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Understanding practitioner professionalism in Aboriginal and Torres Strait Islander health: lessons from student and registrar placements at an urban Aboriginal and Torres Strait Islander primary health care service

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Title

Understanding practitioner professionalism in Aboriginal and Torres Strait Islander health: lessons from student and registrar placements at an urban Aboriginal and Torres Strait Islander primary health care service; a pilot study.

Abstract:

Aboriginal and Torres Strait Islander peoples continue to be pathologised in medical curriculum, leaving graduates feeling unequipped to effectively work cross-culturally. These factors create barriers to culturally safe health care for Aboriginal and Torres Strait Islander peoples.

In this pilot pre-post study, we followed the learning experiences of 7 medical students and 4 medical registrars undertaking clinical placements at an urban Aboriginal and Torres Strait Islander primary health care service in 2014. Through analysis and comparison of pre- and post-placement responses to a paper-based case study of a fictitious Aboriginal patient, we identified four learning principles for medical professionalism: student exposure to nuanced, complex and positive representations of Aboriginal peoples; positive practitioner role modelling; interpersonal skills that build trust and minimise patient-practitioner relational power imbalances; and, knowledge, understanding and skills for providing patient centred, holistic care. Though not exhaustive, these principles can increase the capacity of practitioners to foster culturally safe and optimal health care for Aboriginal peoples. Furthermore, competence and effectiveness in Aboriginal health contexts is an essential component of medical professionalism.

Key words: Aboriginal health, professionalism, medical education, practitioner bias

What is known about the topic?

- Aboriginal and Torres Strait Islander peoples are pathologised in medical curriculum and evidence points to graduates having low confidence to work cross-culturally.

What does this paper add?

- Teaching of medical professionalism which includes patient-centred care of Aboriginal peoples can increase health professionals' capacity to provide culturally safe and optimal Aboriginal health care.

Introduction

Aboriginal and Torres Strait Islander (hereafter respectfully referred to as Aboriginal) health has been a comprehensive accreditation requirement in medical education since 2006 (Australian Medical Council 2012). Extending from a primarily public health model, medical curricula have typically pathologised Aboriginal peoples. This representation of Aboriginal peoples has been criticised (Ewen and Hollinsworth 2016) and has failed to adequately prepare graduates to deliver care cross-culturally (Weissman *et al.* 2005). Different approaches are needed that increase the likelihood of culturally safe health care experiences and improved health outcomes for Aboriginal peoples.

Professionalism is an emerging issue in medical education, but a single definition of medical professionalism that has universal agreement does not exist (Birden *et al.* 2014). Nonetheless, professionalism and leadership is one of the domains of the Australian Medical Council (AMC) Graduate Outcome Statements that medical students in Australia and New Zealand must demonstrate at graduation (Australian Medical Council 2012). Taking the stance that medical professionalism is a set of attributes, Epstein and Hundert (2002: 226), have broadly defined medical professionalism as involving competence in "communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served". Thus, medical professionalism is essential in practitioner-patient relationships, and in sustaining the public's trust in the medical profession (Pearson *et al.* 2015). Furthermore, purposefully teaching professionalism and identifying and addressing unprofessional behaviours during training is essential to ensuring the post-training manifestation of professional behaviours: primacy of patient welfare; patient autonomy; and social justice (Kirk 2007).

In this paper we argue that the competence and effectiveness of health practitioners in Aboriginal health is linked to professionalism. Particularly, that medical professionalism should explicitly incorporate principles for achieving optimal care for Aboriginal peoples. Professionalism is pertinent given evidence that implicit (unconscious and automatic) practitioner bias contributes to health disparities (Phelan *et al.* 2015). Such bias is known to influence practitioners' interpersonal communication and clinical decision-making, compounding Aboriginal peoples' mistrust of the medical profession (van Ryn *et al.* 2015).

We have previously reported how medical students and registrars undertaking clinical placements in a well-resourced Aboriginal primary health care service revealed a consistent shift away from a narrow focus on biomedical care, and a realisation that their pre-placement assumptions were based on negative stereotypical conceptions of Aboriginal people (Askew *et al.* 2017). Here, we aimed to identify evidence of participants' learning that aided development of medical professionalism to foster optimal health care for Aboriginal peoples.

Methods

Setting

The Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care (CoE) is a Queensland Government general practice located in Inala, a South-Western suburb 18 km from Brisbane's central business district. The CoE is committed to teaching health students about Aboriginal health and culturally safe practices (Hayman *et al.* 2014).

Design

This pilot pre-post study replicated, in part, our previous study that investigated student clinical decision making (Ewen *et al.* 2015). Details of this current study have been reported elsewhere (Askew *et al.* 2017), but in summary, at the commencement of their clinical placement at the CoE, medical students and registrars reviewed a one-page paper-based vignette describing Liz, a 46 year old Aboriginal woman with Type 2 Diabetes, a two month sore on her foot, symptoms suggestive of poor blood sugar control and a particular set of family social circumstances.

Participants' written responses to five questions requiring clinical decisions guided semi-structured interviews where participants described their imaginings of the patient and the reasoning and assumptions behind their clinical decision making. The questions for the written response and the interview guide have been presented previously (Ewen *et al.* 2015). At the end of their placement, participants reviewed their pre-placement interview transcript, and a semi-structured interview facilitated their reflections on their initial responses and assumptions (Figure 1). Pre and post-placement interviews were digitally recorded, transcribed verbatim, de-identified, and checked for accuracy. Transcripts were analysed using inductive thematic analysis.

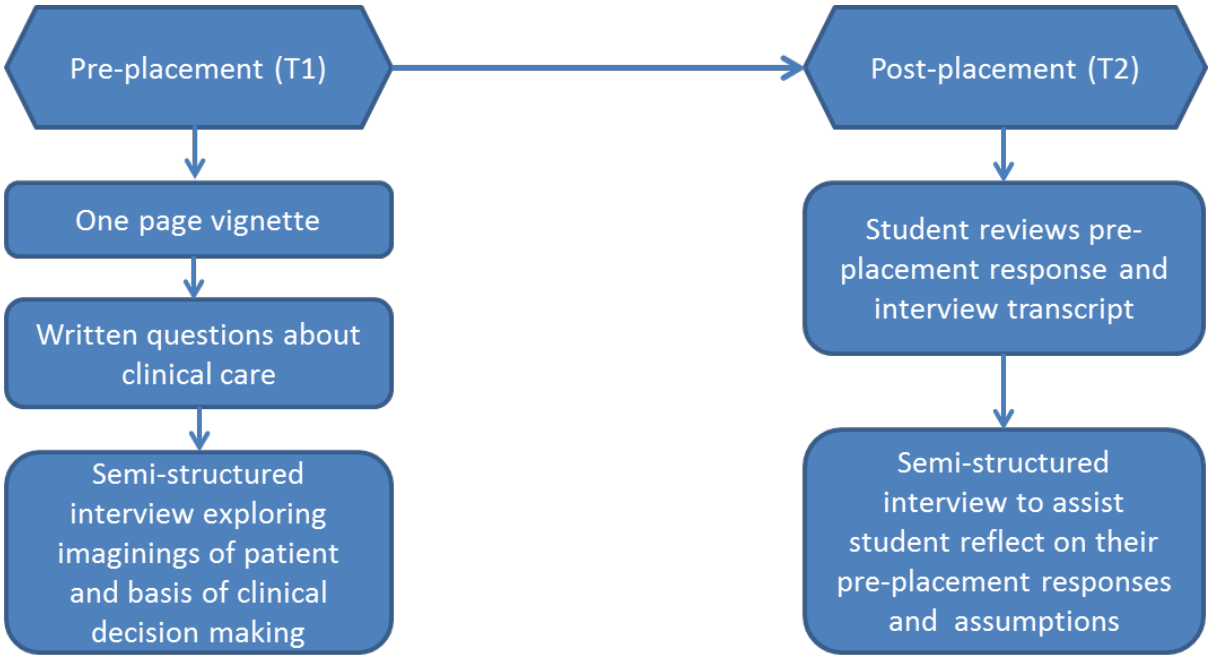

Fig 1: Study schema

Ethics

The Inala Community Jury for Aboriginal and Torres Strait Islander Health Research (a group of Aboriginal and Torres Strait Islander people who guide all research undertaken at the CoE) provided support for the project (Bond *et al.* 2016). Ethical clearance was obtained from the Metro South Human Research Ethics Committee (HREC/13/QPAH/502). Results were disseminated back to the Community Jury at project completion and to the CoE staff at a staff forum.

Results

Seven medical students (MS), three general practitioner registrars (GPR) and one psychiatric registrar (PR) participated in this study. No students and one registrar (paediatric) declined participation due to a stated lack of knowledge about type 2 diabetes. Participants varied in ethnicity, approximately half were female, and their ages ranged from 22 to 38 years old. Placements ranged from 4 weeks to 12 months.

Three themes were identified from participants' pre- and post-interview data: practitioner confidence and cultural safety; approaches to the practitioner-patient relationship; and shifting from theoretical knowledge to experiential knowledge (Table 1).

Table 1 Emergent themes and illustrative quotes

Pre-placement	Post-placement	ID
Theme: Practitioner confidence and cultural safety		
I guess I see her as sort of a middle-aged Aboriginal woman, maybe a bit overweight in line with your typical type II diabetic.	Just thinking of it from a statistical sort of point of view last time, I know there are greatest of numbers of issues in that demographic. But, yeah, from what I've seen in the placement, no, it's not necessarily like that… Everyone is just as diverse in that demographic than they are in other ones.	MS11
Theme: Approaches to the practitioner-patient relationship		
I think it would be important to provide Liz with the education – enough education, enough understanding of her illness to manage it as much as she can.	So previously, when I said good practice or best practice, I meant the check list of things I'm supposed to do according to what the medical school wants. I think good practice though, for working with Aboriginal and Torres Strait Islander people does revolve around that central relationship with respect and good communication, and to ensure that they're comfortable and that they feel that the care is good for them and helping them.	MS10
Theme: Shifting from theoretical knowledge to practical understanding		
Good quality care for her, I think, and this is not just for Liz, I think it's for everyone, but in particular for her, would be a more holistic care…	…in my things before I said I'll look at treating her as a whole, but now I can actually say what I meant by that, whereas before I wouldn't have known what I meant by that.	MS9

Practitioner confidence and cultural safety

While students and registrars differed in experience, all increased their ability to work in a more humanistic manner, with increased capacity to practice in a culturally safe manner. Participants' exposure to both diverse and positive experiences with Aboriginal peoples challenged previously held assumptions of homogenous Aboriginal appearances and attitudes towards treatment. Participants also expressed greater recognition of the nuances and complexities inherent in their patients' Aboriginality (Table 1, MS11). Simultaneously, some recognised the medical and social needs common to Aboriginal peoples and prioritised tailoring diagnostic and treatment strategies accordingly. Several participants also gained awareness of the impact of past aggressive assimilationist policies on Aboriginal health today,

I've had some quite stark examples of intergenerational trauma and sort of historical mental health coming down through families which can be traced back to events 100 years ago that still affect the family and it's about breaking the cycle of mental health issues (MS4).

All participants gained confidence and skills to work more effectively with complexities and consultation timeframes, which they attributed to the positive learning environment, opportunities to actively participate in patient care, GP role modelling, and the culture of curiosity and learning at the health service. The time given to patients, and the positive impact this had on care, was acknowledged by participants.

Approaches to the practitioner-patient relationship

All participants gained greater understanding of therapeutic relationships. Participant-patient relationships moved from being largely illness-focused to patient-focussed, with an emphasis on working in partnership with patients (Table 1, MS10). Pre-placement, participants emphasised the importance of trust, rapport and relationship building. Understandings, however, were often brief and theoretical. Post-placement, all participants exhibited deeper and more practical understandings of the role of trust in patient engagement, emphasising the importance of this for a patient's ongoing engagement with the health sector and adherence to a treatment plan,

I have thrown out trust there and I think before I started I …[…]…, I didn't understand how big that term is… after this rotation I've really understood how important it is (MS4).

Several participants gained enhanced relationship building skills, incorporating a place-based focus. Some stressed the importance of doctors serving longer terms for relationship continuity and several highlighted the need for practitioner responsiveness to the community's cultural needs. Post-placement, participants detailed several verbal and non-verbal communication skills beneficial for building patient trust and rapport, including a greater focus on listening and minimising the patient-practitioner power differential through informal speech and open body language. Furthermore, some participants emphasised being an ally, non-judgemental, and achieving relationships based on equal footing.

Shifting from theoretical knowledge to practical understanding

Pre-placement, although most participants stressed a holistic approach to patient care, understandings of this concept were often theoretical based on knowledge gained in lectures or textbooks and treatment plans remained largely biomedically focused. For some, a lack of understanding concerning the relationship between social determinants of health and patient access and adherence to medical care was apparent. Addressing patient social and emotional needs was frequently delegated to allied health professionals. Post-placements, social and emotional needs were prioritised over biomedical needs, unless the latter were urgent,

> *…I never realised the social component of medicine until this week… you're briefly taught about it in lectures in year 2, but you never really grasp how important it was until I was actually in the consultation and 80% of the consultation goes towards that* (MS1).

Post placement, perceptions that Aboriginal patients did not engage with health care and were unwilling to improve their health were debunked. All participants clarified the skills required to practice in a more holistic manner, and some developed new skills, including: motivational counselling; ability to deal with complex health scenarios; less dependency on allied health referrals; and self-education for accessing supports and resources in the community, or social prescribing. Finally, several participants' shared new understandings of the importance of identifying and working with patient strengths,

> *I've seen a lot of resilience… I think I've learnt a bit more how to use that strength to help the patient* (PR8)

Discussion and conclusions

The three key themes of practitioner confidence and cultural safety, approaches to the practitioner-patient relationship and shifting from theoretical knowledge to practical understanding were consistent across our sample, irrespective of stage of training (student or registrar), type of speciality training program (GP or psychiatrist) or duration of placement (four weeks to 12 months). These themes inform four learning principles for medical professionalism. First, participants' exposure to more nuanced, complex and positive representations of Aboriginality challenged some of their assumptions about Aboriginal people. Strength-based approaches to Aboriginality, where Aboriginal identity is not defined by disease or deficit are important in unsettling students' implicit biases (Ewen and Hollinsworth (2016: 312). Second, participants were exposed to positive GP role

modelling at the health service. As Phelan *et al.* (2015: 990) uphold, practitioner role modelling constitutes "an important part of medical education and socialisation, and is a primary vehicle for learning professionalism". Third, appreciation of the importance of the practitioner-patient relationship developed participants' interpersonal skills that built trust and minimised patient-practitioner power imbalances, which assisted them in deepening their engagement with Aboriginal peoples. Such skills have remedial effects in care contexts fraught with patient wariness and mistrust (Cass *et al.* 2002). Furthermore, refined communication skills enabled greater responsiveness to patient priorities and needs. Lastly, participants acquired greater knowledge, understanding and skills to provide holistic care, broadening their practice scope to deal directly with patients' social and emotional needs. Participants' understanding of patient-centred care evolved to be more responsive rather than prescriptive, occurring in partnership to achieve shared understandings between patient and doctor (Balint 1969). Care also became more place-based – responsive to the unique cultures, resources and needs of the community.

While we have highlighted the potential of the learning principles identified in this study, these should not be viewed as exhaustive, taken out of context, nor used without caution. To help avoid reinstating pathologising approaches to Aboriginal health, previous studies have highlighted the importance of practitioner reflexivity to help foster a critical consciousness of the practitioner in relation to 'the Other' (Paul *et al.* 2014). Such practices can unsettle practitioner biases, and prevent development of a professional identity that is 'all knowing' and 'well-meaning'. Borrowing words of an old proverb, the history of Aboriginal – non-Aboriginal relations shows that the road to hell for Aboriginal peoples has indeed been paved with the good intentions of experts. In an effort to avoid this trajectory, the learning principles identified in this study can assist the practitioner in fostering understandings and skills to navigate medical and relational uncertainties. And critically, to do so within a place and patient-centred practice that is tailored to the patient and their context.

Despite the encouraging outcomes of this study, this pilot study was exploratory and small in its scope. To progress our learning as educators and academics in this crucial area, these learning principles need testing with larger samples in different locations through more robust methodologies. Such a pursuit will contribute to the further development of medical professionalism that better meets the needs of Aboriginal peoples – a type of professionalism we view as being critical for advancing Aboriginal health, and a necessary addition to medical education accreditation processes.

In considering the transferability of these principles to other learning sites, Murray *et al.* (2012: 3) point to the limitations of classroom learning and the importance of "quality practical experiences for students in community-centred models of health care delivery". Indeed, student and registrar learnings in this study revealed the transformation that can occur when theoretical knowledge is reinforced and brought to life with practical experience. While the urban location of this study challenges conventional notions that cultural immersion in medical education primarily occurs in remote locations, the resource capacity and finite number of such services to accommodate student learning *en masse* is clearly limited. Here it should also be stressed that cultural immersion begins in the classroom through student socialisation into medical culture (van Ryn *et al.* 2015). As such, appreciation of Aboriginal health as core component of professionalism is a critical initial step in shaping the enculturation of medical students into their profession.

Conflict of interest

Both Deborah Askew and Vivian Lyall are employees of Metro South Health, and work at the Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care where this research took place.

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