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Can my mechanic fix blue cars? Discussion of health clinician's interactions with Aboriginal Australian clients

Abstract

We expect our professional mechanics to 'diagnose' and 'treat' our cars irrespective of colour, but are we expecting less from our health professionals? There is an increasing focus in the literature on health practitioner decision-making and its influence on the nature and quality of health care. In this article we explore how the basic diagnostic and therapeutic skills that health care practitioners have should be utilised equitably for all clients and propose ways this might be realised. Could the development of Indigenous specific curricula be teaching our medical students to think that Aboriginal patients are different from the norm? We conclude that despite the gains in introducing more comprehensive Aboriginal health curricula there remains considerable work to be done before we can be confident that we are ensuring that health practitioners are no longer contributing to health disparities.

Key words:

Aboriginal Health, Indigenous Health, health professional, racism in health, health disparities.

Applying ones expertise ...

Consider the following: if we own a car that is experiencing mechanical problems we usually would seek the advice and services of a mechanic, whose expertise in mechanics as demonstrated by their qualifications. We expect the mechanic to be able to diagnose any known mechanical problems that we, as the car owner, cannot be expected to know. We expect the mechanic to explain to us what is wrong with my car, to investigate and apply the most efficient ways of fixing the car and to be held accountable if she/he misdiagnoses or maltreats the mechanical needs of the car. We, as the owner, cannot be responsible for fixing the mechanical problems that are beyond my particular expertise and knowledge.

Acknowledging the somewhat simple nature of this analogy, we ask what does such an analogy offer when considering the health of Aboriginal people? No other group within the Australian population experiences the level of health disparity that exists within Aboriginal communities. Health professionals –with their qualifications, health knowledge and skills – play a role in reducing these ongoing health disparities between Aboriginal and non-Aboriginal people. For the purposes of this article the term ‘Aboriginal’ will be used to represent Australian Aboriginal and Torres Strait Islander peoples.

Despite health professionals only playing a small part in the diverse factors influencing health and health care outcomes, it is useful to ask a range of questions. These questions include, could the continuing poor health of Aboriginal people be partly caused by health practitioners due to the practitioners not receiving the education required for reducing the ongoing health disparities? Could health professional's engagement with individuals and / or community also be a factor? Have practitioners not made the contribution they could or should do in this area? And, do we expect practitioners to be sufficiently skilled to substantially reduce the gap?

Just as we would expect a qualified mechanic to be able to repair different cars, regardless of their colour, a qualified doctor or other health professional should be able to effectively treat people from different populations with identified medical problems – regardless of their background. What if a mechanic said they could not work on your car because it is blue and they have not received blue car training? If we would not normally accept this from our mechanics why should we accept this from our health professionals? In other words, the generic skills of health care professionals are assumed. What is of interest here is what can influence the application of these skills?

From mechanic to practitioner

Specialists, professionals, authorities, experts – these are the types of qualified individuals we often seek out to provide us with the best possible service to achieve the best possible outcome/s. We rely on qualified people in their respective fields to assist us with particular problems and minimise or prevent further issues occurring. Their qualification places them in a primary position to offer and, in partnership with the patient, implement solutions. Their qualifications also demand accountability to ensure that their knowledge and skills are appropriately applied .

We expect our professional mechanics to ‘diagnose’ and ‘treat’ our cars irrespective of colour, but are we expecting less from our health professionals? There is an increasing focus in the literature on health practitioner decision-making and the influence on the nature and quality of health care ¹⁻⁵. In this article we explore how the basic diagnostic and therapeutic skills that health care practitioners have should be utilised equitably for all clients and how the education of health practitioners can contribute to this.

Australia's Aboriginal population remains the least healthy population group within Australia⁶⁻⁸. Despite targeted interventions to improve the health of Aboriginal people, there remains a life expectancy gap of 9.7 years for women and 11.5 years for men⁷. The reasons for this depends upon one's perspective: for example, health professionals frequently assume that poor health outcomes result from an individual failing to take responsibility for one's own health⁹⁻¹¹ and non-adherence with a doctor's health advice¹²⁻¹⁴. Lloyd et al., when interviewing doctors about Aboriginal health policy, found that commonly doctors perceived Aboriginal patients to be non-adherent with one doctor stating that 'Aboriginal patients are non-compliant because they are not committed to their health'^{14(p9)}. However there is evidence that Aboriginal peoples adherence to health care advice is no worse than that for non-Aboriginal peoples¹⁵. Further, attributing blame on the patient's ethnicity as the cause of less than ideal health behaviours can affect the doctor/patient relationship¹.

From an Aboriginal community perspective, the barrier between the doctor and patient can exist because of long-standing issues such as the role that health practitioners and health services have played perpetuating, or inflicting, injustices upon some members the community¹⁶. For example, throughout the 1890's –1970's, Australian hospitals actively participated in the removal of Aboriginal children from their families when they presented for treatment¹⁶. Larger hospitals are also often associated with the death of family and friends who went there for treatment and never returned^{17,18}. And, many Aboriginal patients frequently experience racism during their treatment¹³.

What if you had a blue car?

So how can Aboriginal health related content in tertiary health science curricula improve the skills of health professionals to enable more equitable health care outcomes? One of the known barriers to health access and subsequent poor outcomes in Aboriginal health is racism and perceived racism^{10,19,20}. Durey investigated

whether educating health professionals and undergraduate students in culturally respectful health service delivery is effective in reducing racism^{20(p87)}.

While the study lacked direct evidence to reveal a reduction in racism, Durey concluded that a key requirement to attain better health outcomes for Aboriginal Australians was to have

collaboration between policy makers, mainstream inter-disciplinary health services, academia and key Aboriginal stakeholders^{20(p91)}.

The behavior of health care providers contributes to health disparities, albeit unintentionally¹.

In addition, this behaviour can be more pronounced when there is discordance between the ethnicity of the practitioner and client²¹. Understanding how practitioner decision making contributes to disparity and the mechanisms at play warrants further inquiry¹, particularly given the substantially lower rates of intervention experienced by minority groups^{4, 5, 22}. Such inequitable outcomes are the product of a mix of unconscious bias³, more explicit racial discrimination⁵ and institutional racism²³ within health care systems and structures.

The influence of formal tertiary level education on health professionals could play a part, although it is not the only contributing factor^{2,19,20}, in equipping the students with cultural understandings and ways of working as a means of reducing the impacts of racism and bias

within health care decision making and hence improve patient outcomes. However, due to a lack of evaluation in this area to date, this is only an assumption^{20,24} based on anecdotal evidence.

Aboriginal health content in tertiary level health sciences is commonly titled 'Cultural Competency' or 'Aboriginal health' but there are few other consistencies in delivery²⁵⁻²⁷.

There are several models of teaching Aboriginal health: from one-off guest lecturers through an intensive five-day course²⁸, to semester-long courses or, rarely, comprehensive vertically integrated curricula embedded in each year of the health professional course²⁹. Additionally Aboriginal health can be offered as an optional or core subject²⁴. Such diversity of approaches sits at odds with what is recognised as the most effective way of teaching future health practitioners about culture and context, namely, an integrated curricular approach³⁰⁻³².

There can be several problems with the above ways of teaching health professionals about Aboriginal health. When the content is a 'one-off' unit or lecturer or intensive workshop the course structure may be inadvertently reinforcing the idea that Aboriginal patients lie outside the realm of the average patient, which can lead to essentialism and subsequent stereotyping^{33,34}. Additionally, when Aboriginal health is taught as integrated curricula in some cases it "can be simply vertically collocated, rather than meaningfully integrated"²⁴ and

without a meaningfully integrated approach, cultural competence curricula is at risk of being perceived by students and faculty alike as an 'add-on' to the important core curricula^{24(p22)}.

The perception of being an "add on" is a key issue, because by failing to meaningfully integrate Aboriginal health curricula, educators are potentially setting future health

practitioners up to not prioritise Aboriginal health issues. It is over ten years since the CDAMS Indigenous Health Curriculum Framework was developed and endorsed in Australia and New Zealand in 2004³⁵. The recent review of the implementation of the Framework shows that despite gains, there remains considerable diversity in the level of implementation across the medical schools in Australia³⁶.

This is not only an issue in Australia and New Zealand, there are some factors that are common to Indigenous communities worldwide, particularly in settler colonial contexts, which have contributed to ongoing health disparities. For example loss of country, subsequent government policies that included forced child removal and repression of culture^{16,37}. However these similarities do not mean that Aboriginal health can be essentialised nor an 'add on' in health professional training.

It is too soon for us to be confident that the existing changes to the education of health professionals will ensure more equitable health care delivery to all peoples irrespective of background and ethnicity. The way in which future health care professionals are taught, as well as what they are taught, needs further investigation. Factors that enable health professionals to continue in-equitable management of patients need to be more clearly defined, rather than assumed. In particular there is scope to ensure that practitioners do not continue to learn from a structure that can reinforce the idea that Aboriginal patients are unlike 'normal' patients. Just as if a mechanic was taught that blue cars require a different diagnostic approach when the only difference is the paint.

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