MONASH University
Medicine, Nursing and Health Sciences

The question of culture: supervisors, students, clients and care

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Outline of the lecture

- Defining culture
- The client and the clinic
- The supervisor and the student
- Questions

Aims

- Highlight how culturally based beliefs, values, attitudes and practices can influence patients' understanding of health and illness, and expectations for treatment.
- Consider how differing styles of communication impact on supervisory and care interactions and clinical effectiveness in cross-cultural encounters.
- Identify value orientations inherent in the culture of psychology and psychiatry, and identify cultural dynamics in supervisory and clinical encounters.
- Identify institutional systemic biases, and become aware of one's own responses to bias.

Culture, convention & tradition

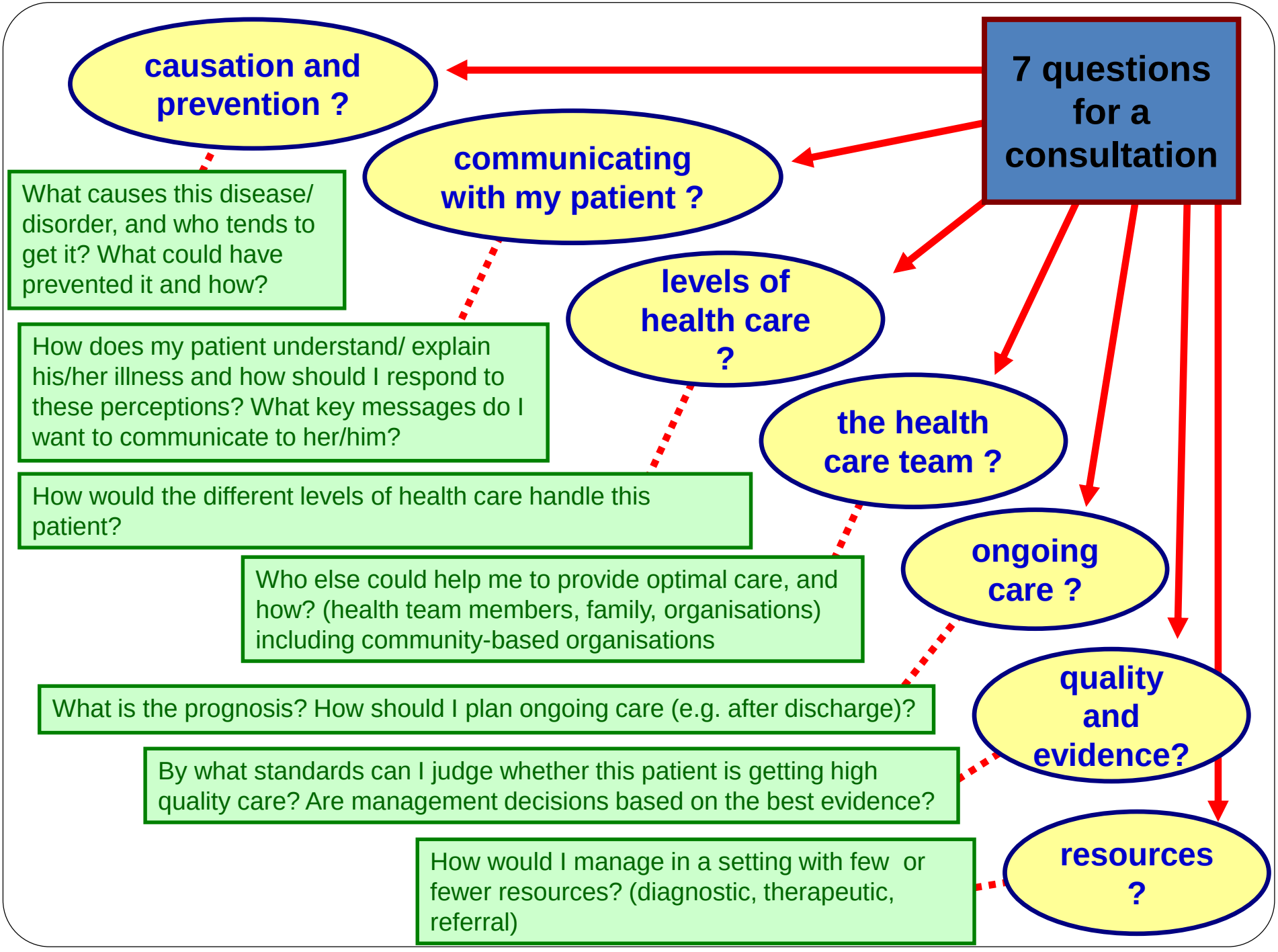
- Culture – shared and learned patterns of behaviour, practices and ideas
- Morals, traditions, practices, beliefs, rituals, values,

nherited and shared beliefs, knowledge and practice

- These structure how we are in the world, and how we relate to individuals in given settings
- Educational and health institutions are cultural artefacts, and the behaviour of people within educational settings are learnt
- We bring to a university, or to a clinic, or a hospital, a set of expectations about the nature of the place, and of how we should behave within it
- Much of this is learnt as we enter the institution, so we also gain familiarity over time

Culture and illness

- Classic distinction is between illness and disease
- Different understandings in terms of etiology, presentation, diagnosis, management and prognosis
  - Natural causes
  - Biomedical explanations
  - Supernatural
  - Past misdeeds …
- Different conditions attract more or less stigma
- This influences willingness to present for care, family support, discussions in the community


7 questions for a consultation
causation and prevention ?
What causes this disease/ disorder, and who tends to get it? What could have prevented it and how?
communicating with my patient ?
How does my patient understand/ explain his/her illness and how should I respond to these perceptions? What key messages do I want to communicate to her/him?
levels of health care ?
How would the different levels of health care handle this patient?
the health care team ?
Who else could help me to provide optimal care, and how? (health team members, family, organisations) including community-based organisations
ongoing care ?
What is the prognosis? How should I plan ongoing care (e.g. after discharge)?
quality and evidence?
By what standards can I judge whether this patient is getting high quality care? Are management decisions based on the best evidence?
resources ?
How would I manage in a setting with few or fewer resources? (diagnostic, therapeutic, referral)

Explanatory models of illness

- Arthur Kleinman (Harvard)
- To understand others, ask *What, Why, How, and Who* questions:

What do you call the problem?

What do you think the illness does?

What do you think the natural course of the illness is?

What do you fear?

Why do you think this illness or problem has occurred?

How do you think the sickness should be treated

- **How** do want us to help you?
  Who do you turn to for help?
- **Who** should be involved in decision making?

What causes this disease/ disorder, and who tends to get it? What could have prevented it and how?

communicating with a patient ?

Inquiring about a patient's or family's explanatory model works best in the context of a meaningful relationship. The inquiry is best initiated with a statement of respect such as, *"I know different people have very different ways of understanding illness... Please help me understand how you see things."*

Using the model in communication

- The explanatory model can be useful in interpreting the culture of Western medicine to others who find our explanatory model peculiar.
- The Western medical model is mechanistic in nature; the body is a machine, prone to malfunctions, requiring tune-ups or occasional part replacement. The patient's obligation is to present this 'machine' to the 'mechanic' (physician) who will make repairs.
- This explanatory model differs greatly from other models which view illness more as an imbalance of forces (ex: Chinese - yin-yang, Hispanic- hot-cold) or as being influenced by unseen forces such as spirits, demons or curses

Pre- and postnatal depression

- Study in Indonesia
- Presentation of symptoms of depression consistent with that elsewhere
- Contextual factors are used as descriptions – idioms – of the condition
  - No money
  - No husband
  - Violent husband
  - Not enough food
  - Lonely
  - Being ‘bad’ or failing

Diabetes & depression in Melbourne

- Greek, Pacific Island, Chinese & Indians – differences in structure and size of communities but in all cases greater than average incidence of DM
- Complex associations of DM and depression (and later, cognitive impairment)
- Because doctors, diabetes educators and the media talk about stress, so too people with diabetes use stress as an explanatory model for diabetes
- Diabetes is conceptualised as deteriorating through a feed-back loop
- Health education strategies do not work for all people

The personal context of distress

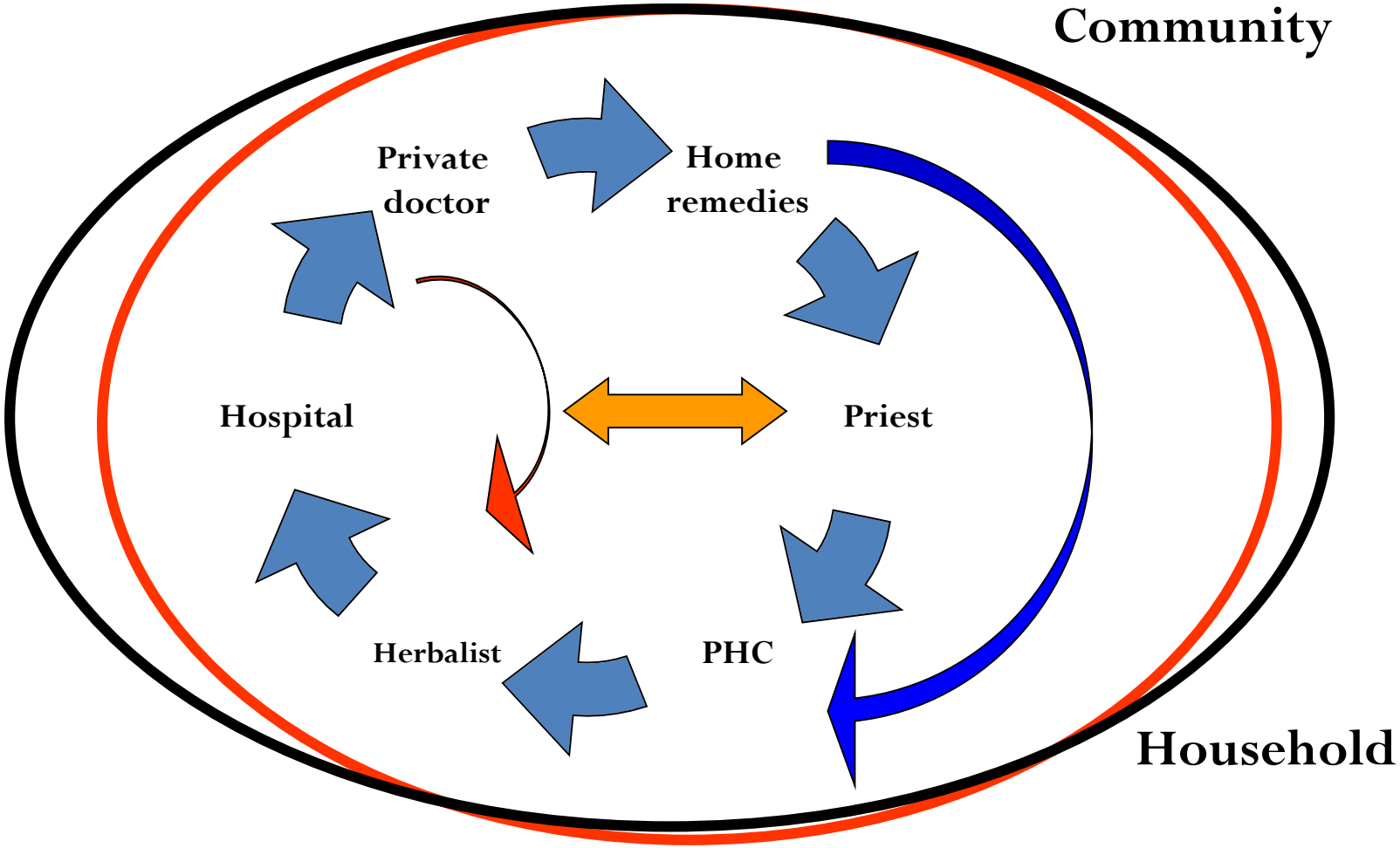
- He (one son) was in the drugs. The other, the younger son, is a gambler… Disgusting. So I can't press myself not to get worried. So well, you say not to worry because it is not good for you, but I cannot help myself. Sometimes I worry too much. I sit here in my garden. I cry. The children, they are not married. They are not working. These are not small things. Big problems.
- I cry very easy. So I think because I feel I am too much soft character. My character is soft. When I think too much …when I think of the past. What the future brings nobody knows. The past … I say, 'Why has this happened to me?' Not with diabetes. With my wife, I have no problem. Between us – everything is good … (pause) … Only the boys.

levels of health care?

- How people understand an illness influences what they do
- A *hierarchy of resort* describes the steps people might take to resolve symptoms or cure illness
- The hierarchy exists between doing nothing, home care, and first step of treatment seeking. After that, there are many things that influence who a patient might see
  - CATS team
  - Counsellor
  - Hospital outpatient clinic
  - Neighbor
  - Family member
  - Private doctor
  - Public doctor
  - Psychologist

How can I organise or assist with optimal care (health team members, family, organisations)

Pathways always vary



the health care team?

How does my patient understand/ explain his/her illness and how should I respond to these perceptions? What key messages do I want to communicate to her/him?

- Whose culture is represented?
- Relationship of health care team and patient, and patient and family
- Who do you include in the health care team?
- What cultural and social factors interfere with quality of care?

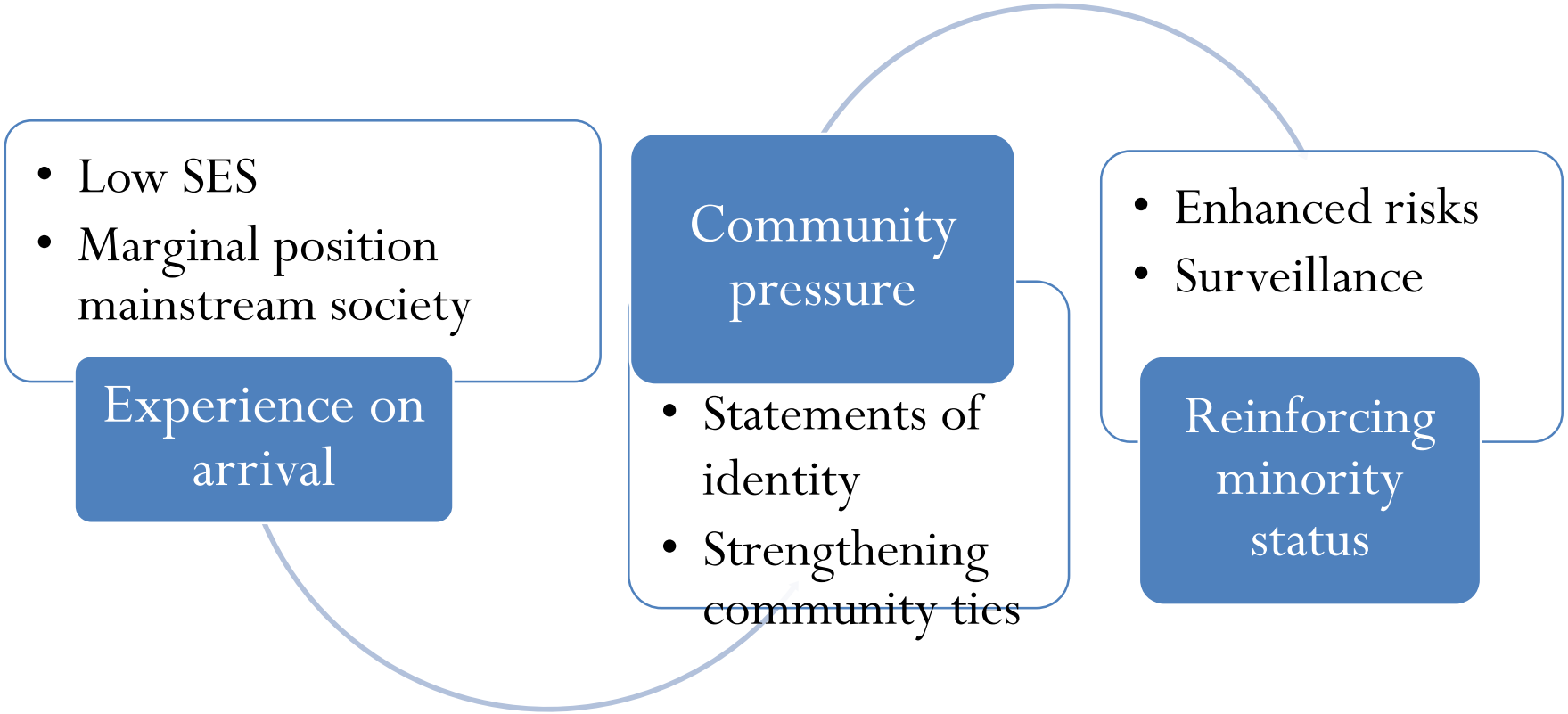
ongoing care?

- What is the prognosis?
- How should I plan ongoing care (e.g. after discharge)?
- But of the patient, you might ask: Can I discuss the prognosis?
- Do they understand probability? How do people interpret risk? Chance? Range of time …
- Soft truth or direct statement – how does this vary?
- Do people have caregivers? What does this mean? Social and household economics of caregiving? Poverty? Time? What needs to be done by family and community?

Gender, stigma, violence …

- Addressing the emotional and physical effects on women
- Surveillance and access to legal aid
- Sanctuary and refuge
- Women's need for health services (including for STD and HIV tests, pregnancy tests, checking for tears and fistulas)
- Re-victimisation (both of violence and of discussions of it)
- Young children experiencing and witnessing abuse
- Intergenerational transmission of violence
- Impact on family cohesion and stability

Stigma and the social context of exclusion



The supervisor – academic & clinical

- The old apprenticeship model and its problems
- Changes in approaches to learning and training
  - In Australia
  - To what extent does this vary in other settings?
  - What do supervisors and students bring into the clinic?
  - Traditional notions of hierarchy and power
  - The value of learning
  - The culture of learning
  - Education and status

Finding a fit

- A student asks for a particular supervisor
  The supervisor will be allocated if appropriate and he or she agrees to take the student. *The choice is yours.*
- An student requires supervision
  An email may be sent around academic staff seeking interest and availability, or the person is appointed to you
- There is a clear link between the intended student's interest and a supervisor's expertise.
- You have specific skills or experience that the student will need to learn
- This does not always work out the way you want it

The role of the supervisor

- The relationship is based on regular contact between supervisor and student.
- Regular meetings are encouraged to develop a collaborative relationship and to maintain progress, including through debriefing
- Develop a timetable of regular meetings
- Supervisors need to be available
- Doubts and what to do:
  - You don’t think the candidate is capable
  - You react negatively to the candidate at a personal level
  - You agreed to supervise, but you have multiple meetings during the sessions

The student

- Stereotypes are just that – they don't describe all people. Yet there are patterns, cultural and contextual
- Learning diversity exists, even so
- Theories of "Asian" and "American/Australian" learning styles have some currency and can be helpful in how we think about learning
- These influence self-directed learning, theory building, the capacity to criticise or question, independent tasks, ability and willingness to take responsibility, experimentation

Asian	Australian
Rote learning is common	Evaluative learning is preferred
Non critical reception of information	Critical thought is expected
Students work hard to learn everything	Students selectively learn the central concepts as well as detail
Students are inclined to seek clarification	Students are willing to seek assistance as part of the learning process
Few initiatives are taken	Independent learning and research are rewarded
A willingness to accept one interpretation	Students are encouraged to apply general principles to specific situations and to test various interpretations
Overall concepts are seen as important to understanding	Analytical thinking is encouraged. Students are expected to support opinions with logical argument.

Cultural variation in learning

- Can we move beyond stereotyping and presumptions of static behaviour?
- Consider the relevance of variations in individuals' and groups' histories of engagement with institutions and in terms of cultural values and practices
- Variations in learning style may be proclivities of people with certain histories of engagement with specific cultural activities
- Circumstances shape how important these are
  - Relationships with authorities
  - Conventions of engagement and gender dimensions of this

Gender, national context, age ..

- Authoritarian states discourage challenges to authority
- Family expectations of children may influence interactional styles (and add to anxiety)
- Cultural and religious precepts may affect engagement
- Gender-appropriate behaviour may be internalised in students
- Gender-appropriate rules of interaction among students and with patients/clients

Expectations of clinical work

- Willingness of student to take on responsibility
- Ability to establish rapport with clients
- Both the client and the student/trainee bring cultural questions into their interactions
- What values and attitudes to students bring to the clinic?
- If these are not well addressed in the classroom or tutorials, how can they be addressed in the clinic?
- Willingness and ability of student to discuss difficulties with supervisor

What do we expect of supervisors?

Consider

- Your role as a supervisor is that of professional developer
- You need to identify and articulate key components of academic/clinical supervision
- To yourself and to the person you are supervising
- You may want to develop a supervisory contract/agreement
- You need to critically evaluate your own supervisory style
- You need to understand common blocks in supervision and how to overcome these – in relation to personality (yours and theirs), time, intellectual capacity, and expectations