

Shared medical appointments for Aboriginal and Torres Strait Islander men

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Background

Aboriginal and Torres Strait Islander health is generally the worst of any population group in Australia. Inaccessibility to health services is one possible cause of this. Shared medical appointments (SMAs) appear to be a culturally competent and appropriate way of improving access to, and the quality of, primary healthcare services for Aboriginal and Torres Strait Islander peoples.

Objective

The objective of this article is to assess the acceptability and appropriateness of SMAs as an adjunct process in primary care for Aboriginal and Torres Strait Islander men.

Methods

As part of a broader study on SMAs, three SMA sessions were delivered at an Aboriginal men's health centre in northern New South Wales. One-day training sessions in SMA facilitation were also provided to two groups of 12–14 Aboriginal health workers (AHWs). Mixed methods were used to assess patient and provider satisfaction, subjective outcomes, and operational procedures in the SMA groups, as well as interest in the SMA process by AHWs.

Results

Satisfaction with SMAs among Aboriginal men was unanimously positive, with the numbers in the group increasing over time. Patients most enjoyed the 'yarn up' nature of SMAs with peer support, which reduced the 'scary' and culturally 'unnatural' nature of one-on-one consultations with a general practitioner (GP). AHWs who were trained to a level to conduct SMAs saw this as an effective way of improving cultural competence in, and accessibility of, their various Aboriginal health services.

Discussion

The results, though not generalisable, suggest that SMAs may offer a culturally safe and appropriate tool to enhance Aboriginal and Torres Strait Islander peoples' access to primary care.

The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (the Plan)¹ established the overarching health goal of 'achieving equality of health status and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2031'. According to the Plan, one of the main ways in which this goal would be reached is through making services accessible, affordable, appropriate and acceptable (ie culturally competent and non-discriminatory).^{1,2} Although a wide range of Aboriginal and Torres Strait Islander health services exist in urban and regional centres, they are not considered culturally competent or appropriate for Aboriginal and Torres Strait Islander patients.^{1–7} According to the Australian Institute of Health and Welfare (AIHW),² cultural competency and appropriateness of a service depends on the service being developed and delivered with a deep understanding and recognition of the 'lasting effects of colonisation, past injustices and ongoing systemic, societal and individual-level racism'. This article examines the use of shared medical appointments (SMAs) as an alternative method of primary healthcare service delivery for Aboriginal clients.

SMAs are comprehensive medical visits run with groups of participating patients. They offer a novel and creative approach to healthcare that may provide a more culturally appropriate process to improve access to healthcare for Aboriginal and Torres Strait Islander peoples and their communities. SMAs have previously been discussed in detail in *Australian Family Physician* and other literature.^{8–12} A trial funded by The Royal Australian College of General Practitioners (RACGP) showed high levels of general practitioner (GP) and patient satisfaction, and efficiencies from SMAs in a wide range of patients. Concerns and limitations of SMAs have been explored in these publications as well. An aim of this broader trial was to explore the potential of SMAs with Aboriginal men as there has been no work reported in this area with men and women of this population group. We proposed that because SMAs have similar features as the Aboriginal and Torres Strait Islander concept of 'yarn ups' (ie group talk, peer support), and the fact that Aboriginal and Torres Strait Islander peoples can lead SMAs, this forum may be a more culturally competent way to deliver health at the primary care level for this patient group. We tested this with a group of Aboriginal men and two groups of

Aboriginal health workers (AHWs) from the North Coast of New South Wales.

Method Groups

A detailed description of the SMA process is presented elsewhere.¹⁰ Three SMA sessions were scheduled to be run with an Aboriginal men's group in northern New South Wales, approximately one month apart. Mixed methods were used to assess:

- patient and provider satisfaction
- subjective outcomes
- operational procedures in the groups.

A non-contributing observer was used after each session to conduct and record a semi-formal affinity/discussion group with patients. A questionnaire was used after the third session to quantify patients' opinions of their experience. Debriefing interviews with the GP and facilitator were carried out after each session. A more detailed semi-formal interview was carried out with the GP after the third session. Field notes were also collected at each session by at least one of the researchers to assist in triangulating findings.

As a result of the outcome of these groups, one-day training sessions were offered to Aboriginal Medical Services (AMSs) in the area with AHWs who were interested in becoming facilitators for SMAs. These were used to further assess provider interest in the concept of SMAs in Aboriginal and Torres Strait Islander men's health through semi-quantitative (open-ended questionnaire) assessment and post-training affinity groups.

The research was approved by Southern Cross University's Human Research Ethics Committee (approval number ECN 13-270).

Analysis

The affinity group discussions, semi-quantitative interviews and field notes were thematically analysed. The two principal researchers undertook the analyses and compared notes. As a quality measure, only the themes, perceived outcomes and quotes that both analyses agreed on were used in this report. The survey questionnaire results were tallied and also reported.

Participants Aboriginal men

Men were recruited through an Aboriginal community centre in Lismore, New South Wales. The community centre had previously established a weekly men's social and cultural support group, a 'sharing circle' to have a 'yarn' about issues affecting them. The SMA sessions were scheduled to run prior to the sharing circle to minimise inconvenience and maximise attendance. Men were invited to attend the SMA research by a community centre leader during one of their regular groups.

AHWs

On the basis of awareness of the Lismore SMAs, AHWs in two regional centres in northern New South Wales (Ballina and Kempsey) were invited by the local AMSs to attend one-day training sessions for facilitators in running SMAs. A total of 26 (14 and 12 for Ballina and Kempsey respectively) AHWs attended these sessions and were asked to provide feedback on the concept.

Others

The GP in these groups was not an Aboriginal or Torres Strait Islander. At the time of the research, he had more than 35 years' experience as a GP and had worked for many years with the local AMSs. Some of the participants were already familiar with this GP. The two principal researchers (one of whom was also the facilitator) are not Aboriginal or Torres Strait Islander, but have more than 60 years' research experience between them. The Aboriginal centre coordinator was interviewed after the third session.

Procedure The SMA process

The Aboriginal men who attended the program were invited to three sessions, approximately one month apart. They were advised of the medical research purpose of the sessions. Information was provided verbally and by printed handouts during recruitment, and again at the first session. The men signed consent and confidentiality agreements.

Each group session started with a session of 20–30 minutes in which the SMA facilitator welcomed and explained the research and process before the GP arrived. The facilitator asked the men one by one what they would like to talk about with the GP in the session and recorded their responses next to their names on a whiteboard. The facilitator entered into some brief discussion if it was appropriate to respond to some of the issues raised; otherwise, he asked that discussion wait until the GP arrived. After around 60 minutes of GP time, the GP left the room. The facilitator then summed up the session with the group in the final 10–20 minutes. Visit www.youtube.com/watch?v=Q7tiCU0t5zc&feature=youtu.be to view the SMA process in more detail.

Results

Session one had 12 participants, session two had 13 and session three had 18. Participants were Aboriginal men aged 18–60 years (mean ~40 years). The participants all lived in the local community.

In the first session, the focus of the men was initially on diabetes. Five of the men revealed they had type 2 diabetes mellitus (T2DM) and all knew family and others in their community with T2DM. About halfway through the session, the men came to understand that they were not obliged to keep their consultation exclusively to issues about diabetes. Eventually, the participants started to consult with the GP about other health problems they were experiencing.

The second and third sessions evolved into more of a general health clinic, with more men presenting with a wide range of health issues. Some of these still included diabetes-related concerns, while others included lumps under the arm, sore feet, caffeine and cigarette addiction, skin irritations, weight loss, and plantar warts.

Questionnaire assessments

A survey questionnaire was administered to 18 men at the third and final SMA session, of which 14 were returned completed. The completed surveys were from eight men who had attended all three sessions, three

who had had attended two sessions and one man who attended the last session only.

The participants were asked to rate their overall perception of SMAs on a five-point Likert scale, where 1 = 'poor' and 5 = 'great'. The overall mean score rating for this form of care was 4.86.

Items reflecting potential and future use of SMAs were measured on a similar five-point scale where 1 = 'definitely not' and 5 = 'definitely'. The overall mean score ratings to each question are shown in Table 1.

SMA enjoyment

Participants were asked to rate (on a scale of 1 to 5, where 1 = 'did not enjoy at all' and 5 = 'enjoyed very much') how much they enjoyed particular aspects of the SMAs they attended. Mean score ratings to each question are shown in Table 2.

AHWs on completion of facilitator training

A total of 26 AHWs undertook SMA facilitator training in two locations in northern New South Wales. Overall, their responses to the process of SMAs were favourable. They confirmed in their affinity group sessions that SMAs would provide them with a culturally appropriate and competent method to engage their people in primary healthcare. Indeed, they unanimously commented that they committed to the training day because they could see the value of SMAs in their work with their communities. The biggest concern for some was around managing privacy issues. The AHWs saw that the internet and Facebook could potentially be used to leak damaging private health information shared in SMAs to their Aboriginal community. On departure from the training days, many of the AHW had decided to set up SMAs in their services. The authors have been invited to assist in setting up evaluations of these SMAs.

Thematic analysis of Aboriginal men's SMA affinity groups and field notes

Theme 1: Enjoying the SMA

The most common theme that emerged from the data was that the men:

- enjoyed the SMA
- would like to do/attend more
- would recommend it to their friends and family.

The most common reasons explaining why they enjoyed the SMA were:

- peer support
... feeling you're not alone with your disease – Patient 1
Everyone respected what I had to say. No one gave me heaps for what I had to say. I don't normally talk in groups ... but this was different – Patient 2
- learning from others in the groups
It's good to hear other people's issues – Patient 3
I got so much out of this because I heard answers to questions that I always forget to ask the doctor – Patient 4

The older men also enjoyed, and felt impassioned by, the opportunity to engage in the learning by 'teaching' the younger men:

- ... look at me now. Don't do what I have done – Patient 4*
- I got the opportunity to tell the young ones about what had happened to me and I look forward to thinking more about that for next time – Patient 5*

Theme 2: Engaging the healthcare system

Many of the ailments (illustrated above) with which the men presented at the SMA had never been medically managed. They would not seek help at a regular medical practice because they felt intimidated by doctors and the health system, even at the

Topics	Mean score
Would you continue to come to SMAs if these were available at your medical centre?	4.86
Would you ever use an SMA instead of a standard medical appointment?	4.56
Do you think SMAs would reduce the number of other visits you would need with your doctor alone?	2.71
Do you think SMAs should be paid for by Medicare?	5.00
Do you think people would pay a co-payment to come to an SMA? If yes, how much do you think most people would be prepared to pay?	4.20 2*
How many ordinary visits to your doctor might you not need over six months as a result of attending an SMA?	1.92*†

Mean score: 1 = poor, 5 = great
**Range = \$0–5; †Three participants wrote that they would go more often*

Topics	Mean score
Having more time for asking questions	4.86
Seeing the doctor more relaxed	4.86
Having the doctor's full attention	4.86
Getting support from other patients	5.00
Contribution of other health people	4.86
Hearing experiences of other patients	5.00
Getting information from others	5.00

Mean score: 1 = did not enjoy at all, 5 = enjoyed very much

local AMS. The SMAs not only provided peer support and learning opportunities, they also exposed the participants to an experienced local GP, who by his perceived good practice and relaxed approach, changed some of their opinions of doctors:

If I'd go to a doctor he would talk at me with words I couldn't understand. I'd nod my head like I understood but I didn't understand a word he said. I'd leave not knowing what was wrong or what I had to do and it made me feel like an idiot. So I stopped going. I haven't been to a doctor for years except at the hospital. – Patient 7

Theme 3: Confidentiality

Confidentiality is mentioned here as a theme because it was a common question asked by the researchers in many different ways. The responses were unanimous in that not one participant felt their confidentiality was compromised through the SMA process:

No bugger's going to talk about what I said in here without me finding out about it, so it better be bloody nice if they do – Patient 5

Provider evaluation

As with other GPs involved in the larger SMA project, the GP involved with this SMA reported that he received a lot of personal and professional satisfaction from undertaking the SMA with Aboriginal men. According to the GP, the SMA process was an efficient use of time. Assisted by the facilitator, the GP was only required for a maximum of 60 minutes at the SMA:

... (SMAs) lead to an increase in efficiency and ... it helps us do health promotion/education better – GP

When patient management went outside the scope and time frame of the SMA, a referral for follow-up was provided. On the third visit, the GP was able to provide consultations with up to 18 men in one hour. Although some patients were referred for another appointment during the SMA, the GP judged that this would have occurred even if he had seen them one-to-one initially in his clinic:

Most importantly, it gave me time to provide education when I saw the need and to draw on the expertise of the facilitator when appropriate. [The men] would discuss things among themselves as a group that you would never hear about in a one-on-one consultation – GP

Some of the concerns about the SMA related to organisational and administrative issues. Because of the location and uncertainty around who would attend the SMA, it was difficult to have all the patients' medical records available. In addition, medical notes that were made at the time were in a notebook and had to be transcribed into electronic records later.

Another concern was around ensuring correct processes for Medicare Benefits Schedule (MBS) and payments for services. As this project was a trial, the GP elected not to charge for services for the SMA. One of the objectives of the overall SMA trial was to consider the financial models that could be applied. This analysis is ongoing.

Reflections from an Aboriginal academic researcher

At the third session, a co-author (BM) who identifies himself as 'an Indigenous academic and educator with over 40 years' experience in Australia and internationally' reflected on what he observed at the SMA:

The opportunity to observe the SMA in practice with a group of Aboriginal men confirmed for me the transformational potential that SMAs have not only for Aboriginal men, but women as well. Having worked with many Indigenous men in sharing circles over the years I know how important shared knowledge and experience is; it helps break down the fear of the unknown, the often paternalistic and silencing methods and processes utilised in conventional Indigenous healthcare, and it is a source of empowerment for people usually seen and treated as victims. If the SMA model and practice is adopted in Australia I believe that it would radically change the Indigenous healthcare landscape and dramatically impact closing the gap on Indigenous health targets.

Obviously there are cultural matters and protocols to consider in the application of the SMA model in Indigenous healthcare contexts. Once these are acknowledged and respectfully addressed, however, the principles and practice of SMAs could be an important innovation in Indigenous healthcare – BM

Aboriginal centre coordinator

The centre coordinator was interviewed at the end of the third session. He was enthusiastic about the SMA and described it as similar to what they already do in their general talking group or 'yarning'. He called SMA 'medical yarning' or 'medical yarn ups'. Many of his men did not engage with primary healthcare because they felt intimidated. But, they were very comfortable seeing the doctor in the SMA while being supported by their peers:

You only got to look at that we started with 12 and three months later we had 18. These guys won't stick around or bring their mates back with them if it was not working for them. – Centre coordinator

The coordinator commenced a regular SMA with the same doctor after the trial was completed.

Discussion

This paper presents a subset of data and findings from a trial that was previously reported on that explored SMAs in Australia.

In this subset of data, patient and provider satisfaction (like the findings in the broader project)¹⁰ were unanimous. Patients most enjoyed:

- peer support and hearing experiences and getting information from others
- the feeling of not being alone with their disease
- having more time with the doctor for questions
- having questions being asked by others that they may not have thought to ask
- hearing and learning about other peoples' ailments and how they dealt with these
- the more relaxed atmosphere of the group approach to treatment.

All patients wanted to continue with SMAs – in many cases instead of, but more often

in addition to, standard medical one-to-one consultations.

The GP involved reported (in line with the broader project):

- less need for repetition of lifestyle advice
- apparent better uptake of advice when agreed to and supported by peers
- the opportunity to better educate patients
- the relaxed atmosphere and ability to focus on patients because he was part of a team with the facilitator.

The centre coordinator endorsed SMAs as a ‘medical yarn up’ and a useful process to engage his men in primary healthcare. The fact that the number of men attending increased from 12 to 18 over the three sessions, and the centre coordinator continued to offer SMA after the trial, using himself as the facilitator, seem to indicate that SMAs have the appearance of being culturally competent, and thus more appropriate and acceptable to Aboriginal and Torres Strait Islander men (and potentially women). This appears to be supported by the AHW who undertook the facilitator training, who could see the potential for increasing accessibility to their services by using SMA.

As with the broader study, this subset of data concerning Aboriginal men was not designed or powered to measure ‘hard’ outcomes. The limitations include the small numbers involved in this pilot project. The sample of men may not be typical of the wider population of Aboriginal and Torres Strait Islander men, given they were already meeting regularly as a group and were familiar with each other and their own sharing process. However, the unanimity of response and interest in adapting the process by AHWs who trained as facilitators suggests the approach is worth considering further in Aboriginal and Torres Strait Islander healthcare delivery. Future studies would hopefully examine the implementation of SMA in a range of environments and gender groups as well as look more closely at health and cultural outcomes.

‘Sharing circles’ in a gender-specific environment are a common cultural

practice in Aboriginal and Torres Strait Islander societies. The SMA idea capitalises on the ‘sharing circle’ or ‘yarn up’ concept and as such appears more natural than a one-to-one medical consultation, which many described in various ways as ‘intimidating’. It remains to be seen if this is peculiar to Aboriginal men only or whether such a process would work equally well with Aboriginal and Torres Strait Islander women.

Implications for general practice

Evidence from the literature, and supported by this study, suggests that non-Indigenous health services are not always appropriate, accessible or culturally competent for Aboriginal and Torres Strait Islander peoples. From the limited findings reported here, and our previous work, it appears that SMAs would not only be acceptable, but would be preferred to standard medical consultations by Aboriginal men.

SMAs potentially offer a culturally responsive, appropriate, competent and accessible approach to healthcare, at least for Aboriginal and Torres Strait Islander men (but potentially also women), that may assist in achieving the goals set out in the Plan1 for closing the gap in Aboriginal and Torres Strait Islander health.

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