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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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1 **Title**

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

5

6 **Abstract:**

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

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

21

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

23

24 **What is known about the topic?**

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

27 **What does this paper add?**

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

31

32

33 **Introduction**

34

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

43

44

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

58

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

66

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

73

## 74 **Methods**

75

### 76 *Setting*

77

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

82

### 83 *Design*

84

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

91

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

100

101

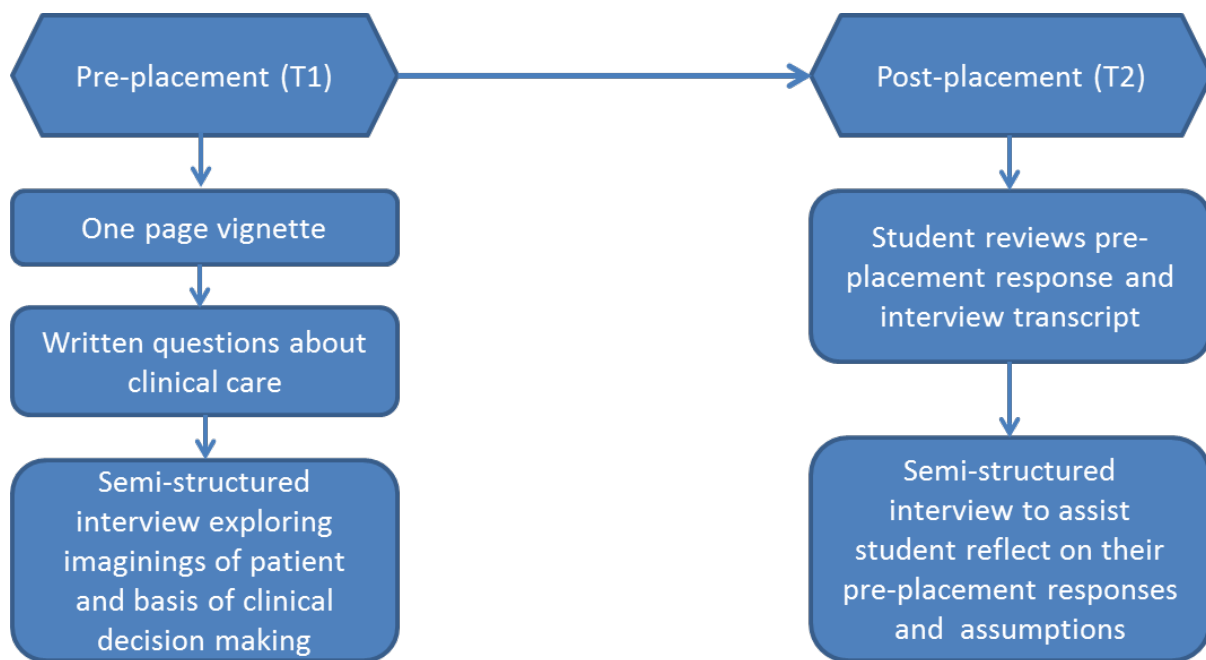


Fig 1: Study schema

102

### 103 *Ethics*

104

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

110

### 111 **Results**

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

117

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

121

122 **Table 1** Emergent themes and illustrative quotes

Pre-placement	Post-placement	ID
<b>Theme: Practitioner confidence and cultural safety</b>		
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
<b>Theme: Approaches to the practitioner-patient relationship</b>		
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
<b>Theme: Shifting from theoretical knowledge to practical understanding</b>		
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

123

124 *Practitioner confidence and cultural safety*

125

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

135



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

139

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

145

#### 146 *Approaches to the practitioner-patient relationship*

147

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

155

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

158

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

167

#### 168 *Shifting from theoretical knowledge to practical understanding*

169

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

177

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

181

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

189

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

192

### 193 **Discussion and conclusions**

194

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

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

217

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

229

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

237

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

249

#### 250 **Conflict of interest**

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

254

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