

It hinges on the door: Time, spaces and identity in Australian Aboriginal Health Services

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Abstract

This paper explores how the structuring of places and time influence Aboriginal and Torres Strait Islander patient and carer experiences of health services. Face-to-face in-depth interviews were conducted with urban Aboriginal and Torres Strait Islander people with diabetes, chronic heart failure or chronic obstructive pulmonary disease as well as family carers (N = 19). Content analysis was undertaken. Participants report that each element of the time spent in Aboriginal Medical Services is seen as more valuable and worthwhile than in mainstream health services, from social and health sharing experiences in the waiting room to health care in clinical places; and that users feel they can rely on sufficient time and respectful care in their clinical consultation. Purposeful design of both physical and temporal aspects of health services is called for. We suggest re-introducing opportunities for spatiotemporal design in health care that have been limited by the segmented 'person as illness' design features of Australia's current mainstream health system.

KEYWORDS: Aboriginal and Torres Strait Islander; Indigenous; chronic illness; health services; time; space; sociology

INTRODUCTION

Aboriginal and Torres Strait Islander people, the Indigenous people of Australia, have a specific history of colonisation, which has negatively impacted on the health of these populations (Kowal & Paradies, 2005; Paul, 2000). Past experiences of colonisation, health and illness inform Aboriginal and Torres Strait Islander experiences and choices in the present (Nathan, 1980). The experience of Aboriginal and Torres Strait Islander people in mainstream health services (MHSs) is presently poor, with services often failing to provide a care experience that is seen by Aboriginal and Torres Strait Islander people as respectful, culturally safe, fair and worthwhile (Kowal & Paradies, 2005; Paul, 2000). According to Gracey et al., this is due to MHSs lacking understanding of Indigenous issues and being unwilling to 'meaningfully engage Indigenous people in their own health' (Gracey et al., 2006, p. 332). Personal and community experience of past

and present discrimination and racism has also been linked to poor health and further creates a barrier to service use (Harris-Haywood, Sylvia-Bobiak, Stange, & Flocke, 2007; Humphery, 2001; Larson, Gillies, Howard, & Coffin, 2007; Paradies, Harris, & Anderson, 2008). Indigenous people talking about barriers to the use of Australian MHSs describe the feeling of an alien environment, with no familiar faces or places to link them to the service (Lawrence et al., 2009). Some MHSs have tried to address this by recruiting Indigenous staff as health workers and as 'front of house' staff, using local Indigenous artworks in clinic and waiting places, or by providing sessions available only to Indigenous people (Hayman et al., 2009). These attempts have had limited success and often fade away under the demand pressure of other users (ACT Health, personal communication, 2011). MHSs continue to be spaces in which 'primarily middle-class, university-educated and White' health professionals work (Kowal & Paradies, 2005).

Many MHSs try to optimise patient flow and quality care through the design of health centres such as hospitals [see the *Guidelines on Emergency Department Design* (Australasian College for Emergency Medicine, 2007)], but do not make significant attempts to make such places welcoming. Nor have they made effort to identify the temporal rhythms that govern health service delivery and how these rhythms intersect with patient and carer rhythms. In particular, temporalities such as past, present and future (Connerton, 1989), and clocked time (Fabian, 1983; Postill, 2002) may operate and be experienced in different ways by health professionals and patients and carers. Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMSs), on the other hand, are the service of choice for many Indigenous people, partly because they consistently attempt to make their places (Couzos, 2008) and temporalities welcoming in culturally specific ways. Several AMSs in Australia are ACCHS. They follow a model of comprehensive care that is 'different to mainstream services and contributes to high quality care, acceptability and accessibility of these [AMSs]' (Herceg, personal communication; National Aboriginal Community Controlled Health Organisation, 2008).

This study is concerned with understanding how space and time are operationalised in different health services, and how this operationalisation contributes to Aboriginal and Torres Strait Islander patient and carer experiences. The lessons from these experiences are of use to all health services.

Places and spaces

This paper uses the term 'place' to refer to defined areas within health service environments and the term 'space' to refer to often abstract meanings, boundaries and uses associated with places (Gans, 2002; Gieryn, 2000). Architects, cultural geographers, sociologists and anthropologists of the built environment continue to explore ways in which health care places reflect and shape behaviour and experiences; as well as ways in which discourses, meanings and imaginings about places inform how they are used (Gieryn, 2000). Three key analytical areas of place include location, material form, and meaningfulness (Gieryn, 2000). In addition, social

spaces or social phenomenon emerge within and in relation to places (Gans, 2002).

In his architecturally-based guide to primary health care design, Purves (2002) examines places in terms of location and material form. He looks specifically at their accessibility, sustainability, convenience to transport, and ease of use or functionality. He also briefly touches on the meanings that people create in response to experiences of places. Williams (2002) further examines meaningfulness in her study of the shift towards informal care giving in the home in addition to formal care provision by health services. She writes:

Places, together with the health care services which characterize them, are increasingly being seen as a context for the development and maintenance of the health of populations. Health geographers are interested in exploring the links between landscape, health and healing as they move away from viewing place as a physical landscape, and towards a relational view in which space is implicated as human activity or vice versa. Meaning is the key to the importance of places, and it is the subjective experiences that people have within places that give them significance. (Williams, 2002, p. 154)

Not only are spaces subjectively imbued with meanings, but they also create meanings, invoke responses and shape flows of power (Lawrence & Low 1990). In a recent study that explored how health professionals experience different clinical settings Nugus, Greenfield, Travaglia, Westbrook, and Braithwaite (2010, p. 903) have identified that the care setting both influenced and reaffirmed flows of power through, for example, the distribution of speaking between health professionals. Flows of power in healthcare settings has also been studied in such terms as patient experiences, patient-doctor communication, patient autonomy and empowerment (see for example, Aujoulat, Marcolongo, Bonadiman, & Deccache, 2008; Beisecker, 1990); and disempowerment and empowerment of disadvantaged groups, migrants and Indigenous people [see for example (Aujoulat et al., 2008; Beisecker, 1990; Goodyear-Smith & Buetow, 2001; Jowsey, Gillespie, & Aspin, 2011; Quill & Brody, 1996)]. Our literature search did not identify any studies concerned equally with flows of power in terms of adult patients *and* space or place.

Time

In comparison with literature about meanings of place and space held by health service users, health service issues pertaining to time use and temporality have been measured and reported in the literature more abundantly. This may be due to the Western understandings of cause-and-effect and measurability of time (Postill, 2002). It may also reflect how time is culturally embedded as a key indicator of efficacy and, by extension, quality in the health industry, and is also the measurable unit equated to finance: that is, time is money (Gell, 1992). Health services research has addressed how health services manage the time use of health professionals and patients, for instance, in terms of waiting times for access to health care such as in emergency departments or other areas within the hospital, in doctor waiting rooms, or on elective surgery waiting lists [see for example, (Cohn, 2001; Muntlin, Gunningberg, & Carlsson, 2006; Poissant, Pereira, Tamblyn, & Kawasumi, 2005; Siciliani & Hurst, 2004)]. The temporality of health service provision has also been researched in relation to embodied concepts of time (Morris, 2008; Rittman et al., 2004) and health professional capacity to 'make time' for providing preventive services in the restricted structure of health services systems (Kottke, Brekke, & Solberg, 1993).

Research that combines sociological analysis of both places and temporality in health research has been minimal. In a rare study by Warin, Baum, Kalucy, Murray, and Veale (2000), research concerning patient spatiotemporal experiences of community health centres in South Australia was undertaken. They argue that 'experiences associated with space and time had a positive effect on health status by: diminishing barriers to health services, improving quality of care, increasing community participation, providing safe places for social interaction and strengthening people's sense of belonging or attachment to a particular community and place' (Warin et al., 2000, p. 1863).

In an effort to build on the space-use literature, and to link it with time use in particular, this paper addresses the question: How does the structuring of time and spaces influence Aboriginal and Torres Strait Islander patient experiences of health services? While our use of the term

'structure' can be taken to refer to the way that the physical environment is organised, our particular emphasis is the structuring of space through the interpersonal usages of the physical setting.

METHODS

The Serious and Continuing Illness Policy and Practice Study (SCIPPS) aimed to develop policy and health system interventions that are patient-centred and support the provision of optimal care for patients with chronic illness and carers of family members. SCIPPS focused on three serious and long-term diseases: complicated type 2 diabetes ('diabetes'), chronic obstructive pulmonary disease (COPD) and chronic heart failure (CHF). These diseases are common, costly and require ongoing care from multiple providers and services (Jeon et al., 2010). To better understand the experiences of urban Aboriginal and Torres Strait Islander people affected by chronic illness SCIPPS researchers carried out a small qualitative study.

Study approval was obtained from the Australian National University Human Research Ethics Committee, the ACT Health ACT Human Research Ethics Committee, the University of Sydney Human Research Ethics Committee, Sydney West Area Health Service Human Research Ethics Committee and the Aboriginal Health and Medical Research Council of NSW. Consent was obtained from all participants prior to interview. The sub-study of Aboriginal and Torres Strait Islander experiences was planned with and informed by our ACCHS/AMSs collaborators who advised that participant confidentiality was of utmost importance, particularly given the small sample. Accordingly as much identifying data as possible has been removed from this paper and the referencing style 'participant' is used, as advised by the ACCHS/AMSs collaborators. The ACCHS/AMSs collaborators approved this paper prior to its submission for publication.

Recruitment

Data collection occurred during two 3-month periods between March 2007 and November 2009. Nineteen Indigenous participants living with diabetes ($N = 19$), COPD ($N = 3$) and

CHF ($N = 11$) were recruited by purposive sampling through referrals from two ACCHS AMSs as well as a carer group in the Australian Capital Territory (ACT) and Western Sydney in New South Wales (NSW). Eligible participants included people living with one or more of these three conditions aged between 30 and 85 years. The relatively low age cut-off was chosen to reflect the earlier onset of chronic illness and shorter life expectancy of Indigenous Australians (Council of Australian Governments, 2009).

Percival (2004) and Wagner (1998) argue that family carers of people with chronic illness can provide important insight into the experiences of people living with chronic illness (Percival, 2004; Wagner, 1998). Three family carers of people with the sentinel chronic illnesses, two of whom were related to patient participants, were included in this study, with these people being recruited through an Indigenous informal chronic illness support group in the ACT.

The data collection and analysis was guided by the work of Lincoln and Guba (1985) in terms of the credibility, confirmability, transferability, and dependability to maximise the rigour of the study. We followed the advice of staff of the recruiting AMSs as well as members of the Indigenous Health Interest Group of the Australian National University (ANU) to assure appropriate Indigenous health research methods and community engagement (Humphery, 2001). Interviews continued until saturation of themes occurred (Morse & Field, 1995) at which point the dataset was closed and completed with 19 patients.

Participant characteristics

Interviews

Semi-structured in-depth interviews were conducted with participants by four researchers with experience in multi-cultural research, none of whom were Australian Indigenous researchers (Table 1). Each interview took between 45 to 90 minutes, following an interview guide. Participants were asked to describe their experience of living with a chronic illness as well as their experiences of interactions with health care professionals including doctors, nurses, health care workers, allied health practitioners in different

TABLE 1: PARTICIPANT CHARACTERISTICS

Characteristic	Number of participants
Aboriginal and/or Torres Strait Islander	19
Age (years)	34–70
Diagnosis	
Chronic heart failure	11
Chronic obstructive pulmonary disease	3
Type II diabetes mellitus	17
Duration of illness (years)	1–47

health service places such as hospitals, general practices, AMSs, palliative care services. The research team judged that sufficient data had been gathered when interviews were no longer providing new insights or ideas central to the experience of having DM/COPD/CHF. Participants also completed a 10-minute survey addressing demographics, their health conditions and health care encounters.

Analysis

All interviews were electronically recorded and transcribed following assignment of verbatim transcript codes and pseudonyms. The data were analysed using secondary qualitative content and thematic analysis, assisted by QSR NVivo8 (QSR, 2008). The research team modified, by iteration, the coding scheme used in the general cohort. This scheme was used to code all transcripts with each transcript coded by three members of the research team and checked by two other members of the research team to ensure rigour. Following Morse and Field (1995) and Heaton (1998), we used secondary content analysis to identify issues in the data that were commonly raised by participants. The content analysis was assisted by frequency matrix coding in NVivo8. These issues were then further explored thematically. The findings that are the subject of this paper relate to the interconnected themes listed in Table 2. Other themes are reported elsewhere.

RESULTS

Participants in this study reported spatiotemporal dynamics in their experiences of health care services in MHSs and in AMSs. All participants

TABLE 2: IDENTIFIED INTERCONNECTED THEMES IN THE HEALTH SERVICE FINDINGS

Theme (parent node)	Subtheme (child node)
Experiences of time (and space)	Waiting time
	Unproductive time
	Productive time (value)
	Continuity of care
Space and meaning (over time)	Standards of care
	Cultural safety
	Flexibility of health services
	Access to health services
Feelings	Feeling cared for (feeling safe)
	Quality of care
	Feeling uncared for
Experiences of health service places	Mainstream health services
	Aboriginal Medical Services

reported experiences of both MHSs and AMSs. The two AMSs that participants in this study accessed were characterised by small waiting rooms covered in Aboriginal art and health posters, and a door separating the waiting room from private consultation rooms. In the case of MHSs, participant experiences reflected negative encounters with both the clinical and non-clinical aspects of the service. Participants described positive experiences in general in an AMS context, but with experiences in the waiting room being quite different from their experiences with health professionals in the consulting rooms.

Articulations of culture with space: Being known in the AMSs waiting room

The AMSs waiting room space contains strong cultural inflections. These track in two key directions, both of which can be understood as adding cultural ‘value’ to the place (see Table 2). The first aspect of value and space we draw attention to is the strong perception that it is a meeting place – a place of easy and enjoyable interaction. ‘I just, just ah come here on one of my day off and sit out here, have a talk with all my mates [laugh],’ comments participant A. To which he adds ‘... there’s always someone you know here [laugh]. So you see it can pass the time away. For me it’s a social event too [laugh] coming here [laugh]. ... you find out what goes on, yeah.’

In the words of participant B ‘mostly Kooris [Aboriginal people] are coming here ... it’s sort of like a meeting place.’ Here the environment of the clinic waiting room is discursively formed into an informal environment within a formal setting where enjoyable interactions are mobilised around community seemingly as much as sickness. Something of the specialness of the space, then, is linked to the quality and tone of interactions between peers. Patient and carer constructions around sociality in the waiting room negate and deflect representation of the space use as one that is solely about sickness. Where MHSs waiting rooms are constructed as quiet and formal sick spaces, AMSs waiting rooms are constructed as meeting and speaking spaces, where people happen to be sick.

This interaction between peers links to the second value, the fact that it creates a space in which the sharing of health information between equals occurs. Participant C said:

We share a lot. You know when we meet people we talk about things. It’s like when you go into [an MHSs] you as a whiter person, you might be lucky if somebody says hello to you. If we go in and I know someone we’ll have a good yarn. ‘How you going with yours?’ ‘You got diabetes yeah. How many tablets are you on?’ ‘I’m on the needle.’ ‘Why? How high does yours get?’ So there’s always that yarn that we can pass on that information, ‘What do you do about it?’ and all this stuff. and I think sharing a lot of the things that we do that’s the difference ... And not only that, if you’re a bit nervous then it calms you down, a lot of us, so there’s a lot of aspects I suppose we think on a cultural basis.

In this way participant C links the sharing of health information within the space with his culture, suggesting that the sharing is a cultural marker. Socialisation and informal sharing of information in AMSs waiting rooms serves to transform a place within the formal health service delivery environment into one of informality, but also one of increasing knowledge. There is some indication in the above quote that people also have the opportunity to offer and receive what we refer to elsewhere as ‘unsolicited

support' (Ward, Jowsey, Haora, Aspin, & Yen, 2011). Flows of informal and unsolicited support within the space in the waiting room are an important part of how the front of clinic space is constructed by people using it.

Temporal experiences of health service places

Participants reported informally sharing health information with peers in the waiting room, in contrast to the formal sharing of health information with health professionals that took place during consultations. The process of establishing shared knowledge between patients and doctors took place over 'clock' time and participants portrayed quality of care in terms of the way they perceived time use. If the participants identified both the immediate and long-term time they spent with health professionals and health services as beneficial, they identified that time use as well spent and reported their health care encounters as quality care. In addition, quality care incorporated the notion that doctors made sufficient time to spend with patients. Participants made comments such as 'that's the thing that AMs do really well, they take their time. There are not time limits, so they can actually spend a bit more time with you' (participant D) and 'the doctors, they give up their time wherever they are, whether in the surgery, or even the dentist ... they've got a lot of things here for people, and they give up their time, and I think [it is] wonderful' (participant E). In this way participant temporal rhythms were synchronized with those of the health professionals. Participants also couched quality of care in terms of timely access to services and what they deemed to be appropriate patient time use in terms of seeing specialists and having tests. A participant with CHF put it this way: 'You can appreciate that it's important to me. If I spend half a day somewhere, it's half a day of my life gone and I think 'Well, do I bother?' For what I'm getting out of it, do I need to go? There are other appointments I've got to see but in some of them I wonder if it's worth it' (participant F). In this example the participant's temporal experience of health services is acutely informed by his sense of having limited time to live.

Also of note is the interpretation of time in participant accounts of experiences in the waiting room, which we refer to as the space 'in front of the door'; the door referencing the doctor's consultation room door and/or the door separating the waiting room from the hallway of consultation rooms. The time spent waiting was not often constructed as being wasted, as it was in the accounts of non-Indigenous participants accessing MHSs (Jeon et al., 2010). Rather it was constructed as creating an opportunity for other valued and important aspects of daily life to take place – sharing health information and spending time with friends and family.

Perceptions of time spent in the waiting room were intrinsically linked with the value that Indigenous participants placed on feeling that they had sufficient time with health professionals. This value was often expressed in statements about time spent 'in front of the door'. Although participants indicated that strong value of using the waiting room as a space for meeting with other members of the community, they said sometimes they did get frustrated with waiting a long time to see the health professional. This was immediately linked with a statement that once the participant got 'behind the door' they would have as much time as they needed to consult the health professional, and this was strongly associated with cultural safety, described below, as well as good quality of care (see Table 2). Participant C said:

It's a cultural aspect as well where we get to meet people. We get longer consultations with doctors. We sometimes get cheesed off about that but ... you get plenty of time to explain your problems. So we've got a lot of advantages.' Another said 'when it's your turn to go in with a doctor, you look at the time on the wall ... when you come out have a look at the time ... you know you've been in there for an hour, like it's only supposed to be half an hour, but the doctors ... go over thoroughly ... really take their time ... that's the good thing about here, the doctors (participant G).

It hinges on the door

While the space in front of the door is one of informal and valued social interaction, the space behind

the door is one of formal and professional interface with health carers. In both spaces cultural values and engagement of patients are evident. Behind the door, however, the cultural values are framed slightly differently. In addition to it being a space of sociality and sharing, it is also one of feeling safe and cared for, precisely because there is a perceived recognition of the cultural markers of sharing health information, health services as a meeting space, having a yarn, feeling valued that flow between the informal and formal spaces. Participants felt they had enough time with health care workers and that cultural safety was present in the formal spaces. Additionally, participant feelings of value and perceptions that they could have a yarn with health care workers further was evidence of the flow of cultural markers between these two spaces.

Continuity of identity and value in the clinical space: Behind the door

Participants portrayed AMSs doctors as trusted and valued health professionals because they felt known by them. Participants were known in front of the door and also behind the door, albeit in different ways. Behind the door in the clinical consultation space, part of being known was signalled by a perception of cultural safety – a perception that their identity will not be assaulted, challenged or denied, and that they will be respected and that they shared similar meanings and cultural knowledge with the health care provider (Eckermann, Dowd, Chong, Nixon, & Gray, 2010). This contrasts with experiences of non-AMSs settings where they were unknown and were treated differently. For example, participant H who had experienced explicit racism from a specialist in MHSs said ‘so I talk to [my AMSs GP] about anything and everything, you know, and then of course he refers me on to the [MHSs] specialist. He refers me, but he doesn’t know what these specialists are like, you know’. For this participant, the experience of racism was identified as resulting from being unknown by the specialist, thus reinforcing the intrinsic value of being known to their experiences at the AMSs of quality care. This might signal a patient perception that the doctor and specialist are largely unknown to one another and therefore explain that the general practitioner

(GP) does not realise the specialist may be treating people inappropriately. Alternatively, it may signal that the patient and the GP have different perceptions of the specialist that reflect their different positions within established hierarchies of power in the bio-medical sphere, both of which have implications for perceptions of continuity and coordination of care. We can also understand this participant’s description as referencing the valued feelings of safety and feeling cared for that are present behind the door in the AMSs that the participant couches within a cultural safety framework; perceptions and feelings that participants did not often report having experienced behind MHSs doors. However, we also note that in this participant’s account there is an implicit criticism of the AMSs in that they are unaware of the cultural insensitivity and danger represented by the specialist to whom they have been referred.

Picking up on the perception of feeling cared for and the importance of communication, participant J compared her experiences of health professionals at the AMSs and MHSs. She said ‘[AMSs] Dr 1 helps out a lot. But like I said, Dr 1’s good. She’s very caring. Like the, the heart doctors [at MHSs] they just tell you, ‘you got to go here and go there’ and it’s up to you to do all that yourself, yeah. I think Dr 1’s very caring. A carer participant described cultural safety: There’s already cultural safety in AMSs so people can go in then they’re going to be comfortable to know that their needs are going to be met and that what they say is, if at times it’s not taken serious by the doctor you have other alternatives in an AMSs like the Aboriginal health workers or the registered nurses’ (participant D). The importance placed on cultural safety in AMSs needs to be understood in the context of entrenched social and personal memories of not feeling safe in MHSs. This participant also signals a value of the option to interact with other AMSs Health professionals. Unlike the peer socialisation that occurs in the waiting room in front of the door, the formal space behind the door sees the appearance of hierarchies of resort described below, deployed around explicit professional statuses of different AMS staff. This participant, for example, described cultural safety in terms of patients

having options to seek advice from health professionals other than or in addition to their GP. This is different from MHS settings, where there is no invitation to enter other doors and visit other health professionals.

DISCUSSION

Indigenous health advocates assert the integrated service offered by ACCHS AMSs exemplify what good primary care truly means (Tongs, personal communication, 2006). Providing as many services in the one location as possible, with strong links to visiting specialist services, is one of the factors that enable AMSs to claim that they truly look after the whole person. The primary care concept of looking after the whole person is one in which the person experiences continuity of identity, community and value through the whole journey through health services (Dussart, 2010; Herceg, T. Jowsey, 07 April 2011, Canberra).

Our research suggests that in the Australian context there may be differences in patient satisfaction with services offered by MHSs and ACCHS AMSs. That is, the whole journey through these services and not just health professional encounters contributes to patient satisfaction, empowerment and engagement in managing their health. These findings confirm and support those reported by Nathan (1980). MHS staff interviewed in Nathan's study reported their perception that 'aboriginals hate waiting' and that long waiting period prevents their attending health services. In our study people commented on long waiting times when attending health services, however they also noted that:

1. The waiting provided an opportunity to share experiences with other members of the community; and
2. The waiting was acceptable on the grounds that once they got through to the consultation they knew they would have adequate time with the health professional.

In addition, our findings suggest that the spatiotemporal experiential characteristics of healthcare services are different in AMSs and MHSs spaces, and that the meanings of both

spaces can be altered. While MHSs may be genuine in their attempts to create an environment of welcome and respect, there is not good evidence of actions that encourage and sustain personal identity, community connectedness and personal value. There is considerable evidence in the literature of how health services are seen by consumers as disempowering, requiring people to follow the established rules and processes of 'good patient' in medical settings (Aujoulat et al., 2008; Jowsey et al., 2011). Many of the concerns of health consumer organisations are directed to remedying the failure of respect by health services for the person or to provide patient-centred care (HCCA, 2009).

Participants in this study identified waiting rooms in AMSs as spaces in which they felt the time spent was valued. The significant aspect of valued time in this regard is intrinsically connected to an ability to engage in meaningful interactions with other peers. It is therefore directly linked to issues around relationship. Nathan (1980) reports that urban Aboriginal people rely on community for support in their health management and are consistently likely to seek health information from family and friends before seeking health care from MHS, even though seeking health information from peers is sometimes associated with shame, such as information concerning contraception. People in our study sought and shared health information from both peers *and* health professionals in different spaces within the AMS. Much has been written about informal and family support networks for those with chronic conditions outside the places of formal health care delivery (Dussart, 2010; Essue et al., 2010), but perceptions of the informal sociality that occur within these places suggests that the physical settings of the clinic space may have a role to play. This revolves around the question of how interactions in the spaces in front of the door might be used, or capitalised on, to create or enhance networks of support that would then flow out into the non-clinic community spaces or vice versa. Finding ways to address this would be consistent with a whole person or patient-centred approach to health service delivery (see Nathan, 1980). People are not their condition; they have different articulations of the self that do not necessarily

centre on their just happening to live with a chronic illness (Heil & Macdonald, 2008).

Similarly, participants in this study strongly articulated value in terms of time and connection with health professionals 'behind the door'. There are resonances here with Atlas, Grant, Ferris, Chang, and Barry's (2009) concept of patient-physician connectedness. They suggest that physicians who foster closer relationships with their patients and identify them as their own may adhere more closely to the guidelines and by extension, secure better patient outcomes. Again, this is a question of relationship, and our findings suggest that the two AMSs in our study are very good at fostering strong relationships with those who attend the clinics. However, Atlas et al. (2009, p. 332) are careful to stress that 'a close continuous relationship requires the active participation of both the patient and the physician'. In terms of the findings presented here, there seems to be scope for more than one type of connectedness, which was seen in relation to AMS attendees having available to them what Kleinman (1980) referred to as a 'hierarchy of resort': a sense of feeling safe about approaching other health professionals in the clinic (Dussart, 2009; Kleinman, 1980). Kleinman has suggested that people seeking help with their health place health practitioners, specialists, and spiritualists in hierarchies. The person they believe holds the potential to affect the best possible health outcome for the patient is situated at the top of the hierarchy. For example, a hierarchy might have a priest at the top, followed by the GP, and a naturopath at the bottom or it might comprise another ordering. Hierarchies of resort offer patients directional processes in seeking health care. The fostering of these kinds of hierarchies provides opportunities to mitigate situations where there may be break-downs in relationship between different health professionals and patients, as described above. This is especially important in settings where one cannot be guaranteed access to the same doctor on every visit as a consequence of ongoing capacity issues in the health services. In essence, this creates a community style interaction between clinic attendees behind the door that is analogous, although different in scope, to community as it is actualised in the space in front of the door. While this concept offers useful ways of understanding how multidisciplinary teams can work, the atomisation of the team

and the places and spaces within which they work in many MHSs prevents the patient having choices about engaging that hierarchy of resort and gaining the benefit it offers.

Similar experiences to those of the ACCHS AMSs occur in other specialised, segregated services, such as some women's health, HIV health, or migrant health or services where the waiting room offers a community of support, with a clear and specific identity that is carried through to the clinical space (see for example, Warin et al., 2000). Our findings suggest that the strength of these and ACCHS experiences lies in the continuous thread of patients feeling valued in and between these spaces. Extending this notion, Nathan (1980) and Heil and Macdonald (2008), note that Aboriginal peoples experience life as 'self-as-social' rather than self-as-individual (cf. Adams, 1988). Understanding the complexities of value intrinsically tied to this notion is imperative to shaping health service behaviour.

The connection between community-oriented specialised health services and improved client-focussed culturally or socially appropriate health care is not limited to the GP waiting room or to service provision. The HIV literature was quick to identify that prevention was most effective when it was developed and implemented with broader gay community support. For example, the Australian National Centre in HIV Social Research's large scale Social Aspects of AIDS study illustrated a positive correlation between a gay community attachment index and the adoption of safer sex practices (Kippax, Connell, Dowsett, & Crawford, 1993) and in the mid-1990s *The Lancet* published an article extolling the virtues of a community-based approach in HIV prevention (Coates et al., 1996).

What this paper offers is a snapshot of integration within a primary care service that is not limited to the relationships and communication between the clinical providers but incorporates integration for the patient on their journey through each component of the service. When we think of what characteristics we need to cement into new models of primary health care provision through one stop shops such as advanced medical homes (American College of Physicians, 2006) and multidisciplinary primary health care teams (Usherwood, Long, &

Joesbury, 1997), we could well learn from the lessons of the AMSs. Health care providers want people using services to see those services positively, to want to attend, to value the contribution that each health professional plays in their good health care and through that make the most of health services and optimise their own health. This is of particular importance in managing chronic illness. The long-term relationship between the person and the services they use is crucial to planned and monitored care, and better health outcomes.

However, the quality of what goes on behind the door must match the experience of what goes on in front of the door. Not all people using a health service will want to meet people they know and/or engage in conversation with others while they wait to see a health professional. Indeed, most people in a waiting room in a mainstream practice may not know each other or even see each other as part of one community. Their needs and expectations are equally important and support the notion that there is no ideal one way to meet the diverse needs of people. This diversity notwithstanding, people of all creeds and walks of life hold a desire to feel valued and this paper has indicated some of the ways in which ACCHS AMSs contributes to those feelings and optimises health care.

Limitations

We did not aim for generalisability; rather, we aimed for a small representative sample of people living with the three index conditions, saturation of issues raised in responses from our participants, and coherent interpretations of our data. While the research was conducted across two local sites the findings do not indicate they are site-specific. The study recruited participants through AMSs and as such does not represent the views of people, who for whatever reason, choose not to access AMSs. The study also only included people living in urban areas and their experiences are likely to differ considerably from those people living in rural and remote areas.

CONCLUSION

The experience of Indigenous Australians with chronic illness using health services is positive when the time spent by the person at each step of the service journey is worthwhile. Physical and

temporal design of services could create this characteristic by going beyond the well-intentioned but superficial gestures of attempting to make a welcoming environment through displaying Indigenous artworks. Purposeful design to make each aspect of the experience meaningful and relevant to the whole person will be challenging, but will re-introduce opportunities for health care that have been limited by the segmented person as illness design features of our current system.

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