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When a patient's ethnicity is declared, medical students' decision-making processes are affected

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Abstract

Background: Disparity in health status and healthcare outcomes is widespread and well known. This holds true for Indigenous peoples in many settings including Australia and Hawaii. While multi-factorial, there is increasing evidence of health practitioner contribution to this disparity. This research explored senior medical students' clinical decision-making processes.

Methods: A qualitative study was conducted in 2014 with 30 final year medical students from The University of Melbourne, Australia, and The John Burns Medical School, Hawaii, USA. Each student responded to questions about a paper-based case, first in writing and elaborated further in an interview. Half the students were given a case of a patient whose ethnicity was not declared; the other half considered the patient who was Native Hawaiian or Australian Aboriginal. A systematic thematic analysis of the interview transcripts was conducted.

Results: The study detected subtle biases in students' ways of talking about the Indigenous person and their anticipation of interacting with her as a patient. Four main themes emerged from the interview transcripts: the patient as a person; constructions of the person as patient; patient-student/doctor interactions; and the value of various education settings. There was a strong commitment to the patient's agenda and to the element of trust in the doctor-patient interaction.

Conclusion: These findings will help to advance medical curricula so that institutions graduate physicians who are increasingly able to contribute to equitable outcomes for all patients in their care. The study also draws attention to subtle biases based on ethnicity that may be currently at play in physicians' practices.

Key words

Aboriginal health, bias, clinical decision-making, health disparity, Indigenous

health, medical curriculum.

Introduction

Disparity in health status and health care outcomes is widespread and well known. This holds true for indigenous peoples of many countries, including Australia and Hawaii (*). Whilst we know that this disparity is multi-factorial, there is increasing evidence of health practitioner contribution¹⁻¹⁰. This research explored senior medical students' clinical decision-making processes. The findings can be used to advance medical curricula so that medical schools graduate practitioners who are increasingly able to contribute to equitable outcomes for all patients in their care. The findings also draw attention to decision-making biases based on ethnicity that may be currently influencing medical practice.

Unequal treatment of patients according to their ethnicity has been shown in decades of clinical¹⁻⁶ and vignette-based research⁷⁻¹⁰. Among the range of factors known to contribute to inequitable outcomes is healthcare-provider behaviour. Moscovitz et al found an implicit association of certain diseases and social behaviours with African American patients; they also found that this implicit stereotyping altered physician behavior¹¹. Diagnostic and treatment decisions as well as feelings about patients are also influenced by the health care providers' bias, prejudice and stereotyping¹². One feasible explanation is that while practitioners attempt to view patients without bias, their efforts often fail in the context of clinical decision-making pressure, so the power of unconscious stereotypes prevails¹³.

Furthermore, a systematic review of international research found statistically significant evidence of racist beliefs, emotions and practices among physicians in relation to minority groups¹⁴. The authors concluded, however, that 'we still know little about the extent of healthcare-provider racism'^{14, p364}. This is also true for Australia where there is clear evidence that Aboriginal and Torres Strait Islander peoples experience a greater burden of socio-economic disadvantage and poor health than do non-Indigenous Australians^{15,16}. In past attempts to explain this disparity there was an assumption that improved practitioner skills, knowledge and attitudes will bring about improvements in health outcomes for these patients. However, more recently it has been proposed that a better understanding is needed of the very nature of clinical interactions between indigenous people and health professionals. For the most part these two parties have limited prior shared experience of each other's life circumstances and often experience the interactions as difficult^{17,18}. This study is one step towards a better understanding of these patient-doctor interactions.

Our study continued investigations of the ways that practitioners' behavior may contribute to the disparities in health care and health outcomes. Our responsibility for the education of students led us to investigate senior medical students' decision-making in encounters with paper-based patient scenarios. The research was guided by the question: 'In what ways does identifying ethnicity

influence clinical decision-making?'. We also sought answers to three sub-questions:

1. What are the factors/assumptions that influence clinical decisions?
2. What is the influence of declared ethnicity in chronic disease management decisions and processes?
3. What contexts influence participant responses?

Methodology

The overview of the methodology provides a basis for the reader to make judgments about the 'transferability' (generalisability) of the study in terms of the usefulness of the findings in other contexts¹⁹.

We conducted a qualitative study at the Melbourne Medical School, Australia (MMS) and the John A. Burns School of Medicine (JABSoM), Hawaii, USA and involved medical students from the final year of their post-graduate (graduate entry) medical course. Email invitations were sent to the whole final year student group at each of the two sites (a total of approximately 370 students). Students who responded were recruited by email and provided with written information about the study. Recruitment stopped when 30 students had participated and saturation achieved, that is, no new factors were emerging and there was sufficient data to enable thematic analysis²⁰.

This is an exploratory study. It required a methodology that would draw participants into discussions, allowing the interviewer to listen to and explore their perspectives. A semi-structured written and interview-based approach was therefore preferable to the use of, for example, a semi-quantitative instrument that would have directed the students more than necessary for the purposes of an exploratory study. We consulted with clinicians, educators and researchers with expertise in Indigenous health to develop a one-page written vignette. The same patient case was given to all participants except for one factor: for half the students, the patient was described as 'Aboriginal' (Liz A for Australian students) or 'Native Hawaiian' (Liz H for students in Hawaii); for the other half of the students, the patient's ethnicity was not mentioned (Liz). While methodologies other than paper-based cases have been used to answer similar research questions in other settings¹⁻¹⁰ our employment of a paper-based case rather than actual or virtual patients is necessary for two reasons. First, the diversity of Indigenous populations does not allow generalization based upon physical appearance. A person's ethnicity or affinity with any cultural group cannot be based on the colour of their skin, nor necessarily any other physical or social markers that may or may not be present at a clinical encounter. Second, for research that builds on this exploratory study, more sophisticated methodologies can be considered, such as studies of interactions with simulated and actual patients.

The case presented clinical information about a patient visiting a General Practitioner/Family Physician in a comprehensive primary care service. Liz's history included:

- a 2month-old sore on her foot;
- HbA1c test result of 9% from 12 months ago as reported by the patient;

- tiredness and urinary frequency;
- a particular set of family social circumstances;
- a diagnosis of Type 2 Diabetes Mellitus;
- symptoms suggestive of poor blood sugar control.

Each participant was first asked to respond in writing to five written questions requiring clinical decisions for the patient. In the subsequent semi-structured interview, the student was asked questions to elaborate their thoughts about the patient and the bases of their clinical decisions for her (Tables 1 and 2). The written responses were collated and evaluated at a group level based on current clinical management protocols and guidelines²¹. The interviews were digitally recorded and transcribed verbatim and inductive procedures associated with thematic analysis - moving from margin notes (codes), to categories (sub-themes) and themes²² - were used to analyse the transcripts. We regarded the vignettes as mechanisms that provided insight into participants' ways of thinking about clinical decisions and medical interactions²³. The results of this analysis were discussed at meetings of the research team.

The Human Research Ethics Committee at The University of Melbourne approved the research, Number 1340618.

Results

Saturation was reached when 30 medical students had participated, 20 at the Australian site and 10 in Hawaii. Fourteen of the participants were female and sixteen male, and the average age was 27 (range 23-35). We present the results as one group, referring to participants as 'P1' - 'P30'. Students considering Liz (whose ethnicity was not declared) are referred to with odd numbers (P1, P3, etc); those considering Liz A (Aboriginal) or Liz H (Native Hawaiian) are referred to with even numbers (P2, P4, etc).

The clinical decisions that students made for the patient will be discussed in a separate paper. The focus here is on the subtle effects of declared ethnicity on the students' approaches to the patient and the consultation. Four themes emerged from the analysis of the interview transcripts:

- perceptions of the patient as a person;
- constructions of the person as a patient;
- anticipations of dynamics and priorities in the patient-student/doctor interactions;
- the value of particular teaching and learning experiences and settings.

The patient as person

When asked to describe Liz, participants mostly stopped after identifying her roles as a mother and wife, only one mentioned that she may work, and most were unwilling or unable to imagine her in detail. Two participants offered descriptions of what she might look like. However, in their responses to the subsequent three questions, almost all of the participants characterized her life as stressful, seeing her as feeling '*overwhelmed*' by her four children and perhaps not feeling '*in*

control' of things (see Table 3). Two students considered the possibility of marital discontent particularly given that she had wanted to move closer to her family; and, four students considered the possibility of domestic abuse.

All MMS participants were alert to Liz's statement that she was 'having trouble coping'. The spectrum of responses to this cue ranged from the benign to the extreme:

'just by virtue of human nature running into obstacles in the course of their daily lives' (P26);

'maybe she's feeling overwhelmed ... feeling anxious' (P20);

'good quality care for her would be starting off with a really thorough psychiatric assessment' (P1).

Participants from JABSoM were more likely to respond at the benign end of the spectrum, seeing troubles as part of daily life: only half of them made comment on this cue, and only one suggested screening for depression. In contrast, all of the MMS group made comment on this cue: two considered the need for psychiatric assessment, two thought the problem was minor and the other responses were between these extremes. We did not detect bias based on the patient's ethnicity here.

Constructions of 'the patient'

Two sub-themes relate to way participants talked about the person as their patient and the patient's ethnicity. Indigenous status was associated with commentary that assumed low health literacy where statements about the patient's '*understanding*' or '*education*' dominated the participants' constructions of the person as their patient. Many students extrapolated from the information in the paper case that the patient thought her last HbA1c test was about 12 months ago and that she thinks the result was 9%; they used these facts to evaluate and comment on '*her understanding*'. There was more concern about this amongst MMS students than in the JABSOM group. Across the whole participant group, students who considered Liz A were more likely than those considering Liz to see her as not understanding relevant features of her situation – her medical condition or the doctor's rationale for treatment or the medical system. Importantly, this perspective on the patient appeared to influence their priorities. For example, if '*this patient just doesn't have a full grasp of the issues ... [then] just to educate them*' was one participant's priority (P10). Furthermore, if the patient was seen to not '*understand the importance of these different services ... you could give her lots of referrals but unless she realises how important it is ...*' she will not follow up (P14) – and if a patient does not attend a referral that a doctor has made it will '*look bad on me*' (P28).

Second, a number of the participants characterised Liz A as a difficult patient: possibly limited by financial constraints (P4); perhaps not 'co-operative' or not attending '*voluntarily*' (P6); perhaps having no '*supports*' to help her look after her health (P8); she moves from GP to GP (P10); she may not follow doctor's advice

(P12) or may not follow up on your referrals (P14); the doctor will have to *'work really hard'* for her (P28). Two coined the colloquial term *'heartsink'* patient, someone with the triad of chronic diseases. The quotations in Table 3 illustrate how P6 constructs her, from thinking about the person to thinking about what it will be like to consult with her: frustrating, time-consuming, and anticipating her *'attitude'*. This may reflect the students' lack of confidence in approaching patients with complex issues and/or Indigenous patients. Alternatively, it may reflect that they have not yet developed a framework to approach complex clinical scenarios.

We acknowledge students and medical trainees are usually rewarded for responding to all possible cues in clinical cases presented to them in teaching and assessment. This may have contributed to how they noticed and sometimes dealt extensively with details of the case.

Features of the patient-doctor interaction

All participants emphasized the importance of appreciating the patient's *'priorities'* and *'agenda'* and many had a related commitment to establishing and maintaining a foundational *'trust'* in the clinical relationship (see Table 3). Many participants were also alert to the likelihood of the interaction uncovering *'mismatches'* between doctors and their patients in relation to:

- cultural views of medicine
- levels of knowledge/education
- conceptualisations of wellness
- perspectives on the seriousness of the condition of diabetes and its place in an individual's life
- patients' beliefs and preferences.

Where the patient's ethnicity was declared, participants noted even more potentially complex mismatches, including:

- a social history of negative experiences resulting in distrust of medical practitioners and the health system
- the use of (alternative) traditional healing practices that are or are not declared
- a more holistic/less individualized conceptualization of wellness.

The notion of *'trust'* was presented as embedded in the interaction as students promoted different behaviours:

- hearing what this patient wants
- comprehending both the risks and strengths in her life situation
- gently guiding her to do what the doctor knows is important (medication, investigations, specialist consultations) but within the constraints of her personal resources
- negotiating starting points and priorities for the longer term.

Ultimately, the role of trust was seen as directed towards ensuring that the patient returns to the doctor: for this patient this was seen as critical because without

agreed priorities and trust, as one said, '*nothing will work*' (P25). While this essential feature of doctor-patient interactions was common across many transcripts, the extra layer of historical mistrust and perceived additional '*mismatches*' with the Indigenous patient, positions '*trust*', at the centre of the interaction (Table 3).

Education settings

There are references in the transcripts to the emphasis in formal teaching programs on the importance of a holistic approach to clinical practice, particularly on the psychosocial aspects of care. Also, a number of participants spoke passionately and at length about the value of their rotations in general practice settings. It was in '*good*' clinics that they were able to observe practitioners as well as see patients themselves, sometimes experiencing the rewards of working with the patient's agenda (Table 3). In contrast, hospital wards offered only '*walk in, walk out*' experiences.

Here too, the serendipity that dominates clinical learning was highlighted and this randomness was particularly evident when participants were considering the Indigenous patient. There was luck in having had a friend who had undertaken a rotation in a remote Indigenous health service, or to have been awakened by one's own life experience to do the same or just to have read a book about Indigenous health. Participants also highlighted the good luck of being allocated to a well-supervised (*good*) GP clinic or the bad luck of being allocated to one that does brief consults where the student is no more than an observer in the corner. Some MMS students '*admitted*' that their knowledge of Aboriginal and Torres Strait Islander peoples (and/or their health) is poor (Table 3).

Discussion: Patients, ethnicity and decision making

This qualitative study with senior medical students aimed to generate insights into ways that a patient's declared ethnicity influences processes of clinical decision-making. The study did not explicitly explore the interaction of ethnicity and gender in clinical consultations although we acknowledge that this is important²⁴. We found that subtle biases influenced the ways the participants thought about Aboriginal patients and these biases affected some of the priorities they had for the patients. We also identified small differences between students from the two medical schools. The findings suggest medical curriculum reforms are necessary to address ways students learn about Indigenous health, about patient-doctor interactions and about their own biases. These reforms will be both general as well as particular to the school.

We did not find evidence of the extent of unequal treatment of the Indigenous patient that has previously been reported and explained by the presence of implicit bias^{11,12,13}. However, we did find important differences in the ways that these senior medical students talked about the Indigenous patient and how they would approach a consultation with her. Biases were evident in many of the commentaries on the patient's medical condition, her health literacy and/or assumptions they made about her social situation. Furthermore, if the patient was

viewed as having multiple social problems in addition to the chronic medical condition, participants were more likely to construct the consultation and their interaction with her as difficult. Here, a number of students anticipated feeling overwhelmed, or out of their depth; as a consequence they might focus on educating the patient before treating her or referring her to a range of specialists rather than working out their own approach. The subtlety of these expressions requires attention across the medical curricula to help students identify their own (and others') biases and if necessary modify their approaches to practice. It is here, too, that the medical schools need to ensure that students are adequately equipped with a framework to approach what they anticipate as or encounter as difficult consultations: as a specific curriculum reform, this is especially important given the likely increase in complex, chronic conditions that patients bring to them.

The value of the two-school study is apparent in finding differences between the two student groups: students' knowledge of Indigenous health; biased inferences about patient's health literacy; their responses to the patient 'having trouble coping'. While we do not know the reasons for these differences, we presume they result from complex interactions of formal, informal and hidden curricula²⁵ as well as societal and cultural differences. It is not possible in this paper to deliberate on or suggest curriculum changes for schools; rather, this exploratory study highlights the need to place the goal of equitable outcomes for all patients as an underpinning principle of curriculum.

There is evidence in this study that medical students anticipate many '*mismatches*' at play between doctors and their patients regardless of ethnicity, different views of motivations for attending clinic, beliefs about health, attitudes to medical treatment and personal/professional priorities. Here, in recognizing these mismatches, the students drew attention to the value they place on attending to the patient's agenda, and to the centrality of '*trust*' in the therapeutic relationship. In relation to interactions with Indigenous patients, trust was endowed with even more significance because of the extra layer of potential mismatches given the historically poor relationship between Indigenous peoples and the medical profession²⁶. The study therefore highlights an awareness amongst these medical students' of the interplay of mismatches, trust and ethnicity particularly in doctors' interactions with Indigenous peoples. This is clearly a positive finding, though not a cause for complacency given that these good intentions and patient-centred values (attention to the patient's agenda and the creation of trust) are often and easily overpowered when decisions are made under pressure of time and clinical workloads¹³. In such contexts, unconscious stereotypes are likely to influence decisions more than they influence in the quiet of a paper case. Here we note the wisdom and caution that the prejudices of good people are those that should concern us²⁷.

At the heart of the matter here is the subtlety and persistence of the findings: biases appear to affect how students think about different patients and biases seem to influence how they shape their consultations with Indigenous patients. These preconceptions might generate in their negative expectations of the

encounters with Indigenous patients, possibly influencing these future health practitioners to engage less with Indigenous patients than they do with other patients. Curriculum developers, teachers and medical practitioners alike can heed these findings as they work to recognize their own biases and influence students' biases. The goal is equitable treatment of patients and equitable patient outcomes – equitable, not equal.

The findings of this research indicate that further research with more complex methodologies is required into the perceptions and biases that students bring to, medical school as well as the impact on these students of medical school and subsequent experiences in vocational medical training programs and associated clinical/hospital rotations. The research also signals the value of a longitudinal study with these students as medical practitioners to continue to probe the influences of their biases on their decision-making and on health disparities.

Conclusion

This was an exploratory study that suggests ways of thinking that senior medical students bring to their clinical decision-making. Indigenous patients need practitioners who are sensitive to the consequences of historical and ongoing mistreatment, who can acknowledge difference and disadvantage and bring that knowledge into their plans for these patients. They need practitioners who interact with them equitably – not equally. These principles need to pervade medical curricula at university and training institutions so that students and trainees become conscious of their own biases as well as knowledgeable about different patient groups. Perhaps the approaches we found in this study – a move away from treating all patients the same, to treating each patient according to need – reflect the gains being made after more than a decade of the inclusion of Indigenous health curricula in medical education at university.

(*) *Note:* We use the terms 'Indigenous patients' and 'Indigenous peoples' to refer to Australian Aboriginal, Torres Strait Islanders and Native Hawaiian peoples.

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Tables

Table 1: Questions for written responses

1. Write a summary of what is going on for Liz
2. Based on the information available what would you do now?
3. What additional information do you want to know to enable you to develop Liz's care plan for the next 12 months?
4. What would be in your ideal preliminary health care plan for Liz?
5. What assumptions have you made to develop this health care plan?

Table 2: Interview Guide

1. Can you describe Liz to me and tell me about her situation? Consider how you imagine she looks, for example some details about how she looked in the waiting room, how she's dressed/presented, the way she interacted with you, her demeanour.
2. What do you think being well means for Liz?
3. What do you think good quality care is for Liz?
4. What do you think Liz wants from this consultation?
5. Looking at your responses to the questions, tell me what you were thinking when you made this /those decisions?
6. Additional question to some interviewees:
 - (a) If a participant who was given the Liz A or Liz H case does not mention her ethnicity in the written responses or the interview, the interviewer will ask: 'Do you think your approach to Liz was influenced by her [Aboriginality/being Native Hawaiian]?'

(b) If a participant who was given the Liz case (i.e. where no ethnicity is declared) does not mention ethnicity in the written responses or the interview, the interviewer will ask: 'Do you have assumptions in your head about this patient's ethnicity given that it wasn't mentioned in the script?'

Table 3: Four themes: Evidence/illustrative quotations

Themes with Illustrative Quotations	P#
THEME: The patient as a person	
<i>... there's too much going on and [she's] not managing it or in control in some sense. So, you know, four kids, don't know where the 23 year old is, the 20 year old has just had a baby, the 16 year old is not certain about completing school and struggling with the moves and her youngest child's deaf and has got some learning difficulties so I can see that even on</i>	P12

<p><i>that front you'd feel a little overwhelmed by all of that. And then moving, I mean five times in 15 years ...</i></p>	
<p>THEME: Construction of the patient</p>	
<p>[Describing Liz A]</p> <p><i>I imagined her to be a friendly, middle-aged patient but one of the very common sort of heart-sink patients that have multiple co-morbidities, and um yeah just the real triad of chronic diseases. ... I didn't even get a good sense of whether she had come voluntarily ... Or whether she was coming because she got told to come back. ... her patient agenda would be really important for setting the tone of the interview, how co-operative she was and how open she was with history-taking.</i></p> <p>[What the consultation might be like]</p> <p><i>It would obviously be rather frustrating because this is a long, time-consuming sort of case, um to be undertaken in the 10 minute medicine of General Practice ... she's a complex patient and it's going to be very time consuming, um yeah, it's sort of there are a number of these patients out there that people colloquially refer to as 'heartsink' patients, where they've got lots of things wrong with them, and you don't know where to start sort of and how to make a positive improvement in their health because it seems that everything that can go wrong, does go wrong, yeah, they can just be really frustrating ...</i></p>	<p>P6</p>
<p>THEME: The patient-doctor interaction: patient agenda; trust</p>	

<p><i>I like to ask the patients what their priorities are ... And then I can work from there ... just because my priorities are different doesn't mean that her priorities are less important. They're equally as important and I should base my priorities on what she also thinks is important because if I don't consider her priorities then she's not going to listen to what I tell her, and ... Nothing will work.</i></p>	<p>P25</p>
<p><i>I think if she can trust you it'll work.</i></p>	<p>P12</p>
<p><i>You know I just think with every patient they look for trust. I mean trust, a physician that's willing to listen, actively listen, also give, you know, great advice. A physician or a clinic that's willing to follow up and actually play an active role in her physical and social wellbeing. ... I think that's the, I think along with the medical recommendations I think her being comfortable and actually feeling that she can trust the physician will kind of determine her return and actually compliance as well.</i></p>	<p>P22</p>
<p><i>... some friends of mine who have done a fair bit of placement in indigenous communities and what they've kind of shared with me about the distrust that people in those communities have for, I guess, non-indigenous Australians sometimes and the kind of care they can provide. And, without assuming too much, I know that sort of history with the Stolen Generations. People just don't get that. That's another factor that could cause mistrust of bringing kids to sort of non-indigenous Australians or fronting up there. So, you know, I admit that</i></p>	<p>P16</p>

<p><i>I'm kind of ignorant overall for how ... So, yeah, I don't want to assume too much but, you know, I'd probably sort of want to see how much, yeah, they trust that sort of system. ... I guess then I'd try and gain her trust and sort of convince her of the seriousness of the situation and how I'd like to help her</i></p>	
<p>THEME: Education Settings</p>	
<p><i>I've always wanted to be, or always thought, you know, I'd be a physician or be a specialist of some sort but, and I thought general practice was quite boring, but after doing that and I was given a lot of autonomy as well ... in this particular practice the students had their own rooms and we got to see our patients before [the GP who was] such a great mentor as well ...</i></p> <p><i>I think they had a good work ethic there ... it wasn't like a super clinic or anything like that. Even though the patients ... were poor people, they had an appreciation for coming to the doctors even though it was bulk billed, you know and they really valued your opinion and they love their GP so much that, you know like if they wanted to see that particular doctor they had to see students [first]</i></p>	<p>P11</p>
<p><i>I can't remember where I picked it up from. I think it might be sort of some other, some friends of mine who have done a fair bit of placement in indigenous communities and what they've kind of shared with me about the distrust that people in those communities have for, I guess, non-indigenous Australians sometimes and the kind of care they can provide. And, without assuming too much, I know that sort of history with the Stolen Generations. People just don't get that.</i></p>	<p>P16</p>

<p><i>That's another factor that could cause mistrust of bringing kids to sort of non-indigenous Australians or fronting up there. So, you know, I admit that I'm kind of ignorant overall</i></p> <p>...</p>	
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