

# **Achieving gender and cultural competence by Australia's medical workforce**

**A joint project of Australian Federation of Medical Women, Centre for Culture and Health and Australian Resource Centre for Healthcare Innovations, in association with University of New South Wales, University of Adelaide, University of Melbourne and Monash University**

*The voice of community women and their preferred ways for receiving culturally appropriate care.*

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## **Aim:**

The aim of the study was to give women from culturally and linguistically diverse backgrounds, an opportunity to voice their opinions on the health care within a multicultural setting, to hear their views around this theme and what they felt was important for doctors to know in order for them to provide culturally acceptable care.

Documenting the views of culturally and linguistically diverse women, who at present are largely unheard by medical professionals and educators, would help inform future changes in curriculum and teaching materials tailored from undergraduates through to specialists training in relation to the gender-cultural competence of their medical workforce.

## **Method**

A mixed method approach was adopted for this small scale study. Group discussions were the major source of information on how respondents thought about the influence of cultural factors in their medical encounters. These discussions were facilitated and the information recorded by volunteers from the community women's groups. In addition to discussion groups and in an attempt to reach more women, a few individual interviews were also conducted. The questionnaire was also circulated amongst community women's organizations for members to complete at leisure.

Access to women from culturally and linguistically backgrounds were brokered through the executive of the FECCA women's committee and other member organizations of FECCA, such as the South Australian Multicultural Council, and the migrant women's lobby group. Similarly, in partnership with AFMW the help of the Australian Women's Coalition was sought to access more women from culturally and linguistically diverse backgrounds.

The women were asked several key questions which revolved around the theme of "*what do you want a doctor treating you to be aware of and how would you like to be treated i.e. in a culturally appropriate way*"? This also covered the needs of women in clinics, doctor-patient relationships, as well as cultural and linguistic issues of women. Additionally, a further few questions were asked around the role of women in their particular community and how they could help address gender-cultural competence in the medical workforce.

## **Findings**

Over 95 responses from community women of various cultural and linguistic backgrounds were collated and analysed. The majority of the women were from Asian (e.g. Vietnamese, Indonesian, Pilipino, Taiwanese, Thai, Japanese, Chinese), Spanish speaking Latin American or European (e.g. Greek, Italian, Russian, Portuguese, Hungarian, Bosnian, Croatian, Serbian, Polish) background. In addition, a few (< 15) responses were received from native English speaking women from Australia and Britain.

In general, the participants were older, typically ranging in age from about 35 to 75 years with the average age being about 55 years. Most of the respondents have been living in Australia for several years ranging from about 20 to 40 years, with some arriving in Australia as far back as the 1960's. A few women were recent arrivals in Australia, having only been here for less than 5 years.

Adopting a grounded theory approach to the data analysis, responses to the core questions were categorised into themes as they emerged. These themes are reported against statements, which captured the essence of what the question was asking. Sifting through the mass of information it became evident that a constant comparative approach would help in identifying the many similarities and differences in the data. This subsequently helped to generate the categories and their properties.

Owing to its narrative nature, it is the intention of the report to keep the responses as authentic as possible. Due to the nature of the questions and possible difficulties in their interpretation, many responses appeared to be repetitive. However, it must be emphasised that valuable points were raised by the women with regards to culturally appropriate care and illustrative examples were presented to support their responses.

### ***I. Based on their cultural background, issues that women thought were important for their doctor to know about in order to provide them with better health care.***

The most quoted response about what women felt was important for their doctor to know was '**awareness of the family history and their cultural background**'. This included knowing about their medical history, cultural and religious beliefs. Women expressed their need to be treated as individuals, with respect for who they are and their gender and with sensitivity to their beliefs. Women also expressed the need for their doctors to be aware of their preference for what should or should not be disclosed during a medical consultation.

One native English speaking lady mentioned that she would not necessarily want to be told if she was suffering from a terminal illness. She would want her doctor to do what was necessary to keep her comfortable.

The women felt it was also important their doctor knew about special **dietary requirements and preferences**, so that when recommendations were made in reference to their diet, they could negotiate all available options.

A woman of Muslim faith expressed the need for doctors to be aware of fasting during religious periods and how it would impact on her treatment.

A Finish lady spoke of her mother's experience with a doctor from a different cultural background to hers. This doctor tried to influence the mother to change her nutritional habits to

those that he followed and said how better off she would be! The mother said that it might be so, but coming from a long line of porridge eater it was not an option for her!

Although not necessarily of cultural relevance, but nevertheless of particularly important consideration for recent migrants, was the issue of finance. Some women expressed the need for their doctor to be aware of their **financial situation**, so that when treatment plans are put forward, doctors would be sensitive and not suggest the most expensive treatment as the first option. This was expressed by several women as being their personal experience. Women felt they needed to be able to place trust in their doctor and the doctors in turn to empathise with their situation, particularly with regards to their **role in the family** and other prevailing circumstances.

One Greek woman from a community organization said that the doctor needed to know about the family environment and how it affected her, especially if she was tired, stressed and sick. This way she is not advised to do things that are impossible or inappropriate to her situation. It was no good saying go home and go to bed for three days if she couldn't. Or perhaps it would be preferable to say do only the essentials, or ask a friend to help and spend the afternoon resting. This is more helpful and shows that the doctor is sensitive to gender issues.

Another issue that women raised was for doctors to have an understanding of **complimentary and alternative medicines (CAM)**. Be it cultural or otherwise, many women said they had turned to traditional medicines for relief and treatment of symptoms and conditions at some point in their lives. They did not want doctors to dismiss their belief in the benefits of CAM and instead wanted them to be aware and understanding of its use when it came to prescribing western medication.

Most women clearly believed that these cultural issues and language contributed largely to the delivery of health care. It impacted considerably on how they access and respond to health care services and their local medical practitioner. Doctors paying due attention to their patient's cultural needs would lead to better health outcomes, better interaction during medical consultations, less stress and anxiety to the patient and greater trust and confidence between themselves and the patient.

### **Actions to be taken:**

#### *Training in cross-cultural communication*

- Provide training so that doctors are able to read verbal and nonverbal communication across cultures and empower the people to clearly convey their needs, preferences and situation.

#### *Education about difference:*

- Emphasise the need for reflective practice and encourage doctors to identify his/her own cultural values, assumptions and beliefs that affect their patient care and clinical decision making; respects, informs, consults, negotiates and plans healthcare with the patient's in a way that accounts for patient's cultural choices.

#### *Help with understanding and managing issues that impact health care delivery to patients*

- Provide learning opportunities in medical training that highlight the impact of individual, professional, community and institutional cultures on health care delivery and the need to respect

the culture of others when working together; provide doctors with an understanding of traditional medicines so they can safely manage Western allopathic medicine and other complementary systems;

## ***II. What doctors need to learn during their training (other's culture) to provide better health care to people from culturally and linguistically diverse backgrounds.***

Many women believed that it was important for their doctor to be aware of the patient's **body and facial expressions** (e.g. avoiding eye contact, lowered head) during the consultation. Such expressions are not universal and can differ from one culture to another. Not picking up on these signals leads to misunderstanding or discomfort, which hampers further interaction between the patient and doctor.

Although it was recognized that learning about all religions and cultures is not practical, the women were of the opinion that being aware of the varied **cultural and religious beliefs** held by people, which can be different to your own, was important. Some women believed that awareness about some major cultures (e.g. Middle Eastern, Asian) and religions (e.g. Muslim, Jewish, Catholic and Buddhist) would not be a bad idea as they differ so much in the way they are applied to day to day living. These cultural and religious beliefs affect their health and concordance (which the women in their discussions termed 'compliance') with prescribed treatment.

Blood transfusions, surgery - cuts to the body, contraception (e.g. catholic teaching on birth control, abortion) traditions during child birth (e.g. some Javanese women keep the afterbirth i.e. the placenta and bury it after special ceremonies over 7 days).

These are normative beliefs held by members of ethnic communities which are important at key moments in life e.g. blood transfusions, surgery, birth etc. Doctors need training to develop their capacity for cultural humility, sensitivity and competence in these cross cultural situations. Women appreciated doctors who did not ridicule or dismiss their deep held beliefs, but rather were sympathetic towards them.

Teaching medical students **listening skills and general good communication** was high on the list of requirements for training. Almost all women expressed the need for good communication between the doctor and patient and mentioned that it was a skill they all looked for in a competent doctor. These skills need to be developed over time and it is necessary to start early in their medical training. Language and communication skills impacts largely on the outcome of the medical encounter and effective dialogue between the doctor and patient is necessary to provide each other with vital information for correct diagnosis and treatment and concordance.

Many women of Russian, Greek and Spanish origin expressed their frustration about the fact that some doctors did not seem to be aware of the role of interpreters and did not seem to use them. If language was a difficulty, the women felt that doctors ought to ask them if they would like to have an interpreter to aid communication between them.

One Japanese woman quoted a situation where she did not know the term 'German Measles' and when referred to it by the doctor, simply said 'No' without understanding what was asked of her. The lady having moved from Japan recently was confused, as in their language German Measles is referred to by another term.

The case for integrating cultural competence into medical education is ever important, as women spoke of the need for doctors to be **culturally sensitive and respectful, be aware of cultural taboos, not be judgmental, not stereotype people** etc. These sentiments were recurrent in the responses of culturally and linguistically diverse women and indicated a strong feeling about the current lack of cultural competence among many doctors.

A Pilipino woman was accused of dropping her baby because the baby had a blue mark on the body. The medical officer was not aware that it was usual for Asian babies to have a blue mark somewhere on the body usually on the back, buttocks or leg. Babies are born with the special “Mongolian Spot” at birth which then fades as the baby grows. The woman in this instance found it distressing to be accused of causing bruising to her baby.

As women, **gender issues and women’s health** were also mentioned. Many women made specific reference to reproductive health, i.e. birth control, domestic violence, role of women in the family etc. and wanted doctors to be aware of gender differences when they were presented with female patients. This was a particular issue for Muslim women with male doctors.

One woman of Muslim faith expressed her experiences such as her husband insisting on being with her if she was seeing a male doctor and even objecting to internal examinations.

Generally speaking such situations would prove to be a barrier for the doctor to make an accurate diagnosis and having to rely on an oral description of the ailment. Although current medical curricular include women’s health, more can be done to integrate culture and gender into medical training. Cultural taboos, how to address women and what is appropriate to ask, doing patient examinations etc are all areas that needed to be approached sensitively. Women feel that without satisfactory training, many doctors would not have the necessary gender-cultural competency skills to deliver appropriate care to their patients.

Last but not least, the women expressed the benefits of introducing doctors to **complimentary and alternative medicines** at some point in their training. There is growing evidence of its use amongst people from across many communities and general awareness of CAM would lead to risk management and aid in better compliance to treatment from patients.

Actions to be taken:

#### *Reflecting on personal value system*

- Medical schools and hospitals to provide in their training opportunities for doctors to explore the cultural determinants of their own values and be respectful of their patients’ and colleagues culturally constructed values and attitudes in the professional relationship, thus ensuring cultural safety and acceptability
- Medical programs to deal with the social aspects of health and disease by identifying and reconciling cultural views of health held by patients, doctors, colleagues and communities.

#### *Working with interpreters*

- Medical schools to develop communication skills programs that help doctors to understand and utilize good communication principles. This includes having an understanding of the role of interpreters and how to work with them and being able to explain procedures for obtaining consent.

*Teaching about cultural and gender issues and the impact in medicine*

- When teaching about specific areas of medicine such as cardiology or gastro critically discuss the contribution of cultural and gender factors towards biological principles/explanations of health including responses to treatment and the mechanisms of health and disease.

***III. Important cultural issues for women when seeing a doctor and cultural barriers that could limit doctors providing the best care.***

Almost all women expressed that it was important for them to see a doctor with **good communication** skills. The doctor would take the time to listen to their concerns, ask questions, speak clearly and explain conditions and treatment. The women did not want their doctor to stereotype them, speak down to them or treat them as uneducated if they spoke with an accent. They also said that it was necessary that doctors were **friendly and sympathetic** and not dismissive of their fears and beliefs. They wanted to see a doctor they could **trust, who would create a safe environment** for them to interact and reassure them about their health.

Again, as women, they wanted their doctor to have an **understanding of gender issues and particular knowledge about women's health, be sensitive to their needs and have the right attitudes towards women**. One of the main issues that women considered when consulting a doctor was the **gender of the doctor**. Many culturally and linguistically diverse women preferred to see a female doctor, particularly if it concerned reproductive health.

Culturally and linguistically diverse women in particular expressed their discomfort and difficulty talking about problems with reproductive organs. They said they felt shy to talk about women's reproductive issues and embarrassed by examinations of breasts etc where they had to remove their clothing. They also have trouble making an appointment in the first instance and difficulty explaining their symptoms.

What also became evident was the fact that some women preferred to see a doctor from their same cultural and linguistic background, as they believed it would lead to less communication breakdown and misunderstandings. They could explain their medical condition to the doctor in their own language and know that the doctor would be aware of common cultural and religious beliefs.

One Pilipino woman mentioned the case of a Filipino doctor's patient numbers doubling since moving to Adelaide. Many Filipino's preferred to see a doctor from their own cultural background, and currently there is a lack of Filipino doctors to service their population.

In terms of barriers, the women felt that **ignorance** was a major drawback to a satisfactory consultation. **Poor understanding of gender and women's health and their role, lack of experience working across different cultures and a general lack of awareness of socio-economic issues** were also factors they felt contributed to poor health care.

**Stereotyping** and treating all culturally and linguistically diverse women the same, **not being open and accepting of all cultures, patronising behaviour and thinking they know everything about the patient's culture** were the main cause of problems in a consultation.

Several Latin American women expressed their concern about cultural insensitivity and assumptions that doctors have made about them i.e. that all culturally and linguistically diverse women are homesick and therefore unwell and needing tranquillizers in order to cope.

One African lady expressed that barriers to do with ignorance, bias, racism etc were problematic. She said that some doctors, many well intentioned, think they know or understand a cultural group – but sometimes it is these so called understandings or experiences that come across as patronizing, sometimes even offensive.

Needless to say, many women were of the opinion that language and communication problems cause a huge barrier during their consultations, as such, they felt the use of interpreters in such situations was necessary.

Women from Asian background and Middle Eastern origin in particular mentioned that they tend to say 'yes' to everything the doctor says. They do not admit to not understanding their doctor because of their limited language skills. They also did not question the doctor's opinion.

It was noteworthy that a small number of women (~ 6 out of 90 women) predominantly native English speakers thought that the doctor needed to be medically competent, be able to tell them what was wrong and treat them with medication. They were not too concerned about cultural differences and their interplay during the consultation and did not think about culture when visiting a doctor. The native English speaking women did not express any concerns with language difficulties or cultural issues although they believed that everyone had a culture and should be treated with respect and dignity.

Actions to be taken

*Training about cultural sensitivity, tolerance and respect for others*

- Medical schools and hospitals to integrate into their training programs social and cultural determinants of health. This includes teaching about influence of cultural factors and the view points of others including patients when discussing issues or when formulating clinical plans, awareness of cultural disadvantage and bias and being able to respond appropriately to situations that might compromise the wellbeing of patients.

***IV. What women felt was important for a satisfactory consultation if the doctor and patient were from different cultural and linguistic backgrounds, and what they believed were characteristics of a culturally competent doctor.***

Although the questions were posed separately, responses were very similar and therefore it seemed appropriate to bring them together and draw parallels rather than duplicate. Women felt that first and foremost the doctor would need to be **aware that there would be cultural differences** between the him/her and patient. Therefore, it would be necessary for the doctor to be **open and flexible, respect the diversity and be conscious not to impose his/her own values** on the patient.

One Anglosaxon lady described a situation where a doctor from a different cultural background to hers was very insensitive and had no understanding of what she was trying to tell her and was not interested in finding out. Because it wasn't relevant or applicable to the doctor's culture she simply did not want to know and instead imposed her own views on the matter.

Be it cultural competence or not, the women felt that **taking time** to explain treatment and condition was important. They also said they appreciated doctors who **encouraged their participation in decision making as it felt it valued them and respected their own knowledge** of the illness. More specifically, the women felt that a **holistic** approach, showing a genuine interest in the person and their culture, family and situation went a long way in making the consultation satisfactory.

From a cultural and linguistic perspective, the women felt that little things like **displaying notices in different languages and having handouts/leaflets in different languages** in the clinic was very helpful and indicated cultural sensitivity. They felt a culturally competent doctor would **ask questions about their cultural background, acknowledged complimentary and alternative medicines, respected their cultural and religious values and beliefs, and generally was polite, caring, sensitive and compassionate.**

One woman articulated this very clearly 'self awareness, knowledge and skills are principle components in developing a therapeutic relationship with a patient'. She believed that 'medical students should through reflection cultivate self awareness and increased understanding of his/her personal culture and professional socialisation and consider the resultant impact on the doctor/patient relationship. Accordingly, furthering self awareness cultivates sensitivity and awareness of the patient's cultural heritage, belief, attitudes and behaviour and as a consequence skills become modified specifically to suit the patient's needs'.

The women also believed that a culturally competent doctor would be aware of communication issues and therefore would **check for understanding by asking questions and seek clarification.** They would take the trouble to **consider patients suggestions and negotiate treatment and management plans** with them.

## **V. Problems that can be alleviated by improving the cultural competence of doctors.**

The women were of the firm belief that if doctors were culturally competent their patient's would have complete trust and confidence in their doctor to make the correct diagnosis and prescribe the most appropriate treatment leading to greater concordance and thus better health outcomes. They thought that patients would feel less reluctant to visit a doctor. Instead of feeling belittled they would be empowered and reassured. It would help to reduce the stress and anxiety and the fear of rejection that can surround a consultation. Good communication and cultural sensitivity would prevent misunderstandings and confusion, and encourage good interaction between the patient and doctor.

A lady of Chinese origin stated that some cultural assumptions made by doctors left her feeling disempowered. She felt the ideal situation was for the patient to be made to feel their best and treated as an individual. In some instances because of unacceptable care, generally female patients find themselves 'doctor shopping'.

## **VI. How women in the community can contribute to medical training**

From the women's responses it was strongly evident that they felt they had an obligation to help in whatever way they could to improve health outcomes for all people. They affirmed that good medical training was the key to this process and believed they could be a resource that could be tapped on. They felt they could contribute in several ways, e.g. speaking to medical students, sharing their experiences of medical encounters with other doctors and the community at large, discussing core values and beliefs, providing information about their heritage and religious beliefs, letting doctors know what was helpful during the consultation and encouraging them to demonstrate such skills.

They also expressed the value in participating in projects such as this, holding discussion groups and learning from each other. Attending seminars, meetings and forums and doing their own research by reading and learning about medical issues was a good way to increase their own knowledge about health and expectations from medical encounters.

### **Summary/Outcomes**

Women from culturally diverse backgrounds in Australia are at particular risk of poor medical care, with doctors often poorly equipped to respond. This is a crisis situation for women, especially those from a culturally diverse background, of which almost one-third of women in Australia are. Peak ethnic community organisations have become alarmed by the inequities in the quality of care available for women because of ethnic, cultural, language, race and other barriers.

In response, Australian medical educators have been calling to include 'gender competence' and 'cultural competence' as core components of medical education – for doctors in training, young graduate doctors, specialist trainees, and mature doctors in continuing education. Moreover, medical professionals and educators are worried about equity and risk management issues. They are also increasingly discomfited by the gap between women's need and their inability to respond because of a lack of accessible and useful educational resources on gender/cultural competence.

This study aimed to hear the community women's voice and document from the perspective of female patients of culturally and linguistically diverse backgrounds, how culture influences the quality of medical visits. It aimed to highlight their preferred ways for receiving care and what women believe is important for doctors to know and be aware of if they are to deliver culturally appropriate care. It was clear from the respondents of the study that culture plays an important part in health care delivery. They believed that their medical encounters would be less stressful and more productive if doctors recognized cultural differences and had the necessary skills to deal with cross cultural situations.

From the community women's perspective this project identified the following issues as being most important for doctors to be concerned about when treating culturally and linguistically diverse women. Such issues that the women alluded to were:

- Being aware of family history and cultural background
- Being aware of cultural differences
  - body and facial expressions
  - cultural and religious beliefs
  - cultural taboos
  - dietary requirements and preferences

- Not stereotyping and making assumptions
  - show cultural humility and respect for others from different cultures
  - ask questions about cultural background, willing to learn
  - be sensitive, open and accepting of all cultures
  - be aware of own values and beliefs and not impose them on others
- Being aware of the use of complimentary and alternative medicines
- Having good listening skills and good communication; awareness of interpreters and their role
  - seek clarification and check for understanding
  - encourage patient participation in negotiating treatment
  - respected the patients own knowledge about their health
  - display notices/handouts in different languages
- Being aware of gender and women's health issues
  - right attitudes to women and respect
  - role of women in the family
- Creating trust and safe environment for doctor patient interaction
- Adopting a holistic approach

The women also cited proposed actions that would lead to future doctors becoming competent at delivering appropriate care to any patient no matter what their cultural and linguistic background might be. These include:

- *Training in cross-cultural communication and working with interpreters*
- *Education about difference*
- *Help with understanding and managing issues that impact health care delivery to patients*
- *Reflecting on personal value system*
- *Teaching about cultural and gender issues and the impact in medicine*
- *Training about cultural sensitivity, tolerance and respect for others*

### **Highlights and difficulties**

One of the highlights of this study was the evident enthusiasm of the women who participated in the discussion groups. They expressed their satisfaction and enjoyment at being able to share their experiences and encounters with medical practitioners with other women whilst learning so much about each other and their cultures. They mentioned how much they enjoyed the process and expressed their interest to continue participating in forums and discussions of a similar nature thus supporting future projects and collaborations.

The time taken to obtain ethics clearance from the University impacted on the project and cut into the time line. The shortened timeframe made it difficult to coordinate the various aspects of the project and get all components of the study completed by the deadline.

The recruitment of participants within a short space of time also proved to be rather difficult. Access to culturally and linguistically diverse women had to be brokered through women's groups and

organisations with existing networks and links to community women. This was a time consuming process and required considerable goodwill and efforts in communication.

Because of the mixed method approach that was adopted for the study the nature of the data received was diverse. Therefore, its interpretation, collation and subsequent analysis was rather time consuming and tedious. Several rounds of summaries had to be done and reviewed each time before specific themes could be established and categorized.