Our aboriginal relations

When family doctors and aboriginal patients meet

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When I was a medical student, one of my teachers warned me to be wary of misunderstandings that could cloud my judgment. He described a case in which the powerful negative image of "drunken Indian" impaired a physician's ability to assess and treat a man with diabetic ketoacidosis. The aboriginal patient waited in a wheelchair in the waiting room for several hours until the next physician came on shift and discovered the error. I wondered how such an error could occur.

Five years later, I was covering inpatients for a northern family medicine group. One of my patients was an elderly First Nations woman with chronic obstructive pulmonary disease and pneumonia. I spent some time learning about her symptoms, examining her, and working on establishing rapport. When I returned to her chart, I noticed she was in the process of being tested for tuberculosis (TB). The clinical standard was to isolate the patient until 3 sputum test results came back negative for the bacillus. I wrote an order for respiratory isolation and discussed this with the nurses. In my haste I didn't return to talk with the patient. The next morning she looked troubled. She told me that because she was on isolation for TB, she thought that she was going to die. I was astounded; I had not appreciated how the history of TB treatment and this patient's personal experience would produce such different meaning around "isolation" from the meaning I had. I apologized. We spent some time discussing the situation, and I believe she saw that isolation was merely precautionary. She taught me a lot that day.

How had such a misunderstanding arisen? Like most Canadians, few of us appreciate the historical implications of TB for First Nations people. It is a history linked to residential schools, sanatoriums, and lonely deaths far from families and home communities.[1] We can all learn from the lessons of that encounter, which illustrates the need for physicians to consider the histories and contexts that patients bring with them to medical encounters.

Encounters between family physicians and patients can be laden with expectations, hopes, and assumptions. Both patient and physician bring their backgrounds to the doctor-patient relationship. Family physicians might bring medical knowledge, communication skills, and clinical acumen. Patients often bring their current symptoms and experiences of illness. When physicians meet aboriginal patients, additional factors enter the relationship. These include knowledge about aboriginal cultures, assumptions about aboriginal health and socioeconomic status, and a shared aboriginal-nonaboriginal history of colonization in Canada. Aboriginal patients, like all patients, bring both their personal and family histories and their experiences of previous interactions with physicians. Physicians have a certain social power, located in specialized medical knowledge, which holds a promise of healing. This social power might be amplified for some aboriginal patients who feel powerless as patients.

How, then, can physicians develop meaningful and therapeutic relationships with aboriginal patients? Like developing relationships with other patients, this involves social cues (eg, eye contact, body language), cues that might differ between physicians' and aboriginal patients' cultures. When working with aboriginal patients, it is our experience that physicians, for ostensibly indiscernible reasons, can struggle to elicit a chief complaint and have difficulty developing a management plan that is relevant to the patient. These challenges run very deep. The solution might lie in how we use knowledge and curiosity in our relationships with aboriginal patients.

Stumbling over knowledge

Factual knowledge is of great value to physicians. This knowledge, however, can blind us to other truths in clinical encounters.

In medical school, one of the first "facts" learned about Canada's aboriginal peoples is that they have poor health status and experience substandard social and economic conditions. Many of us do not come to understand the historical and social contexts of these facts. This can lead to a sense that "being aboriginal" means having poor health and social conditions. This belief might leave us vulnerable to adopting common social stereotypes.

The practice of conflating health outcomes with cultural norms, when they are better explained by social, political, and economic factors, has a long history in Canada. It can occur when members of one group become marginalized and impoverished, and their behaviour in response to the marginalization is deemed "part of their culture." For example, in the early 1900s when First Nations in British Columbia were separated from their land and resources, their ways of life changed from migratory to sedentary. Previously healthy living conditions became unsanitary, and high mortality rates

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from infectious disease ensued. The historical record suggests that First Nations themselves were blamed for their poor health, without an appreciation of the social effects of this dramatic change in way of life. Poor health was deemed "an inherent part of indigenous lifestyles."[1]

Interpreting health behaviour in reference to historical and social contexts might seem irrelevant to patient care in the 21st century. Unfortunately, this is not always the case. Although very little is published on health professionals' knowledge about aboriginal patients, some studies have found that many of us continue to attribute poor health to cultural factors, not socioeconomic ones. In one study aboriginal women were perceived to be negligent and uncaring owing to an epidemic of fetal alcohol syndrome in their community.[2] Another study found that professionals believed poor health, addictions, and physical and sexual abuse among aboriginal patients were simply cultural (or natural) as opposed to being linked to historical and social conditions.[3] In other words, professionals had internalized negative attitudes, pervasive in popular media, about aboriginal peoples. These then informed relationships with patients.

Physicians can face a shortage of resources that provide insightful and sensitive information about aboriginal peoples. So perhaps it is not surprising that many physicians gain knowledge through popular media or from scarce research that often highlights the health problems of aboriginal peoples. These same sources can, without offering critical commentary on the myriad expressions of aboriginal life in modern Canadian society, emphasize "traditional aboriginal lifestyle," such as teachings of the medicine wheel and attendance at potlatches. While it is valuable to learn about aboriginal peoples in Canada, we must remain critical of our evidence.

Knowledge as a springboard for curiosity

Even good evidence can present barriers to meaningful clinical encounters with aboriginal patients. If physicians gather knowledge about aboriginal peoples in much the same way we gather knowledge about diseases and treatments, we can have a false sense of confidence about our patients. This false confidence can impede our curiosity about the individual patient's specific beliefs and cultural practices. Simply stated, this approach can generate a static and stereotypical picture that inadequately describes the diversity of those it attempts to explain. It does not do justice to the complexity and fluidity of peoples and thus can hinder meaningful exchanges between doctors and patients.

On the other hand, if knowledge is used as a platform from which to engage our curiosity with each aboriginal patient, it can build relationships. In one study, researchers asked aboriginal patients about their communication experiences with physicians.[3] Aboriginal community members and physicians felt that it was useful for physicians to understand aboriginal history, particularly the history of residential schools. Aboriginal patients appreciated physicians who asked about home communities and personal histories. Patients preferred when physicians were not rushed and took the time to listen without interrupting.

Patients described how their own reactions to physicians were influenced by experiences at residential school. Feelings of inferiority and powerlessness, stemming from residential school experience, could be revived in physician-patient interactions. Still, patients who trusted their physicians did not experience the same negative associations between power differentials in the doctor-patient relationship and power differentials experienced as residential school students. Aboriginal patients said it was important that their physicians understood aboriginal history in Canada. It was even more important that their physicians *understood them as individuals*. This feeling of being understood as an individual helped to build the trust necessary for meaningful and therapeutic relationships.

As family physicians we are members of Canadian society. We cannot avoid depictions of aboriginal peoples in mainstream media. These ideas might slip into our unconscious and thus emerge in our encounters with aboriginal patients. They can impede our communication by dampening our curiosity. They can impair our clinical judgment. These assumptions might also emerge in subtle ways: perhaps in how we speak with our patients or the treatment options that we consider.

As family physicians we can strive to actively question the images and stereotypes equating aboriginal culture with the fallout of colonialization. We can, in the words of Cree Elder Willie Ermine, avoid "pathologization" of aboriginal peoples.[4] We can use our knowledge about historical and current issues regarding aboriginal peoples in Canada to illuminate preconceptions that we bring to the interaction. An appreciation of the social context, coupled with an understanding of the diversity of aboriginal cultures, can form a springboard from which to learn about an individual patient. This open-minded curiosity about each person can provide a bridge to understanding patients' experiences. In fact, this interest in patients as individuals is exactly what some aboriginal patients have stated that they would like from their doctors.

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Competing interests
None declared

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