Doctor–patient communications in the Aboriginal community: Towards the development of educational programs

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Abstract

Objective: Aboriginal people in Canada have poorer health than the rest of the population. Reasons for health disparities are many and include problems in communication between doctor and patient. The objective of this study was to understand doctor–patient communication in Aboriginal communities in order to design educational interventions for medical students based on the needs and experiences of patients.

Methods: Experiences of good and poor communication were studied by semi-structured interviews or focus groups with 22 Aboriginal community members, 2 community health representatives and 2 Aboriginal trainee physicians. Transcribed data were coded and subjected to thematic analysis.

Results: Positive and negative experiences of communicating with physicians fell into three broad and interrelated themes: their histories as First Nations citizens; the extent to which the physician was trusted; time in the medical interview.

Conclusion: Aboriginal peoples’ history affects their communication with physicians; barriers may be overcome when patients feel they have a voice and the time for it to be heard.

Practice Implications: Physicians can improve communication with Aboriginal patients by learning about their history, building trust and giving time.

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1. Introduction

The health of the indigenous Aboriginal people of Canada (including First Nations, Inuit and Métis) is worse than that of the general population on virtually every measure of health and every health condition [1,2]; a similar situation is found with other native populations in westernized regions such as the USA and Australasia. Reasons for health disparities are multifactoral and include historical loss of cultural and political institutions, colonialism, racism, and residential school experiences that have had multigenerational impacts. For example, the mental health of Aboriginal people in Canada has been linked to the history of colonialism and government interventions, including the residential school system, out-adoption and centralized bureaucratic control [3]. In a public opinion poll of First Nations people in 2002, 68% identified the residential school experience and 63% the loss of land and culture as contributing to poorer health [4]. The need to improve health care through culturally relevant, community-based initiatives has been recognized and a variety of strategies have been proposed, including the specific training of health professionals to deliver culturally appropriate care. Although most Canadian medical schools have initiatives to increase the number of Aboriginal doctors [5], currently only 0.3% of Canadian doctors are Aboriginal [6]. The majority of medical care for Aboriginal people will therefore continue to be delivered by non-Aboriginal physicians.
The quality of the doctor–patient relationship and communication affects health. Good communication has been demonstrated to lead to good health outcomes [7], including emotional health, symptom resolution, function, physiologic measures and pain control [8], and increases patient satisfaction, recall and understanding of information, and adherence to treatment [9,10]. Poor communication can lead to adverse outcomes, including non-adherence to treatment and medical error [11], as well as patient complaints and claims for malpractice [12]. Communication behaviours found to be positively associated with health outcomes include empathy, reassurance and support, various patient-centred questioning techniques, encounter length, history taking, explanations, positive reinforcement, humour, psychosocial talk, time in health education and information sharing, friendliness, courtesy and summarization and clarification [13]. Physicians have poorer communication with minority patients that lead to health disparities [14]. Specific problems in miscommunication and misunderstandings between health care providers and Aboriginal people have been documented in Canada [15], the USA [16] and Australia [17]. Kaplan [18] has identified three primary areas where the different cultural backgrounds of North American Indians and the white medical profession cause communication difficulties: language use, worldview and different understandings of the history of Indian–white relations. Studies have demonstrated the limitations of the medical model [19] and the need to consider political and cultural factors that lie outside the immediate context of the medical encounter and beyond the control of either physician or patient [20].

Various guidelines for health professionals are available. For example, Ellerby et al. [21] identify seven essential qualities of ethical approaches to communication and caregiving involving Aboriginal people: respect the individual; practice conscious communication; use interpreters; involve the family; recognize alternative approaches to truth telling; practice non-interference; allow for Aboriginal medicine. Other guidelines deal with a particular type of communication such as counseling [22] or with the culture of specific First Nations communities [23].

How do non-native physicians navigate through these complexities to provide culturally sensitive care? Kelly and Brown [24] documented a process of acculturation that occurred for non-native physicians working in First Nations communities. The evolutionary communication process involved several variables including: awareness of the different styles of verbal and non-verbal communication strategies (e.g. speaking less and avoiding eye-contact), increased understanding of the connection between illness and community context, and over time, a greater respect for the culture within First Nations communities. As this progression occurred physicians became more aware of the need for specific behaviours required to communicate with patients. While their results provided important departure points for doctors seeking to better understand interactions with patients in a Canadian First Nations environment, the authors conceded that to understand communication dynamics better, the opinions of both participants in the interaction, namely physicians and patients, should be included. They also concluded that the process of successful physician acculturation and development of culturally appropriate communication strategies was difficult and took years to develop.

This study builds upon the work of Kelly and Brown by asking Aboriginal patients to provide perspectives on their interactions with physicians, with a focus on communication processes. The goal of this qualitative exploratory study was to understand the complexity of doctor–patient communication in Aboriginal communities in order to design educational interventions to assist medical students to develop culturally appropriate relationships with Aboriginal patients.

### 2. Methods

Data were collected through semi-structured interviews and focus groups with Aboriginal people. Focus groups were chosen to promote a less threatening setting for participants in community settings, consistent with the literature that suggests that focus groups are best used when a power differential exists between participants and decision makers, and when a gap exists between professionals and their target audiences [25].

Participants were recruited through key contacts at the University of British Columbia and in the Vancouver community working in Aboriginal health, and through health professionals working in Aboriginal communities. Recruitment by a snowball sampling strategy was used whereby initial participants recommended others as candidates for the study.

Interview questions were designed to explore experiences of doctor–patient communication. A draft list of interview questions was developed and pilot tested with a variety of Aboriginal informants in the community including community health representatives, First Nations patient advocates and a member of the Chiefs’ Health Committee. Suggestions for changes were mostly in wording (grammar and vocabulary), resulting in the final list of questions shown in Table 1. The protocol was flexible covering each topic area without a set question and answer format.

Semi-structured interviews were conducted with two Aboriginal trainee physicians (family practice residents at UBC), two community health representatives (from Mount Currie Indian Reserve and Haida Gwaii) and four Aboriginal community members (two recruited through South Vancouver Neighborhood House and two from Mount Currie Indian Reserve). In addition three focus groups were held at two Aboriginal community organizations in urban Vancouver, the Vancouver Aboriginal Friendship Centre (n = 7) and Vancouver Native Health (n = 7), and a native housing association (To’o) in a nearby city (n = 4).

Interviews and focus groups were up to 2 h in length and conducted by two of the authors of this paper (AT and WG)
and a research assistant. Participants were given an honorarium of CAN$ 40 (interviews) or small gifts (focus groups). Data collection occurred between March and December 2002 and continued until further interviews did not reveal new findings (saturation).

Ethics approval for the project was granted by the University of British Columbia Behavioural Research Ethics Board.

Participants varied in terms of their First Nations cultural background. All were mature adults; four were male. All spoke English fluently. With the exception of the Aboriginal family practice residents, all participants had a number of health problems, including diabetes and high blood pressure, and frequent encounters with different physicians.

All interviews and focus groups were audiorecorded and transcribed into MS Word files. The text files were then analyzed using Atlas.ti, a qualitative analysis program designed to assist with the organization and thematic analysis of qualitative data [26]. The initial coding list was developed in relation to the research questions from a preliminary reading of the transcripts. The data were coded using the list and the list was expanded to include descriptive codes of recurring events in the focus groups. The items identified through the coding process were developed into themes [27].

3. Results

The most frequently coded themes in the interviews and focus groups that related to positive and negative encounters between Aboriginal people and physicians were: history, trust and time. They were often coded simultaneously suggesting an interaction between them.

3.1. History

This theme involved their histories as First Nations citizens in a society dominated by Western thoughts and values and, for those living on reserves, a separate federally run health care service.

“I came from a close knit small community and I recall my grandmother, my, even my mom, they could only go to, um, a certain clinic. We weren’t allowed to go to the other clinic, which was, um, it seemed like for the rich and fancy . . . So you, you carry this remembering . . .”

Patients discussed stories of their time in residential schools and spoke about the feelings of inferiority and helplessness that were carried over into their interactions with physicians. For example, when asked whether or not she would express her opinion that pain medication may not be a suitable solution for her back problem, one patient said:

“No I don’t because I, I’m scared. I’m scared to talk to a doctor because they’re, their voice, the way they talk is like an, like authority kind of thing with me. I don’t know if that’s, if it’s just with me but I find that with a lot of my friends too that are Aboriginal that they go to doctors, they feel inferior. Probably because we were raised in residential schools and look, you know, looked down upon. And we also feel that. Like still, today, you know, just grown up and everything and adults, but we still feel that.”

The residential school system created experiences of abandonment and anonymity in the past that were remembered in present day experiences with physicians. A focus group member who wanted a doctor who would “not abandon you at the first sight of a little bit of trouble” said:

“There’s been abandonment, abandonment in so many different things in life. You’re forgotten, you don’t count, you don’t exist, you know . . . I was numbered when I was in a residential school. The only way I could, I could exist. The nuns didn’t know my name, I was a number. My number would get called out . . .”

Another example of the historical legacy that relates to the doctor–patient relationship was fear that doctors were implicated in a plot to kill Aboriginal people as part of a government plan.

“Their fear was that they were going to, um, kill them. That there was this huge design to get rid of us all. And, and sometimes when you go in the hospital it was, um, their belief that it was an opportune time for them to give us the wrong medicine and kill us.”

Two focus group participants talked about young people being forced to have hysterectomies as part of a government “genocide” campaign, and another spoke of doctors in the north of the province “legalized to kill Natives”.

3.2. Trust

The second theme that patients raised as being important to their understanding of the doctor–patient relationship is
the extent to which the physician is trusted. Distrust was connected to the historical legacy.

“And, and a lot of them don’t know the history of where we’ve been. Why, why do we distrust doctors? Why, why do we distrust, um, they should know where that comes from.”

In comparing a “good doctor” with prior experiences, one patient gave a specific example that linked trust with their residential school experience.

“For years, I never trust the doctors. I don’t allow them to touch my feet because of residential issues. Like the first time I went, by the second time I went to my doctor at the Vancouver Native Health and they were trying to involve my feet and my ankles swelling up and I didn’t notice it until she was finished. It’s the first time I let a doctor touch my feet. Without jerkin’ my feet.”

Distrust was maintained by a sense that the doctors communicate in an impersonal manner that the patients cannot relate to or feel uncomfortable with:

“Professional. To be not so, to be not so, I don’t know what word would probably, yeah to be professional but not so professional. Like it’s, I mean I’ve known her years and years but I don’t know her. I know it’s professional, it’s her job but she could at least take the time.”

Aboriginal patients who did indicate that they had generally positive communication experiences with their doctors usually revealed some ideas about a process they had gone through to develop a good relationship.

“Um, I hear people talking about him saying that they don’t trust him or they don’t like him and everything, stuff like that. But, um, I told them well this is what I did and we’re talking about natural medicines, we’re talking about anything. And we can sit down and have a good open discussion. And they, they said well we never tried that.”

This was contrasted by patients who had negative experiences who often described the struggle of finding a good doctor involving many changes of physicians. The development of trust and the ability to confide in their physician was rated highly by patients who had invested time in the relationship.

“My doctor that I have right now is really easy to talk to. I just feel really comfortable with him. It took me a while, a few doctors to get, find the right one and feel comfortable. And now I’ve stuck with this one for about 11 years.”

Trust could also be earned by physicians, through taking time to learn about their history and culture and by developing a more personal relationship.

“They just have to gain their trust and lots have, you know. I’ve seen lots gain trust real fast and some never, never get the trust . . . . The ones that seem to get it, uh, tried extra hard to communicate with them more, you know. Uh, the ones that went on home visits were always solidly in quicker . . . . The ones that came to things was a sign that they respected our ways.”

3.3. Time

Time was the third important theme related to patients’ level of trust and confidence with their physician or the extent to which they related their usually negative experiences with Western institutions. The Aboriginal patients interviewed were very aware of the amount of time that physicians dedicated to their interactions and related time to caring:

“The time and feeling comfortable with the doctor. I feel comfortable with both doctors but its, there’s a difference between them. Um, my family doctor is more like in a rush, in a hurry and just basically diagnoses me as, as you see. Whereas the other one takes the time to find out more questions, she asks me questions and, and I feel she’s got more feeling towards me than the other doctor. You know, she’s more caring. That’s the word, caring, not feelings but caring. Yeah, more care.”

Another aspect of time that was raised was that Aboriginal people have a different concept of time that may cause conflicts with the medical system.

“Non-Native people are a fast paced, so really grabby fast, because they’re looking at the time and a lot of us First Nations, we’re, we’re not in that mode. We run into problems because of a time factor . . . . So my experience has been that I have to sit and listen and did I really understand, what the doctor said to me because I’m digesting this in my, in my thoughts of my language. And so, um, if the doctor or even the nurse doesn’t understand, why we are silent, that says a lot when you are silent as First Nations because you’re thinking about what’s being said and you need to give the right answers back.”

Aboriginal people were sensitive to signs that they are not being given enough time and related to the physician trying to get rid of them (lack of caring).

“Because, you know, they give you things they don’t even know your real background. You know, they don’t take the time to ask you if you’re, why you need that certain thing. They just, they’re just there and they’re like okay, there’s a pen, okay write it out and you’re on your way. In and out in five minutes.”

Patients often related a good level of communication with doctors when they felt that their doctor was dedicating an adequate amount of time to learning about them. When patients did not have positive experiences with physicians they were often critical of not only the doctor but of the medical profession in general, such as how much money doctors make or how quickly doctors prescribe drugs as the solution to the problem.
“And the more patients you can push [through] the office, you know, the more money it is for them.”

“I’ve gone to some of the walk in clinics, some of the doctors weren’t that, you know, they don’t seem to give you enough time to explain what, how you feel and they just kind of just want to rush into the prescription right away.”

3.4. What can doctors do?

The suggestions for what physicians could do to improve communications followed the three themes of history, trust and time. Ideas came from the community members and were mirrored by the Aboriginal trainee family physicians based on their own experience and observation of other physicians. People thought that doctors needed to understand the history of Aboriginal people in Canada and its effect on individuals and communities. The trainees had been surprised that even their well educated classmates knew little about the residential school system and its legacy.

Trust was related to the doctor getting to know the patient as an individual and as a member of their community.

“Talk with them, get to know them. ‘Cos that’s what really makes a difference with this doctor that I’ve got. He really knows a lot about me and my family situation, my upbringing and it really, it made me feel comfortable.”

Trust was built by allowing the person to tell their story without interruption. The trainee physicians spoke of the need to be patient that interruptions are not only rude but may result in the person never opening up again.

Time was needed for the patient to explain, for the physician to understand. The trainee family physicians spoke of ways in which they planned to organize their practices to accommodate their Aboriginal patients' need for time and their different concept of time. They spoke of having a “comfortable waiting area with plenty of tea and crackers”, of saying to people that “it’s all right to come in and chat with the doctor if nothing is wrong with you, just as a kind of check in” and of scheduling patients so that they could do other useful things in the office if a patient were late or absent.

4. Discussion and conclusions

4.1. Discussion

Based on the data, we propose a model for the relationship between the major themes of history, trust and time that affect the doctor–patient relationship (Fig. 1a). Depending on the initial interactions with their physician, Aboriginal patients place different weights on these three factors when forming perceptions of their relationship with their physician.

For patients who relate feelings of fear and distrust of physicians we suggest that the relationship looks like that in Fig. 1b. For example, the patient quoted earlier (“I’m scared to talk to a doctor because . . .”) obviously has a history that is influencing her opinion of who has power in the doctor–patient relationship. Either because the doctor did not recognize the need to devote some time or the need to build the trust of the patient in this interaction, the patient is more mindful of the negative power relations that are happening and is relating these feelings to her negative history of the residential schools program. In this situation, the negative experiences from history (either personal or community) interfere with the present doctor–patient relationship and history becomes a big factor (but possibly not mentioned) in the present relationship.

However, in the case of the patient who described positive communications with her physician (“He really knows a lot about me and my family situation, my upbringing and it really made me feel comfortable”) we suggest that the relationship looks like that shown in Fig. 1c. In this situation when time is given and trust is gained the negative legacy of
history can become disconnected from the current doctor–
patient relationship.

Although this model appears valid and informative, it
may lead to the simple conclusion that medical students
need merely to have more lectures about the history of
Aboriginal people. We think this would fail and would be a
misinterpretation of our study. Our understanding of the
complex way in which history could interfere with the
doctor–patient relationship came from listening to the
stories of our informants. In the same way the Aboriginal
physician trainees spoke about the importance of learning
from their patients.

“...its really taking an interest in the person as a whole and
finding out, you know, where did you come from. That’s a
really nice question to ask any Aboriginal person ‘cause
most of them are transplanted from somewhere else when
you’re in this kind of environment in the city. And you know,
just take some interest outside of their, that instant and, um,
engage in conversations that show that you are interested.
And if you don’t understand something just say, “I’m a little
bit stupid, I don’t quite understand that, can you help me
with that?” and I think that the response to those sorts of
things is quite positive.”

We believe that facilitating the ability of students to
acquire this experiential learning will create the most
effective educational intervention.

We were surprised how little reference was made in the
interviews and focus groups to the specific communication
issues that are advocated when communicating with
Aboriginal people (such as avoiding eye contact or direct
questioning) or to the differences in world view between
Aboriginal and White cultures. While these clearly cannot
be dismissed as unimportant sources of communication
difficulty, the main conclusion we draw from our work is that
it is possible for all physicians to make an initial
improvement in the quality of the doctor–patient relation-
ship by a relatively simple attention to history, time and trust.

The need for physicians to learn about a patient’s history,
build trust and give time is not unique to those caring for
Aboriginal patients but are characteristics of good com-
munication with most patients. Research shows that longer
visits allow for more attention to aspects of care such as
increased patient participation and patient education [28];
shorter visits clearly limit the ability of physicians to listen
to patient histories and provide information, and put quality
of care in jeopardy [29]. Aboriginal people who have
complex stories that combine the personal, social and
historical, and who have culturally different concepts of
time in human interactions, suffer additional disadvantages
from having insufficient time in the encounter. Trust is a
complex construct that may refer to trust of the health care
system, general trust in physicians or interpersonal trust in a
specific physician. In two carefully developed and reported
scales, one for general trust [30] and another for trust of
specific physicians [31], items related to time, e.g. the
‘attention’ given by physicians and the behaviours of
‘explaining and listening’, were significant dimensions and
correlates of trust. However, they were only one of several
and not the most important. Good ‘communication skills’ of
physicians may help to improve trust but different factors
appear to have different influences on trust across racial
groups [32]. Aboriginal people come to the doctor–patient
encounter with an historical legacy of cultural suppression
and forced assimilation which makes trust in any authority
figure associated with western institutions especially
difficult [3].

We acknowledge that one of the limitations of the study is
that the snowball sampling may not be representative of the
wider Aboriginal community. The majority of informants
were living in urban areas, mature adults and female.
However, the purpose of the study was to provide direction
for the development of educational programs for medical
students, and most students will go on to practice in an urban
setting.

4.2. Conclusion

Communication in the medical interview is affected by
Aboriginal patients’ perceptions of history, trust and time.
Aboriginal peoples’ history affects their communication
with health care providers; barriers may be overcome when
patients feel they have a voice and the time for it to be heard,
e.g. a perception that they are treated as individuals,
respected and listened to.

4.3. Practice implications

Physicians can greatly improve the quality of their
relationships with Aboriginal people by learning about their
history; building trust by finding out about the patients as
individuals and members of their community; by giving
patients time in the interview.

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