APPENDIX 5

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

Final Report 21 June 2005
Contract Schedule 1 Records & Reports (clause 3.2)

This report was prepared by the Centre for Culture and Health, University of New South Wales on behalf of the project partners. The report was written by Ms Lilanthi Ambanpola in her capacity as project officer and with contributions from Professor Maurice Eisenbruch, Centre Director and Dr Gabrielle Casper, School of Women's and Children's Health, University of New South Wales. Contributions to relevant sections of the report were made by project collaborators at the University of Melbourne (A/Professor Deb Colville), Monash University (Dr Jo Wainer), University of Adelaide (Ms Ann Lawless) and ARCHI (Dr Char Weeks).

The report is set out as follows. The project outcomes are described against the deliverables. After a preamble that sets the context, the two research arms of the project are described and reported – first, the community women's voices, second the voices of young doctors. Then comes a description of the learning resources developed, and the establishment of an e-library. Difficulties and highlights are described, followed by evaluation, conclusion and recommendations.

The aim of the project was to enable the medical workforce to be equipped with clinical skills to care for all women in Australia appropriate to any cultural background – that is, with 'gender/cultural competence'.

The enabling objectives were to (a) voice the opinions of women drawn from a spectrum of culturally diverse community groups, about the skills needed by a medical practitioner providing culturally acceptable care; (b) snapshot the needs of a range of medical specialties (including primary care) in relation to the gender/cultural competence of their medical workforce; (c) modify key curriculum and teaching materials, tailored from undergraduates through to specialists and clinical leaders; (d) harness established platforms by which these resources in gender/cultural competence can reach the Australian health care workforce effectively and efficiently through established web based clearing house for innovations in clinical management.

Project outcomes

New opportunities for bridging between women from culturally diverse backgrounds, the medical profession and those involved in medical education, and strengthening of women's voice in existing national academic and health networks

The Centre for Culture and Health in partnership with FECCA approached their women's committee, to provide them with information and seek their assistance in being involved with the project. Subsequently, several members of committees volunteered their time and came forth to help with data collection. Many openly expressed their enthusiasm and willingness to be involved in this project, seeing it as a major step towards giving women the opportunity to be heard and having an impact in improving health care delivery.

Women from member groups of FECCA further expressed their interest to serve in the capacity of an advisory committee reviewing gender-culture curricular material that will be developed from the project and used in future medical education.

Similarly, CCH in partnership with Australian Federation of Medical Women (AFMW) approached the AWC to seek their help in accessing women from culturally diverse backgrounds. The member organisations willingly extended their support and contributed extensively to the project by carrying out discussion groups and interviews with community women and helping in the data collection process.

There was strong expression by the women about the need to be involved in projects such as this which they saw as opportunities to connect women from culturally diverse backgrounds with the medical profession and those involved in medical education. They felt empowered to speak and highlighted concerns in health care delivery and believed it was an opportunity for strengthening their voice in existing national academic and health networks.

The context for the two research arms

Educational perspective of achieving gender and cultural competence: curriculum, pedagogy, equity and diversity

(Acknowledgement Ann Lawless University of Adelaide)

"To be truly accessible, courses need a different pedagogy, curricula, counselling systems and staff development which are at variance with traditional institutions" (Taylor 1997, 135 quoting Harrison 1990)

Australia's medical workforce begins its formal preparation in the initial professional education phase (the first experience of medical school where both undergraduate and graduate access is available), and continues in the graduate and continuing professional development years and furthermore continues throughout their medical career in a lifelong learning strategy and the need for continuous re-accreditation.

Australia's medical workforce is highly diverse in its own right, reflecting the diversity of the Australian population in race, ethnicity, gender, age, sexual identity, ability/disability and geography: for example, the medical workforce has

- a growing number of Indigenous doctors who have formed their own association to promote workforce issues (http://aidauser.brinkster.net/default.aspx)
- second generation Australian doctors of European, Middle Eastern, African and Asian descent; as well as
- stakeholder and lobby groups for rural doctors http://www.acrrm.org.au,
- medical women (such as Australian Federation Medical Women - see website http://www.afmw.org.au/ etc.),
- lesbian and Gay Doctors (Rogers and Booth 2004; also see website for Australian Lesbian Medical Association http://www.bnews.net.au/content2/hm_content.pl?page_id=Category::Popup&id=3358)
- doctors with disabilities (an under-addressed issue in Australia see Dr K Phillips http://www.ama.com.au/web.nsf/doc/WEEN-5JB7PE).

In addition to a workforce trained in Australia, there are many overseas trained doctors, all working in the context of an active social agenda about the accountability and responsibility of the medical workforce.
This diverse and complex medical profession delivers medical services in a complex health delivery system in partnerships with allied health professionals to a population which is equally diverse and dynamic, and increasingly demanding of accountability.

The challenge for medical schools and other stakeholders is to create a medical curriculum which can address this diversity and prepare doctors for practice in dynamic, complex and diverse futures. More than just creating and delivering curriculum, medical schools are also challenged to foster inclusive pedagogies which maximise the opportunities offered by diversity among students and educators. Taylor points to the need to address inequity in education "Inequities in access to higher education and inaccessible courses have particularly serious implications for professional education" (97, 130) and recommends that professional educators design curriculum and pedagogies that address and value diversity among students and educators. More specifically she espouses the benefit of a balance within curriculum design of "kinds of knowledge" (propositional, process, personal) and from a pedagogical approach of being encouraged to learn both interdependently and independently (97, 130).

References

Booth A & Rogers G. Out of the Closet and onto the Couch: Towards Gay-affirming Psychological Practice, in Out in the Antipodes: Australian and New Zealand Perspectives on Gay and Lesbian Issues in Psychology Riggs DW & Walker GA (Eds.) Brightfire Press, Perth, 2004.

Rogers G & Booth A. Queer Goings-on: A Genealogy of Lesbian and Gay Psychology, in Out in the Antipodes: Australian and New Zealand Perspectives on Gay and Lesbian Issues in Psychology Riggs DW & Walker GA (Eds.) Brightfire Press, Perth, 2004.

Taylor Imogen, 1997. Developing Learning in Professional Education.

Partnerships for Practice. Bristol, Society for Research into Higher Education and Open University Press.

Report setting out the community voices of women of culturally and linguistically diverse backgrounds and including a description of their encounters with doctors and their preferred ways for receiving care in culturally acceptable form

(See full report in Appendix A)

With the increasing diversity in the Australian population there is increasing cultural and gender differences in patient's perceptions of their health, the health care system, doctors and their gender-cultural competence. 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. There is evidence to suggest that in many instances women in particular prefer to see a same gender doctor and in some instances prefer to see a doctor from the same cultural and linguistic background.

In response, Australian medical educators have been calling to include 'gender competence' and 'cultural competence' as core components of medical education – for all 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 discomforted 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.

In this component of the project a mixed method approach was adopted for obtaining data. Several group discussions of community women were held. It was the major source of information on how respondents thought about the influence of cultural factors in their medical encounters. The discussions were facilitated and the information recorded by volunteers from the community women's groups. In addition to discussion groups a few individual interviews were also conducted and the questionnaire 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 Federation of Ethnic Communities Council of Australia's women's committee and the Australian Women's Coalition in partnership with Australian Federation of Medical Women.

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"?* Additionally, further 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.

The majority of community women who participated in this component of the project said 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 and gender differences and had the necessary skills to deal with cross cultural-gender situations.

The community women 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 could take place during their training to enable future doctors to become gender-culture competent. 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*

The women wanted doctors in training to be taught about cultural and gender differences as they might present clinically. This way they would posses the necessary skills to deal with medical encounters in the most appropriate way no matter the cultural and linguistic background or the gender of doctor and patient.

Report on the perceived needs of doctors in equipping them with gender/culture competence

(See full report in Appendix B)

(Acknowledgement Jo Wainer, Monash University)

Young doctors in Australia now work in an ethnically and culturally diverse workforce with a rapidly changing sex ratio of doctors. There are approximately 4000 overseas trained doctors working in Australia in addition to the cultural diversity of Australian trained doctors[1]. They work with great ethnic and cultural diversity among their patients. This diversity carries within it important differences in the way health, illness, illness management and medical authority are perceived. There is no necessary match between the health and illness beliefs of the doctors, and those of their patients. There are also major gender issues concerning medical authority, who is allowed to have it and who is not. These issues are compounded by cultural differences in the roles of women and men, and what are seen to be appropriate behaviours for the different sexes.

In this component of the project we held two discussion groups with young doctors to begin to understand what young doctors need to know about the gender/culture interface in order to be the best doctors they can be. Doctors were recruited from two Melbourne hospitals. There were a variety of gender and ethnic backgrounds represented. Doctors who were female and Caucasian were over-represented. They ranged from interns (post-graduate year 1) to registrars in medicine and surgery. The discussions were led by Dr Jo Wainer from Monash University and Associate Professor Deb Colville from the University of Melbourne. Signed consent forms were obtained from all participants. Notes were taken of the discussion and the discussions were digitally-recorded. Analysis of data was undertaken with the qualitative software programme NVivo (QSR 2002).
The discussion centered around three topics:

1) Gender/culture and the patient
2) Gender/culture and the doctor
3) Gender/culture and medicine

The doctors identified problems and training needs in each area. They detailed how women and men present differently as patients, and that this difference was also a reflection of the age and cultural background of the patient. The doctors were able to identify gender-based illness management and communication styles of patients, as well as identifying their anxieties about managing gender dynamics in intimate examinations and fears of litigation if they got it wrong. This is particularly difficult to manage cross-culturally. They are aware that issues of gender are played out differently in different ethnic groups and that they do not have the knowledge about how to engage with that difference. They are also aware that patients from diverse cultural backgrounds may have had life experiences that they know nothing about, and that may affect both the clinical interaction and the way illness and health care is experienced.

The main issues identified for patients are:

[1] Private communication, Dr Bob Birrell, Director of the Centre for Population and Urban Research, Monash University, 14th June 2005

- Attitudes to male and female doctors
- Effective cross-cultural communication
- Different illness coping mechanisms and the effect on the consultation
- Concern about litigation

Young female doctors are puzzled about how to demonstrate their authority as doctors, both with colleagues and with patients. There are powerful underlying cultural issues about who holds authority and how it is demonstrated, and these are triggered by the gender of the doctor for female as well as male patients. In many of the cultures of the immigrant communities women are not permitted to hold authority in the public domain. Patients with these beliefs will find it difficult to accept that their medical care is in the hands of a young woman. Young female doctors find their authority challenged by men from strongly patriarchal cultures. It is also clear that family dynamics within a variety of cultures have significant gender dimensions that make communication during illness and treatment likely to go completely astray.

The main gender/culture issues identified for doctors are:

- The doctor's authority in conveying medical information and advice
- The working relationship between the doctor and other staff, particularly nurses
- The perception of the doctor held by the medical team
- Accessing specialty training
- Family life within the medical profession
- Bullying and sexual harassment
- Medicine is being devalued by the presence in large numbers of women and doctors from non-Anglo cultures

The doctors articulated a need for systematic exposure to teaching about difference in the epidemiology, pathophysiology and clinical pathways of patients of diverse gender and ethnic groups. They are peripherally aware of an emerging body of evidence about difference and want to know about it if it is relevant to clinical care. The issues they identified included:

- Gender and culture competent appraisal of medical knowledge is not taught systematically
- Currently gender and ethnic variation in epidemiology not emphasized enough within medical curriculum, therefore lack awareness
- Research still mainly focused on Caucasian men and assumed to apply to all men and all women

They want to be taught about difference if it is relevant to clinical care, and some help understanding how gender and culture impacts on health and illness presentations and management, as well in managing their authority, particularly in cross-cultural encounters.

QSR (2002). NVivo. Melbourne, QSR International Pty Ltd**:** Qualitative data analysis package.

A set of learning resources suitable for use and adaptation in education from undergraduates through to specialist and clinical leaders

This aspect of the project was addressed collaboratively by colleagues at UNSW, University of Melbourne and Monash University. In addition, the gender-culture curriculum expert at the University of Adelaide also contributed to the development of curriculum review and learning resources. The resultant work forms a collection of learning resources that will help extend the gender-cultural competence of the medical workforce. These resources can be viewed on the ARCHI website URL http://www.archi.net.au/content/index.phtml/itemId/170991

An established e-library with a range of catalogued resources, tools and information and links

(Acknowledgement Catherine Knight and Char Weeks, ARCHI)

ARCHI has established and maintains an e-library of resources through their website, including practical reference and educational material through their website. The aim of the e-library is to provide a resource, for educators, medical professionals and community groups to facilitate gender & cultural competency. The website is a living resource and constantly updated as new material becomes available. They are actively sourced by the project team. At the end of this project they will continue to be sourced by ARCHI. The following outlines the stages involved in setting up the e-library.

- The Gender_and_Culture discussion group was set up to facilitate communication within the Project team.
- The organisation of the content, terms and categories were established in consultation with the Project team.
- The ARCHI website was modified to provide the link shown on the toolbar above.
- The Project pages were designed and established.
- The resources were added to the ARCHI e-library and the Project pages.
- ARCHI continues to be in contact with relevant community, education and medical groups to ensure the resources on these pages are relevant, useful and current.

ARCHI Gender & Culture Project website outline

Below is a graphic of the ARCHI website toolbar with which the Gender & Culture Project has been added. This provides a direct link from every ARCHI page to the Project homepage.

- About Cultural Competence
- About Gender Competence
- Information Resources
  - Cultural Competency Resources
    - Cultural Competency Links
  - Gender Competency Resources
    - Gender Competency Links
  - Communication Resources
    - Communication Links
  - CALD Communities Resources
    - CALD Communities Links
  - Health Services Delivery Resources
    - Health Services Delivery Links

Achieving gender and cultural competence by Australia's medical workforce.

This is the homepage of the Project. It is an introductory page. It has brief summary of the Project and invites contributions. The Project reports will be added as articles to this page.

⇐ The **text box** to the left shows the index to the web-pages. This box appears as a menu on every Project page.

About Cultural Competence

A statement about Cultural Competence: what it is and why it is important in the health services.

About Gender Competence

A paper about Gender Competence by Jo Wainer. It has definitions of gender and gender competence and identifies gender issues.

Information Resources

This webpage provides links to information resources within the different subject areas. ARCHI has established an e-library of appropriate and practical resources. The aim of these pages is to facilitate gender and cultural competency for educators, community groups and health professionals. This is a growing site and will be continually updated as new resources become available. We are actively sourcing new material.
The resources posted here are divided into the main topics of the Project:

- Cultural Competence: resources specific to developing Cultural Competency
- Gender competence: resources for developing Gender Competency
- Gender & Cross Cultural Communication: resources for Gender and Cross-cultural communication. It includes things like, issues relating to interpreters / translations, medical terminology, gender issues.
- Culturally and Linguistically Diverse (CALD) Communities: resources pertaining to specific CALD communities.
- Health Services Delivery: the application of Gender & Cultural Competencies in health services.

Each of the topic areas are divided into the following:

- General resources: includes definitions, papers and presentations describing the topic.
- Guidelines, Policies, Procedures, Frameworks and Models: specific material on the application of the competencies in the workplace.
- Case studies: particular case studies relevant to each topic.
- Educational / teaching materials: material designed to facilitate the teaching of each topic. It includes course notes, scenarios for discussion, etc.

- Bibliographies: lists of relevant materials available outside this site in other formats, e.g. video, papers.
- Links: provides links to other organizations and web sites of particular relevance to each topic. The sites are divided in to Australian and International sites.

Potential resources are identified, using a set of selection criteria.

- **Subject coverage**: gender and cultural competency within the medical workforce.
- **Geographic coverage**: focus is on Australian material, but some international resources are included if they are particularly relevant.
- **Currency**: recent material, i.e. last 5 years. Older material is included if it is of particular merit.
- **Bibliographic data**: ensure full citation and / or bibliographic data is available for the resource (e.g. title, author, edition, organization, publisher, date of publication)

Resources are evaluated by the relevant members of the Project team and added to the e-library.

Difficulties encountered & highlights

The timeline for the project activity was slightly put back due to the initial delays in signing off the contract, running into the university summer vacation and the subsequent late start of the project. The extended time taken by the ethics committees at the various universities to grant approval and provide the go ahead for data collection also affected the schedule. As a result a new time line had to be established for the project activities.

The small delay did not affect the overall deliverables set out for the project. In order to maintain the timeline small adjustments were made to details of project tasks, to ensure that the tasks such as data collection were focused and strategic. This meant that the extent of data collection and development of e-library resources while meeting the deliverables was not as comprehensive as a longer project would have allowed.

Highlights and difficulties related to the two specific research arms of the project are addressed in Appendices A and B.

Evaluation of the project

Details can be found in Appendix C

Conclusion and recommendations:

(Acknowledgement to Ann Lawless, University Adelaide)

The challenge for medical schools and other stakeholders is to create a medical curriculum which can address patient and doctor diversity and prepare doctors for practice in dynamic, complex and diverse future environments.

This requires fostering cooperation and collaboration between medical schools and stakeholders in ways that enhance and extend understandings of diversity, curriculum design and delivery, and pedagogical practices that address and value the diversity of learners and educators. Such cooperation and collaboration will contribute to
the emergence in Australia of (1) good practice and later best practice in medical education, perhaps embedded in a proactive quality approach to medical education (2) mutually agreed processes and "instruments" that encourage audit, evaluation and review of each other's curriculum and pedagogical practices, especially those that value-add diversity.

It is significant that medical schools are involved with professional education not just with participation in the higher education system - medical schools must understand and deliver professional education. As Imogen Taylor (1997, 3) has pointed out "Professional education is distinctively different than higher education primarily because of its dynamic relationship with the professions, and more recently with employers and the government. These forces both shape course structures and management, as well as curriculum content and delivery." She describes the unique need of professional educators to prepare practitioners who are able to

- manage rapid change, uncertainty and an unpredictable future
- practice interprofessionally, amidst shifts in professional boundaries (eg with nursing and medicine, such as responding to risk)
- reflect on practice and be reflexive
- engage in lifelong learning
- act in partnerships with consumers and patients

She argues that professional educators must address diversity issues among students, among staff, in curriculum design and in pedagogical practices, and must also address concerns about authentic partnerships with patients and consumers and other stakeholders (Taylor, 1997).

Working with diversity as an asset which value-adds to education is a current concern of emerging Australian literature and projects. Indigenous Australians have effectively advocated for curriculum and pedagogical reform in medical schools, culminating in 2004 in the launch, after many years of negotiation and development, of the CDAMS Indigenous Health Curriculum Framework. The new curriculum framework is the result of a joint initiative between the Committee of Deans of Australian Medical Schools (CDAMS) and the Office of Aboriginal and Torres Strait Islander Health. A copy can be found at http://www.amsa.org.au/docs/CDAMS%20Indigenous%20Health%20Curriculum%20Framework.pdf A copy of a national audit of medical curriculum conducted by the CDAMS Indigenous Health Curriculum Development project can be found at http://www.amsa.org.au/docs/CDAMS%20Indigenous%20Audit.pdf

An Australian project which affirms that diversity value-adds to education is the Department of Immigration, Multiculturalism and Indigenous Affairs project "Diversity Works!" which is

currently developing resources for the higher education and other educational sectors (http://www.diversityaustralia.gov.au/) and which includes a resource paper by Eisenbruch and Dowton of UNSW's Medical School on productive diversity for the health of Australians (http://www.diversityaustralia.gov.au/_inc/doc_pdf/21c_8.pdf)

Eisenbruch and Dowton's paper of 2000 points out that diversity issues for a medical school are similar to those that apply to business, as this quote from the "Diversity Australia" website summarises (http://www.diversityaustralia.gov.au/educate/index.htm) downloaded 05.05.05:

- assessing the diversity skills of the medical student and staff
- population to determine how those skills can be used for benefit;
- improving recruitment and promotion strategies to select medical
- students and staff with language and cultural skills relevant to servicing diverse clients in domestic and overseas niche markets;
- improving communication in the medical school and teaching hospital and health care system so that it is open and involves all staff;
- equipping clinical supervisors with skills to appropriately manage and support a diverse workforce; and
- improving service to patients through the use of well-trained staff with cultural and language skills appropriate to multicultural health settings.

An essential question for medical educators and their allies is: HOW do we address diversity in ways that transform and improve medical curriculum and pedagogy so that the medical workforce achieves diversity-competency?
One answer to this is to

- re-visit models of curriculum change; customise them to the context of developing diversity-competency in dimensions such as curriculum, pedagogy etc; and implement or apply them in a transformative project endorsed and resourced by "champions at the top" such as Deans of Schools of Medicine
- continue to develop collaborations among Australian medical schools and their partnership/stakeholders in an effort to build dialogue and mutual understanding of the issues
- incorporate complex and achievable understandings of diversity and equity in medical education into the transformative project i.e. one that is multifaceted and which recognises the contexts of change processes (nb simplistic, single factor change models are ineffective and serve to reproduce the status quo)

Recommendations specific to the two research arms can be read in Appendices A and B.

References:

Eisenbruch M and Dowton S Bruce 2000
(http://www.diversityaustralia.gov.au/_inc/doc_pdf/21c_8.pdf)
A proposed multicultural health program at UNSW: Productive Diversity for the health of the people of Australia.

Taylor Imogen, 1997. Developing Learning in Professional Education.
Partnerships for Practice. Bristol, Society for Research into Higher Education and Open University Press.

List of personnel involved in the project:

Management partners

Dr. Gabrielle Casper (President - AFMW)
Professor Maurice Eisenbruch (Director - Centre for Culture and Health, UNSW)
Ms. Char Weeks (Executive Director - ARCHI)

In close association with

Associate Professor Deborah Colville (Head, Education and Training Unit, Division of Clinical Epidemiology, Centre for Eye Research Australia, University of Melbourne)
Ms. Ann Lawless (Course Coordinator - Clinical Skills 3, Department of General Practice University of Adelaide)
Dr. Jo Wainer (Director - Centre for Gender and Medicine, Monash Institute of Health Services Research)

And carried out through project officer

Ms. Lilanthi Ambanpola (Research Associate - Centre for Culture and Health, UNSW)

Statement of expenditure to date on major items

This has already been sent to OFW by the Treasurer of AFMW – Dr. Sharon Tivey, prior to this report.

Appendix A - The voice of community women and their preferred ways for receiving culturally appropriate care.

Lilanthi Ambanpola and Maurice Eisenbruch (Centre for Culture and Health, UNSW)

Aim

The aim of the component of the project 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 component of the project. 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 75years with the average age being about 55years. 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 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 woman 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 woman 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 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, e.g.

> 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 and not stereotype people.** These sentiments were recurrent in the responses of culturally and linguistically diverse women indicating 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 found it very 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.

> A woman of Muslim faith mentioned her experiences with her husband where he insisted on being with her when 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 would have 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 need 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.

> Some Asian 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 increasing rapidly 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 serve 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, 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 delivery.

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.

> A woman of African origin 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 particular concerns with 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 Anglo-Saxon 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, respect their cultural and religious values and beliefs, and generally be 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 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.

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 discomforted 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 component of the project 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 component of the project 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 to health care

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. In brief, 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, breakthroughs and difficulties

One of the highlights of this component of the project 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.

It was particularly exciting that women from diverse backgrounds felt empowered to freely voice their opinions regarding their preference for care when seeing a doctor. The women, highlighting the importance of both cultural and gender issues in medical encounters, have added value to the case for further developing the gender-culture intersect in medical education and integrating gender-cultural competence in the training of all future doctors.

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 component of the project 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 component of the project the nature of the data received was diverse. Its interpretation, collation and analysis was time consuming and problematic, with continuous review, summarising and categorizing of themes. This is often characteristic of this methodology and of grounded approaches to such research and can become especially problematic in any research project which is also small, part-time and short tem. This research management challenge has been addressed in the life of this project.

Appendix B - Achieving gender and cultural competence by Australia's medical workforce: what young doctors want.

Jo Wainer (Centre for Gender and Medicine, Monash University), Deb Colville (University of Melbourne) and Karen Ng

Aim

The objective of this section of the project was to:

1) *snapshot* the needs of a range of medical specialties (including primary care) in relation to the gender/cultural competence of their medical workforce

Method

A management group was established, comprising academics from two universities. Dr Jo Wainer from Monash University Centre for Gender and Medicine, and Associate Professor Deb Colville from the Centre for Eye Research at Melbourne University.

A first-year doctor-in-training (intern), Dr Karen Ng, was recruited to revise existing curriculum and gender documents from the Monash University 'gendermed' website at http://www.med.monash.edu.au/gendermed and culture and medicine documents from University of New South Wales Centre for Culture and Health at http://cch.med.unsw.edu.au/ . These were used as the basis of recruitment materials to attract young doctors to a focused discussion. The key question for discussion was what they want to know about gender, culture and medicine in order to be the best doctors they can be.

Ethics approval was given by the Monash University Standing Committee on Ethics in Research on Humans.

Doctors were recruited from two hospitals in Melbourne, Monash Medical Centre, and Dandenong Hospital. Two separate discussions were held. The groups comprised 6-8 junior doctors ranging from HMOs to junior registrars. Cultural backgrounds were predominantly European, several were Anglo-Saxon, and two were of Asian background. All had English as a first language. Male and Female doctors took part, from the disciplines of medicine, surgery and the generalist intern year. The following materials were provided:

1) Consent form regarding participation
2) Explanatory statement including contact details of a psychiatrist for debriefing, if required
3) List of questions to identify important issues for discussion
4) Information leaflets with brief detail of gender/culture perspectives
5) Some examples of gender-competent medical research

Signed consent was obtained from each participant.

The doctors were asked to prioritise the questions and these questions were explored in detail. The discussion centered around three topics:

4) Gender/culture and the patient
5) Gender/culture and the doctor
6) Gender/culture and medicine

The discussion was facilitated by Dr Wainer, Monash University and Associate Professor Deb Colville, University of Melbourne. Questions were based on the questions being discussed by the consumer arm of the project, with the addition of questions relevant to doctors that were based on extensive prior work by the two facilitators.

Notes were taken by 3 people at the time of the discussion, supported by digital-recording of the discussion. Notes and quotes were de-identified. Their analysis forms the basis of this report.

Findings

Gender, culture and the patient

Female doctor: '…men deny the psychological impact of illness, or it just comes out as rage. It gives them energy'

M: 'I am rigidly aware of every word I say when I am examining a woman…'

Female doctor: 'Especially different cultures, and I don't think I have a very good idea of a lot of things, what people have been through'.

M: 'I have no problems examining men's testicles…'

The doctors chose the question 'What are the most important gender/culture issues for you when consulting a patient ?' and 'What do you think doctors need to learn about gender, culture and health in their training in order to be able to better treat people ? A consistent theme to emerge from the discussions was the different way patients viewed the authority of the doctor, depending on the sex of the doctor. The relationship between gender and authority was reflected in interactions with patients, with medical and nursing colleagues, and in the actions that the young doctors suggested could be taken to improve professional practice.

The doctors were able to identify gender-based illness management and communication styles of patients, as well as their anxieties about managing gender dynamics in intimate examinations and fears of litigation if they got it wrong. This is particularly difficult to manage cross-culturally. They are aware that issues of gender are played out differently in different ethnic groups and that they do not have the knowledge about how to engage with that difference. They are also aware that patients from diverse cultural backgrounds may have had life experiences that they know nothing about, and that may affect both the clinical interaction and the way illness and health care is experienced.

They want to be taught about difference if it is relevant to clinical care, and some help understanding how gender and culture impacts on health and illness presentations and management, as well in managing their authority, particularly in cross-cultural encounters. Young female doctors find their authority challenged by men from strongly patriarchal cultures.

The main issues are highlighted below, supported by quotations or detailed notes from the discussion. Where possible the sex of the doctor is identified.

Main issues

- Attitudes to male and female doctors

Different cultures make it harder to work out the gender dynamics.

Male doctor: 'I am tall and white and male and have never been assumed to be anything other than a doctor. I have never been called a nurse. I have an unfortunate advantage, but it is something I notice. It is disappointing, talking with my friends who are constantly confused for nurses. I don't have to try as hard to meet patient expectations about being a good doctor.'

If the doctor is a middle-aged man patients will remember what he says.

Female doctor: 'Once the older ones find out you are the doctor they treat you with respect, and the young ones do because they don't know any different, but 'There is a group in the middle, especially the males, who will treat you like dirt'.

Female doctor: 'There are a couple of groups of people, young guys, who are shockers'.

Female doctor: told the story about the angry young man, a truck driver by profession, who 'towered over' the female registrar when she said he would have to have his driver's license reviewed, and how the registrar held her ground and reframed his feelings as frustration rather than anger with her, and how the young female resident went and stood behind the registrar and the male resident saw her do it and did the same.

- Effective communication

Female doctor: 'It is an advantage to be a female in that situation because it is more culturally acceptable for them (male patient) to open up and say stuff to you than to say it to another male. Because it is fine for you to fall to pieces, to say personal stuff, because it is acceptable in our culture to share it with a woman, you know, females are expected to be able to listen to those things and not measure your masculinity or anything without loosing face. Whereas if they said it to a male they might feel they were being compared, especially to a young male, if it was one-to-one. Like some sort of competition going on.'

Female doctor: Especially different cultures as well. At Dandenong we have so many different nationalities and I don't feel I have a very good idea about a lot of things, what people have been through. Like we had an Afghani guy who had so many family around, and yet the women always left the room when we were talking with him about stuff and that is a bit detrimental because often it is the women who, when they go home, have to do the looking after. They tended to leave, especially the wife.'

Male doctor: we need white coats back to help identify who is who in the team.

Female doctor: often the sex of the doctor is more important to the patient than to us in the profession.

Male doctor: I had to ask a guy about my age, I had good rapport with him, whether he was gay and that felt awkward

Male doctor: 'male patients don't disclose as much' and older stoic men have to act tough, they 'downplay everything', and' women don't tend to do that'.

Female doctor: 'men are either in denial or in a rage. It seems to give them energy to move on'

Male doctor: the gender of the doctor does make a difference, it is important.

Female doctor: I felt uncomfortable doing rectal exam and catheter insertion in a male patient, not because of me, but because he obviously did.

Female doctor: older men constantly make comments about the gender of the doctor such as 'hi sexy'.

- Different illness coping mechanisms and the effect on the consultation

Male doctor: Male patients don't disclose, they present late, 'I'll be right', they downplay symptoms.

Female doctor: "Sometimes I wish the male patients would just come out with their problem. Many male patients say "I'll be right" rather than give symptoms or other history to the doctor. And it makes our jobs as interns harder, they are annoying.'

Female doctor: 'I have found with a few men you just get so frustrated. Women take their health and your advice more seriously, they take medication'

Female doctor: 'I have noticed that men with chronic health conditions have more anxiety than women and it actually makes their disease worse.'

Female doctor: 'Women bounce back in (to hospital) less often, they tend to be more cautious.'

- Concern about litigation

Female doctor: Litigation and appropriate behaviour are the two major issues. Easier for women but I go to great lengths to explain and get agreement to intimate exams. I nearly always get a nurse, if not to within the curtain then standing outside.'

Male doctor: You think about it less if the patient is of your own gender, especially for men.

'guys need to be pretty careful'

Female doctor: In the UK the doctor is always chaperoned for intimate examinations. I am very cautious of any invasive examination.

Male doctor: Men performing examinations on women is the big one. ' I always have a chaperone if there is any uncovering of a woman'.

- Male & female doctors would like patients to tell them if their gender is a problem for them.

Female doctor: described a general practice training placement in which she was taking a history from a middle aged man, and it was pointing to a prostate problem and neither she nor he were comfortable, so she ended her role in taking the history.

Female doctor: want patients to' just be honest'

Male doctor: if the patient is feeling uncomfortable because I am a male I want them to tell me, it will make it nicer for them.

Actions to be taken

Education about difference

Provide training to promote understanding of the different ways gender is understood in different cultures as it relates to health and illness

A programme to develop an understanding of illness coping mechanisms of each gender and long term disease outcomes, treatment, relapses, prognosis

Exposure to education about difference that is clinically important

Introduction to education about research on difference

Training in history taking that takes culture and gender into account 'it would be helpful to know what is helpful'

Training in primary health and public health about difference. Men's health and andrology are developing fields and must be included

Training in physiologic differences between women and men

Training in gender/culture and authority

Training for doctors to learn to exercise appropriate authority, and how to manage this with different ethnic groups

Training in impression-management and how to manage angry young male patients

Leadership training
White coats for doctors to help identify who is who in the team
Help with managing culture/gender/patient interactions
Assertiveness training and how to hold your own with culturally diverse patients and doctors

Gender, culture and the doctor

'We are not all tall like male doctors. Our authority is as if screened out or ignored…'

'…there are differences in the way staff, particularly nurses, react. They overrule female doctors'

'Women interns are attacked by nurses, but they respond to me...'

'Women have to paddle harder, to prove themselves to be taken seriously as a candidate for specialty training'

'The path for men is smoother, maybe because its well-trodden…'

'…hardest thing to change is the internalized sexism of women. Discrimination against women is so pervasive'

The doctors lingered over the question that asked 'how does the gender/culture of the doctor influence their role in the profession ?' The responses covered medical authority, pathways to specialist training, relationships with colleagues and when, where and how to fit babies into the post-graduate training process if you are a woman. They spoke about bullying within some medical cultures and how it affected both men and women and how they wanted something done to stop it.

Main issues:

- The doctor's authority in conveying medical information and advice

Male doctor: 'I remember when I was an intern, I was doing it with my best mate, who was a great tall bloke. Our registrar was a little, petite Lebanese gal. And it was quite obvious that she was the registrar, she always introduced herself as the registrar, and we would stand behind her. And what would happen is that whenever the patient had questions they would look past her and look at us, and we felt very uncomfortable because it was like, you know 'that's the boss'. It was an uncomfortable situation, where they assumed we were the more senior. '

Female doctor: I was asked 'Who are you, the work experience student ? No, I am the surgeon' - that was from the patient's mother.

Female doctor: Patients think you are "some stranger who has wandered in".

Female doctor: I guess because they still don't perceive you as 'their' doctor, they take you for a nurse, or a physio.

Female doctor: Whatever you tell them about their diagnosis or their treatment they don't believe you, or they don't remember. They even say to the consultant that nobody has told them, when you have actually told them five minutes ago and said 'this is your diagnosis'. They say 'No doctor has spoken to me today about it'. Whereas if you are a big, white middle age man you are a doctor and they will listen to you and they will remember. Information lands differently. It is not so much about authority, it gets processed differently, and it stays in their minds, whereas we get screened out.

Male doctor: You don't see respect on the wards, they ask for a second opinion 'there is all this kind of second guessing going on and you don't see much respect going on'.

Female doctor: We have an Afghani woman patient who is convinced that female doctors are no good at putting cannulas in, and every time she wants care, she insists on the male doctor. When I went to put a cannula in she went 'no, no, I don't want it there, I want it here, here'. And she had tiny veins so I missed and the daughter said 'you can leave the room now, no more tries'. So I asked (the male doctor) to give it a try and he missed as well but they allowed him a second try and because he got it he became God, he can cannulate ! We wanted the female medical student to do it next time and they said 'no, we want the male doctor'. She wouldn't even let her in the room. 'No, no'.

Female doctor: It is a very different way male and female doctors are treated, particularly by elderly patients. I had spent a lot of time with him, organising surgery, after he had his surgery and came back to the ward I went in and ask him how are you, and I did not re-introduce myself as a doctor and just as I was leaving he said 'excuse me love, "Are you the nurse looking after me ?"

Female doctor: 'we don't want to use the old authoritarian style, 'there you go dear, you do this'. How do we negotiate a different relationship that recognises us as professionals but does not need to be authoritarian ?'

Female doctor: 'I am continually being asked if I am the nurse.'

Female doctor: I wish the hospital would just say we had to wear white coats. When I did electives I got laughed at because I didn't have a while coat.

Male doctor: we have changed, we are not like that anymore, so we can wear white coats without the 'doctor is god' reaction.

- The working relationship between the doctor and other staff, particularly nurses

Female doctor: There is a big difference in the way female registrars are accepted by other staff, the nursing staff in particular. Sometimes this evolves into maladaptive behaviours, otherwise known as the 'bitch registrar'. With nursing staff you say 'this is my plan, this is what I want to do' and you get overruled or they wait until the consultant comes in.'

Female doctor: there are differences in the way other staff, particularly nurses, react. Nurses will over-rule female doctors. Men seem to have more authority.

Male doctor: I agree with that. Women interns are attacked by nurses, and they respond to me.

Male doctor: 'I think this is true of all staff. When a female intern ordered 'sub-cut fluids' the nurses said 'no, it is not in the notes' and when I came by and said 'yes, sub-cut fluids' they did it without question.

Male doctor: 'if a male doctor comes along they can see that doctor as other, but with a female doctor they represent what they could have been and they need to protect themselves.

Female doctor: 'I don't think they want to be doctors.' But doctors get more respect.

Female doctor: 'With nurses, you have to be meticulous about communication with nurses, whereas the guys can give orders. Male nursing staff are really easy to get along with. You are so used to having a barrier, a real struggle, that when a male nurse comes along you think,' oh there should be more of this.'

Female doctor: male nurses are easier to get along with

Male doctor: we get on with male nurses 'really well'

Male doctor: a lovely, lovely young female intern, and the nurses kept complaining to me about her, 'bitch about nothing and I didn't understand what the fuss was about because I had done exactly the same thing.'

Female doctor: nurses seem to feel female doctors are above themselves and they need to slap them around. This is particularly so with midwives, for them men are beyond the pale.

Female doctor: specialty nurses are much easier to get along with. They are academic and confident in their abilities.

Female doctor: 'Specialty nurses are so much easier to get on with. That relationship is quite different. I learnt more from the cardiology nurses than anyone else. They are quite confident in their ability and there is not the need to get the respect out of you.'

- The perception of the doctor held by the medical team

Female doctor: With regards to being Asian and female, I suppose the female part meets similar challenges other to women. It's hard knowing how to quantify the extent as I have never been other than Asian and so would not have an accurate idea of what that experience entails.

Female doctor: 'There are many gender stories after 10 years of practice.'

Female doctor: Asked by registrar when applying for surgical training programme: "So what makes you think you will make a good female surgeon ?" I can play a 5 part fugue on the piano, can you ?" 'I happen to be female, I wish to be a good surgeon." This was in 2002.

Female doctor: 'I was tying on my surgical booties and I looked up and found a surgeon was staring straight down the front of my surgical greens. Because of course they don't fit. They are baggy. And you can't do anything about it.'

Female doctor: We did this assessment, an oral exam being video-taped, with a person role-playing the patient. It was our first one so we got some feedback, and the consultant observing the patient encounter said 'I was young and beautiful and he (simulated patient) was trying to look down my top the whole time and I should be aware of that in the future'. And I was absolutely shocked.

Female doctor: 'it is shocking but useful to get that feedback' because that is what patients do. It is really confronting when it happens, but as feedback from patients it is useful. It is potentially, with young female patients as well, be careful of whether they are seeing you as the 'doctor' figure or the 'attractive young guy' figure.

- Accessing specialty training

Female doctor: there are 2 male bastions, surgery and intensive care, plus cardiology

Female doctor: women go into areas of the profession that are flexible. Guys like cardiology because it is fast paced, procedural, protocol driven, physics rather than biology.

Female doctor: ' there is a perception that if you are a female you have to give up all the things that come with that in order to be taken seriously and to get to the top in the profession. Women aren't seen as serious candidates for specialties because it seems they are going to opt out to have families, and perhaps work part time, whereas men are prepared to give up their life for their career. Looking at male and female candidates you have to be an exceptional female to be taken into a training programme.'

Female doctor: 'I don't think my gender is holding me back, but I don't know, and maybe I am just not aware of it.' 'You haven't reached a point where it matters yet.'

Female doctor: 'The only thing I have come up against was when I wanted to do anaesthetics and the consultant said 'well it would help if you were blonde and good looking'. And I was shocked.

Male doctor: 'Men only talk about 'how I am going to get into the plastics programme', not 'when am I going to have kids'. Hardly anybody talks about that'.

We don't see our careers in terms of us as people.

Male doctor: 'discrimination comes from internalised sexism in women and is the hardest thing to overcome, the biggest obstacle.' Our generation would not put any differences between men and women but if you grew up with it becomes part of you.'

Female doctor: We want it all. We want a good career and we want families and that is always going to be a problem.

Male doctor: Men don't talk about how to 'have it all'. They are focused on getting into the training programme.

Male doctor: men don't think like that. Being a doctor 'is who we are, not just a job'.

Male doctor: It is possible now to work part-time in the training programmes.

Female doctor: 'I am seriously considering not sub-specialising because I don't want to have IVF'. I don't want to be having my first kid at 42. I suspect there is still a very strong bias and a great propensity among female surgical registrars to be single.'

Male doctor: 'I don't know any guys who job-share'.

Female doctor: When I was an intern doing surgery 'give you a few years you will be quitting surgery and having children, why am I even bothering with you'. Said with humour. Because we are big strong girls and they knew it would piss us off.

Female doctor: ' I do know of a surgical registrar who diagnosed his own appendicitis, wrote up his own blood tests, went down to casualty, much to the annoyance of his consultant

because he should have been in theatre, arranged his own admission and organised his own operation.'

- Family life within the medical profession

Female doctor: I think people feel lonely in our profession because they never get to see family, and the home. Women would never let it get to the state, they wouldn't make that choice where they didn't see their kids. They would rather not have kids than let it get to that stage.

Female doctor: 'you don't have time to meet anyone'.

Female doctor: "I realised there is no right time to have a baby'.

Female doctor: "My fellow intern just had a baby and most people never knew she had realised this; that no-one will tell you this is the right time- and just went ahead during internship.

Female doctor: told a story about a female colleague who was totally focused on getting into a training programme, then realised what she might lose, and had a child. 'I was blown away by how courageous she was. She didn't feel she needed to justify it (her decision).'

Female doctor: It works better for men because they don't have to take big breaks for having children.

Female doctor: Assumptions are made that women are going to have babies and that will interfere with specialist training and therefore you are not serious. It is scary. 'I am not the only person in my marriage'. I am freaked out that I wont get a job, that it will go to some female who is prepared to wait to have children, or not have them at all (the speaker is visibly pregnant).

Female doctor: I probably won't sub-specialise because it makes it too late to have children. Very few of my female colleagues have partners 'we don't have time to meet anyone'.

Female doctor: there was a renal registrar who took a year off and had a baby and her husband, an anaesthetist, then took a year off to be a father.

"but men (in medicine) can still be the active father without going part-time"

Female doctor: The gastro registrar they hired they said 'whatever you do don't have a baby' and so she has put it off.

Female doctor: "I am not the only person in my marriage" says a female doctor, however it is assumed she will take the role of child minder. 'I am more concerned about what age my kids are at various times than whether I am 3 years advanced in my training programme.'

Female doctor: 'Women want more. We want a good career and to be treated differently, but we want families and to spend time with them'.

Male doctor: 'Men don't think like that. We see ourselves as 'that is what you are'. We don't think that being a doctor is just our job.' ' I am a married doctor with children'. ' When I think of my future I think about what I will be doing….. it is really sad.'. 'No-one tells you what it is going to be like juggling family and medicine.'

Female doctor: Medicine is a vocation for men, a career for women, rather than who you are. We consider other possibilities in our lives, we can have children. I am a doctor, I am a mother.

- Bullying, sexual harassment and ports of call

Male doctor: the culture of the surgical training programme is "sexist, racist, and any other 'ist"

Female doctor: 'I still had to paddle harder to keep my place. There is a generation of doctors in the middle (between older ones who are courteous and younger ones who are less sexist) who really go for you. Bullying that goes on and on until you get to tears, in front of interns and the patient.' .

Male doctor: discrimination against women is so pervasive we can't even see it. 'bullying needs to be reported'

Female doctor: junior consultant was being bullied by the senior consultant but there was nothing she could do because he was at the top of the college tree and he was writing her report.

Female doctor : The surgical registrar told how she was groped. The consultant 'grabbed my tits at the scrub sink' and did this to all the young female doctors. Everyone knew but could not do anything because he is senior in the college. 'The groping of the breasts happened to every female Caucasian for 20 years'.

Female doctor: unwell, so marginalised within surgery. 'we can't force you out of surgery but do you think you will cope ?'. 'And even now when you say 'I have to get to the doctor at a certain time' they don't let you. And every term I have had a crash because I could not get the treatment I needed in time. People look at me as though I have 2 heads.'

Female doctor: I think illness is very poorly accepted. I think gender and illness are interlinked. There is a generation in the middle who really go for you. I have had 2 males who have gone out to make my life a misery, bullying to the point of tears and it has gone on and on and on, in front of the intern and the patient.'. 'I have had some very nasty experiences' '

Female doctor: 'My surgical supervisor was the junior to the bully and was being bullied by him so I could not turn to either of them and if I had gone to the college they would say I was whingeing because I was afraid of failing.'

Female doctor: 'you don't want to appear weak to yourself as well.'

Female doctor: 'I think you can re-educate upwards'

Female doctor: 'my surgical consultant would scream at me, swear, change management decisions in front of patients, whack me across the knuckles with surgical instruments, scream at me for half an hour. You can't re-educate that.'. 'the man is a classic psycho-path.' I have never been so systematically abused. I was called 'princess' and 'darling'. I eventually challenged him about this, saying 'I am not princess or darling and if you can't remember my name you can call me 'doctor'."

Female doctor: we are not powerless

Female doctor: as an intern and RMO you have much more support than as a registrar. The HMO officers at the hospitals are great.

Male doctor: abuse is much more common in surgery than in medicine. 'In surgery it happens more than in medical'

Female doctor: 'I have seen male surgical registrars have strips torn off them, absolutely appalling' and in inappropriate places.

Female's bully too.

- Medicine is being devalued by the presence in large numbers of women and doctors from non-Anglo cultures

Female doctor: There is a conversation that the profession is losing prestige because of the presence of women, the way teaching did. Because it is losing its aggressiveness and patriarchy where doctors told patients what to do, and then you've got the female element and we are not as aggressive and we don't fight as much to maintain status. Doctors are losing their authority to ask for what they want.

Female doctor: in the media, doctors are portrayed differently today. We get the dodgy ones, and personal lives, rather than the 'god-doctor' we used to get. There is a general breakdown in respect for authority and doctors are caught up in that.

Male doctor: previously unfair power balance is being corrected. In the past crimes have been committed by arrogant doctors.

Male doctor: I don't think more women has devalued the profession. We are trained differently now, less authoritarian.

Male doctor: It is better now than when doctors were 'passing down their judgments and people not questioning their doctors and being hurt as a result'.

Female doctor: 'feminising the role, even if it is not about how many male and female doctors there are.'

Male doctor: 'having women in medicine has liberated the workforce. A few years ago doctors were men who went to work and worked hard all the time and if you didn't you had to get out of the profession. And now as a young doctor I know I can take some time off, I am allowed to have a life, which is great.'

Actions to be taken

Development of appropriate systems to deal with discrimination based on race or gender within the medical profession and hospitals.

Hospitals to provide assertiveness training, regarding interactions with patients and colleagues, particularly during ward rounds, in the 2nd year after graduation.

Hospitals and medical colleges must provide a supervisor the trainee can go to who is not involved in their training.

Introduce systematic management of bullying of trainees, particularly in surgery, by hospital management and the Royal Australasian College of Surgeons.

Establish a reporting and support mechanism for young doctors subject to harassment and discrimination.

Medical schools, hospitals and medical colleges to provide help to young doctors to 'unpack our own experiences'. 3rd year medicine might be the place to start because is not important when you are young. 2nd year intern is more sensitised.

Medical schools and hospitals to establish a dialogue between nurses and doctors about the impact of culture and gender on their communications.

Medical colleges and hospitals to make a continued effort to balance work-life flexibility within medical training

Change medical culture to include acceptance that doctors are human beings.

Gender, culture and medicine

'We need to know about difference if it's there and if it's important…'

'We need to know in public health about difference. Men's health and andrology are developing fields'

'…To say that women ought to have 0.85 of the normal creatinine values of men, that's too simple'

……..'We need to know about research on difference…'

'We don't know what we don't know'

Main issues:

- Gender and culture competent appraisal of medical knowledge is not taught systematically

Female doctor: As for being Asian, there were times initially when my cultural beliefs and the facts I was taught within medicine did come into conflict. I suppose the easiest answer to that conflict is then to distance yourself from what is perceived to threaten the thing you currently hold dear, which at that point was the idea behind scientific medicine.

Male doctor: not always taught about gender or culture, but would like to be. We had some teaching about men being late presenters. Men < 30 are wooses. Women don't have 'typical' chest pain.

Male doctor: We need to know more about "the silent infarct". "It's interesting that it gets constructed that way"

Male doctor: I was surprised to find that women almost never have 'typical chest pain'. Never acknowledgement that women don't have crushing chest pain radiating down the arm.'

Female doctor: Silent MI is the classic. Women are more likely to have silent infarcts. I overhead my consultant woman over 70 I would never give a certificate to go to the gym because they are such high risk. A silent MI is one that does not have 'classic symptoms'. More women do (have them), and more diabetics do.

Female doctor: 'we had one woman with chest pain and she did not report it until the next morning'. She did not think to call out, she couldn't sleep, and just mentioned it in the morning.'

Male doctor: Maybe there is a difference in symptoms compared with men

Male doctor: Doing nights in cardiology, when women in their 50's came in, if there was any history of depression and the symptoms deviated at all from the classic presentations, then it wasn't angina. They might have got their angiogram on the 3rd presentation rather than the 1st. Women are much more likely to be branded as having an anxiety attack.

Male doctor: I had a Greek female patient with numbness in her arm, she had a history of depression. She was given morphine, there was no relief, then diazepam which helped and we assumed she was just depressed. We were so skeptical, assumed it was anxiety. She had triple vessel disease.

Male doctor: Doctors have always been men, so 'men wrote the text books' so the male experience is better documented.

Female doctor: 'nobody is 'classic' and medicine is evolving'

Female doctor: There are not many areas where you would miss diagnoses or rule something out because of gender or culture, but there may be some. Abdominal pain in women is assumed to be gynae.

Female doctor: 'It is hard to know what you need to know about what you don't know' and 'we need to know about difference if it is going to change what we do'.

- Currently gender and culture variation in epidemiology not emphasized enough within medical curriculum, therefore lack awareness

Male doctor: We want to know about the relationship between gender and health, how with different diseases there is a difference, heart disease and what not. A lot of the common diseases, they have shown there is a difference and the epidemiology of the disease changes. We were taught, dogmatically, that the major risk factor for heart disease was male sex, yet it seems that after a certain age group, after menopause, it is the same, and yet we had drummed into us 'male sex, male sex'. And now I know that women have heart disease too'.

Male doctor: be aware that there is a difference, physiologically.

Female doctor: in cardiology, if women present with pain that is not in the exactly right place, and have any history of depression, they are not considered to be cardiac patients. 'Late to recognise cardiac disease' in women.

Female: 'Men under 30 are real wooses with needles and a women who has had kids who complains about pain gets morphine, but a 26 year old male doesn't. Young guys can't take pain.'

- Research still mainly focused on Caucasian men and applied to all men and all women

M: I have seen a couple of times in Harrisons where it says 'women present atypically'.

Female doctor: Men's health is only now getting a bit more promotion.

M: Research is done on men and then extended to women.

Actions to be taken

Integrate gender and cultural competence into mainstream curriculum, not delivered as separate subject

Teach about gender and culture in medicine e.g. 3rd year medicine, 'when we remember learning so much about sex and medicine from meeting a raped woman and an HIV positive man'.

Development of gender based research to deepen understanding of intrinsic physiological differences in illness.

When teaching the specific areas of medicine, such as cardiology or gastro, teach 'how this is seen in men, and women present like this.'

Provide information regarding gender differences in pathophysiology of diseases

Outcomes

Young doctors in Australia now work in an ethnically and culturally diverse workforce with a rapidly changing sex ratio of doctors. They work with great ethnic and cultural diversity among their patients. This diversity carries within it important differences in the way health, illness, illness management and medical authority is perceived. There is no necessary match between the health and illness beliefs of the doctors, and those of their patients. There are also major gender issues concerning medical authority, who is allowed to have it and who is not. These issues are compounded by cultural differences in the roles of women and men, and what are seen to be appropriate behaviours for the different sexes.

Australia is developing a culturally diverse medical workforce and it already has a culturally diverse patient population. There are approximately 4000 overseas trained doctors working in Australia in addition to the cultural diversity of Australian trained doctors.[2] This is presenting great challenges to doctors and their patients as they attempt to communicate across cultural gaps that can render behaviours and attitudes of either the doctor or the patient as quite mysterious to the other. Understandings about health and illness are cultural artifacts. The roles that people play as patients or carers or health care providers vary from culture to culture. The roles that people play as men or women or other sexual categories are strongly culturally determined. The intersection between gender and culture creates a potent dynamic, with multiple chances for misunderstandings, broadenings of perception of what is possible, and miscommunications.

It is likely that there is a much greater cohesion in the knowledge base and agreed values among doctors of diverse gender and culture than among their patients. Doctors who are trained in allopathic medicine agree to put aside prior beliefs about how the world works and what constitutes health, illness, and appropriate health care, and adopt Western science as the knowledge paradigm they work with. They also adapt to the prevailing hierarchical and patriarchical systems that were established when doctors were men. The doctors who cannot do this are likely to move to the margins of the profession, kill themselves, or leave altogether (Clode 2004).

People who use the medical system for health care bring with them their established beliefs about health and illness. These may not match those of allopathic medicine, and this is likely to cause considerable difficulty and confusion. Doctors in this project were aware of cultural differences in understanding about health and illness, but had no training or skills in how to manage this. They are better trained in the interaction between gender and health than between culture and health, although they identified a clear need for systematic education and training in gender and difference as it applies to clinical care, and to their roles in the profession.

Young female doctors are puzzled about how to demonstrate their authority as doctors, both with colleagues and with patients. There are powerful underlying cultural issues about who holds authority and how it is demonstrated, and these are triggered by the gender of the doctor for female as well as male patients. In many of the cultures of the immigrant communities to Australia women are not permitted to hold authority in the public domain, and instead are required to serve the needs of men. Patients with these beliefs will find it difficult to accept that their medical care is in the hands of a young woman. It is also clear that family dynamics

[2] Private communication, Dr Bob Birrell, Director of the Centre for Population and Urban Research, Monash University, 14th June 2005

within a variety of cultures have significant gender dimensions that make communication during illness and treatment likely to go completely astray.

This project has identified that young doctors say they would be better clinicians if they understood cultural and gender differences in health, illness and illness management, where these differences are important. This is reflected in the heart-felt comments made by the culturally diverse women who are their patients. The doctors need help in negotiating the complexity of their patient base and their working environment in terms of culture and gender. They are aware, on the margins of their thinking, that a science based on the 70kg Caucasian male may not be safely applied to the diversity of patients who present for their care, and are asking for systematic instruction in how to apply the mono-cultural knowledge-base they have to the diverse patient group they take care of. This is a serious business, with likely consequences for safety and efficacy of health encounters for our diverse population.

The young doctors identified actions that will improve their ability to deliver health care to culturally diverse populations and to manage their lives as doctors. These include:

1) Systematic teaching about difference where it is clinically important
2) Teaching about the impact of gender and culture on the experience and management of illness
3) Help in identifying effective strategies for communication with opposite sex and culturally diverse patients
4) A need for information regarding gender differences in epidemiology and pathophysiology of diseases
5) Help in developing an understanding of illness coping mechanisms of each gender and culture, and long term disease outcomes – treatment, relapses, prognosis
6) Necessity for training for doctors to learn to exercise appropriate authority
7) A continued effort to balance work-life flexibility within medical training
8) Development of appropriate systems to deal with harassment within the medical profession
9) Development of gender and ethnic competent research to deepen understanding of intrinsic physiological differences in illness

Highlights

- the participants related well to one another and demonstrated respect for each other's experiences
- the participants understood the topic of discussion and attempted a thorough exploration of the topic
- the willingness of participants to acknowledge current challenges
- their creativity in addressing possible solutions

Breakthroughs

- consideration of the intersection of culture/gender and its impact on illness management

- information ‘lands on the patient’ differently depending on the gender and culture of the doctor
- a developing awareness of possible differences in gender based epidemiology, pathophysiology and presentation of disease
- acknowledgement of a lack of resources within the area of gender based medicine

Difficulties

- the recruitment of participants into the component of the project
- the conflict between short time-frame for the project and lengthy time taken by ethics committees to approve research
- current information is still anecdotal, which provides a basis for the acknowledgement of the need for further component of the project – but we need more statistical data to underpin policy and programatic change
- difficult to research a topic of such complexity in a short time

Clode, D. (2004). The Conspiracy of Silence: Emotional health among medical practitioners. Melbourne, Royal Australian College of General Practitioners: 40.

Appendix C - Evaluation of Project

Deb Colville (University of Melbourne)

Introduction

The evaluation section of this project report consists of firstly an analysis of evaluability, mainly an exposition of the program logic itself within the conduct of the project, and secondly a resultant proposed framework for educational process and impact evaluation. Lastly, generalisability is discussed and some brief conclusions included.

This evaluation draws broadly on Owen (1993), Madeus, Scriven & Stufflebeam (1983) and Linn and Gronlund (1995:50).

Regarding information collected, the project involved two basic forms of data, firstly the researchers' discussions on the problem, scoping, constraints, design and results, and secondly, sets of focus group data from component of the project participants in two subprojects. Focus group data was detailed and relevant.

Program logic

The logic model is dealt with here under program logic. Conceptually the most important, yet also potentially the most challenging aspect of the project is the program logic. The analysis of program logic here will be approached by identifying a philosophical stance of each of the two major teams or subprojects 1 and 2, followed by a view of how synthesis of the two occurred through the project.

- Subproject 1

The emphasis in this subproject is culture.

The underpinning construct held draws on Cross (1989) who highlights 'cultural competence' as key to 'communication in cross-cultural framework(s)'. Not surprisingly, emphasis tends to be upon the word culture itself, the notion of ethnicity however a major unstated understanding. Language, custom, and diversity tend to be emphasised. Abstractions such as equity and social justice, as shown in the website extract below, are frequent references. The term diversity is favoured over the term difference.

"Cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system or agency or among professionals that enable effective communications in cross-cultural framework (Cross 1989). Cultural competence supports the core principles and values of study in medicine and health:

- *Equity and social justice, and community service, with clear identification of the impact of cultural diversity*
- *Commitment to learning, discovery and engagement from an adult learning approach, with recognition of the diversity in learning styles brought by students of culturally diverse backgrounds*
- *Customer focus – access; practice & prevention orientation; population based, with adaptation to cultural diversity*
- *Ultimate values – including ethical reflection and spirituality as defined from the whole compass of cultural, spiritual and religious values." Source: Centre for Culture and Health (2001-5). Accessed 9th June 05 http://cch.med.unsw.edu.au/cch.nsf/website/education Last updated 18.5*

The expressed ‘ultimate values’ of ‘ethical reflection’ in this quote lead the way to a potentially very nuanced discussion of implications for education.

An integrative approach is used, and this emphasises the value of aggregating cultural factors within provider education, and thus within clinical knowledge and practice, although inexplicitly rather than explicitly so. These values are exemplified below in the piece by Tervalon and Garcia (1998) which seems to posit ‘attitude’ development as the key focus for educators:

“Cultural humility has been described by Melanie Tervalon and Jann Murray-Garcia as a lifelong process of self-reflection and self-critique. Cultural humility does not require mastery of lists of "different" or peculiar beliefs and behaviors supposedly pertaining to certain groups of patients. Rather, the provider is encouraged to develop a respectful partnership with each patient through patient-focused interviewing, exploring similarities and differences between his own and each patient's priorities, goals, and capacities. In this model, the most serious barrier to culturally appropriate care is not a lack of knowledge of the details of any given cultural orientation, but the providers' failure to develop self-awareness and a respectful attitude toward diverse points of view.” Source: http://www.parkridgecenter.org/Page1882.html

The data obtained by this group backs up this view of cultural competence strongly, emphasising ‘understanding’ and ‘listening’ as key themes from research participants, with the implications for those interested in developing attitudes and listening skills amongst medical students and other health care providers. Regarding adult education, the emphasis here is primarily on what would be called a self-actualising curriculum (Eisner & Vallace 1974), characterised by an emphasis on personal growth and change, in contrast to training, for example, towards a role as an agent of social change or reform on a wider scale. The emphasis is culture, and the curriculum development model one of self-actualisation.

- Subproject 2

The emphasis in this subproject is gender.

Symmetrically with the above subproject, culture is implicit rather than explicit, implied to be an important contribution to health status, culture being referred to indirectly via ‘different roles’, and language such as the ‘nature’ of ‘medical knowledge’.

“A gender perspective in medicine includes...“(a) gender perspective of

...medical evidence (which) acknowledges the clinical consequences of gender blind medical research and the resulting medical evidence

....the patient (which) acknowledges the different roles that masculinity and femininity play in men’s and women’s health

....the provider (which) acknowledges the ways in which the sex or gender of the provider impacts on the health care event

....medical education (which) identifies the gendered nature of medical knowledge/education/texts/teaching styles and environments (and)

....clinical practice (which) acknowledges the way in which the sex or gender of the patient impacts on clinical testing, diagnostics, treatment and outcomes"

Regarding curriculum, argument that gender mainstreaming is an educational strategy of social reconstruction is manifested, for example in a guide for medical educators about gender (Nobelius & Wainer 2004) there appears the following discourse urging patience, engagement, clarification, and evidence in countering resistance to achieving educational goals:

Most innovations take both time and a weight of evidence to become accepted. The mainstreaming of a gender perspective is no exception. Most of the resistance to the concept is based in the misinterpretations and misunderstanding outlined above. Resistance can be passionate and outspoken or stony-silent and disapproving. Whatever the form it takes it can only be engaged and overcome through clarification of the concepts, supported by reference to the medical evidence (Nobelius & Wainer (2004 page 15)

Finally, the relevance and importance of teaching gender as a 'cross-cultural competence' for medical students is expressed in a recent guide for medical educators (Nobelius & Wainer 2004), in its Forward:

"This Guide has a high cross-cultural competence and encompasses the principles of evidence based medicine. This will be an area of increasing importance for both health care educators and practitioners in the years ahead". Nobelius & Wainer (2004, page 3)

The philosophy is of gender as a prime cultural theme, and that a key model for curriculum development may be that of social reconstruction.

- Combined subprojects

The project's processes of focus groups resulted initially in separate lists of themes and points emerging from the two subprojects. The combination was achieved by shared reporting, mutual critique and serial revisions of the report. A validity framework for candidate items for evaluation of both process and impact is found in the table below. This reflects the levels of agreement reached, being that the quality of the doctor-patient relationship, and hence ultimately health status, is influenced by the cultural competence of the provider, and that such competence essentially includes the gender competence of that provider.

Clear agreement emerged that doctors themselves are interested in difference, and in improving their medical practice in accord with acknowledging, and dealing with difference in a myriad of meaningful ways. Women as patients strongly expressed this as a need too. Both articulated this move in terms of learning needs for doctors. The achievement of competence is known to be problematic for medical educators, and a large number of tips for achieving competence in gender and in culture emerged from the project's data collection strategies.

A critique of subproject 1's outlook would be that all emphasis appears to be on the culture of the patient, or of the health care students, rather than that of medicine, the educational body, or of the doctor himself or herself. Although clearly a major cultural determinant, gender is not articulated specifically in this perspective, nor are any specifically gendered features emphasised, such as customs, language, or more contentiously, power. Specific factors such as gender tend to be less dominantly articulated in this discourse, with the presentation of philosophy tending towards abstractions such as equity and social justice, as shown in the website extract above.

Power or social position are silent, gender inequities in health, both for women and for men, for instance, could be argued as backgrounded as a factor in cultural competence. A critique of subproject 1's stance on education would be that little explicit conclusion was taken about the cultural roles of doctors themselves, leaving the question of self-actualisation via role modelling open to question.
A critique of subproject 2's take on the problem would be that the place of gender in the spectrum of cultural determinants of health might be underplayed. Educationally, taking one factor in isolation risks reduction of teaching to one aspect of culture only, ignoring the complex and embedded nature of any cultural factor amongst others. Educational debate on this point seems under-addressed in the medical education literature also. The social reconstruction curriculum suggested by this group is open to the critique that educational institutions ought not necessarily challenge the value frame of funders, policy makers and established institutions. It is recognised that issues of power imbalances in society are not necessarily served by explicit strategies by institutions, as they are always contested areas, and success not always served by explicit articulation of educational strategies.

Feasibility factors
On the one hand a number of existing educational strategies are in place, on the other there are numerous difficulties assessing the impact of educational strategies in the shorter term, and even more difficulties with far transfer of learning some years from the educational intervention. On another axis, the difficulties in assessing attitudes in a consultation are acknowledged, as are the challenges involved in analysing outcomes in social problems generally.

Proposed Process and Impact Evaluation Framework

The following table shows how future projects might be evaluated as a larger program, and across several locations. Its key features draw on the program logic expressed by researchers. The table shows two key axes, that of a gender/culture intersection, and that of medical education. The processes of identifying gender and culture both alone and together are addressed in this framework. The assumption that provider competence and behaviour in medical practice are influenced by medical education is expressed by the researchers and their intersection widely advocated in the health policy literature, although the medical education literature under-addresses cultural competence (Mittman & Siu 1992; Eboni et al 2005). In discussing education and curriculum some key elements such as goals and objectives, delivery, sequencing, train the trainers, assessment (Print 1993) are specified as examples (see table on the last page).

Generalisability

Successful approaches

The educational rationale seems, in general, under theorised. To improve evaluability therefore further exploration of concordance between the philosophies espoused in both gender/culture competence, and in the underpinning educational strategies to match, ought to be more explicitly drawn out in future project designs.

Replicability in other locations

The question of replicability, once internal validity is addressed, is also important. The importance of setting is accepted as crucially deterministic for gender-culture inclusive practice and teaching, and hence replicability ought to take this into account. The medical education literature addresses hospital wards, ambulatory clinics, and theatre, but these settings are relatively glossed in the gender-culture literature thus far. To conduct a full evaluation of process and impact, a variety of settings for medical practice would need to be tested particularly from the educational impact point of view.

Final Conclusions about Evaluation

In summary, the researchers' assumption overall was that the quality of the doctor-patient relationship is influenced by cultural competence, including the gender competence, of the provider. All agreed that education would assist this goal of competence. Various views were held as to what would be effective in achieving this goal of educating providers, including both self-actualising and social reconstruction models of medical curriculum.

Doctors in the focus groups emphasise that they want to know about difference, meaning cultural difference, and exemplified at length that gender is a good example. They elaborated in depth on this, in terms of medical knowledge, patients, the provider, medical education in the clinical environment, and clinical practice. Female patients in the focus groups drew the researchers' attention to the lack of respect that some doctors might have for cultural difference - some saw gender as a typical example - with consequent alteration of access, effectiveness of treatment including agreement to undertake therapy, capacity to deal with the complexities of an individual's health problem, and health outcomes.

The project overall has a relatively simple, clear, design, with explicit processes. The intended communication between researchers worked out in practice as such, being productive and well co-ordinated, including frequent electronic and teleconference contact for effective decision making. Prompt, clear documentation of the various subprojects led to cohesive synthesis of the project.

Any gaps resulted from the challenge of combining seemingly disparate aspects of philosophies about the nature of achieving change to existing medical practice through education. The curriculum model ought to be more specifically addressed, teasing out the relation between curriculum and practice, as there are so many implications at a model's core for the delivery and evaluation of medical curriculum. Nevertheless the project yielded significant engagement with the challenge posed, and was closely in accord with the project brief.

The evaluability of the project proved high. The two subprojects, though each complex, were well melded and productively so. A program logic is present, and a framework suitable for evaluation emerges from this project.

References

Bickman L The Functions of Program Theory in Bickman L (1990) Advances in Program Theory San Francisco, Jossey-Bass

Chen, H. T. (1990). Theory driven evaluations. Newbury Park, CA, Sage Publications.

Chen, H. T. and P. Rossi (1983). "Evaluating with sense: the theory-driven approach." Evaluation Review **7**(3): 283-302.

Eboni G. Price, MD, MPH, Mary Catherine Beach, MD, MPH, Tiffany L. Gary, PhD, Karen A. Robinson, MSc, Aysegul Gozu, MD, Ana Palacio, MD, MPH, Carole Smarth, MD, Mollie Jenckes, MHS, RN, Carolyn Feuerstein, Eric B. Bass, MD, MPH, Neil R. Powe, MD, MPH, MBA and Lisa A. Cooper, MD, MPH A Systematic Review of the Methodological Rigor of Studies Evaluating Cultural Competence Training of Health Professionals (2005) Academic Medicine 80: 578-586.

Educators Monash University School of Rural Health, Traralgon, Vic.

Eisner, Elliot; Vallance, Elizabeth (eds) (1974) Conflicting Conceptions of Curriculum. Chicago: McCutcheon Publishing.

Gelman R Greeno J (1989) On the Nature of Competence: Principles for Understanding in a domain in Resnick LB (1989) Knowing, Learning and Instruction: Essays in honour of Robert Glaser New Jersey, Lawrence Erlbaum Associates

Linn R Gronlund (1995) Measurement and Assessment in Teaching (7th ed) New Jersey, Prentice Hall

Madaus G Scriven M Stufflebeam (eds) (1983) Evaluation Models: Viewpoints on Educational and Human Services Evaluation, Boston, Kluwer-Nijhoff

Mittman B, Siu A (1992) Changing Provider Behaviour: Applying Research on Outcomes and Effectiveness in Health Care in Shortell S Reinhardt U Improving Health Policy and Management: Nine Critical Research Issues for the 1990's. 1992, Ann Arbor Michigan, Health Administration Press

Nobelius, AM & Wainer, J, (2004) Gender and Medicine: a conceptual guide for medical

Owen J (1993). Program Evaluation: Forms and Approaches Sydney, Allen & Unwin

Print M (1993). Curriculum Development and Design (2nd ed) St Leonards, Allen & Unwin

Tervalon M & Murray-Garcia, J. (1998) Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care for the Poor and Underserved. (9):117–25

Weiss, C. H. (1995). Nothing as practical as a good theory: exploring theory-based evaluation for comprehensive community initiatives for families and children. In New Approaches to Evaluating Community Initiatives. J. P. Connell, A. C. Kubisch, L. B. Schorr and C. H. Weiss. New York, NY, Aspin Institute.

Weiss, C. H. (1997). "How can theory-based evaluation make greater headway?" Evaluation Review 21(4): 501-524.

Weiss, C. H. (1997). Theory-based evaluation: past, present, and future. . in L. Bickman Progress and Future Using Program Theory in Evaluation. San Francisco, CA, Jossey-Bass.

Wholey, J. S. (1979). Evaluation: promise and performance. Washington, DC, Urban Institute

Wholey, J. S. (1983). Evaluation and effective public management. Boston, MA, Little Brown.

Wholey, J. S. (1987). Evaluability assessment: developing program theory.