Improving cultural respect to improve Aboriginal health in general practice: a multi-methods and multi-perspective pragmatic study

Siaw-Teng Liaw, Iqbal Hasan, Vicki Wade, Rosa Canalese, Margaret Kelaher, Phyllis Lau, Mark Harris

Background

To address the gap in access to healthcare between Aboriginal people and other Australians, we developed *Ways of Thinking, Ways of Doing* (*WoTWoD*) to embed cultural respect into routine clinical practice. *WoTWoD* includes a workshop, toolkit and cultural mentors in a partnership of general practice and Aboriginal organisations. The aim of this study was to examine the impact of *WoTWoD* on cultural respect, health checks and risk factor management for Aboriginal patients in general practice.

Methods

A multi-methods and multi-perspective pre- and-post-intervention pragmatic study with 10 general practices was undertaken, using information from medical records, practice staff, cultural mentors and patients.

Results

Cultural respect, service and clinical measures improved after implementing *WoTWoD*. Qualitative information confirmed and explained improvements. Knowledge of Aboriginal history needed further improvement.

Discussion

The *WoTWoD* may improve culturally appropriate care in general practice. Further research requires adequately powered randomised controlled trials.

Inequitable access and inappropriate care[1] are significant causes of the gap in health status between Aboriginal people and other Australians.[2–4] The Council of Australian Governments (COAG) launched *Closing the Gap* (CtG) to 'reduce Indigenous disadvantage with respect to life expectancy, child mortality, access to early childhood education, educational achievement and employment outcomes' to achieve Aboriginal and Torres Strait Islander health equality within 25 years.[5] Success will require culturally respectful social, welfare, educational and health services.[6]

General practice and primary care organisations have achieved some success with Aboriginal Liaison Officers, practice visits, seminars and informal meetings, although implementation has been variable.[7] Identified barriers to the provision of culturally and clinically appropriate care to a relatively mobile Aboriginal population included a lack of Aboriginal patient identification[8] and appropriate cultural training.[9] Guidelines to develop skills and confidence in these areas exist,[7] but there is little consensus on benchmarks for cultural training and support.

The *Ways of Thinking and Ways of Doing* (*WoTWoD*) Cultural Respect Program is a trans-theoretical approach to harmonise the many (similar) conceptual frameworks applied to Aboriginal and cross-cultural health in Australia. We drew on the theoretical domains[10] and cultural intelligence frameworks;[11] existing Australian developments in cultural respect,[6] safety[9] and competence;[12] a review of successful Aboriginal programs;[13] and comprehensive consultations with Aboriginal communities, health professionals and policy makers[14,15] to guide the development of a whole-of-practice clinical re-design program to improve ways of thinking and ways of doing cultural respect.

The *WoTWoD* consists of a cultural respect workshop, practice support from a cultural mentor and a toolkit to guide activities to embed cultural respect into routine practice. The toolkit is based

on 10 scenarios developed from true stories shared, depicting respectful and disrespectful behaviour, and discusses issues and potential solutions as identified and proposed by the Aboriginal people consulted. The toolkit also contains a list of general and local Aboriginal health and welfare resources and services. The half-day cultural respect workshop orientates participants to the *WoTWoD* program and toolkit, and involves reflection as a group on a baseline medical records audit and cultural quotient (CQ) measure.[11] The *WoTWoD* implementation is overseen by a local care partnership of Aboriginal Community Controlled Organisations (ACCO), GP organisations and general practices. A cultural mentor nominated by the local care partnership guides the practice through this flexible redesign process, with implementation in stages according to the practice's readiness. Details of the *WoTWoD* can be examined at www.cphce.unsw.edu.au/our-member-centres/academic-general-practice-unit.

This study was approved by the Ethics Committees of University of New South Wales (Approval number 11223) and Aboriginal Health & Medical Research Council (Approval number 802/11).

Hypothesis

The *WoTWoD* will promote cultural respect, as measured by a cultural quotient, and culturally and clinically appropriate care of Aboriginal patients, as measured by Aboriginal health checks done and management of risk factors.

Methods

A pragmatic pre- and post-study,[16] using qualitative and quantitative methodologies to collect and analyse data from multiple sources, was conducted in South Western Sydney in 2012–13. The study protocol included:

- establishing a local care partnership
- recruiting general practices and conducting a baseline audit of Aboriginal patients identified, health checks done and clinical risk factors managed
- completion of a generic cultural quotient (CQ) questionnaire by practice staff,[11] which measured cultural strategic thinking, motivation and behaviour. Each question had two possible answers, all applicable. One answer was allocated three points and the other zero. A higher score was equivalent to a higher CQ (*Table 1*)
- the cultural respect workshop was delivered by authors (Liaw, Wade, Canalese) and attended by at least one GP and the practice manager from each practice
- implementation of cultural respect activities, selected by practice staff with support from an Aboriginal cultural mentor
- repeating the audit and CQ 6 months after the workshop
- one-on-one interviews of GPs, practice managers and cultural mentors, conducted by an author (Hasan) at the end of the study to seek information about their experience with the study and the toolkit (*Supplementary file number 1*, available online only). Each practice nominated some Aboriginal patients to be interviewed by phone to seek information about the cultural appropriateness of care they received at the practice, from reception to the consulting room. In addition to a thematic analysis, relevant quotes were extracted from the transcripts and categorised by research questions (*Supplementary file number 2*, available online only).
- All participating practices were paid an honorarium of $500 on completion of all study tasks, which also met RACGP QI&CPD requirements.

Data analysis

SPSS Version 21.0.0.1 was used to conduct chi-square analyses for categorical variables (eg Aboriginal health checks conducted) and paired t-test analyses for continuous variables (eg CQ). Statistical significance was set at $P < 0.05$. Qualitative data were coded and checked by authors, and analysed thematically using QSR NVivo Version 6. The themes for practice staff and cultural mentors were also examined for congruence with the Theoretical Domains[10] and cultural intelligence,[11] respect,[6] safety,[9] and competence[12] frameworks.

Results

Participants

Fourteen practices expressed interest; three withdrew and one GP moved during the study, leaving 10 participating practices that completed all aspects of the study. Practices ranged from solo to large group practices, which provided a range of management models and insights into clinical and organisational redesign processes, and engagement in the local care partnership. Face-to-face interviews were conducted with 18 practice staff (one GP per practice, seven practice managers and one receptionist), three cultural mentors and 10 Aboriginal patients across all practices at the end of the study. Forty-eight Aboriginal patients were approached and 10 (six men) agreed to a telephone interview: mean age 51.4 years (SD = 9.9; range = 27–61 years); five were employed, two were retired, two were on disability pensions and one was a student. Education levels included tertiary (five), TAFE (one), secondary (three) and primary (one) school.

Outcome measures

Table 2 describes the quantitative information collected at baseline and after the intervention. At the end of the study, practices improved their readiness to provide culturally appropriate care to their Aboriginal patients, including:

- displaying Aboriginal posters, flags, and brochures in the waiting room
- registering for Indigenous Practice Incentive Payment (IPIP)
- liaising with Aboriginal organisations and encouraging staff to undertake Aboriginal cultural training.

Individual practice staff improved their cultural strategic thinking.

Qualitative findings

A number of themes emerged within the interview template used, including identification strategies and issues, cultural

awareness of practice staff, roles of cultural mentors, embedding cultural respect in practice, utility of the toolkit, Aboriginal culture and history, among others.

The new patient registration form seemed to be the preferred method for identification. The apparent reluctance to identify ethnicity in the reception may be addressed with the support of cultural mentors:

' … It is difficult to ask people about their ethnicity at the front desk ... but if they see the doctor, people tend to open up more … people are standing at the front reception desk and it's very open … [they] don't feel comfortable … ' (female receptionist in a general practice with about 900 active patients and one FTE GP).

' … Now, the front desk has been identifying them in a very sensitive manner as suggested by the mentors …' (female GP in a practice with 8750 active patients and three FTE GPs).

Practice staff reported that *WoTWoD* improved knowledge and behaviour, particularly the one-to-one engagement with the cultural mentor, and increased their sensitivity and confidence in dealing with Aboriginal patients.

' … The workshop and looking at some of the materials that we're provided, for example the toolkit, made us think what we needed to do at our practice. We identified two priorities – we needed to register for Indigenous PIP and also start using the Closing the Gap initiative for our Aboriginal patients … and we are now registered for PIP and Closing the Gap … ' (female GP in practice with 762 active patients and 1 FTE GP).

' … The information that was given to our surgery by the mentor visit was very useful and we were able to implement the toolkit very successfully … ' (female GP in practice with 1874 active patients and three FTE GPs).

' … The Aboriginal people coming now feel that we are interested in serving them better and they themselves feel more comfortable identifying themselves ... ' (female GP in a practice with 8750 active patients and three FTE GPs).

Patients confirmed the improvement, emphasising the importance of Aboriginal-specific information:

' … The practice has become friendlier over the past few months. They have made available more information on different conditions which are common among Aboriginal and Torres Strait people … ' (Aboriginal woman, late 40s, in a general practice with about 8750 active patients and three FTE GPs).

Table 1. Cultural quotient

The cultural quotient (CQ) is a measure of three distinct capabilities:

- cultural strategic thinking (CST)
- cultural motivation (MOT)
- cultural behaviour (BEH)

A 54-question assessment provides an overall CQ score as well as a score for each of the three capabilities.

The CQ is often self-assessed by individuals, but may be done objectively for individuals or organisations.

The CQ, based on the cultural intelligence scale (CIS), was developed and validated by Ang and Van Dyne.[11] Ongoing refinement and validation is being conducted, using empirical studies with experts in business, psychology, sociology, education and anthropology. The CQ instrument is now being used widely both in business and at universities.

Examples of questions include:

CST question: When it comes to knowing how to cope with cultural diversity, would you say you are very knowledgeable, or a neophyte?

MOT question: In your daily work, would you prefer a job in a culture that is similar to your own, or different from your own?

BEH question: When speaking to people from diverse cultures, do you use a consistent speaking style, or variety of accents?

Cultural mentors confirmed staff positivity and enthusiasm to learn and implement cultural respect activities. Interactions with general practice staff improved the mentors' knowledge and understanding of barriers faced by Aboriginal people attending mainstream general practices, which will help them and their local ACCO to develop new and/or modify existing programs to better engage with mainstream primary care services and enhance the referral relationship. Nevertheless, cultural mentors felt that many practice staff were still unaware of Aboriginal history, stolen generations, the assimilation policy and their negative impact on health behaviour and trust in mainstream services.

' … They [practice staff] were very, very willing to listen to us and to look at how they could improve their practices, to address Aboriginal people's needs, and I felt that all of them were prepared to make changes. All of them took on board suggestions we made, and all of them were very, very willing to learn how to engage more Aboriginal people in their practices or encourage them to identify themselves … ' (female cultural mentor – manager of local Aboriginal health service).

' ... I think it's a good initiative. It brings the awareness into the practice and it gives us some resource material and it made us aware of things, which at least I was not aware of. So overall it has been at least a good educational thing for us' (male practice manager in a practice with 8750 active patients and three FTE GPs).

' … Now we know about more of their [Aboriginal patients] entitlements, which we didn't know before ... so that they actually can benefit from it as well, and we know a little more about their culture and, I think, they do appreciate the efforts that we are putting [in] for them … ' (male GP in a practice with 24,287 active patients and six FTE GPs).

Our observations suggest that a local care partnership that nurtured a supportive environment for the participants and cultural mentors was also an important enabler of the *WoTWoD*.

Table 2. Changes in cultural quotient, identification, health checks and clinical risk factors

	Baseline	Post-intervention	
Demographics of practices (n = 10)	**Number (%)**	**Number (%)**	***P* value**
All active patients	98,824	97,030	NS
Aboriginal patients (total)	122 (0.12%)	197 (0.2%)	<0.05
Number by age group			
0–4 years	11 (9.0%)	19 (9.6%)	
5–14 years	15 (12.3%)	28 (14.2%)	
15–24 years	24 (19.7%)	26 (13.2%)	
25–44 years	43 (35.2%)	68 (34.5%)	
45–54 years	17 (14.0%)	28 (14.2%)	
≥55 years	12 (9.8%)	28 (14.2%)	
Identification of new patients	**Number**	**Number**	***P* value**
Patient registration form	6	8	NA
Reception staff ask	2	1	NA
GP ask during consultation	1	1	NA
Identification of existing patients	**Number**	**Number**	***P* value**
From practice software	7	7	NA
Reception staff ask	1	0	NA
GP ask during consultation	1	3	NA
Practice organisational arrangement	**Number**	**Number**	***P* value**
Registration for Aboriginal PIP	7	10	NA
Liaise with Aboriginal Controlled Organisation	2	7	NA
Staff undertook cultural training	–	23	NA
Chronic disease risk factor recorded	**Number (%)**	**Number (%)**	***P* value**
Body mass index	61 (50%)	94 (48%)	NS
Waist circumference	22 (18%)	44 (22%)	NS
Blood pressure	77 (63%)	119 (60%)	NS
Smoking	97 (80%)	166 (84%)	NS
Alcohol intake	41 (34%)	111 (56%)	<0.05
Cardiovascular risk assessment	25 (20%)	47 (24%)	NS
Lipids	45 (37%)	76 (39%)	NS
Fasting blood glucose	29 (24%)	70 (36%)	<0.05
Health assessment billed	**Number (%)**	**Number (%)**	***P* value**
MBS Item 721	29 (24%)	44 (22%)	NS
MBS Item 723	25 (20%)	39 (20%)	NS
MBS Item 715	19 (16%)	46 (23%)	NS
Cultural quotient (n = 14 staff from 10 practices)	**Mean (SD)**	**Mean (SD)**	***P* value (95% confidence intervals)**
Cultural strategic thinking (CST)	29.8 (6.2)	36.0 (9.2)	*P* <0.05 (1.5–10.9)
Motivation (MOT)	23.8 (9.7)	29.1 (8.1)	*P* >0.05 (0.0–10.7)
Behaviour (BEH)	21.2 (7.4)	24.6 (7.5)	*P* >0.05 –1.4–8.3)
Total CQ score	74.8 (17.6)	89.8 (18.8)	*P* <0.05 (4.1–25.9)

Finally, general practice staff recognised the need for information about Aboriginal-friendly services and to contextualise the provision of culturally and clinically appropriate care. Cultural mentors and GPs described the toolkit as a 'one-stop shop' – concise and to the point – with all the important information in one place to support their cross-cultural needs in context.

' ... (the toolkit) is a very handy document. I like the case studies because it puts Aboriginal health into a scenario that the GP can look at and understand. It will also be useful for practice accreditation process … ' (female cultural mentor – registered nurse at local Aboriginal health service).

These findings must be taken in context. Cultural strategic thinking was improved along with screening for chronic disease risk factors and conduct of health assessments for both Aboriginal and non-Aboriginal patients (*Table 2*) However, knowledge about Aboriginal-specific services seemed to be limited, particularly from the patient's perspective.

' … she is a brilliant doctor and … very proactive in a lot of things. But I think the knowledge base on the services available to Indigenous people is very, very limited ... ' (Aboriginal man, mid 50s, in a general practice with 1874 active patients and three FTE GPs).

Discussion

The findings suggest that the *WoTWoD* could improve cultural strategic thinking and culturally appropriate care, as indicated by the changes in practice physical settings, organisational processes within the practice and in engaging with Aboriginal organisations, and using the Aboriginal initiatives such as the Indigenous PIP. Because of the short duration of the study, we did not expect any changes in behaviour or clinical risk factor profiles.

The improvements found could be explained by the theoretical domains[10] and cultural intelligence[11] frameworks thus: the *WoTWoD* Program contextualised and addressed knowledge, skills, motivation, environmental context and social/professional role and identity. The toolkit formalised the content, using real-world scenarios illustrating cultural respect and disrespect, beliefs about capabilities and consequences, motivation and goals; it sensitised practice staff to sociocultural influences, beliefs and motivation of Aboriginal patients and improved their cultural strategic thinking. By facilitating access to and knowledge of Aboriginal health services and programs, guidelines, MBS/PBS items and CtG entitlements, the toolkit improved cultural and technical competence to manage Aboriginal health and welfare issues. Improved cultural competence will enable general practice staff to provide more informed feedback to deliverers of cultural awareness training programs,[9] leading to better programs.

Cultural mentors, working with practice staff in their own environment, were effective translators of cultural respect theory and knowledge, as formalised in the toolkit and delivered by the workshop, into practice. They can enhance the WoT (ways of thinking) and WoD (ways of doing) culturally and clinically appropriate care by sharing their understanding of how Aboriginal history influences Aboriginal health behaviour, and their trust in and use of general practice services. Understanding Aboriginal history is important because health professionals often assert that they 'treat all their patients the same', not acknowledging that 'patients are not all equal'. Oliver Wendell Holmes (1860), a dean of Harvard Medical School, described this as '…there is no greater inequality than the equal treatment of unequals'. Cultural respect is more than cultural intelligence or competence; it includes the understanding of, advocating for and acting on the specific needs of the minority culture in question.

While encouraging, this study may not be generalisable beyond general practices that saw a need for cultural respect and had some experience with Aboriginal patients. The lack of a randomised control group and small sample size raises the need for adequately powered randomised controlled trials to robustly evaluate the impact of the *WoTWoD* in a range of settings. Non-participation by practice nurses limited the representativeness of this study. The education and occupation of Aboriginal patients interviewed did not characterise a 'disadvantaged' group, although the perceptions were similar to those found in similar studies with more disadvantaged groups. Not using an independent interviewer raised an issue of reflexity; that participants did not raise issues with feedback was reassuring. Nevertheless, collecting and triangulating rich complementary quantitative and qualitative information from three sources – general practice staff, cultural mentors and patients – improved the rigour of this study.

Conclusion

The *WoTWoD* combined many personal, professional and organisational strategies into a logical 'bundle' of mutually reinforcing activities to embed cultural respect in practice with encouraging improvements in staff cultural quotient, Aboriginal health checks and management of clinical risk factors. Insights into possible mechanisms to improve cultural respect were gained to guide future pragmatic randomised controlled trials to examine the impacts and outcomes of cultural respect and mentorship programs on Aboriginal health specifically and cross-cultural health generally.

Authors

Siaw-Teng Liaw, PhD, FRACGP, FACHI, FACMI, Professor of General Practice, University of New South Wales and Director, General Practice Unit, South West Sydney Local Health District, NSW. siaw@unsw.edu.au

Iqbal Hasan MBBS, MPH, Research Officer, Centre for Primary Health and Equity, University of New South Wales, Sydney, NSW

Vicki Wade MSc (Nursing), Cultural Lead, Aboriginal Health, National Heart Foundation, Sydney, NSW

Rosa Canalese MPH, FRACGP, Director of Training, GP Synergy, Sydney, NSW

Margaret Kelaher BSc, PhD, Deputy Director, Centre for Health Policy, School of Population Health, University of Melbourne, VIC

Phyllis Lau , BPharmSci (Hons), GradDip Drug Eval Pharm Sci, PhD, Research Fellow in Chronic Disease and Indigenous Health, General Practice, University of Melbourne, VIC

Mark Harris MB BS MD Syd, DRACOG, FRACGP, Senior NHMRC Principal Research Fellow, Centre for Primary Health Care and Equity, University of New South Wales, Sydney, NSW

Competing interests: Iqbal Hasan and Siaw-Teng Liaw's institution received grants from GP Synergy and the NSW Health in relation to the work discussed in this article. Siaw-Teng Liaw is also paid as a board member of GP Synergy. Margaret Kelaher and Phyllis Lau's institutions received NHMRC grants for the work discussed in this article.

Provenance and peer review: Not commissioned, externally peer reviewed.

Acknowledgments

Funding was provided by GP Synergy and NSW Health Centre for Aboriginal Health. We gratefully acknowledge the participating general practices and Aboriginal patients for their contributions; management and staff at Gandangara Local Aboriginal Land Council and Marumali Health Services for support and sharing their cultural expertise; Dr Gladys Liaw for guidance on the CQ instrument; and other members of the WoTWoD research team (Prof Lisa Jackson Pulver, A/Prof John Furler, Ms Val Dahlstrom and Prof Yin Paradies).

References

1. Levesque J, Harris M, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health 2013;12:18.
2. Australian Government Department of Health & Ageing. Closing the Gap: Tackling Chronic Disease, The Australian Government's Indigenous Chronic Disease Package. Canberra: Commonwealth of Australia, 2009.
3. Australian Government Department of Health & Ageing. Building a 21st century Primary Health Care System. a draft of Australia's First National Primary Health Care Strategy. Canberra: Commonealth of Australia, 2009.
4. Australian Institute of Health & Welfare. Aboriginal and Torres Straits Islander Health Performance Framework Report 2008: Detailed analyses. Canberra: AIHW, 2008.
5. T Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner. Social Justice Report 2005. Report No. 3/2005. Sydney: Human Rights and Equal Opportunity Commission, 2005
6. Australian Health Ministers' Advisory Council SCoAaTSIHWP. AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004–2009. Canberra: Australian Health Ministers' Advisory Council, 2004.
7. Anikeeva O, Katterl R, Bywood P. The Closing the Gap Initiative – Success & ongoing challenges for divisions of general practice. Aust Fam Physician. 2012;41:523–27.
8. Royal Australian College of General Practitioners. Fact Sheet: The identification of Aboriginal and Torres Strait Islander people. What is required in the RACGP's Standards for general practices. 3rd edn. Melbourne: RACGP, 2006.
9. Royal Australian College of General Practitioners. Identification of cultural safety training needs: Matrix for the identification of cultural safety training. Melbourne: RACGP, 2010.
10. Michie S, Johnston M, Abraham C, Lawton R, Parker D, Walker A. Making psychological theory useful for implementing evidence based practice: a consensus approach. Qual Saf Health Care 2005;14:26–33.
11. Ang S, Van Dyne L, editors. Handbook of Cultural Intelligence. Theory, Measurement and Applications. New York: M.E. Sharpe Inc, 2008.
12. National Health and Medical Research Council. Cultural Competency in Health: A guide for policy, partnerships and participation. Canberra: Commonwealth of Australia, 2005.
13. Liaw S, Lau P, Pyett P, et al. Successful chronic disease care for Aboriginal Australians requires cultural competence. Aust N Z J Public Health 2011;35:238–48.
14. Burchill M, Lau P, Pyett P, Kelly S, Waples-Crowe P, Liaw S. Aboriginalising our research process: 'hunting and gathering' as a focus group methodology. Int J Critical Indigenous Studies 2011;4:29–38.
15. Lau P, Pyett P, Burchill M, et al. Factors influencing access to Urban General Practices and Primary Health Care by Aboriginal Australians—A qualitative study. AlterNative 2012;8:66–84.
16. Campbell N, Murray E, Darbyshire J, et al. Designing and evaluating complex interventions to improve health care. BMJ 2007;334:455–59.

correspondence **afp@racgp.org.au**