Culturally Competent Care in Obstetrics and Gynecology

A Curriculum For Obstetrics and Gynecology Residents and Physicians

IPAC-RCPSC

Indigenous Physicians Association of Canada
Association des médecines Indigènes du Canada
The Royal College of Physicians and Surgeons of Canada
Le Collège royal des médecins et chirurgiens du Canada

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Created by

The IPAC-RCPSC Obstetrics and Gynecology Curriculum Development Working Group

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Introduction

Many Aboriginal people have had negative experiences with the mainstream health-care system, often because of cultural differences between the patient or client and the health-care provider. There is a growing recognition that if the mainstream health-care system in Canada is to be effective in helping to improve the health of its First Nations, Inuit and Métis patients and clients, it must provide culturally safe care. In other words, health-care providers must take into consideration the social, political, linguistic, economic and spiritual realm in which their patient or client lives in order to communicate competently with him or her.

The roots of cultural safety in the health-care system lie in the education of its health-care providers. The Indigenous Physicians Association of Canada (IPAC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) have thus collaborated to produce this training module for obstetrics and gynecology residents and physicians. The material has been developed by the IPAC–RCPSC Obstetrics and Gynecology Curriculum Development Working Group. They have used a Case-Based Learning (CBL) approach as a springboard to guide learners through a consideration of cultural safety, particularly as it relates to First Nations, Inuit and Métis patients.

It is recommended that this educational session be delivered in conjunction with the IPAC-RCPSC preliminary curriculum, ***Promoting Culturally Safe Care for First Nations, Inuit and Métis Patients: A Core Curriculum for Residents and Physicians***, which will provide core knowledge and understanding of First Nations, Inuit and Métis health issues.

For this and ongoing education and professional development in the area of Indigenous Health, physicians should also refer often to the guiding documents:

- First Nations, Inuit and Métis Health Core Competencies for Postgraduate Medical Education
- First Nations, Inuit and Métis Health Core Competencies for Continuing Medical Education

The material in this module is meant to be the first step in a long process. Each physician who uses the module, whether he or she is an educator or a trainee, will bring his or her own perspectives and experiences to the material. We hope that users will share their views of the material with us and suggest ways to improve it; their generosity will enrich the module for the benefit of those who come after them.

For Facilitators

Starting Points

To direct a teaching session to maximize learning, it is useful to assess the learners' level of understanding of such subjects as Indigenous health and health-care disparities, population demographics (remote, rural, urban or northern locations; on or off reserve), socioeconomic issues and other determinants of health. As stated above, it must be confirmed that learners have a basic understanding of cultural competency before they can be expected to take a culturally competent approach to complex clinical cases.

Culturally competent care can be defined as "the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of health care, thereby producing better health outcomes" (Davis, 1997). *Facilitators should challenge learners to be culturally competent in defining where they draw the line at stereotypes, assumptions and racism.*

Facilitators should remember that although programs may have overt teaching sessions, such as workshops, grand rounds and one-on-one teaching in clinics or operating rooms, there are also hidden teaching opportunities during which the words and actions of faculty members will relay the most powerful message of all.

Learners learn from role models in their profession; after their awareness of cultural competency has increased they will look to the facilitator to be an ongoing advocate for culturally competent care. We must all strive to improve our cultural competency and to refine the methods we use to instill it in others. Role modeling is a powerful educational tool and highlights the importance of continuing medical education and faculty development.

"The power of role modeling should never be underestimated. What you do teaches far more than what you say."

(Pinney, Mehta, Pratt, Sarwark, Campion, Blakemore, et al., 2007)

Recommendations

It is recommended that the teaching session(s) be led by a faculty member and a co-facilitator. Depending upon the anticipated size of the group, it may be helpful to also include 1 or 2 learners in planning, moderating and evaluating the session(s).

One of the co-facilitators should have a particular interest in and knowledge of the cultures and health-care issues of Indigenous populations. Co-facilitators may include members of the Faculty of Medicine or other university faculties, allied health-care professionals (e.g., midwives, lactation consultants, nurses, social workers, Aboriginal patient liaison workers) and community elders. The role and involvement of the co-facilitator will vary.

A meeting of the session planners should occur before the seminar it, to review content, receive input from each member and allow a more personal, local lens to be applied to the cases. Indigenous cultures within Canada are heterogeneous and it is vital that the possible similarities and differences be respected.

The faculty member facilitating the session(s), the co-facilitator and the learner(s) are all encouraged to share any personal stories or cases during this learning session.

Format

The learning process for this module is intended to be case-based, with interactive dialogue and reflective thinking being the main components of the methodology. *The discussions must focus on the underlying cultural issues and patient concerns* as opposed to the clinical facts; learners will likely need guidance to maintain this focus.

This document includes clinical information about each case (not contained in the learner handouts) and highlights of the cultural issues and concerns that should be identified by the learners and form the core of the discussions during the session.

Throughout their session, learners will use their knowledge of the *First Nations, Inuit and Métis Health Core Competencies for Postgraduate Medical Education* and/or *First Nations, Inuit and Métis Health Core Competencies for Continuing Medical Education* and will reflect primarily on the competencies related to Health Advocate, Communicator, Collaborator, Manager and Professional as well as Medical Expert.

The suggested cases for the teaching sessions are designed to stimulate active learning of culturally competent and culturally safe care for Indigenous patients. In each teaching scenario, learners should learn to look for, respect and understand possible differences between non-Indigenous and Indigenous patients in similar clinical scenarios.

The discussions must focus on the underlying cultural issues and patient concerns

These case studies are proposed to start dialogue and may be used in part or as a whole, depending on the local context and input from learners, faculty and the co-facilitator. The facilitators may have to encourage the learners to approach the session with the cultural competency lens as opposed to approaching it in the same way they would the classic clinical curriculum.

Each medical school should seek to build ongoing relationships with surrounding Indigenous communities, which will ultimately strengthen teaching and learning. Although it is not mandatory or even possible within the structure of a classic academic session, programs are encouraged to provide opportunities for learner and faculty immersion in local First Nations, Métis or Inuit communities for clinical work or for cultural learning. Such participation could include health advocacy, workshops, traditional practices, ceremonies, and community events where invited.

Teaching requirements

Time:

This training session will require approximately 3-4 hours of teaching time.

Materials:

- Copies of Case Studies (included with curriculum)
- Questions to Challenge Learners
- Internet connection (recommended). Facilitators may wish to review or reference information during the teaching session.
- Flip chart or whiteboard
- paper, pencils

Resources:

- Pre-Reading: (Towle, 2006; see Resources).
- Additional readings as included with resources

Teaching format:

This module is best offered in small to medium-sized group sessions (10-15).

Learners will partake in sharing-circle discussions, oral and written reflection.

Facilitator Copy*

Goals and objectives for culturally competent care in obstetrics and gynecology

Goal

That learners in obstetrics and gynecology develop the knowledge, skills, attitudes and behaviours necessary to support healthy maternal, fetal and child development in a culturally appropriate and relevant way that respects and integrates Indigenous community traditions, practices and beliefs.

Gynecology and pre-pregnancy objectives:

1. Incorporate into patient care aspects of family planning and sexual health education as they relate to Indigenous families and patients, including traditional teachings and values *(e.g., perspective of pregnancy as a gift from the Creator, access to contraceptives, and understanding of risks of sexually transmitted infections).*
2. Recognize and assess three nutritional issues of particular concern for Indigenous women of child-bearing age *(e.g., intake of folic acid, vitamin D and traditional foods; food availability).*
3. Recognize and assess three exposure issues of particular concern in Indigenous women of child-bearing age *(e.g., exposure to alcohol, heavy metals, persistent organic pollutants, illicit drugs, tobacco, and violence).*

Pregnancy objectives:

1. Formulate care plans that incorporate at least two specific Indigenous cultural beliefs, protocols or ceremonies *(such as healing ceremonies and traditions concerning the handling of the products of conception)* related to early pregnancy loss or termination *(including therapeutic abortions, miscarriages and ectopic pregnancies).*
2. Assess the barriers to timely and adequate access to obstetrical services during regular and high-risk pregnancies.
3. Recognize the elements of relevant traditional birthing practices in First Nations, Métis and Inuit communities within the learner's catchment area and where appropriate incorporate these into patient care *(e.g., induction methods, positions in labour, use of anesthesia, caesarean sections, handling of the placenta).*

Postpartum objectives:

1. Assess specific concerns and identify traditional teachings, practices and support networks for both mothers who are breastfeeding and those who are not.
2. Assess and mobilize support resources for the following issues as applicable:

- postpartum depression
- adoption
- contraception

** Contains additional information and examples of the specific elements of the objectives, (indicated in italics for each objective) not found in the learner's copies.*

Case study 1
Part 1

As an OB-GYN physician working at a regional referral centre, you receive a referral from a community health nurse to a 15-year-old Ojibwa girl, Kristin, with low-grade cervical dysplasia noted on her last Pap smear (which was performed by the referring nurse).

Question 1

What issues do you need to consider in gathering a thorough medical history from Kristin?

While the standard approach of "history, physical examination and investigations" is the starting point, the discussion focused on culturally specific aspects of each.

Suggested answers to the questions the learners may indicate that they would pose while taking the patient's medical history are listed below. If the learners request any further information, assume that the patient would provide negative or non-contributory answers; the goal is to try to keep the discussion focused on cultural competence rather than on clinical expertise. Learners should, as a minimum, obtain the information on the checklists below.

... the goal is to try to keep the discussion focused on cultural competence rather than on clinical expertise.

History of present illness and past medical history:

- Recently told of Pap smear results
- HPV (+) on Pap smear 6 months ago, otherwise no previous Pap smear recalls
- No local–regional symptoms
- Feels systemically well
- Sexually active with irregular use of condoms
- On oral conceptive pill
- No previous pregnancies
- Irregular periods? It has been about 5–6 weeks since last period.
- No known medical conditions
- Medications: oral contraceptive pill
- Allergies: none
- Smokes 1-2 packs per week (for the past 3 years)
- Alcohol: weekends; amount: 4–5 drinks
- Illicit drug use: none

Family history:

- No history of gynecologic cancers or related malignancies
- Sister: died in a motor vehicle collision at 22 years of age
- Mother: diabetes, hypothyroidism, alcohol issues
- Maternal aunt: diabetes
- Maternal uncle: alcohol and drug issues
- Maternal grandmother: myocardial infarction at 52 years of age
- Paternal family history: unknown
- Raised by her mother and grandmother on a reserve about a 6-hour drive from the referral centre
- Parents separated; intermittent contact with father

Question 2

What are your thoughts with respect to Kristin's medical history and what effect, if any, does her First Nations culture have on:

a) your level of clinical concern;
b) the issues you would focus on; and
c) the next steps you would take in your consultation.

Possible responses may include the following:

- Abnormal Pap smear results: HPV (+) and dysplasia
- Education regarding safe sex and protective measures for sexually transmitted infections (Banister & Begoray, 2006)
- Irregular menstrual periods combined with possibility of irregular or inadequate contraception
- Pregnant?
- Health status: smokes cigarettes, consumes unspecified amount of alcohol with family history of alcohol abuse

Learners should recognize that many remote First Nations communities have high pregnancy rates (Anderson, 2002; Archibald, 2004) and incidences of sexually transmitted infections (Wong, 2008; Health Canada, 2006). Discuss factors that limit access to condoms and oral contraceptive pill (e.g., issues of confidentiality when nursing station attendants are known to the patient; cost or availability of condoms and other forms of contraception; access to testing for sexually transmitted infections and education regarding the consequences of sexually transmitted infections and unplanned pregnancy).

Quick Facts

Although there are no statistics for urban Aboriginal youth, nor for Aboriginal youth on reserve in Ontario, Health Canada data demonstrates that youth pregnancy among Aboriginal youth on reserve in Alberta, British Columbia, the Prairies and the Atlantic region are up to four times higher than rates among the general population.

For girls under 15, the rates are estimated to be as much as 18 times as high as that of the general teen population in Canada.

General physical examination:

- Consistent with a healthy 15-year-old female

Gynecology/speculum examination:

- Repeat examination did not demonstrate abnormalities on inspection

Question 3

What would be some of your primary concerns during the physical examination portion of the consultation?

As the gynecologic examination is one of the most invasive types of physical examination performed without sedation, particular attention should be paid to this element of the consultation. The following issues should be raised, among others: Kristin is only 15 years old; she may have had a minimal number of gynecologic internal examinations done previously because of limited access to health care; in remote communities it is often nurses (usually female) who do Pap smears and Kristin may never have been examined by a male health-care professional (male learners especially should recognize this); there is a high prevalence of sexual abuse in First Nations communities.

Quick Facts

Up to 75% of victims of sex crimes in Aboriginal communities are females under 18 years of age, 50% of the victims are under 14 years of age and almost 25% of the victims are younger than 7 years of age (Correctional Service of Canada, cited in McIvor & Nahanee, 1998, p. 65)

The incidence of child sexual abuse in some Aboriginal communities is as high as 75% to 80% for girls under 8 years of age (McEvoy & Daniluk, 1995; FREDA Centre for Research on Violence Against Women and Children, 2001)

As the gynecologic examination is one of the most invasive types of physical examination performed without sedation, particular attention should be paid to this element of the consultation.

Question 4

How would you begin the discussion on safe sex and sexually transmitted infections?

Recall the pre-reading: Towle, A., Godolphin, W., & Alexander, T. (2006). Doctor–patient communications in the Aboriginal community: Towards the development of educational programs. *Patient Education and Counseling, 62, 340–346.*

The potential challenges of physician–patient relationships should be mentioned, along with issues such as communication barriers, the need to build a relationship of trust and the need to understand the barriers to care and the ongoing challenges Kristin's personal situation may create.

Consider the following BEFORE the discussion with Kristin:

- Kristin's education: options, challenges, consequences
- Access to options for contraception:
  - Kristin lives in a remote environment without direct access to physicians or pharmacies
  - confidentiality (she probably has family and friends who are employed at her local health centre)
  - possible cultural beliefs regarding birth control
- Financial constraints
- Disparities in health status and statistics
- Rates of sexually transmitted infections in First Nations, Métis and Inuit compared with non-Indigenous Canadians
- Teen pregnancy rates in First Nations, Métis and Inuit compared with non-Indigenous Canadians (the Aboriginal population is the fastest growing population in Canada)

Consider the following DURING the discussion with Kristin:

- Non-verbal communication: eye contact, body language, potential discomfort with touch
- Visual tools often aid with explanations and understandings
- Silences: physicians often assume non-compliance, disinterest, denial, ignorance
- Time: do not assume that tardiness indicates disrespect
- Reciprocity (very important in many First Nations, Inuit and Métis communities): sharing something about yourself to connect with patient
- It is vital to build trust *before* building a treatment plan

Learners might also review what aspects of patient care in terms of evaluation, diagnosis and treatment might be different between this patient, who lives in a remote First Nations village, and the following patients:

- a non-Indigenous patient in the same type of environment and
- an Indigenous patient living in an urban environment.

Investigations:

- Pregnancy test

It is vital to build trust before building a treatment plan.

Case study 1
Part II

Kristin's pregnancy test is positive. This is a surprise to Kristin despite the fact that her menstrual period is 10 days late.

Question 1

What do you anticipate Kristin's response to her pregnancy test will be? What factors might influence Kristin's response to her pregnancy test?

It is best if the physician does not try to anticipate what Kristin's response will be but rather plans to share the test results and is prepared to answer her questions and be supportive.

Learners should not make assumptions on the basis of stereotypes they may hold about young, single mothers. Pregnancy in young, single women is significantly more common in Indigenous populations than in other Canadian populations, and it is often more accepted or even considered normal in some Indigenous communities. Many Indigenous cultures place high value on the belief that conception (and the resulting child) is a gift from the Creator that should be accepted. Traditionally, when young women were preparing for parenthood, elders would begin teaching them about the transition to adulthood and their enhanced responsibilities.

Community and family support of children is usually a high priority. Custom adoption of children by relatives (BC Ministry of Children and Family Development, 2007) is common in many Indigenous communities, especially Inuit ones (Pauktuutit Inuit Women of Canada, 2006a).

Learners should not make assumptions on the basis of stereotypes they may hold about young, single mothers.

Quick Fact

The Indian and Northern Affairs Canada defines custom adoption as follows: "Privately arranged adoption between two Aboriginal families. There are no social workers or lawyers involved in a custom adoption" (Indian and Northern Affairs Canada, 2008).

However, many provinces now either recognize custom adoption outright or allow the person(s) with custody to make an application to have the custom adoption recognized under their jurisdiction's adoption act.

When recognized by the court, a custom adoption has the same status as an adoption arranged under a province or territory's adoption act.

Kristin decides to continue the pregnancy and keep the child.

Question 2

What basic advice for a healthy pregnancy may be of greater importance in Indigenous than in non-Indigenous women?

- Nutrition: food availability, accessibility, affordability, etc. (Health Canada, 2002)
- Vitamin status: vitamin D deficiency (Anonymous, 2007)
- Exposure issues: Persistent Organic Pollutants (Kuhnlein, Receveur, Muir, Chan & Soueida, 1995), alcohol, tobacco, wood smoke (Health Canada, 2004), sexually transmitted infections
- Poor water quality: as of Jan. 31, 2009, 107 First Nations communities across Canada were under a drinking water advisory (Health Canada, 2009)

Kristin presents 6 weeks later with vaginal bleeding and pelvic cramping. The community nurse assesses Kristin and concludes that a spontaneous miscarriage is imminent and explains this diagnosis with Kristin.

Question 3

What are the cultural influences are important to explore with Kristin and with which she will need assistance?

How will you obtain information about these cultural influences from Kristin at such an emotional, difficult time?

If possible, have an elder or community member describe a scenario in which Kristin's grandmother might guide her through a healing ceremony.

Healing ceremonies for miscarriages often include the burial of the fetus on traditional land. Such a practice may be against hospital policy and pathology regulations. *This will highlight a potential divide between Western and traditional medicine and beliefs*; during the teaching session, the facilitator should stress how trust and respect can facilitate and optimize patient care.

Healing ceremonies and grieving practices vary among First Nations and even individual families. A majority of First Nations people are Christian and usually will follow the funerary and burial practices particular to their church. Some may follow native spiritual traditions, and some may incorporate aspects of traditional Aboriginal observances into a typical Christian ritual.

Relevant resources

1. National Defence Canada. (2007). R*eligions in Canada: Native spirituality* [website]. Retrieved March 15, 2009, fromhttp://forces.gc.ca/hr/religions/engraph/religious23_e.asp

2. Canadian Foundation for the Study of Infant Deaths & Teaching & Learning Centre. (2000). *Sudden infant death syndrome: When babies leave the circle* [video program]. Retrieved March 15, 2009, fromhttp://commons.ucalgary.ca/projects/sids.

Case study 2
Part I (Facilitator's Copy)

Mrs. Tucktoo is a 36-year-old Inuit woman from a Nunavut community (population 864). Her husband, a hunter/fisherman, was treated for tuberculosis in the late 1990s. He is the father of all her children. Two years ago, her oldest child committed suicide. Her surviving children are aged 17, 14, 9 and 6 years. She is a stay-at-home mom. The family has a three-bed-room government house. Her parents (both former students of residential schools) live with them. Her mother is unilingual Inuinnaqtun and her father is the mayor of the community.

As a visiting obstetrician, you come to Mrs. Tucktoo's community quarterly and your first appointment with her is booked at 16 weeks gestational age. You bring a portable ultrasound machine to your travel clinics. Mrs. Tucktoo's community has only air access; it has a lit airstrip. Scheduled flights land three times per week (weather permitting) and Med-Evac planes come from a larger settlement on the Arctic Coast (90 minutes away) or from your referral hospital (150 minutes away).

Major supplies come once a year by barge. The referral hospital has many specialists and family physicians but only a level I nursery. Over 90% of the deliveries are done by family physicians or midwives.

Question 1

What do you need to consider in gathering a thorough medical history from Mrs. Tucktoo?

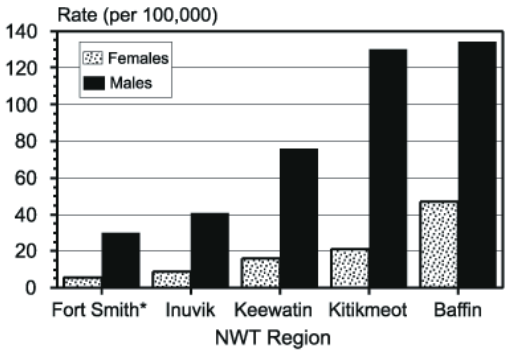
Past medical history

- G8 P5 with history of one ectopic pregnancy and one miscarriage
- Well-documented history of short, quick labour
- Estimated gestational age at the time of her first prenatal visit with the community health nurse was 14 weeks; she was 'on the land' for the summer
- Hemoglobin: 102; RH +
- Ttested positive for the hepatitis B virus
- Urine: trace/proteins
- No known allergies
- Pap: negative
- Vaginal and cervical swabs: negative
- Tested negative for HIV
- LEEP done 4 years ago for a moderate dysplasia (HGSIL)
- Alcohol use: none Patient lives in a 'dry' community – what does this mean?)
- In the summer the patient lives'on the land', 20 km away from her community; she winters in the community,)
- Tobacco use: she smokes half a pack per day

Suicide Rates in the Northwest Territories

FIGURE 1

Average annual suicide rates (per 100,000)
by NWT region, 1986-1996



* Fort Smith refers to the region as defined prior to 1988 and includes the 1997 regional health board jurisdictions of Yellowknife, Ft Smith and Ft Simpson.

FIGURE 2

Average annual suicide rates (per 100,000) by age group,
Western NWT and Nunavut, 1986-1996

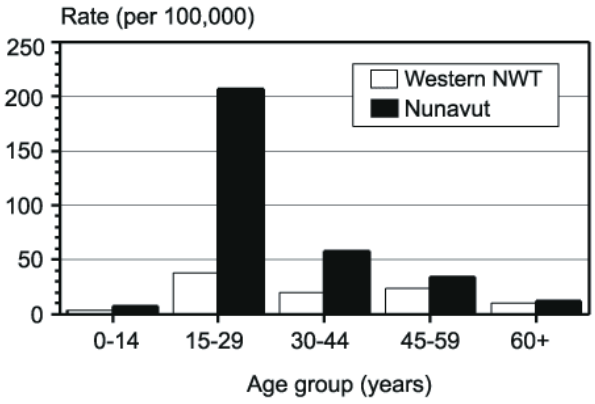
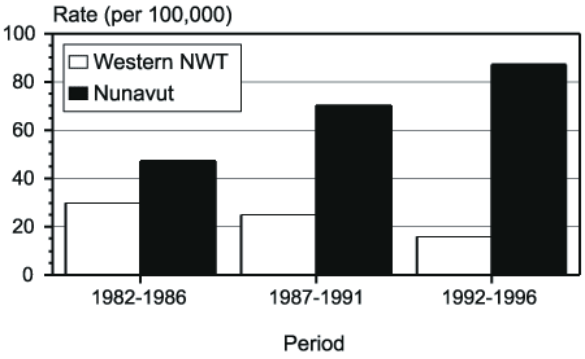


FIGURE 3

Average annual suicide rates (per 100,000) by 5-year period,
Western NWT and Nunavut, 1986-1996



Quick Facts

Lung cancer rates among Inuit in Canada are the highest in the world (Circumpolar Inuit Cancer Review Working Group, 2008) and high smoking rates are likely a contributing factor.

More than half (58%) of Inuit adults smoked on a daily basis18, with another 8% smoking occasionally. The percentage of Inuit smoking daily was over three times that of all adults in Canada (17%) (Canadian Community Health Survey, 2005).

Figures for Inuit remained relatively unchanged from 2001. In 2006, Inuit men and womenwere equally likely to be daily smokers. Inuit adults of all ages were much more likely to smoke on a daily basis than were those in the total Canadian population.

Question 2

Discuss the determinants of health for this patient and her situation.

The discussion should touch on how the loss of the traditional birthing experience in First Nations, Inuit and Métis communities affects the communities' experience of the "circle of life" as in some of these communities the residents now only experience death within their community.

- Income and social status
- Social support networks
- Education and literacy
- Employment, working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services: consider access limitations; need to transfer for regular, low-risk and high-risk deliveries
- Gender: consider the prevalence of violence against Aboriginal women (*Reference the"Sisters In Spirit Initiative: Native Women's Association of Canada, 2007a, 2007b; Pauktuutit Inuit Women of Canada, 2006b*)
- Culture

... the loss of the traditional birthing experience in First Nations, Inuit and Métis communities affects the communities' experience of the "circle of life" as in some of these communities the residents now only experience death within their community.

Quick Facts

There are no national studies providing information on the prevalence or incidence of family violence in Aboriginal communities. However, several provincial and regional studies have been conducted. A 1989 study by the Ontario Native Women's Association had the following findings:

- *Eight out of 10 Aboriginal women in Ontario had personally experienced family violence. Of those women, 87% had been injured physically and 57% had been sexually abused.*
- *In some northern Aboriginal communities, it is believed that between 75% and 90% of women are battered. Forty percent of children in these communities had been physically abused by a family member.*
- *Little is known about the incidence of abuse of older adults, of people with disabilities and of the homosexual population in Aboriginal communities. However, abuse of older adults has been identified as a serious problem in some First Nation communities (Public Health Agency of Canada, 2005).*

Question 3

What are your thoughts with respect to the medical history and what effect, if any, does Mrs. Tucktoo's Inuit culture have on:

a) your level of clinical concern;
b) the issues you would focus on; and
c) the next steps you would take in your consultation?

- Prenatal care initiated later than recommended, as she was on the land,
- Acute care is available in smaller communities through an LPN, RN, NP or itinerant family physician or specialist
- Risk of premature labour with a LEEP is 16 times higher
- Low hemoglobin
- Nutritional needs
  - traditional food versus CO-OP food (Lawn, 2002; Inuit Tapiriit Kanatami, 2008, p. 10; Doran, 2004)
  - Canada's Food Guide for First Nations, Inuit and Métis (see Resources)
- Preterm delivery: What are the risks?
- Pregnancy risks more prevalent in Indigenous populations (Wenman, Joffres, Tataryn & the Edmonton Perinatal Infections Group, 2004; Dyck, Klomp, Tan, Turnell & Boctor, 2002)?
- Overcrowded housing (Tait, 2008)
  - Deficient sanitation and ventilation
  - Spread of infectious diseases,
  - Psycho-social stresses
- Access to other testing?
  - Too late for maternal serum testing
  - Fetal ultrasound markers for chromosomal abnormalities
  - Anatomical ultrasound survey
  - Trutol: 1-hour glucose challenge test.
- Follow-up
  - Patient to be followed by the community health nurse and/or a family physician during monthly prenatal visits

Question 4

Mrs. Tucktoo agrees to an amniocentesis if it can be performed right then and there; she is highly reluctant to travel for it. Why is the patient opposed to travelling for this test?

- Requires her to leave her other children (women are often reluctant to admit their due date because they have to leave their family and are not allowed escorts to assist with their labour and delivery)
- Lack of culturally trained staff (most patients will have experienced some degree of cultural bias by medical officials during their maternity experience)
- Lack of continuity in services
- Women are rushed through tests and shuffled between caregivers, which fosters emotional distress
- Lack of cultural, mental and emotional supports
- Feelings of helplessness and inability to make informed choices
- Lack of supports for parents and families
- Failure to integrate traditional practices into maternity care
- Inuit do not see pregnancy as an illness and resist treating it as such (Olson & Carry, 2007)

How can Health Professionals Contribute to Improved Maternity Care for Remote and Northern Communities?

Be supportive of the participation of traditional midwives during prenatal care, birthing and postnatal care

- Encourage local training of professionals and midwives
- Repatriate the majority of lower risk births
- Provide educational and counseling support
- Create and share more knowledge from both traditional culturally-orientated perspectives and modern Western medical perspectives
- Inuit have a viable understanding of birthing that needs to be supported, encouraged, and integrated into programs and services available remotely and in the North.[27]

Case study 2
Part II (Facilitator's Copy)

Mrs. Tucktoo is now 32 weeks pregnant according to the first ultrasound you did at 16 weeks. A repeat ultrasound at your next clinic when she was 29 weeks pregnant showed good growth.

She presents at the nursing station at 23:00 complaining of slight bleeding and lower abdominal cramping. The latest weather report shows a major storm approaching, which could possibly shut down the area for the next few days. With wind-chill, the temperature on the runway is –62°C.

The regular doctor is on holiday and the replacement nurse (with some labour and delivery experience) has been there for a week. She phones you for your advice.

Question 1

What additional information will you need from the nurse?
What decisions need to be made first?

- Alerting Med-Evac from the Arctic Coast
- Placenta?
  - Posterior; Indicates no praevia.
- FHR?
- Cervix is soft, mid position and admits one finger. Breech?
- What tests can be done?
- Antibiotics IV (Ampicillin? Celestone IM?)
- Safest medication to be given for transportation? Indocid PR? Adalat IV?
- Issues of transporting a woman in premature labour with a breech presentation in the winter in the Arctic?
  - Keep mother warm; keep IV from freezing; access to assessment and medication and what if the baby is delivered

Question 2

Would you be able to describe all the maneuvers to be relayed to the nurse via the pilot (on the phone with you) if a breech delivery were to occur?

Fortunately, the labour stops and the plane lands safely in your town. You plan to keep Mrs. Tucktoo at the Inuit Boarding Home but after with you a couple of days she begs you to let her go back home to the Arctic Coast.

Question 3

A. What are the advantages and disadvantages of a such a Boarding Home?

B. Before you agree to release her, should you consider any other tests for Mrs. Tucktoo?

A.
- Culturally supportive
- Familiar food and language
- Continuity of Care – same attendants
- Improved Access to care
- Still away from homemwith no direct family support
- Unfamiliar surroundings
- Still does not address the loss of community birthing experiences and the fact that many communities now only experiencing community sharing in death

B.
- Fetal fibronectin? Why not?
- BPP?

Question 4

How would your care of Mrs. Tucktoo change if she was living in an urban setting?

You let Mrs. Tucktoo go back to her community with a plan to come back in three weeks. She comes back to town at 36.5 weeks and goes into spontaneous labour at 37.5 weeks with appropriate vertex presentation.

Question5

Comment on the typical behaviour of Inuit women during labour and the different labour positions they use.

How can you tell when Mrs. Tucktoo is ready to deliver?

- Traditionally, Inuit women prefer squatting or kneeling (Kemuksigak, 1990)
- Inuit patients are usually very quiet in labour and often the only sign of eminent delivery is small pearls of sweat on the forehead

Quick Facts

In 1999, the infant mortality rate for First Nations populations was 1.5 times higher than that for other populations in Canada.

The rate of deaths from injuries is three to four times higher for Aboriginal children than for other children in Canada.

Persistent high rates of sudden infant death syndrome have also been documented among Aboriginal children (Human Resources Development Canada & Health Canada, 2002).

Mrs. Tucktoo delivers a 2982-g baby girl with APGAR scores of 7-9-10 at 1-5-10 minutes. Following the birth, Mrs. Tucktoo wishes to have a tubal ligation despite the strong objections of her religious husband.

Question 6

How would you counsel the couple and what factors would you need to consider?

If the decision is to proceed with the bilateral tubal ligation, when would be the appropriate time to perform this? (Consider location.)

- Consider: reluctance of Mrs. Tucktoo to return for follow-up. Intermediate plans for contraception?
- Options for long term plans for contraception? Vasectomy?

Case study 2
Part III (Facilitator's Copy)

Mrs. Tucktoo is unsure whether she will breastfeed, especially considering that her elder sister is to custom adopt the baby (her sister's children are teenagers or young adults).

Question 1

What information should you consider in advising Mrs. Tucktoo about breastfeeding?

- A positive notation that there are increasing rates of breastfeeding in First Nations, Inuit and Métis women (National Council of Welfare, 2007)
- Financial benefits of breastfeeding (consider the cost of formula)
- World Health Organization recommendations concerning the length of breastfeeding and the benefits to the infant
- Access to education during pregnancy in preparation to breastfeeding?
- Support systems available (social supports, lactation consultants)
- Culturally relevant support systems to encourage and promote breastfeeding within the circumstances of custom adoption

Question 2

Discuss various issues related to adoption in First Nations, Inuit and Métis cultures?

The discussion may touch on such issues as the 60s scoop (Sinclair, 2007) and the number of First Nations, Inuit and Métis children currently in the care of the Children's Aid Society (Gough, Trocmé, Brown, Knoke & Blackstock, 2005).

Quick Facts

Data from provincial and territorial ministries of child and family services for 2000–2002 suggest that 30% to 40% of children and youth placed in out-of-home care during those years were Aboriginal, yet Aboriginal children made up less than 5% of the total child population in Canada.

The number of First Nations children from reserves placed in out-of-home care grew rapidly between 1995 and 2001, increasing by 71.5%.

In Manitoba, nearly 80% of the children living in out-of-home care in 2000 were Aboriginal.

Question 3

Do you think Mrs. Tucktoo would be at higher risk of postpartum depression than a non-Aboriginal woman?

There is a general lack of data on the incidence of postpartum depression in Aboriginal women. A recent study of American Indian new mothers in North Carolina revealed that 23% of new mothers in the study sample were suffering from postpartum depression; this rate is significantly higher than even the most liberal estimates in the general population (Baker, Cross, Greaver, Wei, Lewis & Healthy Start Corps, 2005).

- Leaving community and family to give birth
- Previously discussed determinants of health
- Decision to give up baby to her sister (although she will always be close to the child)
- Availability of support systems (mental health needs, breastfeeding support, family support,)
- First Nations women as survivors of intergenerational trauma: this represents a major and pervasive risk factor
- Conflict with spouse regarding birth control decisions

For Facilitators

Additional leading questions to challenge learners:

1. How much of your patient's health concerns are linked to social determinants of health as opposed to the patient's cultural background?
2. How can you address possible cultural needs that may not be being met?
3. Are you surprised by the outcomes, answers or issues that were discussed in either of the case studies? Which ones? Why?
4. Has anyone encountered similar scenarios in their training or practice to date? If so, how did you handle them? Would you change your approach next time?
5. Would your decision, opinion or perspective change if your patient was Caucasian or a patient of another specific cultural background?

Additions:

Evaluation

Proposals for Evaluation of Learning

Facilitators and learners should allow time for a general review and wrap up at the completion of the session.

Written Reflection Exercise:

Learners are asked to write a 750-1000–word reflective narrative on one of the following topics:

1. A professional experience you have had with a First Nations, Inuit or Métis patient.
    - What went well?
    - What did not go well?
    - From your readings and viewings and from today's discussion, what might you do differently now?

2. If you have had no previous interaction with First Nations, Inuit and/or Métis patients, summarize what you have learned in the educational session. Explain how you will integrate this knowledge into practice to provide the best possible care for these patients.

Other proposed evaluation techniques:

- Examination: SAQs – could be developed by facilitator
- Clinical Assessment (mock or actual) i.e. 360˚ evaluation format
    - By faculty
    - By guest co-facilitator
    - By Indigenous patients in teaching hospitals and sites where residents do regular rotations

Notes

Notes

Learner's Copy

Goals and objectives for culturally competent care in obstetrics and gynecology

Goal

That learners in obstetrics and gynecology develop the knowledge, skills, attitudes and behaviours necessary to support healthy maternal, fetal and child development in a culturally appropriate and relevant way that respects and integrates Indigenous community traditions, practices and beliefs.

Gynecology and pre-pregnancy objectives:

1. Incorporate into patient care aspects of family planning and sexual health education as they relate to Indigenous families and patients, including traditional teachings and values.
2. Recognize and assess three nutritional issues of particular concern for Indigenous women of child-bearing age
3. Recognize and assess three exposure issues of particular concern in Indigenous women of child-bearing age.

Pregnancy objectives:

1. Formulate care plans that incorporate at least two specific Indigenous cultural beliefs, protocols or ceremonies related to early pregnancy loss or termination.
2. Assess the barriers to timely and adequate access to obstetrical services during regular and high-risk pregnancies.
3. Recognize the elements of relevant traditional birthing practices in First Nations, Métis and Inuit communities within the learner's catchment area and where appropriate incorporate these into patient care.

Postpartum objectives:

1. Assess specific concerns and identify traditional teachings, practices and support networks for both mothers who are breastfeeding and those who are not.
2. Assess and mobilize support resources for the following issues as applicable:

    - postpartum depression
    - adoption
    - contraception

Case study 1
Part 1

As an OB-GYN physician working at a regional referral centre, you receive a referral from a community health nurse to a 15-year-old Ojibwa girl, Kristin, with low-grade cervical dysplasia noted on her last Pap smear (which was performed by the referring nurse).

Question 1

What issues do you need to consider in gathering a thorough medical history from Kristin?

History of present illness and past medical history:

- Recently told of Pap smear results
- HPV (+) on Pap smear 6 months ago, otherwise no previous Pap smear recalls
- No local–regional symptoms
- Feels systemically well
- Sexually active since 14 years of age with irregular use of condoms
- On oral conceptive pill
- No previous pregnancies
- Irregular periods? It has been about 5–6 weeks since last period.
- No known medical conditions
- Medications: oral contraceptive pill
- Allergies: none
- Smokes one pack per day (for the past 4 years)
- Alcohol: weekends; amount: 4–5 drinks
- Illicit drug use: none

Family history:

- No history of gynecologic cancers or related malignancies
- Sister: died in a motor vehicle collision at 22 years of age
- Mother: diabetes, hypothyroidism, alcohol issues
- Maternal aunt: diabetes
- Maternal uncle: alcohol and drug issues
- Maternal grandmother: myocardial infarction at52 years of age
- Paternal family history: unknown
- Raised by her mother and grandmother on a reserve about a 6-hour drive from the referral centre
- Parents separated; intermittent contact with father

Question 2

What are your thoughts with respect to Kristin's medical history and what effect, if any, does her First Nations culture have on:

a) your level of clinical concern;
b) the issues you would focus on; and
c) the next steps you would take in your consultation.

General physical examination:

- Consistent with a healthy 15-year-old female

Gynecology/speculum examination:

- Repeat examination did not demonstrate abnormalities on inspection

Question 3

What would be some of your primary concerns during the physical examination portion of the consultation?

Question 4

How would you begin the discussion on safe sex and sexually transmitted infections?

Investigations:

- Pregnancy test

Case study 1
Part II

Kristin's pregnancy test is positive. This is a surprise to Kristin despite the fact that her menstrual period is 10 days late.

Question 1

What do you anticipate Kristin's response to her pregnancy test will be? What factors might influence Kristin's response to her pregnancy test?

Kristin decides to continue the pregnancy and keep the child.

Question 2

What basic advice for a healthy pregnancy may be of greater importance in Indigenous than in non-Indigenous women?

Kristin presents 6 weeks later with vaginal bleeding and pelvic cramping. The community nurse assesses Kristin and concludes that a spontaneous miscarriage is imminent and explains this diagnosis with Kristin.

Question 3

What are the cultural influences are important to explore with Kristin and with which she will need assistance?

How will you obtain information about these cultural influences from Kristin at such an emotional, difficult time?

Case study 2
Part I (Learner's Copy)

Mrs. Tucktoo is a 36-year-old Inuit woman from a Nunavut community (population 864). Her husband, a hunter/fisherman, was treated for tuberculosis in the late 1990s. He is the father of all her children. Two years ago, her oldest child committed suicide. Her surviving children are aged 17, 14, 9 and 6 years. She is a stay-at-home mom. The family has a three-bedroom government house. Her parents (both former students of residential schools) live with them. Her mother is unilingual Inuinnaqtun and her father is the mayor of the community.

As a visiting obstetrician, you come to Mrs. Tucktoo's community quarterly and your first appointment with her is booked at 16 weeks gestational age. You bring a portable ultrasound machine to your travel clinics. Mrs. Tucktoo's community has only air access; it has a lit airstrip. Scheduled flights land three times per week (weather permitting) and Med-Evac planes come from a larger settlement on the Arctic Coast (90 minutes away) or from your referral hospital (150 minutes away).

Major supplies come once a year by barge. The referral hospital has many specialists and family physicians but only a level I nursery. Over 90% of the deliveries are done by family physicians or midwives.

Question 1

What do you need to consider in gathering a thorough medical history from Mrs. Tucktoo?

Past medical history

- G8 P5 with history of one ectopic pregnancy and one miscarriage
- Well-documented history of short, quick labour
- Estimated gestational age at the time of her first prenatal visit with the community health nurse was 14 weeks; she was 'on the land' for the summer.
- Hemoglobin: 102; RH +
- Ttested positive for the hepatitis B virus
- Urine: trace/proteins
- No known allergies
- Pap: negative
- Vaginal and cervical swabs: negative
- Tested negative for HIV
- LEEP done 4 years ago for a moderate dysplasia (HGSIL)
- Alcohol use: none (in the summer the patient lives on the land, 20 km away from the closest community; she winters in the community, which is "dry)
- Tobacco use: she smokes half a pack per day

Question 2

Discuss the determinants of health for this patient and her situation.

Question 3

What are your thoughts with respect to the medical history and what effect, if any, does Mrs. Tucktoo's Inuit culture have on:

a) your level of clinical concern;
b) the issues you would focus on; and
c) the next steps you would take in your consultation?

Question 4

Mrs. Tucktoo agrees to an amniocentesis if it can be performed right then and there; she is highly reluctant to travel for it. Why is the patient opposed to travelling for this test?

Case study 2
Part II (Learner's Copy)

Mrs. Tucktoo is now 32 weeks pregnant according to the first ultrasound you did at 16 weeks. A repeat ultrasound at your next clinic when she was 29 weeks pregnant showed good growth.

She presents at the nursing station at 23:00 complaining of slight bleeding and lower abdominal cramping. The latest weather report shows a major storm approaching, which could possibly shut down the area for the next few days. With wind-chill, the temperature on the runway is –62°C.

The regular doctor is on holiday and the replacement nurse (with some labour and delivery experience) has been there for a week. She phones you for your advice.

Question 1

What additional information will you need from the nurse?
What decisions need to be made first?

Question 2

Would you be able to describe all the maneuvers to be relayed to the nurse via the pilot (on the phone with you) if a breech delivery were to occur?

Fortunately, the labour stops and the plane lands safely in your town. You plan to keep Mrs. Tucktoo at the Inuit Boarding Home but after with you a couple of days she begs you to let her go back home to the Arctic Coast.

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Before you agree to release her, should you consider any other tests for Mrs. Tucktoo?

Question 4

How would your care of Mrs. Tucktoo change if she was living in an urban setting?

You let Mrs. Tucktoo go back to her community with a plan to come back in three weeks. She comes back to town at 36.5 weeks and goes into spontaneous labour at 37.5 weeks with appropriate vertex presentation.

Question 5

Comment on the typical behaviour of Inuit women during labour and the different labour positions they use.

How can you tell when Mrs. Tucktoo is ready to deliver?

Mrs. Tucktoo delivers a 2982-g baby girl with APGAR scores of 7-9-10 at 1-5-10 minutes. Following the birth, Mrs. Tucktoo wishes to have a tubal ligation despite the strong objections of her religious husband.

Question 6

How would you counsel the couple and what factors would you need to consider?

If the decision is to proceed with the bilateral tubal ligation, when would be the appropriate time to perform this? (Consider location.)

Case study 2
Part III (Learner's Copy)

Mrs. Tucktoo is unsure whether she will breastfeed, especially considering that her elder sister is to custom adopt the baby (her sister's children are teenagers or young adults).

Question 1

What information should you consider in advising Mrs. Tucktoo about breastfeeding?

Question 2

Discuss various issues related to adoption in First Nations, Inuit and Métis cultures?

Question 3

Do you think Mrs. Tucktoo would be at higher risk of postpartum depression than a non-Aboriginal woman?

Notes

Notes

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Additions:

Notes

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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.

Keywords: Patient physician communication; Communication barriers; First Nations; Aboriginal; Medical education

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.

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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)

Table 1
Interview and focus group questions

1. What does good doctor–patient communication mean to you?
2. What do you feel is important in a good relationship between a patient and a doctor?
3. From your own personal experience, can you give an example of good doctor–patient communication? What happened as a result?
4. From your own personal experience can you give an example of poor doctor patient communication? What happened as a result?
5. What do you think are the major communication problems between Aboriginal patients and doctors?
6. What are some of the things that doctors can do to improve communication with their patients?

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 audiotaped 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 and 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

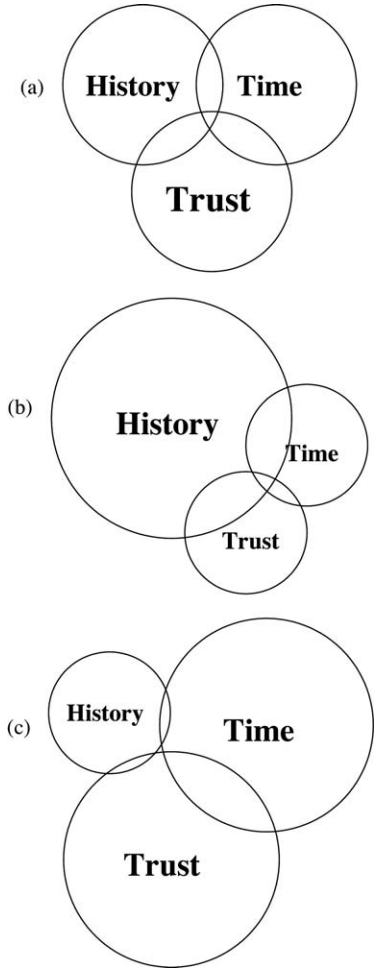

Fig. 1. (a) Conceptual diagram to illustrate the interdependent themes raised by Aboriginal informants about their communications with physicians. (b) When insufficient time is given, then history (e.g. residential school experience) looms large (and silent) and the result is little trust. (c) When sufficient time is given then history recedes as an important barrier to communication and trust grows.

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 relationship 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 communication 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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