve heard way too many stories from colleagues, or past colleagues saying ‘I wouldn’t put that much effort into it, because Mr X is not going to come back.’ Or ‘there's cost involved in this and we should use the dollars more efficiently on people who appreciate or who will benefit most’. Those sorts of blatantly offensive comments, are far too frequent ... I think they are the excuses that people use ... as a rationalisation if you like.

Study participant

The denial of access to medical resources based on previous experiences is not consistent with best practice, and is a reminder that unequal treatment is a relatively common feature in health care. Further, whilst discussed in the context of Aboriginal health, these observations don’t specifically state ethnicity to be a key factor in the use of previous experiences to guide future decisions. That said, one participant noted that previous experiences have more of an impact on decision-making for Aboriginal patients compared with non-Aboriginal patients:

... everyone just expects people don’t refer broken hands to orthopaedics because of the patient they saw that didn’t go to their appointment last time. Then they get a dysfunctional hand and I just don’t think that’s OK. So you’ve got to give that patient a chance. It doesn’t matter what the patient last week did. So, they wouldn’t do that for some other person might walk in that’s equally likely to not attend but they happen to be non-Aboriginal and they get referred.
This is an example of how institutionalised racism impacts on the health and health care of Aboriginal peoples. The need to look beyond past experiences to optimise health outcomes for individuals is clear in this experience. To achieve this requires practitioners to not allow assumptions to influence their decisions, however accurate they may consider them to be. In one interview this was noted to be of particular importance for patients not well known to a practitioner.

And I think there’s this perception of the doctor that they’re wise and they’ve been around for ages and they know what this patient is going to do. Which I think is a real false idea. Because you don’t know what any patient is going to do. And sometimes if you know that patient well, you might have an idea of what they’ll do but, but this is not, they are talking about a patient they have never met before.

Underlying tones of frustration regarding assumptions in decision-making are apparent in this quote. It suggests an additional struggle for practitioners working in Aboriginal health, having to deal with the burden of institutionalised racism that may not be present in other environments.

**We try to be very selective ... if they are Aboriginal**

Another theme that emerged from the interviews was the expectation of poor health and its influence on decision-making. Outcome prediction is a cognitive process used in medicine and health care services to guide, for example, resource allocation and the prioritisation of management. (Marti, Garin et al. 2012) Predictions of various outcomes can be made based on a number of factors, with biological parameters and length of hospital stay being examples used in validated prediction tools. (Marti, Garin et al. 2012) In the interviews, outcome prediction in Aboriginal health played a key role in the decision-making process. Predictions based on the expectation that Aboriginal people would have poorer outcomes and higher infection rates post renal transplant was one example mentioned by a participant:
We make some decisions ... because we know they are prone to more infections or more poorer outcomes. That’s what influences the decision, rather than just being an Aboriginal or not. I don’t see that there is that discrimination based on the decision-making. It’s probably related to the outcomes rather than the race, or what you call.

Study participant

It is unclear in this statement whether or not the decisions made promote better health outcomes, or further disadvantage them. However, the assumptions reflect earlier findings that demonstrate worse outcomes can result from the inaction, or in effect denial of treatment, because clinical decision-making can be influenced by a belief that certain groups of people do not do very well. (Lowe, Kerridge et al. 1995)

Evidence of both ends of the spectrum was observed during the interviews. Participants discussed how guidelines specific for Aboriginal populations recognise the different burden of disease, resulting in different decision-making pathways for Aboriginal people to allow maximum resource allocation and best practice implementation.

Well I think one thing is guidelines, for example otitis media. So non-Aboriginal child comes in with otitis media, I think oh well I’m not going to treat that with antibiotics. But an Aboriginal child I think oh I am going to treat that with antibiotics. And just that general knowledge of increased susceptibility to complications, or ... increased risk of ischaemic heart disease. Knowledge of patterns of disease would influence you to manage people differently.

Study participant

Here the use of guidelines to assist decision-making in populations with a high disease burden is best practice and reflects effective resource allocation. On the other hand, the following comment provides an example of how recognition of the relatively high burden of disease and poor health outcomes may result in the
restricted access to resources and health opportunities. The description is also an example of the use of polarising language when referring to Aboriginal peoples.

Especially in kidney transplant we know they have really bad outcomes with immunosuppression, and so we try to be very selective or extra careful when put the patients for the transplant list if they are Aboriginal.

Study participant

Disparities in Aboriginal patients receiving a renal transplant prior to starting dialysis, being accepted onto transplant lists and receiving well-matched transplants were observed in the early 2000's. (McDonald and Russ 2003) The two participant quotes above provide an indication of how expectations of poor health can result in both increased and restricted access to healthcare. The identified need to work outside the constraints of an expectation of poor health outcomes, and focus on the particular needs of the patient warrants further examination. The idea of patient-centred care is looked at in further depth in the next chapter. When practitioner expectations of poor health outcomes become frequent, views of normality may play a part in health care action.

5.4 Shifting the goalposts.

Participants discussed the tendency for medical practitioners to normalise poor health outcomes experienced by Aboriginal peoples. Analysing the transcripts revealed that normalisation of poor health is a process that does occur. The boundaries between perceptions of reality, normality and acceptability were raised. For example, the perception of normality in health was noted in the following:

...Because there is such a huge gap it has been normalised a bit. An old person is sort of 60, which is not [actually old].

Study participant
It’s reality. There’s a two decade gap, and it’s hardly changed, so it is in fact normal. But is it acceptable? ... I think they do normalise it. And I normalise it. But I don’t think it’s acceptable.

Study participant

From these observations, the act of normalising poor health is not the key issue; rather it is the acceptance of this. This raises the questions; what is normal? And, can something that is normal be unacceptable? One participant observed that prevalence plays a key role in our perception of normality, and further explored the definition of normal.

... what is normal? If normal is defined by prevalence, then some things are normal in this population that should not be normal. So I guess that depends on what you are using as your definitions. If greater than 50% of the population have chronic ear disease, does that make chronic ear disease normal in this population? It still shouldn’t be, but it becomes normal to you and the intact eardrum becomes abnormal, and then you notice it! Oh! Look at that eardrum! It’s amazing! ... Yes sometimes it is, and no it probably shouldn’t be. It’s a consequence of being immersed in a particular community.

Study participant

This idea of immersion in a particular community becomes important when thinking about what is normal and, when considering prevalence, the population in which normality is being assessed is critical. For example, using the above observation, exploring chronic ear disease prevalence rates within the entire Australian population compared to the Aboriginal population will result in very different prevalence figures. These figures may then influence the estimate of normal within each population. For example, in 2008, 9% of Aboriginal and Torres Strait Islander children aged between 0-14 years reported to have ear or hearing problems, a figure three times the rate for non-Aboriginal children. (Australian Bureau of Statistics 2009)

A question that arises here is, should the Aboriginal population be considered separately in our perceptions of normal, or be included in what is evaluated to be
normal for the non-Aboriginal population? I would argue that given Australia is a contemporary society that values equity, the same expectation for health and normality, irrespective of ethnicity should exist. Particularly as some Aboriginal and Torres Strait Islander communities have a prevalence of chronic suppurative otitis media that greatly exceeds the World Health Organisations (WHO) figure of 4%. (World Health Organization 1996, Burns and Thomson 2013) As WHO states:

A prevalence of >4% indicates a massive public health problem of COM [chronic otitis media] which needs urgent attention in targeted populations.  

(World Health Organisation 1996, p. 2)

The relationship between prevalence and perceptions of normality provides an understanding of how the immersion within a population suffering a high burden of disease can increase the likelihood of the normalisation of outcomes that otherwise would not be considered normal nor acceptable in the wider community. For example,

I think it’s a real problem when you work solely within Aboriginal populations, because you get used to what you see. And I don’t think it’s always an us and them. I think I start thinking of life being shorter than it is as well. I think it’s normative not just in terms of something we project but sometimes it’s something we experience.

Study participant

I think maybe exposure to Aboriginal health for a while might lead you to expect that things might always have to be a little bit not quite up to gold standard, which is not good.

Study participant

These viewpoints support the point of perception and construction of reality being influenced by the environment, knowledge, culture and social experiences. (Montero 2002) The first participant’s description above, regarding their own views on life changing from evolving perceptions of what is normal in their
environment, illustrates this. Leading on from this, the impact of normalising poor health on patients is of relevance. For example, does having a low expectation of health outcomes influence how patients are managed?

**Is it worth treating?**

The interviews revealed how normalisation of poor health has the potential to influence both perceived urgency and the level of intervention required in medical presentations. Participants shared their own experiences with this concept, with one participant describing it as a potential pitfall, and another reasoning it is necessary in order to prevent over-investigation. The third participant quote details an experience with a locum doctor unaffected by this process. The locum doctor implemented standard treatment that was perceived unlikely to have been implemented by others working in the regarded environment for a longer period of time.

... it can be a trap that we, that I fall into. Take HbA1c% for example. You get a HBA1C% back of 10 and say ‘oh well at least it’s not 15’.

Study participant

Even when I get my results, I still look at them and go ‘Oh my goodness’. But you go ‘oh everyone’s LFT’s are off.’ I don’t know if it’s normalising it. You have to have a different approach, otherwise you would be over-investigating everybody.

Study participant

I feel a lot of the doctors ... especially in the ED there are locums from other parts of Australia, they have the way they usually practice. And they just implement their usual practice here. Whereas I think doctors maybe that have been here longer, have changed their usual practice to suit the patients. Just even things like impetigo, one of the locums was like ‘this is what I do.’ And he would give everyone Triclosan wash, something that we might not do all the time, because we wouldn’t think it would get done at home. They still implement what they would do normally ... and that’s something I learnt from.
It could be debated that, following best practice standards, if everyone required investigation and/or treatment, this should be implemented for all. I argue the opposing opinions of this process represent a pitfall as opposed to ensuring appropriate level of investigation and need to be interpreted in the context of equitable resource allocation and service provision.

It is well known that for every $1 spent on non-Aboriginal peoples, $1.47 is spent on Aboriginal peoples. (Australian Institute of Health and Welfare 2013) This figure needs to be viewed in the context of different burden of diseases being considerably higher than 0.5 times; for example rates of end-stage renal disease being 8 times that of non-Aboriginal populations. Inadequate funding and reduced resource allocation for level of need may play a part in the mentioned perception of over investigating abnormal results in Aboriginal peoples.

In another clinical context, participants provided an insight into their views regarding normal / acceptable levels of renal function in Aboriginal patients. One participant discusses an experience that resulted in a delayed response to a potentially life-threatening process in the first quote below. As stated,

I had a patient ... the other day who had her creatinine came back really high. I remember saying to someone ‘she’s in renal failure’ and I meant acute renal failure. And they were like ‘yeah but she’s Aboriginal’. And I was like ‘no she’s in acute renal failure’ she had normal renal function a few months ago ... this is all new ... I guess the urgency of this patient, in renal failure, wasn’t really there. Because it was just assumed that it was chronic ... when it was really just acute renal failure.

Study participant

I think something in the forefront of my mind is the different spectrum of disease you might see in Aboriginal people. So working here I’m presuming that most people have got some sort of renal impairment of some type.
These statements encapsulate the shift in perceptions of normal, which can be reflective of disease burden and environmental context. This has obvious implications for health care and health outcomes, with the level and timing of intervention being influenced by these perceptions. On the contrary, having an increased awareness as described in the second quote may potentially work toward better health outcomes if practitioners are vigilant to prevalent conditions in Aboriginal populations. That said, an increased vigilance in recognising disease should be then accompanied with equitable management once the disease or abnormality is identified. The tendency to implement different management plans on identification of pathology was discussed by a number of participants, in the context of a range of abnormal results including; abnormal liver function tests (LFT's), blood sugar levels (BSL's) and glycated haemoglobin. For example:

Even with some of the results that you get, I did six months in private practice and I feel it’s like the goalposts are slightly shifted. So say if a person with slightly deranged LFT’s, in private practice, the gamma GT is just a bit up or if they are a bit off, in private practice you would get them in and talk to them about it, maybe order a liver ultrasound and all these kind of things. And then when you are working in an AMS the gamma GT is a little bit up, and the ALT is maybe a bit up you’re just like ‘oh well, that’s just, that’s normal. Oh look, it’s not over 500!’ It’s down in the single digits, that’s really good. I don’t really know why that is and definitely don’t think that it’s a good thing at all.

If I had a BSL of 40, the treatment is different. I’m going to land in definitely some sort of hyperglycaemic coma or something. But these people they get used to it. So some people, seeing the random BSL of 25 the rest are to hospital but that is not the treatment, because their body got used to it.
... it's not so much difference in term of the medicine itself. But the picture is different. How complex the disease, how you treat it I mean we see these glycated haemoglobin of 13, 12 or 13 plus, we don't see it in the mainstream.

Study participant

It is not only investigations that are managed differently. As one participant observed

... sometimes I see the kids sitting here and I'm like 'oh they've got nits.' And, you're like, is it worth treating? You know they are just going to go back home, where there's more kids with nits. Which I know happens at home as well but I find here, everyone's got scabies, everyone's got, not everyone. But a lot of that just comes to be normal I guess... not that it's normal but it becomes to be expected.

Study participant

The described variability in management of pathology outlines how a 'shifting of the goalposts' can occur when perceptions of normality become altered. The first participant quote details a clear difference in the threshold for resource allocation between a private metropolitan general practice and their current area of work. The inability to reason why this occurs could be due to the multifactorial nature of this process, or could reflect a discomfort in recognising potential influential factors toward this process.

It is difficult to say definitively whether alternate management reasoned for complex patients and those with perceived tolerance will maximise or limit opportunities for better health outcomes, as noted in the second and third statements. The final quote above provides a clear example of limiting access to health resources (head lice treatment), secondary to perceptions of normality and likely re-infestation due to a high prevalence of disease. It suggests a multifactorial issue, whereby health service providers are struggling to have the resources to achieve the health outcomes they want. It raises issues around the provision of resources in challenging scenarios, and considered further in the next sections of this thesis addressing patient-centred care.
In this section a number of important issues have been raised, namely, whether patients will receive better care if they are perceived to belong to a different population group or access services in a different environment. Also, does the process of normalising poor health disadvantage Aboriginal patients accessing healthcare, or promote good health outcomes? The following section considers further participants’ comments in relation to normalising poor health and its role in contemporary medical practice.

**It’s a bit of an easy way out**

Normalising poor health, shifting practitioner expectations and changing thresholds for intervention was considered by participants to be an easy way out for practitioners, resulting in the potential for patients to at best receive less than ideal care and at worst to be ‘written off’. Frustration and burnout were highlighted as contributing to this occurrence, hinting at the relevance of the combination of practitioner and setting structure in this process. Participants discussed a need for practitioners to always have best practice standards in mind, regardless of the patient.

> I think it’s good to recognise that’s what happens but I don’t think it’s good to expect it. Particularly not for young people. I think well, not for anyone but someone who’s got their whole life ahead of them, deserves to be treated just the same as you would treat anyone else. I think that if somebody really is motivated to take care of their health then they should be encouraged to do so … people just get written off, and I really hate that. So it’s a bit about recognising the patient in front of you and not … putting them in a group … but it happens a lot and that’s really frustrating.

*Study participant*

I think by normalising poor health, it makes it a little bit too easy to just say … to not aim high enough. To not really go no we actually can make this better, it’s just a matter of finding the motivation for this particular person, or recognising the barriers and trying to help them … I think it’s a bit of an easy way out going ‘oh well. Close enough is good enough.’… So if you just assume, if you have a lower standard that you are holding yourself and your patient’s to, because you expect poor health
then ... there is no way you are going to achieve the outcomes that you might otherwise set for other patients.

Study participant

I think it's probably frustration with those other patients, possibly, which is also I think it's important to learn how to let go of that because, people do things for a wide range of reasons. And you can't take it into your next consult with another patient. So I think it's probably cynicism and frustration and maybe a bit of burnout. I've seen some people that probably used to try a bit harder to take each case as it comes. And then they get burnt out. And they don't recognise that and they don't do something about it.

Study participant

The preceding quotes reinforce the combination of factors at play here; frustration, burnout and assumptions based on past experience leading to stereotyping. As noted earlier there are a range of contributing factors that include practitioner, setting and resourcing issues.

5.5 Not losing hope

Medical decision-making is a difficult process to engage in, particularly when practitioners have multiple demands and multiple constraints on their ability to do so such as; patient load, previous experiences, time availability, context and available resources. The difficulty in balancing practitioner expectations of health outcomes in a population with such a high burden of disease was evident as participants mention at times feeling jaded and defeated. Despite this, the second participant’s comment of the 'light at the end of the tunnel' reassures there is still hope in the medical profession for better health for Aboriginal peoples.
I think sometimes I can slip into sort of defeatist attitude. So I need to pull myself out of that. I still feel like there is a sense of optimism that even though anaemia and skin sores and ear problems in kids is very common, I still feel we have this sense of optimism that we can do something about this. And there might be some light at the end of the tunnel. So I hope, I hope I don’t slip into that expectation. But having said that you have to acknowledge the burden of disease in Aboriginal populations is so high, so I guess it’s balancing that. Acknowledging the problem exists but not losing hope.

Study participant

This chapter has provided evidence of the increasing need to find ways of capturing that 'light at the end of the tunnel’ and growing it into an achievable reality. The acknowledgement of a high burden of disease in combination with hope for a healthy future for Aboriginal peoples is a goal to strive for in medical practice. How this goal is to be achieved requires a shift in attitudes and understanding. Namely, from relying on data and short-term outcomes to actions that support and promote long-term health benefits. Particularly given that the reliance on data and outcomes can be considered to be a disadvantage in efforts to close the gap in health disparities experienced by Aboriginal peoples.

As medical practitioners and doctors we are trained to look at data. And we know from the past experience, the data shows it’s poor health outcomes ... and despite our best efforts to close the gap, we know that the outcomes are poorer when you compare like to like with the Aboriginals versus non-Aboriginal. So that’s what you expect, because that’s how your brain is trained ... Then you’ve got to think one step ahead to say 'how do I actually make the outcome better’, and that’s where I think we should try and focus as a community. Because we are so used to the way we are medically trained is look at the data. The outcome is poor, and then you seem to accept that ... So there should be a paradigm shift as what we think.

Study participant

When the goalposts are shifted, so should the paradigm of practitioner’s perception of health. Existing focus on data and outcomes needs to transfer to a focus on ways to improve health outcomes for Aboriginal populations in the long-
term. The ability to think one step ahead was noted to be difficult in an environment that favours short-term outcomes, as outlined by the following participants’ remarks.

... you are trying to work in an environment where the 'now' is so important ... trying to get current or future practitioners to understand that, that the now is only relevant if you have it in the context of the future, and how are you working to enable the now to make the future better, rather than the now to be a be all and end all

Study participant
Chapter 6 - ... who is the individual in front of you

We need to be able to deal with the explicit decision-making so that the explicit decision-making is well grounded. It’s grounded in theory, it’s grounded in practice, and it’s grounded in the reality of people’s lives.

Study participant

The complex, multifactorial nature of the factors that influence health outcomes of Aboriginal peoples is evident in preceding chapters. In light of the complexity of the topic, emergent themes regarding solutions and ways forward were present in the interviews. In seeking to achieve the ‘paradigm shift’ referred to above that will enable a greater focus on the future as well as the present draws on the solutions participants proposed. Namely, the common threads that centre on ways to implement best practice and enhance meaningful practitioner engagement in Aboriginal health, which surround core notions of patient-centred care.

In the previous two chapters variations in management regimes and resource allocation for Aboriginal peoples in a health field were considered. Further the implementation of evidence based-medicine in context of patient reality was raised as a key strategy for change. The ability to gain an accurate understanding of a patient’s context and health-related behaviour was considered by participants to be an important influence on clinical decision-making. Also noted is the importance of looking beyond ethnicity to see patients as individuals:

... appreciating the individual, rather than just, ‘I’m working with an Aboriginal person’. Yes that’s part of it but who’s the individual in front of you.

Study participant

In brief, patient-centred care addresses patient needs and concerns, seeking an understanding of their world as a whole. (Bauman, Fardy et al. 2003) This includes the emotional, social and physical aspects of the patient, along with establishing common ground on medical issues to achieve a shared understanding of ways forward and meeting patient priorities for health. (Bauman, Fardy et al. 2003) The
value in meeting patient priorities and creating partnerships in care is communicated in the following participant comments.

If you can just try and figure out, what their story is and what their priorities are, and they are often different to the doctor’s priorities. Just trying to figure out how to meet in the middle.

Study participant

If you are actually treating the individual in front of you then, yes there’s some people that you’ve got to take your little wins that might not be ... the improvement in their health that you want to see. But it’s communicating on a level that they are going to implement, that you are going to find the area ... that they're happy to come along with you on that journey.

Study participant

The described concept of ‘meeting in the middle’ is a good example of efforts to minimise paternalistic approaches to care, building patients’ ability to become empowered in their own health. Ensuring patient needs and priorities are met during doctor-patient interactions is not always a straightforward task, and can be difficult when patient priorities differ to those of the medical practitioner. Differing health priorities of patients need to be recognised and accepted by the practitioner because, as described, it assists the practitioner to develop expectations that reflect the reality of the patient. The ability to do this effectively requires practitioner’s to look past any assumptions they may hold, and to take each patient as a unique individual, within the broader context of which they live. Participants considered this notion in the following statements,

... you don’t consider them as an individual, you look at their family situation and then make a decision ... Are they being carers for very young kids or being supportive partners. So that’s a crucial element, you’re never treating the person it’s the whole family dynamics that’s involved.

Study participant
I mean this is all patients’ really not just Aboriginal patients. But I think, where somebody comes from is really important, and so what their, where they come from and who they have got at home and what their background is. And that’s not just Aboriginal patients that’s all patients. But I think that’s something as doctors that we often kind of forget about.

Study participant

The idea that medical practitioners ‘forget’ to explore the context of the patient could be a key contributor to disparities in Aboriginal health, particularly when patient context can be very different to that experienced by the practitioner. One participant sharing the impact of exploring the reality and context of patient’s lives made the comment that they often ask after they have taken someone’s history:

... did you take a social history? And they say ‘oh yeah, drinking and smoking, where do you live’. And I say ‘did you take a real social history?’ Because I reckon if you ever take a real social history from an Aboriginal patient you burst into tears.

Study participant

This statement may reflect the health and social inequalities experienced by Aboriginal peoples, or the traumatic historical context that impacts many people today.

Appreciating patients as individuals can counter-act potential pitfalls from the use of assumptions in an Aboriginal health context. Participants explained how assumptions have significant impacts, with one sharing an experience of a patient going as far as to demand them practitioner to be mindful of this. The link between assumptions, perceptions of reality and effective communication is expressed in the following statement.

I guess appreciating the same as any patient that the person in front of you is an individual, so not bringing too many assumptions in. Because it is easy to assume either way. Assume that they are going to understand everything you say ... or to assume exactly the opposite ... To think this person is not going to understand what I’m suggesting or not going to be capable of following my instructions so, with any
patient trying to get an idea of where the individual in front of you is at. But then also appreciating some of those challenges and making sure that whatever plan you're suggesting is well communicated and well understood.

Study participant

The difference between eliciting patient needs and capabilities against practitioner assumptions of these needs and capabilities is a key understanding here. This is particularly relevant in a patient-centred approach where the patient rather than the practitioner holds the power in decision-making regarding their health. The powerful statement concerning a patient’s need for acknowledgement of life experiences and ability to cope with medical advice hints toward the ongoing negative treatment Aboriginal peoples continue to experience in modern day society. Such negative treatment, discussed in Chapter five in relation to institutionalised racism, needs action if health equity is to be prioritised. In added support of the argument for patient-centred care, participants spoke in the interviews about patient empowerment in health decision-making.

6.1 ... the patient is the decision-maker

... the assumption that someone you are seeing ... that their only priorities are health. Not being able to understand that there are multiple obligations and multiple priorities. And part of our role as practitioners is to enable health to become a priority without people ignoring their other obligations

Study participant

Involving the patient in decision-making processes is a key step toward both achieving good health outcomes and enabling self-determination. Empowerment of Aboriginal patients to be the decision-maker in their own health is critical, particularly when many basic rights and freedoms have been restricted in previous times. Two participants’ capture the importance of patient’s being the decision-makers to allow empowerment and better health outcomes in Aboriginal communities in the following comments,
... the patient is actually the decision-maker in the relationship. But often despite power in the relationship, might lead an Aboriginal patient to just agree with what they think the doctor wants from them. And it can take quite a long time, the process of decision-making in a situation where someone is feeling disempowered.

Study participant

The same participant further commented on this issue:

I think bad things have happened in the past where Aboriginal people haven't been the decision-makers in their own health, and sometimes it's born out of practitioner frustration when they feel like ... they want to make the decision for them because they feel like they want to make the decision that is going to make them survive, but ultimately you can't make another person's decisions for them.

Study participant

The opening quote in this section reflects a key point in regards to the tension that can occur between patient realities and priorities and practitioner expectations of health. Patient empowerment in decision-making allows for patient realities and personal obligations to be considered in the health consultation. An understanding of these will arguably improve the practitioner's capability to provide care that will achieve best outcomes. The first quote also links together previously discussed points around the importance of setting structure, time availability and effective communication; as without time, the capacity for patients to become empowered in a health interaction likely becomes restricted.

The task of clinical decision-making is complex, cognitively demanding and subject to a range of influences. The capacity to be able to manage the frustration that can arise when there are different priorities and expectations between patients and their practitioner is an issue that requires attention in the health field.
Creating change for the long-term

Practitioner frustration was considered by participants to have a significant presence when working in Aboriginal health. This frustration was perceived to result from difficulties in communication and expectations for patient behaviour. A necessity for appropriate strategies to manage practitioner frustration was voiced in the interviews, to enable practitioners to continue to provide best care in this field. One participant reflects on these feelings in the following statement,

So sometimes you find yourself frustrated because you can’t, you’re struggling to communicate someone, or someone seems not to be responding to what you think something really important is.

Study participant

Experiencing frustration increases the potential to limit patient opportunity for empowerment, as patients may be dismissed in health interactions. Practitioner dissatisfaction arising from expectations for patient health not being met was raised in the interviews. Issues of non-adherence by patients contributed to this frustration. The ability to move beyond the frustration of the moment towards establishing long-term goals was viewed to be a necessity in good healthcare.

... rather than just thinking of this person has this problem is like... why didn’t they come back in, or because you know this has happened at home and all this sort of stuff, so its not kind of taking it on, so you don’t take it to heart. Or kind of dismiss them ‘oh they didn’t come back, this person didn’t care’. Just other stuff happens ... couldn’t get their kids to school that morning was more of the problem than coming back and getting their own health checked...

Study participant

... being able to acknowledge the frustration of the moment, but not to let the frustration of the moment take away the importance of having an achievable long term goal. Because it’s about creating change for the long term rather than getting frustrated with the obstructions of now.
The ability to not ‘take it to heart’ and retain long-term visions for patient health appears to be an ideal strategy for practitioners when faced with challenging or frustrating times. Having a supportive workplace and peer networks that enable practitioners to understand the reality of the context in which they work was mentioned to be highly influential in countering frustration. Access to mentors and peer groups for de-brief sessions were suggested as ways to help practitioners manage assumptions and expectations as well as minimise potential burn out. For example,

I think that mentoring ... people working in Aboriginal health is very important. You need to have someone to help you put things in context. Because, otherwise you either go in with all this optimism that you are going to change things and get really burnt out really quickly, or you need to have someone to help you manage expectations ... when you see something terrible ... you need to be able to have a peer group to do a debrief in. And I think that having people experienced in Aboriginal health mentoring you and a good peer group is one of those things that made a lot of us want to stay...

The need to manage practitioner expectations is apparent in this thesis, as it has been viewed to impact on decision-making and likely ongoing engagement in Aboriginal health. As communicated above, experiences with disappointment and frustration make further efforts at work tiresome, which is a detrimental process if Aboriginal health outcomes are to see a meaningful improvement. The importance of solid support structures for practitioners is clear in these examples.

So far I have considered a number of themes arising during the interviews including, how personal attitudes, values, previous experiences and assumptions for the future all contribute to decision-making processes. This is in combination with the influence of the work environment and the understanding of different disease and risk profiles. The complexity of this in an Aboriginal health context is
such that one participant argued that it was sufficient to warrant a new medical specialty.

... there should be a specialty called Aboriginal Torres Strait Islanders specialization ... geriatric is a medicine, but it is specifically for the elderly ... It is the same with Aboriginal and Torres Strait Islander’s, because it’s medicine ... tailored toward these specific clients, because of the differences in their complexities. The prevalence and the incidence of the disease if you come to diabetes, there is more prevalence ... so you need a specialty to look after that.

Study participant

Identifying a need for an Aboriginal health Specialty, as stated above, conveys the complexity and high priority nature of this area. Whether a recognised medical specialisation would encourage medical practitioner engagement in this area of need is difficult to predict. It may allow for a wider appeal to medical practitioners if accompanied with financial and career incentives. Already looked into in this thesis are potential barriers for engagement, including fear of complexity, association with rural health, burnout, negative stereotypes and attitudes toward Aboriginal health in addition to time and resource availability. Extending the discussion on engagement are participants considerations around what promotes practitioners to become involved in this vital health field.

6.2 Factors promoting engagement in Aboriginal health

... that solidity of understanding ...

Looking into potential influences on engagement and decision-making in this area has revealed notions of prejudice, frustration and challenge balanced with proposed solutions of working with Aboriginal people, supporting community controlled service provision and implementing patient centred care. The next section provides an account of participant thoughts of what promotes engagement in Aboriginal Health, and the need for further understanding of how diversity influences health care provision.
Recognising and valuing concepts of resilience, strength and adversity were discussed in the interviews, highlighting the significance of the importance of having an awareness of Aboriginal people’s context. Resilience is a characteristic that can be found in different forms around the world. (Kirmayer, Marshall et al. 2011) From an Aboriginal perspective, resilience has been defined as:

The ability to have a connection and belonging to one’s land, family and culture: therefore an identity. Resilience allows the pain and suffering caused from adversities to heal. It is having a dreaming, where the past is brought to the present and the present and the past are taken to the future. Resilience is a strong spirit that confronts and conquers racism and oppression strengthening the spirit. It is the ability not just to survive but to thrive in today’s dominant culture.

(Kickett 2011, p. 2)

Witnessing and acknowledging resilience displayed by Aboriginal people in contemporary society was noted to be a key factor influencing engagement in Aboriginal health. Looking closely at the above definition it can be seen how resilience might manifest in several forms. The following quotes are examples of some that were mentioned in the interviews, with one participant looking at the power of humour in demonstrating resilience.

I try and remember. I think it’s just the humour in Aboriginal patients that I’ve found works ... I’ve never known people to have such an amazing sense of humour under trying circumstances.

Study participant

You see someone that’s had so many horrible things happen to them. I guess that sort of makes us ‘how are you functioning at all’ with some of the stuff that’s happened. It’s definitely a lot more sort of, tragedies and things that going, than sort of I guess, in most other people.

Study participant
The acknowledgment of difficulty and tragedy affecting people’s ability to cope with day-to-day life demands are encouraging progressions toward a more just and fair society. As brought up previously, historical events continue to play an ongoing role in people’s lives today. Recognition of this within the medical and wider community is a key step in reconciliation and equitable outcomes for Aboriginal peoples.

Recognising resilience provides another opportunity to outline how notions of equality and equity can be quite different. Acknowledging resilience in light of the historical and political context of the Aboriginal community could be viewed as a form of differential treatment. This type of differential treatment however has a strengths based approach; it does not withhold resources or limit opportunities for health but promotes better awareness of the reality of individuals. A struggle to embrace this notion was demonstrated by a participant,

I think you know that for her, it must be pretty difficult for her, as an Aboriginal to actually rise above everything else. I don't feel they should be treated any different from anybody else. But with them I think we just need to emphasise that they’ve actually done very well.

Study participant

Whilst recognising resilience is expressed in this quote, this view may be interpreted as having elements of paternalism, and lacking awareness of the contextual factors limiting Aboriginal people’s ability to thrive in our current society. It provides another representation of the use of polarising and incorrect terms of reference to Aboriginal peoples; ‘them’, ‘they’ ‘as an Aboriginal’, which have been continuously met throughout this thesis in the results and literature review chapters. Such terms of reference warrant attention within the medical community, as language can reflect beliefs, values and cultural contexts. (New South Wales Department of Health 2004) Language that both promotes and develops positive relationships and perceptions of Aboriginal peoples needs to be embraced to facilitate a socially inclusive and equitable society. (New South Wales Department of Health 2004)
That concludes the presentations of the results of this thesis. The following chapter will provide a deeper discussion of these results, followed by recommendations to the medical community and wider society to assist in the achievement of equity in health for Aboriginal peoples.
Chapter 7 – Shifting the gaze

... the framework of the way we practice Aboriginal health ... it's a really western model. We don't always consider if what we are doing is actually best practice for the patient's whole wellbeing, even though that's what we should be doing ...

Study participant

In this chapter I will look closely at the observations, perceptions and viewpoints shared by participants throughout the interviews, identifying key outcomes of the research aim, which was to explore influences on best practice and engagement in Aboriginal health. The previous results chapters provided evidence and examples of the key emerging themes; unequal treatment, importance of communication, notions of adherence, role of the self and conflicting realities, normalisation of poor health and finally, the value of patient-centred care and respect for diversity. These key themes guide the following discussion, addressing the research aim to investigate what influences best practice and engagement in Aboriginal health.

7.1 Participants

Study participants were a diverse group of practitioners with varying levels of clinical experience, area of expertise, and location of training. The majority of the participant group were confident in their ability to provide health care services to Aboriginal patients. I acknowledge the possibility for bias to impact on these results, as participants may feel embarrassed or reluctant to admit a lack of confidence, particularly if this is perceived to reflect their level of competence as medical practitioners.

The majority of participants identified experiencing targeted Aboriginal health education in their postgraduate careers, a positive reflection of increased recognition of Aboriginal health issues in our society. It is difficult to comment on the content and amount of individual targeted training, as this was not a particular focus of the research. Despite indications of Aboriginal health training, there was a
clear desire for participants to learn more about this field. This demonstrates how even for confident practitioners in Aboriginal health, there is an ongoing need for further learning and professional development.

This is not dissimilar to the dynamic nature of the medical field, and the necessity for practitioners to remain up-to-date with current knowledge and skills. Time availability was a key factor impacting the uptake and provision of Aboriginal health education and training opportunities. Organisations and structures that both promote and accommodate for ongoing professional development in Aboriginal health is an identified area of need.

The viewpoint of how skills acquired in diversity training are applicable to a broad range of patients from diverse backgrounds enhances the value of potential tools to facilitate the development of these skills. As indicated in the research, practitioners skilful in Aboriginal health are better able to implement these competencies widely to the benefit of all their patients. This is supported by social constructionism arguing universal experiences such as pain and death are interpreted within the historical and social setting of occurrence. (Lupton 1994)

Having skills in managing diversity and developing awareness of the impact of context on health experience may work to build better health outcomes.

Participants generally agreed that poor health outcomes in Aboriginal patients were a normal expectation within the medical community. This could be interpreted to reflect an overall view of the medical community regarding Aboriginal health. Expectations of poor health provide an insight to the struggle for equity that continues to impact the effective delivery of healthcare to Aboriginal peoples. If every person has the right to good health, poor health should never be a normal expectation. This highlights the urgent need for a fundamental change in perceptions of our health community toward Aboriginal patient outcomes. Origins and implications of these perceptions were discussed as the result of a reliance on statistical data in the health field, inaccurate representations of patient reality and previous health experiences. This struggle for equity impacts Aboriginal patients and on medical practitioners delivering care to Aboriginal communities.
The diversity in participant characteristics (age, gender, career) reflects the diversity of our current medical profession within the community. (Australian Institute of Health and Welfare 2014) Diversity is to be celebrated and encouraged, both within the medical profession and the community. (Australian Medical Council 2014) Strategies that work toward achieving a healthcare system respectful of diversity for all patients, regardless of ethnicity, are critical. Even with diversity, agreed perspectives of current issues can be obtained. Regardless of personalised influential factors such as attitudes and upbringing, similar experiences and views in this field were found in the interviews. This suggests the possibility for agreed future solutions on key Aboriginal health issues that can be implemented by a diverse group of practitioners. One of these key issues identified in the interviews was that of the presence of unequal treatment of Aboriginal peoples in the health system.

7.2 Unequal Treatment and Institutionalised Racism

Institutionalised racism refers to the differential treatment of patients based on ethnicity, resulting in restricted access to resources, opportunities and services. Experiencing institutionalised racism impacts on the ability for patients to achieve good health outcomes. It is critical to understand that unequal treatment is not always considered to be institutionalised racism if it enhances health opportunities for individuals. (Berman and Paradies 2010) For example, in the interviews a practitioner commented that he/she would probably give antibiotics to an Aboriginal child suffering from a viral illness compared to a non-Aboriginal child. The reason for this was based on the practitioner’s knowledge of otitis media in the Aboriginal community and the seriousness of this condition for Aboriginal children.

Similarly, equal treatment can become a form of institutionalised racism when a path of unequal treatment is the fairer and just option, as described in the above example. (Berman and Paradies 2010) It is of benefit to consider more closely the difference between unequal treatment and institutionalised racism, and the difference between equity and equality. Exploring how social justice and respect for diversity is taught in training institutions, and the impact this has on institutionalised racism, could be a useful future research pathway.
The need for institutionalised racism to be addressed within the health system became clear in this study, as its impact on service delivery and resource allocation for Aboriginal communities was a common thread in the interviews. Unequal treatment was found to spread across different aspects of medical practice; referral, admission, treatment, communication and service delivery. The institutional nature of unequal treatment reveals the importance of service structure and organisational ways of working in facilitating and allowing racially based treatment to occur unaddressed. This provides strength to the viewpoint of health systems failing Aboriginal peoples at a fundamental level. (Durey, Thompson et al. 2012)

The difficulty in discussing institutionalised racism likely stems from the denial and dislike of the existence of this issue in the wider community. There was a reluctance to discuss racism in the interviews, with not all participants reflecting on the problem, and those that did commonly having difficulty explaining its cause. This is not unexpected, as the existence of racism in Australia has been recognised as both controversial and commonly misunderstood. (Berman and Paradies 2010) It could be argued that the relative lack of discussion of this issue by some participants indicates that institutionalised racism is rare or absent in their workplaces. It is difficult to definitely explain this either way given the scope of this study, however one participant clearly stated it to be a common occurrence, which is in concordance with other research findings. (Larson, Gillies et al. 2007, Paradies and Cunningham 2009)

Shared experiences of unequal treatment consisted of observations of others and reflections of practitioner's own behaviours and views. The potential implicit nature of unequal treatment was evident, along with the many influential factors leading to its occurrence. Whilst this does not excuse institutionalised racial behaviour, it provides some reasoning as to why it occurs. Further research into the presence of institutionalised racism in health care services would add to our understanding of the role this plays in the health system. Observational research methods exploring institutionalised racism within organisations could add to the value of this study’s findings.
Key factors identified during this research that contribute to unequal treatment included; conflicting realities, time availability, communication barriers, expectation of poor health, setting characteristics and perceived prejudicial attitudes. These factors provide a deeper understanding of how actions can result in discrimination in the absence of overt racial motives of the individual. This is a central point to be made when addressing this issue, as it would be both inadequate and inappropriate to target individuals based on observations of their behaviours when influences stem from a number of levels. This does not diminish the responsibility of the practitioner to practice in an equitable and just manner. A realistic approach to the issue needs to acknowledge the wider influences on practitioners that facilitate undesirable behaviour.

When exploring ways to address institutionalised racism, the concept of organisational change and social construction is raised. (Emirbayer and Johnson 2008) Researchers exploring the writings of Bourdieu provide guidance here:

> The only way to bring about organizational change that does not entail merely replacing one modality of domination with another is to address specifically and to undo the mechanisms of dehistoricization and universalization – "always and everywhere has it been this way" – whereby arbitrary workings of power are enabled to continue.

(Emirbayer and Johnson 2008, p. 31)

To effectively address racism, organisational structures need to embrace respect for cultural diversity. This involves health service’s policies, practices, attitudes and awareness toward respect for diversity within that organisation. This also includes organisational attitudes toward institutionalised racism and practices that address and minimise this issue. The shock at the relative ease of acceptance within the health system of a lack of treatment options for Aboriginal dialysis patients living in remote areas is one example of the ongoing need for health services to be respectful toward patient diversity and uphold equitable values.

This exemplifies the attitudinal change toward resource allocation and ways of living that needs to occur in order for Aboriginal communities to experience better
health and health care outcomes. Such fundamental issues require organisational leaders to take initiatives and implement strategies that enable health service provision to facilitate improved outcomes for diverse groups of patients. Successful initiatives include partnership with Aboriginal health practitioners, provision of culturally appropriate health information, community engagement and accessibility. (Abbott, Davison et al. 2010, Marley, Dent et al. 2010) These initiatives have proven to improve patient outcomes, patient satisfaction, quality of life and adherence. (Marley, Dent et al. 2010)

There was a perceived influence of popular culture and media on negative myths and stereotypes, an unfortunate circumstance that needs attention for the Australian community to embrace equality and justice. Such viewpoints may also hint toward the ingrained separation of Aboriginal peoples from the rest of Australian society. The issue of racism is being addressed with the recent introduction of the National Aboriginal and Torres Strait Islander Health Plan, which states a key priority to be ‘free of racism and inequity’. (Department of Health Australia 2013) One of the strategies in the Plan includes implementing, promoting and building on good practice initiatives to prevent and reduce systemic racism. (Department of Health Australia 2013)

Recent observations of the Racial Discrimination Act being suspended allowing for discriminatory legislation to be passed demonstrate the need for a collaborative commitment to eliminating institutionalised racism at all levels. (O’Mara 2010) The findings of this study are consistent with this key priority of the National Aboriginal and Torres Strait Islander Health Plan.

Positive steps are being made in contemporary society to tackle racism. In 2012 the National Anti-Racism Strategy was developed by the Human Rights Commission, with the aim to raise awareness of this issue, its impacts and how we as a community can tackle the problem. (Szoke 2012) Part of this strategy utilised the media with key Australian figures, to promote widespread awareness across the community. (Szoke 2012) I argue that these are key steps forward in promoting a more equitable Australian society, and that these steps need to be solidly supported and maintained.
As discussed earlier, institutionalised racism is a complex issue needing to be addressed at multiple levels in order for fundamental change to occur. Policies and practices that promote health opportunities and resource allocation reflecting level of need are to be encouraged, along with processes that ensure organisations and structures are respectful of patient diversity. A better understanding of unequal treatment and differences between equity and equality may assist practitioners in their decision-making processes to support best practice implementation.

Further research into effective strategies to promote respect for diversity both at the individual and organisational level is needed. Such strategies may include organisational policies and interventions as previously described, in conjunction with medical training programs (at pre and post graduate levels) aimed at addressing these core issues.

### 7.3 Importance of communication

The role of communication is crucial in medicine, being the cornerstone to best practice implementation. (Cass, Lowell et al. 2002) It is correlated with improved patient health outcomes. (Stewart 1995) The results of this research have demonstrated how communication can play a key role in unequal treatment, both influencing decision-making, interpretation of patient symptoms, interpersonal style and health-related behaviour.

Influencing factors on a practitioner’s ability to communicate effectively include personality, personal style, background context, education and training and the surrounding environment. Participant reflections of poorly performed communication demonstrate the importance of this process, and the potential impact it can have on patient experience with health services.

For one research participant discovering that they were not communicating with their patient was an ‘eye-opening’ revelation, highlighting the importance of reflexivity and the ability for this issue to be recognised and addressed by individuals themselves. This shows the potential for practitioners to adapt their communication style to suit patient needs, a skill that is highly desirable within
practitioners and organisations. It is also consistent with the notion of continuing medical education required by all specialty colleges.

This idea of adapting communication style to suit the needs of the patient in essence refers to patient-centred care; whereby practitioners take each patient as an individual, exploring the world in which they live to ensure health services are delivered effectively. (Stewart 2001) Rather than leaving practitioners to discover episodes of poor communication on their own, strategies that encourage practitioner monitoring and evaluation of communication effectiveness may lead to better health outcomes. Research exploring the effectiveness of various strategies monitoring and evaluating patient-practitioner communication would be a useful addition to this research project, whereby views and experiences are translated into practice.

Adding to the above, effective strategies promoting good communication skills in medical practitioners need to be supported at an organizational level to ensure communicators have the resources available to implement their essential skills. The impact of time availability, staff, and patient case-load were all identified in the interviews to impact on a practitioner’s ability to communicate effectively with patients and therefore achieve best practice standards. Notions of disempowerment provide further understanding to the need for increased time to effectively communicate and implement patient-centred care. Given Australia’s historical context, it was commented in the interviews how people who have suffered marginalization and disempowerment from institutions need time to regain trust of the system and participate within the decision-making process.

Other recent Australian studies have identified episodes of substandard communication between Aboriginal patients and non-Aboriginal practitioners. (Cass, Lowell et al. 2002) Key contributing factors involved lack of patient empowerment, dominance of biomedical models of knowledge, along with cultural and linguistic barriers. These findings were replicated in this study, with participants describing how the Western framework of medical practice found in many organisations does not always meet the needs of diverse patient ways of understanding health and living. Organisations and practitioners that explore patient health holistically, strive to improve health outcomes by embracing the
diverse needs that can be experienced in contemporary society.

In chapter two I discussed literature supporting the proposal that practitioner behaviour can have strong influences on patient expectations for future care and subsequent health seeking behaviour. (Van Ryn and Fu 2003, Van Ryn, Burgess et al. 2011) Experiences of poor communication and less than ideal treatment in a health service can impact patient adherence to health related advice, whereby the practitioner and the health structure are contributing to less than ideal health outcomes. Participants shared stories about Aboriginal people not receiving follow-up or being refused admission to receive care, which can have immediate health implications. How these experiences impact on an individual’s expectations for themselves, and views for opportunity to access good healthcare in the future could provide a meaningful follow-on research area from this study.

Understanding around the problems and solutions regarding effective communication are deepening. The medical community now needs to direct its attention on how to address this key issue in health service provision. As discussed, study participants reflected on the importance of effective communication to engage in patient-centred care. Strategies that promote this lie at both the individual practitioner and organization level, with high priority placed on ensuring effective organisational structures to support and facilitate change at both the practice (service delivery) and policy levels.

Looking further at the role of organisations and their influence on communication, structures that facilitate poor communication and a relative lack of respect for patient diversity are obvious areas requiring further attention. A shift away from the biomedical framework of health that allows a greater capacity for better meeting diverse needs and health viewpoints is necessary if Aboriginal health outcomes are to see a significant improvement. Such resources include adequate staff, recall systems, availability of time and funding to allow frameworks of health care and service delivery that cater for the diversity of needs in our current society.

Analysing service delivery designed to meet the needs of Aboriginal peoples is a way in which to better understand the power relationships that exist between
Aboriginal peoples and non-Aboriginal health service provides. As explained by Foucault:

For example, to find out what our society means by sanity, perhaps we should investigate what is happening in the field of insanity.

(Foucault 1982, p. 780)

Examples of structures that facilitate effective communication, promoting patient-centred care include Aboriginal Medical Services, which are controlled by the local Aboriginal community. These organisations address key issues including time, respect for diversity and holistic frameworks of health. The ability to cater for patient diversity in these services result from their control by the community served. It is a very simple principle that an individual's needs are best understood by individuals themselves. Organisations that aim to empower patients to determine their own health will inarguably provide better healthcare, than those that don’t recognise this as a valuable principle. This favours the view that good communication requires a power shift from the practitioner to the patient.

(Stewart 1995)

Current trends supporting 'mainstream' health services over Aboriginal Community Controlled Health Services go against the essence of respect for diversity. (Alford 2014) Health services that meet the needs of a select group of people are not equitable for the whole of society, providing argument for diversity in service provision in Australia where needed.

7.4 Notions of Adherence

Patient adherence continues to remain an ingrained issue within Aboriginal health. 'Compliance' was used frequently in this study, despite recent shifts that challenge the appropriateness of this expression. These shifts are due to the increasing recognition of negative connotations of patients associated with this term. (Humphery, Weeramanthri et al. 2001, Benson 2005). The idea of non-adherence is closely linked to effective communication and unequal treatment, and again reflects the critical importance of organisational structures and ways of working addressed above.
Perceptions of adherence were discussed in chapter four, which highlighted how this notion impacted practitioner decision-making regarding Aboriginal patients to prescribe oral versus intravenous medication, to admit patients or send them home, and whether to care. The strong influence of this concept of ‘compliance’ on decision-making appeared to remove focus and effort away from exploring patients as individuals, minimizing engagement in patient-centred care. It also shifted the gaze from practitioner to the patient in an unfavourable way lessening the likelihood for reflection on own ways of practice.

Drivers of non-adherence regarding patient behaviour lie in health service delivery and professional ways of working. It is a vicious cycle beginning with health service provision and perpetuated by organisational structures, described by one participant as ‘self-fulfilling’. The example of different population groups preferring to attend different health services is a very clear example of how health services can have varying levels of respect for patient diversity and patient acceptability. This demonstrates how structure influences patient opportunity for health, and also opportunity to be empowered to adhere to medical advice.

There were mixed views regarding patient adherence found in the research, reflecting varying levels of understanding about its causes and impacts. Participant views ranged from opinions based on observations that patients don’t care about their disease to reflections about how care may have been optimized through better structures and communication processes.

The reflection of one participant regarding their ability to form a good connection impacted on the patient adhering to their recommended advice reveals the importance for practitioners and organisations to take the time to reflect on practice and service delivery issues. In facilitating a discussion around these issues strategies could then be devised to bring about better outcomes at the individual and organizational level. Rather than thinking that patients simply ‘don’t know’ or ‘don’t care’, practitioners need to reflect on the opportunities provided to enable individuals to participate in health decisions.

Of concern in this research was the idea that non-adherence fosters ongoing restriction to health care another example of the cyclical impact of non-adherence
described above. Reluctance to provide services to patients who had either not attended or were not expected to follow medical advice further facilitates the ongoing cycle of poor health. Even more critical is the importance of practitioners recognising the structural role that lies at the heart of this cycle, and further explore strategies to minimise this.

7.5 Role of the self and conflicting realities

Personal aspects of the participants highlighted how individual characteristics such as upbringing, values, family and position in society impacted on decision-making and style of engagement with patients. This very personal role of the practitioner highlights the diversity within our health system, diversity that is to be embraced, encouraged and appreciated. When there is potential for conflict resulting from diversity, ways of working that promote best practice and respect whilst maintaining the values and style of the individual are required. This is another aspect of good medical practice.

While individual doctors have their own personal beliefs and values, there are certain professional values on which all doctors are expected to base their practice.

(Australian Medical Council 2014)

There is a need for caution here to ensure values that conflict with the achievement of equitable, best practice health care are minimised. Empathy and perspective taking are example techniques shown to reduce stereotypes and bias, whilst improving intergroup relationships. (Galinsky and Moskowitz 2000, Dovidio, Johnson et al. 2010)

Given the different historical and socioeconomic contexts across Aboriginal communities, the realities and ways of life can be very different for different people and communities. Looked at in this research is how service provision lacks a similar diversity, which can result in limited access to services for patients in addition to creating to barriers for effective engagement of practitioners in this field.

In this research I have explored how similarities in context between practitioner
and patient promotes good understandings of patient reality, influencing engagement and interpersonal interactions with Aboriginal people. Some participants discussed their experiences in coming from similar less advantaged backgrounds and understanding issues such as travel to large cities to promote their engagement with Aboriginal patients, as these experiences improved their ability to view issues from an alternate perspective.

In contrast to this, another strength that came through in this research were shared experiences of people who reflected how, although they came from different environments, different realities and even positions of ignorance, they had come to engage and enjoy working in Aboriginal health. Factors facilitating this shift in understanding included witnessing resilience in Aboriginal communities, forming connections with Aboriginal people and communities, and gaining an understanding of the burden of trauma and suffering that exists in communities as a result of ongoing impacts of historical displacement and marginalisation.

Also noted as important was a prior exposure to structured learning about Aboriginal health and health issues. In particular, learning about the Stolen Generation was specifically described to have a deep impact on practitioner understanding and interest in Aboriginal health, supporting the need for widespread community understanding of Australia's colonial history. This supports current literature on the positive effect of perspective taking. (Galinsky and Moskowitz 2000) Programs that foster such skills are ideal, rather than relying on practitioners to develop them in their own time.

This demonstrates the necessity of compassion and empathy in health service delivery. Regardless of background, experiences and worldviews, as individuals we hold the capability to be open to different ways of living and relating to the world around us. Such openness to diversity is an ideal characteristic for medical practitioners, finding themselves with the responsibility to care for a diverse range of patients on a daily basis. The challenge that this research exposes is how to develop that openness in those less ready to accept diversity.

Witnessing resilience and understanding the impacts of historical policies and practices is related to practitioner's ability to understand patient reality, allowing
them to appreciate and respect that everyone is different. Inaccurate perceptions of reality of Aboriginal peoples and communities and ways of working were found to be present in the form of stereotypes and assumptions. These were perceived by some participants to have a negative impact on both clinical decision-making and engagement in Aboriginal health, demonstrating the importance of promoting deeper and more contextual understandings within the health profession.

The origins of stereotypes and assumptions regarding Aboriginal peoples and communities were considered by participants to result from negative perceptions that exist within Australian society. Research into the portrayal of Aboriginal people in the West Australian media provides an understanding as to the origins of such stereotypes. A recent study examined the portrayal of Aboriginal health in selected online and print media. (Stoneham, Goodman et al. 2014) It found that articles relating to Aboriginal health had overwhelmingly negative portrayals as opposed to positive (74% vs. 15%) The remaining 11% were deemed neutral. Looking closer at the negative articles, the most common topic descriptors included alcohol, child abuse, petrol sniffing, suicide, deaths in custody and crime. (Stoneham, Goodman et al. 2014) This provides an example of how perceptions of Aboriginal peoples are perpetuated, re-enforced in health and extend beyond the medical profession. How Aboriginal people are portrayed in the media needs to be recognised and challenged by wider society in order for negative assumptions and stereotypes to change and cultural and societal shifts to take place.

In addition to broader societal changes in attitude, medical schools, postgraduate training providers and health service providers also have a responsibility to ensure medical professionals have the opportunity to develop a good appreciation of the diversity in day to day reality for Aboriginal peoples and their communities. The ability for medical practitioners to have respect for diversity in addition to skills that demonstrate this respect is an ideal, and is achievable. Strategies towards achieving this ideal are considered in the conclusion.

Exploring how to maximize the engagement of practitioners who may feel disconnected and unable to work with Aboriginal people is another area for further enquiry. As stated by participants, working with Aboriginal peoples is a skill all medical practitioners are required to have. Being open to different ways of
understanding the world can be challenging and confronting as found in the interviews. It is inevitable in the medical field with exposure to diversity that practitioners will be faced with conflicting values, beliefs and ideals to their own. The need for empathy and compassion is clear in order for respectful healthcare to be maintained.

To sum up, we need to challenge the way society has influenced the way in which we view ourselves. This could be interpreted as the refusal to accept certain ideas of status and power associated with the medical profession, should this result in the disadvantage of others.

Maybe the target nowadays is not to discover what we are but to refuse what we are.

(Foucault 1982, p. 785)

7.6 Normalisation of poor health

During this research most participants agreed that for them poor health outcomes for Aboriginal people were an expected norm in contemporary society. This expectation highlighted the disparity that continues to impact communities today. Before moving any further, it is important to question whether this expectation itself is fair. Participants answered this by stating that whilst poor health outcomes can be expected, they should never be accepted.

Normalising poor health outcomes was considered to influence medical practitioner’s perceptions of Aboriginal health, and also health in general. These perceptions played a role in influencing how practitioners engage with the decision-making process. An example from the research was the conversation about elevated blood sugar levels and how decision-making can be different regarding its management for Aboriginal patients.

Closely examining the impact of these decisions and their consequence on access to health services and opportunities will be a guide as to their place in best practice. Arguably, maximising access to tertiary care for one patient over another with the same presentation is not equitable. It was reasoned by one participant that differences in management assist in ensuring that adverse reactions to acute
changes were minimised. Such approaches to care are in line with best practice if they are also consistent with similar presentations in other ethnic groups, or reflect accepted guidelines.

Looking closer to reasoning that poor health can be an expectation, it was explained how our perceptions of what is normal and what isn’t relates to the context of our medical practice. Immersion within a community suffering a higher burden of disease had accompanying shifts in practice, as practitioners sought to cope with this burden in the context of setting characteristics, resource allocation and availability of time. Often the accepted practice in these settings was far from best practice.

It would be commonly expected that a recognised high prevalence of disease in a community would result in acceptance that such a difference in need would lead to an allocation of additional resources to enable an improvement in health outcomes to follow. In contrast to this, being immersed within communities that suffer high burdens of disease also resulted in decreased urgency and level of intervention, due to an expectation of poorer health.

A key example described in the interview was the initial reluctance of a practitioner to intervene in an Aboriginal patient with acute renal failure, due to the normalisation and expectation of chronic renal failure (see Chapter 5). This deviation from best practice standards and evidence-based medicine needs attention, as health disparities will not improve if patients are not receiving quality health care provision commensurate with their needs and circumstances. The reluctance to treat conditions based on a belief that they will recur is an interesting cognitive concept to balance. Using an example from the interviews, do we treat children for head lice, even if we expect them to be re-infested again on their return home? Guidance from the medical board code of conduct can be interpreted to favour either approach, whereby good medical practice includes responsible and effective use of resources in addition to taking steps to alleviate patient symptoms. (Australian Medical Council 2014)

This reflects a larger issue of social determinants of health, whereby living conditions, education, and income, amongst other things, all play a role in this particular condition. These broader issues are beyond the direct reach of the
individual let alone the medical practitioner, and understandably can lead to feelings of helplessness, frustration and defeat. Added to this complicated situation may be lack of available resources and support structures to facilitate best practice decision-making.

The potential for frustration and burnout when practitioner expectations are not met is high in such circumstances. The risk is not having the ability to contain these frustrations so as to not carry them onto the next patient. It is not an easy task to manage, as one participant described how difficult it was to come back to work the next day after failed attempts at providing care.

Practitioners are only human, and these processes need to be recognised with effective interventions and strategies put in place in order to allow them to receive support and maintain their ability to provide best practice care for patients. Factors that allow for ongoing expectations and unequal treatment need to be held accountable (lack of support and de-brief opportunities, limited resources), and measures that ensure the maintenance of best practice standards at all times are critical. Returning back to the head lice example, small steps for better health care are needed in light of larger issues. This may include regular practitioner debriefing, additional supports for care (health workers, social workers) and improved resources/training to manage difficult issues. I would argue that actions at the basic level, not only recognise patients’ right to good care, but provide the foundation for changes on a larger scale.

The emphasis of universal application of norms, rules and guidelines has been proposed as an effective strategy to minimise the effect of bias on clinical decision-making, particularly in individuals with a favourable view of hierarchical structures. (Van Ryn, Burgess et al. 2011) Another approach to minimising personal influences on decision-making is through improved practitioner awareness, motivation and skills in this area. (Van Ryn, Burgess et al. 2011) An example of this could be reflective sessions and peer debrief groups where scenarios can be talked about and guided through to better equip practitioners to deal with these in a best practice manner.

Another proposed method to enhance best practice care delivery to Aboriginal patients is through the development, implementation and utilisation of guidelines
specific for communities, ensuring management is in concordance with the specific needs of the community. Guidelines for management of otitis media in Aboriginal children were raised in the interview process, maximising access to resources and health opportunities in the relevant context of patient risk for complications and susceptibility for disease. Guidelines may also potentially minimise unfavourable restricted access to health services within a population with an already disproportionately heavy burden of disease.

Not only do expectations of poor health influence decisions, but also how Aboriginal people view their health and their communities. As mentioned earlier, a valuable future avenue of research would be to further explore the impact of these expectations on our community, including how people view their own health.

7.7 Patient centred care and respect for diversity as the key to improvement

The complexity of providing best practice care for Aboriginal communities has been a common thread in the interviews. In regards to this topic I looked at the role of the self; background, values, perceptions and expectations. Also explored was the impact of the setting on decision-making and engagement, along with core ideas of communication and adherence in achieving better health outcomes.

However complex, participants generally agreed patient-centred care to be the key in striving for greater equity in healthcare provision. As each patient is different, core notions of respect for diversity are essential in the ability of a health practitioner or health service to engage in patient-centred care. Key principles of self-determination and accessible health care set out in the Declaration of Alma Ata encompass this, and provide a solid foundation for approaches to service delivery. (World Health Organization 1978)

Respect for diversity has two elements. First, an understanding of core issues that impact Aboriginal communities which influence people’s construction of reality. This includes an understanding of the impact of historical events on contemporary society, along with different models of viewing health. The second aspect to this is
the ability of service providers to implement care respectful of overall issues whilst also tailored to individual patient needs and priorities. This includes both individual practitioner and overall setting factors working together to create a respectful healthcare service.

Participant experiences of Aboriginal people’s strength and wisdom in fighting for social justice and equity were given attention. The importance of gaining perspectives from an Aboriginal viewpoint was expressed, supporting core notions of community control and self-determination, whereby action initiatives in Aboriginal health require strong leadership and partnership with Aboriginal people and communities.

Resilience and strength of Aboriginal peoples may not always be readily appreciated by some, with health reporting in print and online media being one example. (Stoneham, Goodman et al. 2014) These experiences demonstrate how through involvement with Aboriginal people and communities, practitioners can gain an understanding of the relevant historical and political contexts, and the subsequent resilience that is required for the Aboriginal community to thrive.

The importance of addressing patient priorities was discussed by many participants in the interviews, and the occurrence of how these priorities may not always be the same as practitioner priorities. When faced with these dilemmas, reverting back to patient-centred care focusing on the individual and their obligations and needs was viewed to be the key in achieving better health care outcomes. The simple act of having the patient as the core focus of medical practice, not the practitioner, is key. This is mirrored by a recent change favouring the individualistic medical model to a paternalistic one. (Ha and Longnecker 2010)

In addition, participants described the value of having mentors in their practice, and peer support groups to assist with better managing their expectations and reactions. Further understanding of models of support and their impact on practitioner wellbeing and ability to implement best practice care is needed. Working within an environment that can challenge individual perceptions of reality whilst controlling for a number of personal and external influences to achieve best practice is demanding. But as identified in this research, there are
ways this can be done, through addressing core issues that need change, and promoting factors that work toward better health outcomes.

Potential areas of future research that could build the medical communities capacity and knowledge of ways to achieve equality in health for Aboriginal peoples is discussed in the following chapter.
Chapter 8 - Conclusion and Future Directions

I think it always happens and we'd be kidding ourselves as professionals to not recognise that, but I think that people are supporting each other and just letting it happen. Like so, nobody gets pulled up on it. And I think that we need to learn how to pull ourselves up on it. As a group we need to not let that become the norm. And that's what I feel has happened.

Study participant

Decision-making and engagement in Aboriginal health are influenced by a complexity of intertwining factors relating the decision-maker, their personal attitudes and experiences, in addition to the setting in which they practice and the broader context of the society in which they live. The key to striving for equitable health outcomes for Aboriginal peoples lie in the medical profession's ability to embrace respect for diversity and implement patient-centred care. The capacity to do this is influenced by setting characteristics and structures of health service provision. Ideal setting characteristics are those enabling practitioners to implement best care by providing the necessary resources, skills and support that minimise practitioner frustration, burnout and the use of decision-making processes that are not grounded in patient reality or evidence-based medicine.

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

(World Health Organization 1978)

As noted earlier, the Declaration of Alma Ata encompasses the core ideas central to this enquiry. Namely, strategies that promote self-determination, and provide accessible, acceptable quality health care respectful of diversity make for fundamental components for future improvements in health.
The findings of this thesis indicate directions for future strategies and fields of research with the aim to work towards equity in health for all Australians. Potential ways to promote health equity encompass both individual and organisational aspects of health service provision. As these factors are very closely linked, change cannot be achieved by addressing one aspect alone.

The diverse nature of Australia's health workforce was reflected in the participant group, however common viewpoints regarding issues and possible ways forward in Aboriginal health were found. Discovered in this thesis were accounts and experiences with unequal treatment of Aboriginal patients in the health system, which can at times be consistent with institutionalised racism. Notions of equity and equality are important when reasoning whether unequal treatment is fair, along with considering whether patient opportunity for health is being realised or restricted. Solid understanding of this within the health community is a desired future goal of this thesis.

Examples of unequal treatment being in line with best practice have been discussed, in contrast to those clearly disadvantaging people's right to health opportunities. Institutionalised racism needs to be abolished from our society, and efforts to highlight and address this concern are to be made a high priority. A closer examination of the role played by institutionalised racism in our healthcare system, and its impact on Aboriginal patients' health and wellbeing may contribute significantly to the findings of this thesis. Also, health settings and structures that allow for institutionalised racism to occur unaddressed require attention and action to ensure equitable healthcare for all, regardless of patient diversity.

When looking at issues of institutionalised racism, key influencing factors on the individual (time, communication, expectations, and context) need to be considered. This emphasises the above statement outlining the requirement for health service providers to take responsibility for occurrences of institutionalised racism, and put into place effective strategies to address this. Embracing change and not allowing “always and everywhere has it been this way” (Emirbayer and Johnson 2008) may be useful in tackling this issue.
Communication was a core theme in this thesis, found to influence Aboriginal patients’ health and wellbeing. The importance of communication when implementing patient-centred care highlights the necessity of good skills in this area, skills that were viewed as beneficial to working with all patients. Good communication skills in Aboriginal health however need to be adequately supported with adequate resource allocation (time, staff, case-load), to allow these skills to be implemented fully. This is another way health settings and structures can improve their capacity to provide good healthcare to Aboriginal patients, and patients from diverse backgrounds.

Linking to communication, and continuing the importance of health structures, is perceptions of adherence and its impact on health and wellbeing for Aboriginal peoples. It is widely recognised that adherence is closely dependent on health service structures, and this is supported in this thesis. Despite this recognition however, usage of the term ‘compliance’ was frequently encountered throughout the interviews. Experiences of notions of adherence affecting patient access to health resources and opportunities found in this enquiry demonstrate the need for improved understanding of the origins of adherence. This supports the call for health service provision to recognise patient context, priorities and needs in order for best practice care to be realised.

Diverse practitioners working with diverse patients will inevitably result in conflicting realities, contexts and ways of working. Participants described how being able to gain alternate perspectives to ways of life and understand patient reality and context were positive influential factors impacting decision-making and engagement. Providing opportunities for all medical professionals to gain an insight into Aboriginal history and context, whilst retaining skills to implement patient-centred care based on the individual, is a good model to follow. Such opportunities may be realised in medical school and speciality training colleges, and could draw on participant’s value of witnessing strength, resilience and passion within the Aboriginal community.
Stereotypes and negative perceptions of the Aboriginal community continue to exist in current society, despite this no longer being socially acceptable. These perceptions were found to impact practitioner engagement in Aboriginal health. Inaccurate representations and portrayals of Aboriginal peoples points to a larger issue needing action at a societal level, action that is a necessity if our society values social justice and equity. A better understanding of ways to address negative attitudes or views that may impact Aboriginal patients wellbeing, and to maximise engagement in practitioners who feel disconnected with this field, would be a useful addition to the findings of this thesis.

It is well known the high burden of disease suffered by Aboriginal peoples. Adding to this burden is the tendency for poor health to become normalised with Aboriginal populations, and at times, accepted. The potential for this acceptance to influence decision-making and resource allocation reinstates the need for better health structures allowing practitioner implementation of best practice. Indeed this issue does extend beyond the direct reach of service providers as social determinants of health play a key role, and improvement of these will require a collaborative approach from all sectors of the Australian community.

That said, the use of evidence based guidelines and tools that promote best practice and health opportunities for Aboriginal peoples can assist service providers to meet this challenge. Additionally, routine support structures for practitioners working in disease-burdened areas are proposed to manage expectations, prevent frustration, minimise burnout and support best practice. A better understanding of effective ways to do this would be a beneficial addition to this thesis.

In conclusion, Aboriginal health is a dynamic field encompassing people with unique contexts, realities and ways of life. Having an understanding of the broader issues relating to Aboriginal health, and implementing this in a patient-centred context, was viewed to be the key in providing effective healthcare to Aboriginal peoples. Core notions of self-determination and patient empowerment found within the thesis support this idea. Medical practitioners hold the responsibility to enable their patients right to health; working closely with Aboriginal patients,
empowering them in decision-making processes and realising their individual priorities is a step toward equitable health in our society.
References


Australian Medical Council (2014). Good Medical Practice: a code of conduct for doctors in Western Australia, Medical Board of Australia: 1-25.


Burgess, D. J. (2010). "Are providers more likely to contribute to healthcare disparities under high levels of cognitive load? How features of the healthcare setting may lead to biases in medical decision making." Medical Decision Making 30(2): 246-257.


Appendices

Appendix I

THE UNIVERSITY OF WESTERN AUSTRALIA
Achieve International Excellence

Participant Information Sheet

Student Researcher: Andrea McKivett
Phone number: 0407403313
20135627@student.uwa.edu.au

Chief Supervisor: Winthrop Professor Dawn Bessarab
Co-Supervisor: Associate Professor Dr David Paul
Co-Supervisor: Associate Professor Shaun Ewen

How do you decide? Experiences and influences promoting best practice and engagement within Aboriginal health.

Purpose
This project aims to explore the various influences on medical practitioners’ decision-making and preparedness to engage in Aboriginal health. Any key influences or experiences found may then be utilised in forming future educational and training tools for medical practitioners. This would work towards ensuring the ongoing effective development of training medical practitioners in the field of Aboriginal health and the ongoing implementation of best practice.

Methods
Interviews will consist of basic demographic data collection including location of medical training, presence of Aboriginal health education and individual views regarding Aboriginal health. This will be performed in a survey-like manner. Following this, a short, informal discussion will explore influences and experiences that play a role in best practice and engagement in Aboriginal health.

Interview data will be recorded and transcribed. Recordings and transcriptions will be stored on a password protected computer. Written data will be kept in a locked filing cabinet on the University of Western Australia campus. Participants will be de-identified in analysis of results. A coded document will be kept separately to collected data to identify participants and their individual data responses, in the case that identification is required. For example, withdrawal from the study and to enable transcripts to be reviewed by participants if they wish. On analysis of results, reports or documentation will be kept on a password protected computer.

Inconveniences
I acknowledge that practicing medical practitioners are inherently busy and their time invaluable. Thus, the data collection process has been developed into a quick, 15 to 20 minute interview that will be conducted by a time flexible researcher.

Risks
Should any distress arise from the discussions, a list of Aboriginal health resources and medical support services will be provided to each participant. Interviews will be conducted by a registered medical practitioner and will therefore follow Standard Australian Health Practitioner Regulation Agency guidelines.

Benefits
The medical community and Aboriginal population can potentially benefit from this study through the evaluation of potential significant influences and experiences on best practice and engagement in
Aboriginal health. Such influences may be used to guide future training programs for both undergraduate and postgraduate medical practitioners, working towards equality in health outcomes for the Aboriginal population.

For every interview conducted $20 will be donated to the Fred Hollows Foundation, supporting their work in Aboriginal eye health.

Withdrawal from the study
Participation in this research study is voluntary, participants are free to withdraw from the study at any point in time. If a participant chooses to withdraw from the study after information has been recorded, this information will not be included in the final analysis of the study.

Outcomes
The results and report of the research will be available to participants for their information and comment. The final report may be published and presented in a variety of contexts, including report and/or powerpoint presentation to relevant audiences. Participants can request the report not be made public.

This research will form the thesis for a Masters in Aboriginal Health degree at the University of Western Australia.

If you have any further questions in regards to this research study, please contact myself, Andrea McKivett, the student researcher of this project (0407403313, 20135627@student.uwa.edu.au).

Alternatively, you can contact the research Supervisors:

Winthrop Professor Dawn Bessarab, Centre for Aboriginal Medical and Dental Health
University of Western Australia
Phone: 6488 2038
Email: dawn.bessarab@uwa.edu.au

Associate Professor Dr David Paul, Centre for Aboriginal Medical & Dental Health
University of Western Australia
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Email: david.paul@uwa.edu.au

Associate Professor Shaun Ewen, Associate Dean (Indigenous Development) Faculty of Medicine, Dentistry and Health Sciences
Melbourne School of Population and Global Health
Phone: 03 8344 9230
Email: sewen@unimelb.edu.au

Thank you for your time

Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time. In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at The University of Western Australia on (08) 6488 3703 or by
emailing to hreo-research@uwa.edu.au. All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.
Appendix II

How do you decide? Experiences and influences promoting best practice and engagement within Aboriginal health.

Participant Consent Form

I ______________________ have read the information provided and any questions I have asked have been answered to my satisfaction.

I agree to participate in this activity, realising that I may withdraw at any time without reason and without prejudice.

I understand that all identifiable (attributable) information that I provide is treated as strictly confidential and will not be released by the investigator in any form that may identify me. The only exception to this principle of confidentiality is if documents are required by law.

I have been advised as to what data is being collected, the purpose for collecting the data, and what will be done with the data upon completion of the research.

I agree that research data gathered for the study may be published provided my name or other identifying information is not used.

Signature of participant ___________________________ Date ____________

If you have any questions regarding this research please contact the Student Researcher, Andrea Mckivett (20135627@student.uwa.edu.au), or Research Supervisors: Winthrop Professor Dawn Bessarab, Professor David Paul, and/or Associate Professor Shaun Ewen, contact details as provided on the Participant Information Sheet.

Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time. In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at The University of Western Australia on (08) 6488 3703 or by emailing to hreo-research@uwa.edu.au. All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.
Appendix III

How do you decide? Experiences and influences promoting best practice and engagement within Aboriginal health

Please tick the most correct answer in regards to yourself. You may elect to pass on any question.

1. Age
☐ 20-25 yrs  ☐ 30-39 yrs  ☐ 40-49 yrs  ☐ 50-59 yrs  ☐ 60+yrs

2. Gender
☐ Male  ☐ Female

3. Are you Aboriginal and/or Torres Strait Islander?
☐ Yes  ☐ No

4. What is your current level of training?
☐ PGY1 (intern)  ☐ PGY2-4  ☐ Registrar  ☐ Advanced Trainee Registrar
☐ Fellow  ☐ Consultant

5. Which of the following broad clinical fields best describes your current area of practice?
☐ General Practice  ☐ General Medicine  ☐ Surgery
☐ Emergency Medicine  ☐ Medical Specialties  ☐ Psychiatry
☐ Other

6. Which practice location best describes your place of work?
☐ Private General Practice  ☐ Aboriginal Medical Service
☐ Public Tertiary Hospital  ☐ Regional Hospital

7. Did you complete your medical training in Australia?
☐ Yes  ☐ No

8. Did you receive targeted Aboriginal health training as an undergraduate?
☐ Yes  ☐ No

9. Have you ever received targeted Aboriginal health training in your postgraduate career?
☐ Yes  ☐ No

10. How confident are you in managing Aboriginal patients?
☐ Very Confident  ☐ Confident  ☐ Not Confident  ☐ Unsure

11. Do you think poor health outcomes in Aboriginal patients is a normal expectation in the health profession?
☐ Yes  ☐ Sometimes  ☐ No

Thank you for your participation.
How do you decide? Experiences and influences promoting best practice and engagement within Aboriginal health

Interview Questions
Participants are permitted to make no comment on any question.

The following is a list of topics and leading questions which will guide the interviews with medical practitioners. As this is a semi-structured interview, questions may vary according to each individual participant depending on the discussion had.

**Topic 1: Experiences.**

Can you describe a positive experience with an Aboriginal person that has impacted you? Any not so positive?

Do either of these experiences impact on your daily work as a medical practitioner?

**Topic 2: Engagement.**

In your view, what encourages and discourages Doctors to engage with Aboriginal health? Have you ever experienced these?

**Topic 3: Education**

Can you briefly outline what Aboriginal health education you have had to date?

Has a previous educational experience in Aboriginal health ever had a significant impact on yourself? Can you briefly describe this?

Can you please tell me what you think about Aboriginal health education being included in postgraduate training?

Are there any experiences or additional learning opportunities you would like to have to build your capacity to work with Aboriginal people?

**Topic 4: Decision-making**

When working with Aboriginal patients, what factors do you think are important for medical practitioners to consider? Can you describe why they are important?

In your experience, what are the barriers facing medical practitioners when working with Aboriginal patients? Have you had a similar experience?

What do you think about the idea of the medical community normalizing poor health outcomes within the Aboriginal community?

In your view, do the personal attitudes and context of the medical practitioner impact on decision-making? Have you experience this yourself?

Can you tell me about what might influence yourself as a medical practitioner to manage a non-Aboriginal patient with a particular presentation differently to an Aboriginal patient?
Are there any factors/influences at an organizational level that influence how you manage Aboriginal patients?

<table>
<thead>
<tr>
<th>How do you decide?</th>
<th>Survey &amp; interview questions</th>
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Appendix IV

How do you decide? Experiences and influences promoting best practice and engagement within Aboriginal Health.

Participant Resource List

Aboriginal Health resources

1. Combined Universities Centre for Rural Health provides a free online Cultural Orientation course. Course available at: http://lms.cucrh.uwa.edu.au


3. Australian Institute of Health and Welfare 2011. The health and welfare of Australia’s Aboriginal and Torres Strait Islander people, an overview 2011. Cat. no. IHW 42. Canberra: AIHW.


7. Central Australian Art Centre, Aboriginal owned and run. This website contains information regarding Central Australian Aboriginal culture, history and kinship systems along with traditional and contemporary Aboriginal art. Available online: http://aboriginalart.com.au/culture/dreamtime2.html

Support Service Resources

1. Colleague of First Contact: a 24 hour support service for Medical Practitioners. Phone number: (08) 9321 3098

Address: PO Box 21 Parkville VIC 3052

3. Doctors Health Advisory Service. Phone number: (08) 8273 4111
Address: Parlank Medical Practice, Hughes Plaza, University of Adelaide SA 5005.