Listening to Native patients

Changes in physicians' understanding and behaviour

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ABSTRACT

OBJECTIVE To discover how physicians develop an understanding of Native* patients and communities that enables them to communicate better with these patients.

DESIGN Qualitative method of in-depth interviews.

SETTING Native communities across Canada.

PARTICIPANTS Ten non-Native physicians providing primary care to Native patients and communities.

METHOD In-depth, semistructured interviews explored communication strategies developed by primary care physicians working with Native patients. The audiotaped and transcribed interviews were analyzed by the investigators using the phenomenologic approach of immersion and crystallization.

MAIN FINDINGS Three main themes emerged. First was elements of communication: during patient-physician communication, physicians speak less, take more time with patients, and become comfortable with silence. Second was community context: patients' illnesses are not distinct from their community context; patient care and community relations, culture, and values are often inseparable. Third was the process of change in physicians: over time, participants increased understanding of Native culture, ways of communicating, and behaviour. Change comes about through long service, listening well, and participating in community events.

CONCLUSION Developing cross-cultural communication was difficult and took years, if not forever. Understanding Native communities changed physicians. They described a journey of self-examination, development of personal relationships, and rewards and frustrations.

RÉSUMÉ

OBJECTIF Découvrir de quelle façon les médecins développent une meilleure compréhension des patients et des communautés autochtones,* qui leur permet de mieux communiquer avec ces patients.

TYPE D'ÉTUDE Méthode qualitative d'entrevues en profondeur.

CONTEXTE Les communautés autochtones du Canada.

PARTICIPANTS Dix médecins non autochtones dispensant des soins de première ligne à des patients et des communautés autochtones.

MÉTHODE Des entrevues en profondeur semi-structurées ont été utilisées pour identifier les stratégies de communication développées par des médecins dispensant des soins primaires à des patients autochtones. La transcription de ces entrevues enregistrées sur bande magnétique a été analysée par les auteurs à l'aide d'une approche phénoménologique, celle de l'immersion et de la cristallisation.

PRINCIPALES OBSERVATIONS Trois thèmes principaux ont été identifiés. Le premier concerne les éléments de communication: durant la consultation, le médecin parle moins, consacre plus de temps au patient et devient plus à l'aise avec le silence. Le deuxième concerne le contexte propre à ces communautés: les maladies sont indissociables du contexte de la communauté à laquelle appartient le patient et les soins donnés aux malades sont souvent intimement liés aux relations, à la culture et aux valeurs de ces communautés. Le troisième thème concerne le processus de changement survenu chez les médecins: avec le temps, les participants ont amélioré leur compréhension de la culture autochtone, leur façon de communiquer et leur comportement. Ces changements exigent une longue période de service, une écoute attentive et une participation aux activités de la communauté.

CONCLUSION L'établissement d'une communication interculturelle est un processus difficile qui exige plusieurs années, sinon toute une vie. Une meilleure compréhension des communautés autochtones entraîne des changements chez les médecins. Ceux-ci décrivent un long processus d'introspection, le développement de relation interpersonnelles ainsi que diverses récompenses et frustrations.

*The terms Native and First Nations are used throughout this article to denote the original inhabitants of Canada and their descendants.

*Dans cet article, les termes Autochtone et Premières Nations désignent les premiers habitants du Canada et leurs descendants.

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Canada's Native people have high rates of morbidity, mortality, and chronic disease.[1,2] While determinants of health are multifactoral,[3] there is little doubt that Canada's First Nations communities have great need of medical care.

Recently, the Canadian Medical Association and the Society of Obstetricians and Gynaecologists of Canada published documents outlining principles and recommendations for Native health care.[4,5] These documents presented information on historical issues and demographics, and the results of an in-depth examination of the need for culturally relevant, community-based initiatives for First Nations health care. Other literature[6-10] documents the burden of illness among Native people and issues in the structure of health care delivery systems.[11,12]

Physicians enter cross-cultural situations with little or no preparation[13-15] and bringing their own values,[16,17] which often differ from the values prevalent in the communities they serve. First Nations people value sharing and non-interference,[18] and have a tendency to live in the present.[19] A survey of five Ontario medical schools in 1992[13] showed that their undergraduate curriculums offered no formal training in cross-cultural issues. In 1997, a Canada-wide survey[14] of family medicine residency programs had similar findings. International studies of cross-cultural care warn against stereotyping and encourage embracing the values inherent in Native culture[15-19]: respect, understanding, and open communication. What can we learn from physicians caring for Native patients that might inform practising physicians and help prepare medical students for patient-centred care in cross-cultural settings?

Several qualitative studies have concentrated on communication[20-22] with nurses, patients, and interpreters.[23-26] They have identified important cultural elements: tradition; acceptance; equal treatment; respect; the role of family; and the importance of silence, trust, and sincerity during consultations.[23-25] Using medical interpreters and translators has been described[27,28] as have its challenges: appropriate vocabulary,[29,30] ongoing medical education,[28] advocacy,[31] and conflict resolution.[26]

Current evidence on patient-doctor communication documents the effect of communication on health outcomes. Nonjudgmental, patient-centred interviews result in patients being more satisfied with their care[32] and physicians having a better understanding of patients' experience of illness.[33-35] Attention to nonverbal communication[21,36-38] can result in actions that improve patients' outcomes.[39]

The seminal work of Brant,[40] a Native psychiatrist, highlights the core values of Native culture: noninterference, non-competitiveness, emotional restraint, sharing, and a different concept of time. Brant places verbal and nonverbal cross-cultural communication issues clearly within this context and warns us that failure to understand cultural influences can lead to errors in diagnosis and treatment.

This study describes how physicians working with First Nations patients and communities learned to understand and communicate appropriately with their patients. In describing this process, we hope to begin to fill the gap in this area in current literature. This is the first study to explore physicians' experiences of working in First Nations health care. It is also the first time the attitudes and experiences of physicians from across Canada with respect to providing health care to Native people have been explored. While organizations such as the Society of Obstetricians and Gynaecologists of Canada[4] and the Canadian Medical Association[5] have given a comprehensive overview of the macrocosm, we intend to explore the microcosm—to look at physicians' relationships with Native patients.

METHODS

Ten physicians working with Canadian First Nations communities were interviewed. We considered them key informants, people we thought would recount their experiences in an informed, thoughtful way. They gave written consent to a semistructured 1-hour interview. Ethics approval was obtained from the University of Western Ontario's Review Board for Health Science Research Involving Human Subjects.

Participants

Maximum variation sampling was achieved by recruiting through personal contact 10 non-Native family physicians who had worked with various First Nations (Ojibway, Cree, Mohawk, Peigan, Mi'kmaq, Inuit, Oneida, Sukanee, and Haida) across Canada. The six men and four women were interviewed at locations across Canada by one of the authors (L.K.).

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Data gathering

Interviews were audiotaped and transcribed verbatim. Each interview continued until the researcher felt he had a good understanding of participants' experiences. Interviews continued until theme saturation was reached.[41]

Data analysis

Each author read and interpreted the data independently and then repeated the process jointly with the other author. Immersion and crystallization techniques were used to elaborate themes.[41,42] This method of analysis allows researchers to involve themselves in the transcribed texts and experiences of participants. After repeated reflections and immersions, interpretation of themes arising from the interviews crystallized.[42]

Trustworthiness of the data was ensured several ways.[43,44] Independent and team analyses were both conducted. Experienced non-participants (Native and non-Native physicians and nurses) validated the findings. Field notes were taken during data collection, and reflection was undertaken to ensure bias had not influenced the interpretation. Member checking,[45] where participants read and critique researchers' interpretations of their interviews, further validated the data.

FINDINGS

Nine participants were family physicians; one was a specialist. Mean number of years' experience in Native health care was 14.4 years (range 3 to 30 years). Most physicians lived in non-Native communities and made daylong or week-long visits to Native communities. Participants had varied practice profiles, and all provided primary health care. Many were involved in secondary in-hospital care.

Three themes emerged from our findings: elements of communication, illnesses existing in a community context, and changes in behaviour and communication strategies. The first identified certain elements of communication: patient-physician communication in a First Nations setting involves physicians speaking less, taking more time with each patient, and becoming comfortable with silence. Second, patients and their illnesses are not distinct from their community context: patient care and community relations, culture, and values are interwoven. Finally, participants described changes in their communication strategies, behaviour, and understanding of Native culture (**Figure 1**). This gradual process was described by one physician as: "a veil being lifted from my eyes." These changes are affected by duration of service, the quality of listening, and physicians' participation in community events.

Elements of communication

The first indicator of divergent cultural values was the difference in communication styles: a very different pace to the discussion, a need for physicians to become comfortable with silence, and learning how to speak less and listen more. The most striking new communication elements were nonverbal: "Developing the patience, accepting the pregnant pauses, and the loss, the lack of eye contact. Appreciating that it wasn't rude or uncooperative behaviour." Simply speaking less was a common discovery for many: "An elder told me the story that we were born with two ears, two eyes, and one mouth and should use them accordingly. We should use the mouth just half as much as the ears and the eyes."

The amount of patience required was woven into a communication style with nonthreatening body language.

> I would be seeing a teenage girl, who is maybe in some kind of trouble…. My approach in that situation would be to sit down, sometimes on the footstool on the floor, so I don't appear to be this large, white guy looming over a small Native girl, and not say anything for a long time. So that silent thing and getting out of someone's face and avoiding direct eye contact and avoiding pressuring someone for the answers.

The verbal components of communication were rich areas for learning about other cultures. Participants universally described the novel experience of conducting consultations through an interpreter: "I was totally unprepared for how to deal with using an interpreter." Having an interpreter affected the pace, reliability, and content of patient-doctor interviews and altered physicians' way of thinking: "I had to learn how to take my thoughts and break them down into small pieces and leave enough time between the thoughts for the person to respond and the translator to process the information."

Physicians needed to use relevant concepts: "I understood that abstract concepts were sometimes not a part of the language, so [I] learned different approaches." Consultations became indirect: "I am more likely to begin with social, non–illness-related conversation, and I am more likely to talk about family and community events."

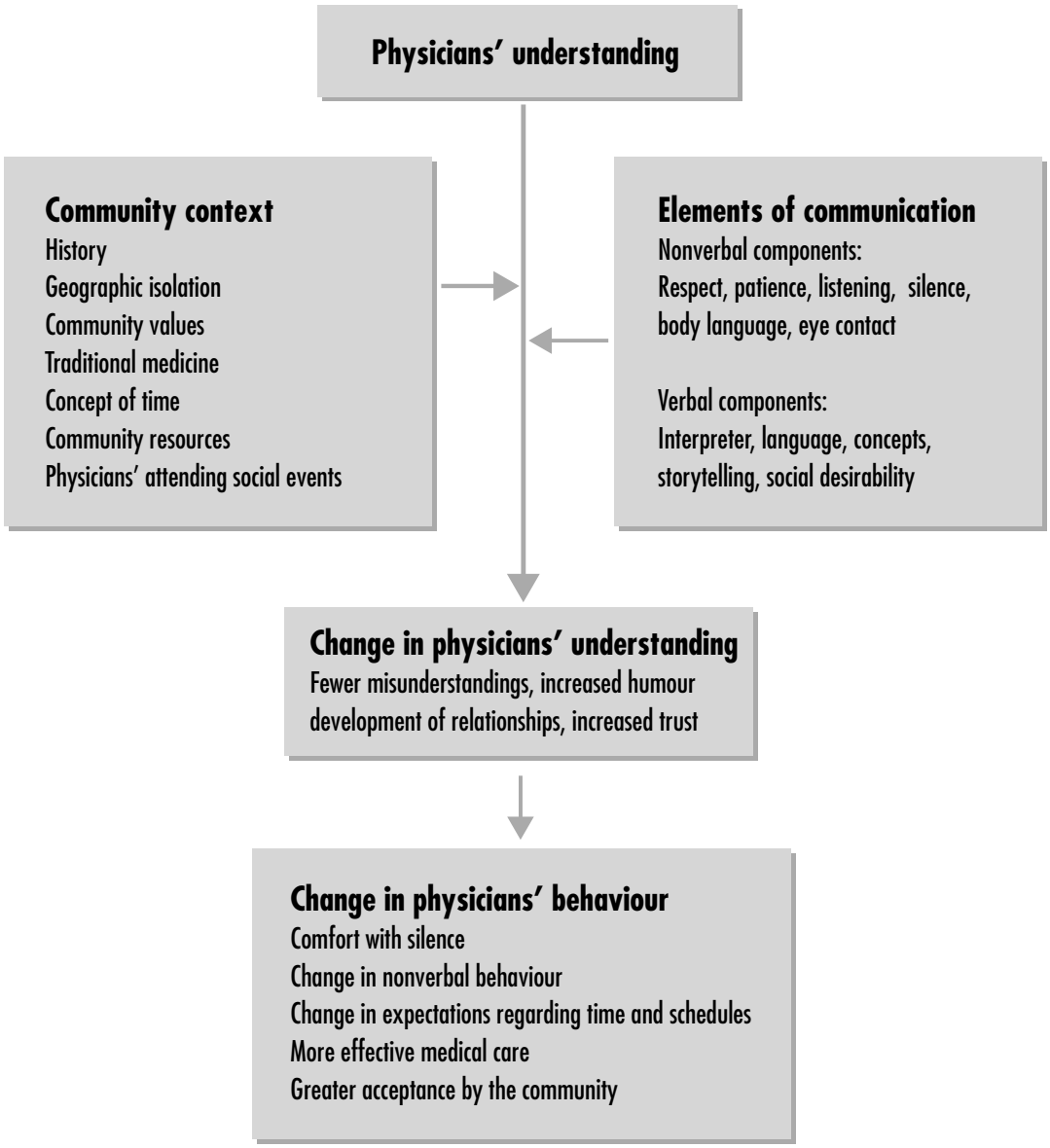
The most unfamiliar mode of verbal communication was the use of metaphor, story telling, and sense of humour, key elements of Native culture.

> One elderly lady who was developing memory loss said to me: "I'm like an old cedar tree; the top is turning silver and grey and the wood is no good, but the bottom is still green." The history of storytelling is really prevalent and if you want to understand, you have to listen to the story.

Patients also answered questions in a manner they thought would please physicians or was socially desirable.

> Well, there were the physical items: like in taking a history of whether you noticed blood mixed in with your stools. People said yes. I realized that they weren't noticing because they used outhouses. So in the context, people were giving me answers to make me happy.

Figure 1. Changes in physicians' understanding of Native culture lead to changes in their behaviour and their acceptance by Native communities



Participants pointed out how much patients varied: "Every person is an individual." They cautioned about stereotyping and identified a cross-generational aspect of nonverbal communication: "…less eye contact: again it's generational; the younger generation is changing."

Community context

Geographic and cultural isolation, history, and political events were part of the context within which patient-physician communication took place.

> The other thing I had to learn, no matter how compassionate I thought I was and sincere in my reasons for being there, I had to prove myself really, largely by being there for a period of time because everybody came and went with all their compassion.

Community context and patients' illnesses were inseparable. Patient-physician communication was a microcosm of physicians' relationships with communities. Participants often thought there was a conflict in the balance between individual rights and more commonly held communal values. Patient confidentiality was often a poor fit.

> Confidentiality is a big, big challenge. Particularly in the community, and I struggled with this, and I still do… [also] issues like abortion, birth control, or sexual abuse or social problems. If the individual's opinion or desires were at odds with the community's, they were really stuck and they were really uncomfortable in revealing that.

The concept of time varies among cultures. Participants experienced a different sense of time in Native communities that began in the waiting room and with booking patients.

> I noted that people did not keep their appointments regularly. I asked "What's wrong, why don't people come on time for their appointments?"… and she [the translator, who was of Native descent] said, "Well, look at them; they are all visiting and laughing in there, they're okay with that, like, who has the problem here?"

Practice of traditional medicine and spirituality varied widely, was controversial, and piqued the curiosity of most participants.

> Because I was quite interested in First Nations spirituality, I would often get a sense that I had said something that was deeply disturbing for people. Some of the elders would recall the days when some of those things were considered devil worship;… then I would speak to typically younger people, who had been in other communities, who had discovered some of their traditional spirituality, and they would be talking to me almost in secret.

Topics difficult to discuss and sometimes steeped in stereotyping were abuse, addiction, anger, sexuality, abortion, and end-of-life directives: "Alcohol abuse was a difficult area because it's part of the stereotypic view that we have of Native patients, and they know it."

When they became familiar with community resources, physicians discovered something of its fabric. One physician spoke of seeking out caregivers, "women who look after the sick, the dying," and asking their advice.

Changes in behaviour and understanding

Participants experienced a process of learning to understand Native culture.

> It took years of building relationships with people, with the culture, with the community, but it facilitated communication in a major way. It takes about a year for docs to feel like they have a handle on it, so that by their second year, they were feeling comfortable with their community… and by their third year, they're veterans; I mean they're almost getting efficient at it, if you can ever be efficient at it.

They described a collateral process of gaining acceptance in the community as their understanding grew. This not only engendered a sense of belonging and trust, but was thought to improve medical outcomes. One participant noted:

> I think it was sort of like a veil that gradually gets lifted. It was like realizing that I didn't know the solutions because I certainly didn't know the problems. So in some ways that's the first hurdle.

The community's trust and acceptance of this physician increased with time and allowed discussion of important issues.

> Many of us feel that if we stay for 1 year, 2 years, 5 years, it's an extraordinary length of time, but from a community standpoint, once a health care professional has been there for 2 years, it's when the community is starting to feel that they are beginning to know that person. There

> seems to be a sort of magic [at] 2 years when somehow the pieces of the jigsaw fall into place,… and I also think that's when the patients start to talk about more issues that are in their background.

Gaining acceptance from the community was facilitated by attending nonmedical community events.

> I think it is a really important way to establish the community's trust in you and to develop the relationship between you and community members. You have to take part in life-cycle events, like going to funerals, attending baptisms and weddings.

First Nations health care involves managing a high burden of chronic illness and acute psychiatric and medical crises. This type of work creates an inherent physical and emotional drain: "My experience was one of perpetual fatigue, so the whole experience was coloured by that feeling of fatigue."

The communal burden of violence and the depth of grief carried by Native communities was hard to understand.

> The most difficult thing for me is the cycle of violence and trying to break that. I try to understand it in an intellectual sense. I get so frustrated because it just seems to never end.

Participants unanimously identified the need for orientation to community values, communication strategies, and ongoing feedback from community members.

> I really learned everything from the school of hard knocks, and so that took me quite a long time to realize where things were at. Like, my first reaction is to say, silence, were just like, "What's wrong with this person? How can I possibly help this person if they won't speak?"… I do think it would have been helpful if someone had given me a bit of the lay of the land and some directives about communication styles and so on.

With so many frustrations, why would physicians endure such cross-cultural medical practice? Participants identified personal growth, personal friendships, witnessing patient triumphs, and acceptance as rewards.

> The biggest reward is establishing a relationship … with elders; they'd show tenderness toward you. And seeing successful outcomes … they will come and shake your hand and smile, without saying anything. But you know that they're saying, "You know I know you. I remember you and thank you."

Participants acquired lifelong skills and greater self-awareness.

> The skills that I learned by being patient, by listening, by understanding, by dropping or rethinking my assumptions, were skills and things that were to my benefit. When I look over, particularly the first 3 or 4 years, there were a lot of challenges to my values and it made me examine my values and I didn't always throw them out, but I certainly understood them better. So I think I became stronger, maybe more aware of myself.

DISCUSSION

Communication issues make cultural differences apparent. Our study explored cross-cultural communication issues and discovered a rich process of change in physicians' behaviour and cultural understanding. In describing the difficulties and rewards, participants showed how changes developed from a cross-cultural approach to patient care. Our study documents for the first time the 2- to 5-year time frame of this process of acculturation.

Deagle[46] identified the need for cross-cultural understanding and openness to nonverbal issues and the value of physicians' participating in nonmedical First Nations' community events. The parallel process of community acceptance and understanding Deagle also described was noted by our participants. The process of change is often difficult: "Be prepared to experience some pain."[46] Brant[40] described the cultural background of many issues highlighted by our participants: non-interference, respect, and an alternative concept of time.

Participants recounted experiencing this alternative concept of time, which required adjustments in interview style and content. They described a need for patience during interviews, in patient management, and in community relations. Communicating appropriately, which was initially very challenging, became second nature.

Patient care and community context are inextricably linked. Physicians need to understand the social structure and value system of the communities they serve. Ultimately, physicians are treating both each patient and the whole community. All

participants mentioned the rewards of cultural acceptance and personal growth, the frustrations of cross-cultural communication, and the burden of a difficult workload. They suggested that formal orientation to community values and appropriate ways to communicate and continuous informed feedback could be helpful.

Our study takes its place in the literature on Native health care by documenting the cross-cultural experiences referred to in other qualitative studies.[23-26] We have described the time frame for acculturation and the parallel process of change in physicians' behaviour and understanding that leads to acceptance by the community.

Implications

We recommend that agencies recruiting physicians for First Nations' communities make efforts to lessen the institutional and bureaucratic frustrations identified by our participants.[47] Such efforts might help retain physicians in Native communities. Most physicians recruited to a Manitoba agency over a 20-year period stayed less than 2 years in their placements,[47] mostly due to difficulties with the administration, which compounded the difficulties inherent in cross-cultural communication and led to a high turnover of physicians.

Second, we recommend orientation to cross-cultural communication and community values[48,49] to increase physicians' effectiveness. Initial formal orientation to the history and politics of the community, followed by mentoring and feedback from other health care providers and First Nations' community members could help new physicians as they begin practice in Native communities.

Limitations and future study

Of the 600 000 First Nations people in Canada, only 30%[50] live on reserves. Contact with patients in this environment taught our participants how varied their patients and communities were, but would not necessarily have addressed issues among the 70% not living on reserves.

The study did not explore the experiences of physicians involved in First Nations health care for less than 3 years. This was intentional because the authors wished to explore communication experiences that had stood the test of time. Certainly, there is also a need to understand and document the experiences of physicians who leave practice in Native communities. Also, we explored the experience of only one party in the communication process. Future studies might explore the experiences of First Nations patients.

Editor's key points

- This qualitative study examines how physicians learn to communicate with Native people.
- Patient-physician communication with Native people involved speaking less, taking more time, and being comfortable with silence.
- Patients and their illnesses are not seen as distinct, but are perceived and described within the context of their communities. This complicates discussions of private issues where patient confidentiality conflicts with community values.
- A gradual process of acclimatization allows non-Native physicians to change their communication patterns and their understanding of Native people. Being patient with this process brings unique personal and professional rewards.

Points de repère du rédacteur

- Cette étude qualitative cherchait à établir comment les médecins apprennent à communiquer avec les Autochtones.
- Pour le médecin, communiquer avec les autochtones signifie parler moins, consacrer plus de temps et être à l'aise avec le silence.
- Les patients et leurs maladies ne sont pas vus comme distincts, mais sont plutôt perçus et décrits dans le contexte de leur communauté. Cela complique la discussion de sujets d'ordre privé, dans lesquels la confidentialité des patients vient en conflit avec les valeurs de la communauté.
- Un lent processus d'adaptation permet aux médecins non autochtones de modifier leurs stratégies de communication et de développer une meilleure compréhension des peuples autochtones. La patience au cours de ce processus est garante de récompenses personnelles et professionnelles uniques.

Conclusion

This study describes a common process of change experienced by physicians working with Canada's First Nations communities. Participants experienced a change in communication style, in their approach to First Nations patients, and in the level of trust and acceptance by the community. The changes in physicians' behaviour and understanding emphasize the unique quality and dynamic nature of physicians' interactions with First Nations patients. One physician recalled:

> The sense of humility that comes with understanding your limitations, I could illustrate with a quick story: I saw a very elderly Native lady; her daughters brought

her in, she was sort of a matriarch and they called me that night and asked would I come to the house and see her and I did. Normal pulse, normal blood pressure, chest was clear, everything seemed fine and I had no idea why they called me out at night, but I was pretty annoyed that they had done that … when one of the daughters said to me: "Would you like a cup of tea?" and I said "Sure, that would be great," and that sort of diffused my little reprimand.

I went into the kitchen and sat down to have my cup of tea and while I was having the tea, the daughters went back into the bedroom, and then one of them walked out and said "Well, she's gone very peacefully now," and I said, "What?" and ran into the bedroom. She was lying there as dead as a doornail and they said: "Thank you very much for coming when mother died. You know we knew she was going to go and we really appreciate just you having been here."

I thought to myself, "Well, first of all am I ever glad that I didn't say what I had intended to say about the unnecessary visit and secondly, how the hell did they know she was dying?" I honestly did not have a clue. That injected in me a great sense of humility, like whoa, they know a lot that I don't know, about their mother but also just about death and dying and anyway I've held onto that sense of humility and that's pretty much where I remain.

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Authors' contributions

Dr Kelly *formulated the research question, designed the study, conducted the interviews, analyzed the data, and prepared the paper for publication.* **Dr Brown** *contributed to development of the research question and the design and participated in data analysis and preparing the paper for publication.*

Competing interests

None declared

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