

Concordance

An alternative term to 'compliance' in the Aboriginal population

BACKGROUND 'Compliance' is an important issue for the health of the Aboriginal people. The word implies that patients are not following the doctor's 'rules'. Concordance may be a better concept to describe both doctor and patient working together in 'harmony and agreement'.

OBJECTIVE This article describes some of the parameters that affect consultations with Aboriginal patients and how they might be better addressed.

DISCUSSION The broader socio-political issues, the 'ethnocentrism' of the doctor, the health literacy of the patient, a more 'patient centred' model of the doctor-patient interaction, and the support of organisations are some of the variables that can be improved. It is important for general practitioners not to have a pessimistic attitude toward these issues, to identify ways in which the best possible results can be achieved, and to work hard to accomplish them.

People of Aboriginal descent are among the diverse patients whose health is overseen by general practitioners across Australia. The Ottawa Charter¹ outlines the prerequisites for health as: 'peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity'. It goes on to describe 'enabling' features such as 'access to information, life skills and opportunities for making healthy choices'. Even for Aboriginal people settled in a major urban centre such as Adelaide (South Australia) these are largely unavailable. Certainly the idea of 'coordinated action by all concerned' to support health seems but a pipe dream.

'Compliance' is a term often used by the medical profession when talking about patients and the investigations, medication and treatment arranged for them. The implication of 'poor compliance' is that the patient is not following the doctor's 'rules' because of ignorance, stupidity or laziness. There may be little acknowledgment that the 'rules' in a consultation are culturally specific with a hierarchy and knowledge that is foreign to those from a different background. The increasingly popular term 'adherence' carries similar connotations of obeying somebody else's rules.

'Concordance' rather than 'compliance' has been suggested as a better concept in dealing with the

Aboriginal population.² Concordance implies that both patient and doctor are in 'a state of agreement or harmony'³ with what is happening in the consultation. Here is an opportunity to try to attain a more cooperative and successful set of goals, with less implied hierarchy.

'Ethnocentrism' describes the normal tendency of both doctor and patient to unconsciously see the world from the viewpoint of their own culture. On top of broader societal influences are the personal life experiences and educational and family training of the individual. 'Egocentrism' describes a 'person who is individualistic, with an identity that emphasises uniqueness, derived from his or her distinct biography', which is usually a western way of thinking. The 'socio-centric' person is embedded in the context of 'membership of the social group to which he or she belongs'.⁴ Individuals reflect the dominance of one of these viewpoints depending on their culture of origin. Indigenous cultures tend to fit into the last group. 'When treating a patient from a culture in which there is a strong socio-centric concept of what a person should be, it would be all too easy to think that the patient was being passive and dependent, with an external locus of control, when in fact all he or she was being was a normal person in that society'.⁵



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When thinking about concordance issues in the Aboriginal community, the variables within a general practice consultation include:

- socio-political issues
- the doctor
- the patient
- the doctor-patient interaction, and
- the organisation.

Socio-political issues

Doctors operate within the broader socio-political landscape which, as is well known, has delivered substantial disadvantage to Aboriginal Australians. ‘Past and ongoing policies and practices have resulted in profound grief, disempowerment and social disadvantage for Aboriginal Australians, leading to multiple physical, spiritual and mental health challenges.’⁶ Aboriginal people are still dying 20 years earlier than their caucasian counterparts and carry a huge burden of acute and chronic ill health.

Issues such as poverty, cultural resistance, hopelessness, dependence on social security and lack of social supports underlie many consultations. Aboriginal people are disadvantaged across a range of socioeconomic factors. They experience lower incomes than the nonindigenous population, higher rates of unemployment, poorer educational outcomes, and lower rates of home ownership – all of which can impact upon a person’s health and wellbeing.⁷ A recent study found that cost, availability of specialist health services and racial discrimination rated as the highest health service issues impacting on Aboriginal people with mental health disorders.⁶ The Australian Health Care Summit discussed the need for ‘national leadership, more engagement with communities, investment in infrastructure (jobs, housing, education, water) and additional resources for health services’.⁸

Most GPs know this, but often feel powerless to intervene successfully, even with the patient before them in the consulting room. It can feel as if all the ‘structural issues of poverty, dispossession, marginalisation and institutionalised racism’⁹ are lined up behind the individual, dooming the outcome from the start. However, while it must be acknowledged that these issues are very real and cannot all be solved within the consultation, the best response would be to identify the ways in which the best possible results can be achieved and work hard to accomplish them.

The doctor

The doctor has his or her own cultural background, and is more likely to reflect the egocentricity of most western contemporary cultures. He or she is likely to have a much clearer sense of personal power to effect change, and therefore finds it hard to understand how even simple steps to deal with serious medical problems are not taken. This can be experienced as rejection of help, or even as the wilful stupidity or laziness of the patient, leading to frustration, or at the worst, contempt, in the doctor. The background awareness of the poor health of Aboriginal Australians may lead to a defeatist attitude with a concomitant failure to address their health problems with the same dedication that other patients could expect.

In fact, doctors are facing issues of conflict between the patient’s own world with its particular exigencies and the changes needed for increased health all the time. Seeking motivating factors and the ways to communicate the necessity for action, are present in consultations with high flying professionals, depressed widows, self injuring adolescents, and other ‘average’ patients. In all of these consultations, GPs recognise elements that can and most likely can’t be changed and try and find a middle path between the ideal but unlikely outcome and what is achievable.

Training in cultural awareness and liaison with Aboriginal health workers can assist doctors in dealing with their own ethnocentrism and challenging the socialised and cultural view of ‘normal’ in consultations. A bio-psycho-socio-spiritual view of illness must take precedence over the usual more narrow view. Doctors also need to be aware of the cultural nature of many illnesses and only diagnose as ‘abnormal’ those behaviours where there is a ‘problem within the individual which interferes with his or her ability to function’.¹⁰

The patient

Literacy, hearing and education can obviously influence how easily a patient will assimilate information. In addition, current theories predict that a person ‘is most likely to intend to adopt, maintain or change a behaviour if they believe the behaviour will benefit their health, is socially desirable and feels social pressure to behave in that way’.¹¹ The development of ‘health literacy’ may be slow, especially in patients from a culture very different from the doctor’s established evidence based model. Change will only come as the patient moves through the different stages from ‘precontemplation’

to ‘maintenance’.¹¹ The speed of this change needs to consider the health impact of a rapidly changing environment and the potential for ‘culture shock’. This process cannot be hurried, and managing the rate of change is part of what is required for an effective health intervention. Seeking concordance in goals between patient and doctor includes enabling the patient to have the social and personal resources to help them have increased control over their own health.

Aboriginal people ‘don’t see [health] as a separate issue from all the other things that are happening in their lives... it’s issues to do with daily living’.¹² Community based programs including sport, art, and traditional cultural activities will help strengthen families, nurture self worth, and support people as they deal with issues such as family violence, sexual abuse, alcohol and cannabis use, parenting, conflict resolution, and grief.¹³ Social responsibilities and obligations may take precedence over health in many cultures and there may be more interest in an explanation for the cause of the illness than in its identification and treatment, and in some cases, supernatural intervention may be seen as the main cause of serious illness.¹⁴

The doctor-patient interaction

Medical consultations, also subject to extensive structural constraints, often fall into an interrogation style format. It has been shown that in an average consultation the patient is only allowed to speak for about 18 seconds before being interrupted, and only disclose about half of his or her problems.¹⁵ One useful way of communicating in a consultation is outlined in the ‘Cultural awareness tool’.¹⁶ It involves a change in the way of relating whereby the ‘patient and family members take on the role of experts while you break out of your doctor role for a moment to become a student intrigued by their culture’.⁹ This is in contrast to the blunt line of questioning sometimes used and emphasises a respect and curiosity for the patient’s different way of viewing their illness. It uses a more ‘patient centred’ approach that attempts to understand the patient as well as the disease.¹⁷

This style is similar to that of narrative therapy which was identified by Aboriginal health workers as more appropriate than more conventional western mental health approaches.¹² It helps authenticate and strengthen the preferred stories about reclaiming Aboriginal knowledge, spirituality and way of life in the face of the ‘dominant’ culture.¹⁸ Patients are more likely to return for appointments if they feel that their cultural experiences

are respected.

One-to-one education, behavioural strategies, recalls, dosage simplification, group sessions and family support have all been shown to improve concordance.¹⁹ However, the GP’s goals in terms of investigations, treatment and education need to be consistent with the ‘world view’ of the patient, in language they understand and using concepts that are meaningful. Using illustrations, models and other visual aides to improve understanding has been shown to have some success in helping patients have more control over their health.²⁰ The cultural experience and knowledge that colours ‘world view’ means that even willing compliance can be impeded without proper communication.²¹ This does not mean the knowledge base is the same, of course it is not. The doctor will have information about medicine that the patient needs, while the patient has understanding about their own world that is useful for the doctor, so that the work they do together is optimised.

The organisation

Community consultation is an integral part of an organisation’s decision making. This means that cultural needs are respected and relevant to the communities being served. Aboriginal health workers and the addition of cultural mentors are a cultural reference for both doctors and patients. They can interpret problems from both sides so there is better understanding and concordance. Ensuring that health services are culturally secure means that ‘the construct and provision of services offered will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people’.²² Concordance is increased in those culturally sensitive community clinics where there is a decreased necessity to be ‘time conscious’.⁷

The ‘identification of obstacles to the adoption of healthy public policies’¹ is a key area where organisations can encourage concordance in a more realistic manner. For example, many organisations supply free medication to those in extreme hardship. To this end, the commonwealth government allows Aboriginal health services in remote areas to buy bulk supplies of Pharmaceutical Benefits Scheme listed medications (see the article *PBS medications – improving access for Aboriginal and Torres Strait Islander peoples* by Sophie Couzos this issue).

Conclusion

It is easy to have a pessimistic stance when faced with the overwhelming problems with achieving

concordance in the Aboriginal population, but all doctors have important roles in advocating for patients and coordinating a return to health through a holistic attitude at all levels of care. Public policy is built, organisational structures changed and community action strengthened as individuals influence committees to set priorities, make decisions and plan and implement strategies that will empower the communities.¹ Traditionally, Aboriginal people perceive that ‘health is not just the physical wellbeing of an individual, but the social, emotional, and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their community’.²³ Concordance rather than ‘compliance’ is an extremely important issue in any consultation, but is paramount if GPs are to fulfil their role in helping improve the health inequality of Aboriginal Australians.

As a nation, and as part of the health profession, the words of Lila Watson, an Aboriginal elder woman from Brisbane, should be heeded:

‘If you have come to help me, you are wasting your time. But if you see my struggles as a part of your own survival, then perhaps we can work together’.

It will only be in such working together that a difference will be made.

Conflict of interest: none declared.

Acknowledgment

Many thanks to Dr Clare Smith for her valuable comments and advice about this paper.

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