

The doctor-patient relationship and its effect on the health of Indigenous Australians

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There is a significant gap in life expectancy between Indigenous and non-Indigenous Australians. This may be due to a number of factors including demographics and poor accessibility to health care, but also to a lack of trust in, “Western medicine” and poor engagement with services. This report considers the cases of two Indigenous patients who presented to Sydney hospitals, in the context of the doctor-patient relationship. The cases and the relevant literature demonstrate that language and cultural barriers for communication between Indigenous patients and health-care staff are numerous, and that the use of clear language, teaching illustrations, informative CDs and DVDs should be emphasised. The presence of an Indigenous Liaison Officer during hospital consultations can be helpful for both the patient and the staff. A good therapeutic relationship is invaluable in gaining Indigenous patients’ trust and improving health-care outcomes. Access and availability of Indigenous Liaison Officers and interpreters is increasing, and the importance of cultural sensitivity and staff training to enhance communication with Indigenous patients is increasingly evident. Continued efforts may move us one step closer to reducing the health-care gap.



Case 1

Ms. NW, a 39-year-old lady who identifies as Indigenous, was brought in by ambulance after multiple episodes of haemetemesis in the preceding eight hours. She also complained of painless menorrhagia with many clots for the past four weeks. This presentation was on a background of chronic alcohol abuse and liver cirrhosis. Ms. NW was investigated and found to have a normocytic, normochromic anemia (Hb 63g/L), in keeping with her acute blood loss. Her liver function tests were consistent with the history of alcoholism and liver disease (raised GGT and AST), and she was found to be in a coagulopathic state (thrombocytopenia; elevated PT and aPTT; INR=1.8). Ms. NW’s management included blood transfusions.

Ms. NW was stabilised and discharged yet her treating team were concerned about her long-term outcome, compliance with treatment and lifestyle modifications, and future health. The discharge plan recommended the involvement of a social worker and an occupational therapist but Ms. NW refused these services saying, “I can do it on my own.”

Case 2

Mr RP is a 73-year-old gentleman who identifies as a Torres Strait Islander (TSI). He left his family at the age of sixteen to move to Sydney to build a life of his own. Mr RP has a background of Type II Diabetes Mellitus (T2DM), from which he suffers both microvascular and macrovascular complications, including ischaemic heart disease and peripheral vascular disease. In 2005, Mr RP developed gangrenous toes on his left foot, which required trans-metatarsal amputation. Two months ago, he again developed gangrenous toes and had the fourth and fifth digits on his right foot amputated. His current hospitalisation was for hyperbaric therapy to facilitate wound healing.

A conversation with Mr RP revealed that he had little knowledge about his T2DM. The hospital staff tried educating Mr RP and providing him with information pamphlets, however Mr RP was unable to read English. He did not regularly record his blood glucose levels and was unaware that his diet was directly correlated with his diabetes and the amputation of his toes. The hospital team offered to arrange an appointment with a Diabetes Educator but this was refused.

Discussion

The above cases demonstrate a number of similarities that are important points of discussion. In case 1, Ms. NW has liver cirrhosis

“I will remember that there is art to medicine as well as science and that warmth, sympathy and understanding may outweigh the surgeon’s knife or chemist’s drug.”

Hippocratic Oath (1964)

Introduction

In 2011, the Australian Institute for Health and Welfare reported a significant gap in life expectancy between Indigenous and non-Indigenous Australians. This gap was 11.5 years for males and 9.7 years for females. [1] Non-communicable diseases explains 70% of the health gap, with cardiovascular disease as the leading cause group (23%), followed by diabetes (12%), mental disorders (10%) and chronic respiratory disease (9%). [2] Many socio-political factors including low socio-economic status, poor accessibility to health care, history of colonisation and marginalisation have contributed to this health gap but poor engagement in services by Indigenous patients as a contributing cause has received increased attention in the recent years. [3] Lack of trust of, “Western medicine” has been suggested as an important mediating factor in poor engagement and access. [4]

As illustrated by the Hippocratic Oath, an empathetic, trusting doctor-patient relationship has always had the utmost regard in the practice of medicine. The quality of the relationship between the patient and health care practitioner is a predictor of adherence to treatment and outcomes. [4] Likewise, poor engagement between doctors and patients is found to be associated with negative outcomes for both patients and doctors. [5] Patient satisfaction improved and emotional distress among patients reduced with better doctor-patient communication. [6]

This report will portray the cases of two Indigenous patients at Sydney hospitals and discuss some of the barriers that Indigenous patients face. It will also illustrate the importance of a trusting relationship between the medical team and Indigenous patients, and give evidence-based suggestions on how to improve health-care outcomes in this population.

from alcohol abuse; in case 2, Mr RP has T2DM with both micro- and macro-vascular complications. Both of these medical conditions are preventable with education, lifestyle changes and early intervention. Both patients are not well educated about their illness, and refused allied health and outpatient services that could help prevent further progression of their conditions.

Barriers to communication and access of services

There are many barriers that may prevent Indigenous patients from communicating freely and accessing available health-care services. These include language, cultural and historical barriers.

In the above cases, both Mr RP and Ms. NW had little knowledge about their medical conditions. Poor knowledge of one's own medical illness is not an uncommon occurrence in the Indigenous community. One Australian study showed that Indigenous patients were less certain about the cause of their illness and reported feeling uninformed but eager for information. [7]. Patients reported dissatisfaction and confusion regarding information about their illness given by doctors. Many felt confused by the advanced language of their physician. Language barriers and cultural distrust prevented them from seeking further information. Furthermore, physicians may interpret the patient's lack of questioning as indicative that their understanding is satisfactory. [7]

Fear of racism and a sense of powerlessness are examples of some of the social barriers that Indigenous patients face when having to interact with healthcare staff. In addition, cultural differences in social cues such as eye contact, body language, volume and tone of speech may hinder the therapeutic relationship. For example, lowering eye gaze when talking to people of authority is a sign of respect in Indigenous culture, while in many other cultures it may be seen as a lack of interest or defiance. [8] These miscommunications between the doctor and patient can result in lack of understanding of diagnoses and therefore poor adherence to treatment plans. Indigenous patients have reported that when they do not understand what a doctor is saying, they feel it is because the doctor does not know what she/he is talking about. Conversely, when patients understand what is being said, they feel the clinician is knowledgeable. [4]

Internationally, minority populations face many barriers to the uptake of mainstream health care services, including language and cultural barriers. Indigenous Australians are identified as a population at risk of not accessing health care services, often because of language and cultural reasons. [3] Traditional Indigenous beliefs may differ from what is practiced at the hospital; many Indigenous people are suspicious of the basic tenets of Western medicine, or "White man's" medicine. [4] For example, many Indigenous people hold the opinion that, "the ability to put on weight during good seasons enables people to survive bad seasons," and, "thinness can indicate weakness, excessive worry, or ill health." [9] Enforcing the importance of weight loss, strict calorie intake, and exercise, in conditions such as diabetes, can be difficult if patients are hesitant towards the accuracy of Western medicine or do not trust the medical professional. [9] Additionally, some Indigenous members of the Stolen Generation may choose not to see a, 'White' or non-Indigenous doctor until absolutely necessary, due to past mistrust. [5] Lack of trust in Western medicine poses a threat to compliance with medical advice and use of recommended services. It is important for culturally appropriate options to be discussed and practiced in order to increase the uptake of available services by Indigenous Australians. [3]

Impact of the doctor-patient relationship on Ms. NW and Mr RP

In the case of Ms. NW, the management team recommended a number of support services that could potentially improve Ms. NW's health outcomes. For example, support services that educate and encourage Ms. NW to adopt a healthier life style with abstinence from alcohol, maintain better nutrition and physical activity, will potentially reduce the impact of her condition on her overall wellbeing. Furthermore, providing counselling to prevent her children from engaging in risk-

taking behaviour may reduce the multigenerational impact of disease.

Ms. NW was not receptive to these services and refused them from the outset. This may be due to a misunderstanding of the services or for various other reasons. The hospital treatment team rightfully offered these services, but it is unknown to what extent an effort was made to help Ms. NW understand the services. With additional efforts it may be possible to explore why she kept to herself and refused support services. However, in a busy hospital setting there are often time restrictions that may interfere with putting these additional efforts into place. Ideally, if someone she could trust and feel comfortable with explained the benefits of these services to Ms. NW in the community, for example a general practitioner (GP), there may have been better engagement and compliance leading to improved outcomes for her and her family. The importance of building a trusting doctor-patient relationship and being culturally sensitive should continue to be addressed in staff training sessions, in both hospital and community settings.

Similarly, Mr RP had refused to engage in any support services over the years and was not open to further discussion about the topic. When asked about connection to an Indigenous Liaison Officer (ILO), Mr RP's response was: "No, I don't use that kinda nonsense. I came here to get my foot fixed, and I'll get my foot fixed then leave. I lived the past 60 years on my own, I didn't need their help before and I don't need it now!" Mr RP described past occasions when people offered him services, but he refused, "I'm no different than anyone else. I don't need any special services."

Perhaps further explanation into the role and services offered by an ILO would decrease Mr RP's hesitancy towards the idea. The involvement of an Indigenous Health Worker (IHW) or ILO can positively impact patient care in many ways. By sharing the same linguistic and cultural background as their patients, ILOs can deliver effective health education to patients. Similarly they can educate other staff about Indigenous patients' needs. It is suggested that involvement of an ILO can reduce rates of discharge against medical advice amongst Indigenous patients, and also increase engagement in outpatient services. [10]

Mr RP knew little about the medical condition of T2DM, likely due to language barriers. His health outcomes may have been very different if he had been educated about the illness in his own language, early in its course. The diabetes educator and support services that were offered to Mr RP would likely have benefited him in the long term. It is unknown whether Mr RP has a GP whom he trusts, but perhaps education and advice from a trusted health care provider could help motivate Mr RP to comply with a healthier diet, exercise and other lifestyle choices, and prevent further deterioration of his condition.

Ways to enhance the doctor-patient relationship

There have been a number of proposed ways that non-Indigenous health care services can make their Indigenous patients feel comfortable, and gain trust. These include educating staff about Indigenous heritage and culture, and training them to use common terms in some Indigenous languages. [5] This has been shown to be appreciated by Indigenous patients and greatly improve rapport. [5] Having an understanding of their health and treatment options enables ownership and a 'sense of control' of their own management and can improve adherence. Displaying Indigenous artwork and employing Indigenous staff may also help Indigenous patients feel at ease and facilitate building of understanding and trust. [4]

Using simple, clear language combined with quality teaching illustrations, anatomical models, and informative CDs or DVDs may be helpful. In addition, Indigenous art and paintings about disease and health, "medical art," can be extremely useful in educating Indigenous patients about their condition. The use of a few terms in the patient's native language about their disease can aid in understanding and trust. [4]

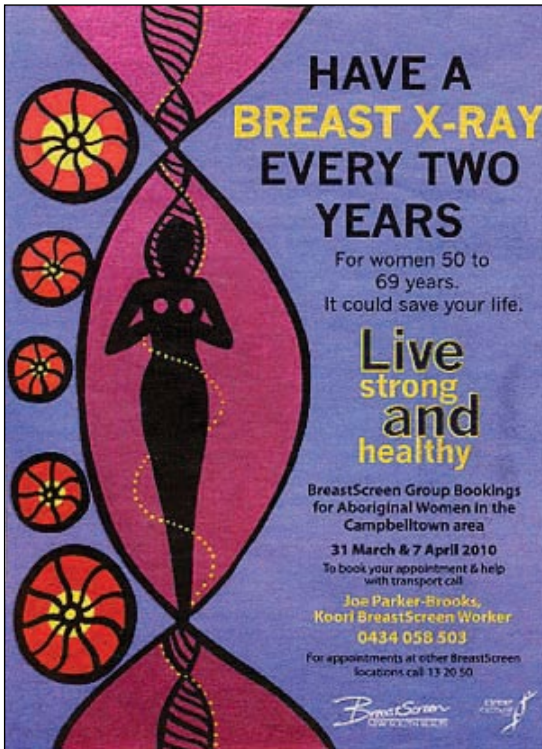


Figure 1. This is an advertisement in a local Indigenous newspaper. [11] Targeting the Indigenous population by advertising a holistic approach to health may encourage patients to use available services.

A study by Browne and Varcoe [12] goes one step further, arguing for a closer scrutiny of the issue of culture. They draw attention to the heterogeneity amongst Indigenous people and warn against, “painting everyone with the same brush.” They urge the medical community to acknowledge individual differences and cultural diversity among Indigenous patients and make room for personal preferences. [12] The importance of building rapport and learning about the patient’s background and individual beliefs, can assist the professional to understand the patient and be clear about the next steps in treatment planning. [5]

Conclusion

There has been a remarkable shift among health care providers and governing bodies to acknowledge the need for cultural sensitivity training for staff and the importance of enhancing communication with indigenous patients. Efforts to improve access to health services

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for Indigenous patients include cultural education, Indigenous liaison workers and the availability of interpreters. Medical training has increasingly emphasised the importance of effective communication and building rapport. Continued mindful efforts to build an empathic, trusting relationship between a doctor and a patient may go a long way in improving health outcomes for Indigenous Australians.

Consent declaration

Informed consent was obtained from both patients for publication of this case report.

Conflict of interest

None declared.

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Figure 2. This Indigenous painting shows the digestive system of the human body. Indigenous people may relate better to this kind of medical art. [11]

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