Adding cultural dimensions to person-centred diabetes care for the Chinese community

Original Research

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Introduction

Person-centred care emphasises the importance of a partnership between the clinician and the individual, with the individual taking an active role in decision-making regarding their healthcare. This person-centred care approach, however, was developed based largely on health communication theories that have been criticised for their individualistic focus, which assumes people value autonomy and appreciate taking an active role in making self-management decisions. While this assumption aligns well with individualistic-oriented Westerners who value autonomy, independence and worldly success, it conflicts with the Chinese philosophy and value-system of societal hierarchy, respect for authority and duty to the group. The Confucian code of social conduct requires that community harmony is maintained, and individualism is discouraged. Traditionally, most Chinese people respect the knowledge and wisdom of their health provider with an unquestioning acceptance, rely on their clinicians to provide them with clear instructions, and have a low level of tolerance for ambiguity and uncertainty. In the diabetes education context, the phrase “everything in moderation” is too vague for most Chinese people.

Chinese learners prefer classroom-style teaching, where structure and rules are emphasised and learning is inductive, while Western learners exercise personal autonomy and deductive approaches to gaining knowledge. The concrete-sequential cognitive style utilised by many Chinese people involves following precise, specific directions from the authority, and uses strategies such as memorisation, lists and repetition. However, memorisation is not used by Chinese learners to gain only a superficial understanding of information, but as a technique to develop deeper insight through repetition. In 2017, a team of clinician-researchers at Monash University designed a six-session diabetes group education program for Chinese Australians with type 2 diabetes, named “Not Scared of Sugar™” that tailored person-centred care approach and aligning this to Chinese-specific learning needs. Over 12 months, the program was piloted in Box Hill, Victoria, to determine the effectiveness of the program, as well as to understand the feasibility and translatable of evidence to practice. The program was delivered in Cantonese (language or translated) by a multidisciplinary team including a dietitian, Credential Diabetes Educator (CDE), physiotherapist and podiatrist. In this study, we aimed to explore the clinicians’ experience of delivering the culturally tailored “Not Scared of Sugar™” program, which may have challenged their traditional practice of person-centred care delivery.

Method

This research adopted a qualitative exploratory approach, with open-ended questions designed to elicit and capture the rich stories in the experience of delivering the “Not Scared of Sugar™” program.

To capture the diversity of clinical and cultural experience in presenting the program, effort was made to include clinicians from Chinese and non-Chinese backgrounds. Using pre-designed open-ended questions, the clinicians involved (authors of this study) each completed descriptive text for analysis. The textual data captured insight into group dynamics, interactions between facilitator and participants, interactions between participants, session structure, room layout and group behaviour, compared and contrasted divergent
experiences from clinicians who have delivered group education to both Chinese and Caucasian participants, highlighted potential barriers to program success and strategies employed to overcome these, and synthesized transversely of learnings to other clinicians in similar contexts.

For data analysis, the researchers adopted a thematic approach. This involved open coding of text, grouping codes into categories, and then generating themes from these categories. Investigator triangulation was employed to enhance research rigour. Textual data was independently analyzed and coded by both authors. Coding discrepancies were resolved by discussion until consensus was achieved.

Results and Discussion

Four pages of single spaced text from each clinician were collected for analysis. The diversity in their cultural backgrounds provided depth and breadth, enhancing richness of the findings. Analysis of these data yielded six main themes.

The culturally tailored version of person-centred care

The contrast between the traditional Western approach of person-centred care and the newly proposed Chinese version of person-centred care was highlighted repeatedly. In the West, person-centred care is about being responsive to an individual's physical and psychological needs, enabling discussion of their concerns, establishing a sense of partnership, and actively involving the person in decision-making. In the Chinese context, to truly be person-centred and responsive to the individual's needs involves establishing a sense of authority in the hierarchical therapeutic relationship and providing clear prescriptive self-management recommendations. Instead of merely language-translating the Western approach, it requires clinicians to reposition themselves and adopt various culturally-specific tailoring strategies when delivering diabetes care services.

Diabetes education instructor not diabetes management partner

Instead of being their diabetes management partner and sharing ownership and responsibilities for their diabetes care, Chinese people prefer clinicians to be their diabetes education instructor, teaching them scientifically sound self-management knowledge and giving them directives for lifestyle modifications. In the 'Not Scared of Sugar™ program, such paternalistic relationships between diabetes clinicians and participants was highlighted as a distinct characteristic of the program, and positively contributed to participant satisfaction, low attrition and successful outcomes of the Chinese diabetes education program. It was noted that the clinician-facilitator spoke in a confident authoritative tone with a strict set of instructions, and the participants, demonstrating a high level of respect for the facilitator, played the obedient learner role. The room used for the diabetes education program was set up with a classroom-style layout, with rows of desks and chairs, instead of a semi-circle, facing the front where the 'diabetes education instructor' stood to emphasize the high power distance. This facilitated the implicit hierarchy Chinese people expect in healthcare, creating a familiar learning environment for diabetes education. This unique classroom-style layout aligns with the Chinese cultural value and respect for teachers and knowledge, suggesting a culturally-specific emphasis on teaching and learning is needed when tailoring diabetes education for Chinese people.

Respect establishment not rapport building

In the 'Not Scared of Sugar™ classroom, clinicians were seen as diabetes experts. The facilitator introduced the multidisciplinary clinicians as guest speakers of the program, stating their qualifications and years of clinical experience. This helped establish trust and respect for the clinician-speakers and the scientific knowledge they shared. In the collective-oriented Chinese culture, the hierarchical social structure and its ordering of relationships are seen as very important cultural values, and people are required to accept their role in the hierarchical structure. It was observed that the participants behaved as 'good' students by being punctual, making an effort to attend every session, diligently taking notes during class, and completing between-session homework designed to facilitate healthy behaviour change. Furthermore, throughout the program, Chinese participants expressed a strong desire for knowledge and interest in the topic by taking photographs of information slides and asking detailed questions after class. The involved clinicians were amazed at the learning attitude of these Chinese people, contributing not only to positive health outcomes of the program but also a rewarding feeling among the clinician-educators.

Fostering sense of community among classmates

While the clinician-facilitator was assuming the 'front teacher' role by instructing the Chinese participants to adopt healthy behaviour change in their lifestyle, the distinct top-down hierarchical relationship helped to foster a strong sense of community among the participants in each class. It was noted that the participants were always interested in others, checking in on their peers before, during and after the sessions, and made encouraging comments to promote healthy behaviour change. At times when an individual participant reported struggling with making lifestyle modifications, the whole class exercised friendly peer-pressure and contributed to brainstorming solutions for the individual. Such unique implicit peer support could play an important part in the diabetes journey of these Chinese people.

Allow questioning at the end of education to clarify understanding

The top-down delivery of diabetes education may suggest that there was minimal participation during the 'Not Scared of Sugar™ class, but this was not the case. The manner of participant engagement in Chinese diabetes education was different. Instead of checking in on prior knowledge and inviting input at the start of the education session, audience engagement only takes place at the end. It was reported that the Question-and-Answer-time at the end of session allowed participants to ask individual questions, connecting the diabetes self-care information presented to their own experience. The purpose of Question-and-Answer-time was to clarify understanding, consolidate knowledge and troubleshoot potential challenges to the application of new information. At every session of 'Not Scared of Sugar™, participants often stayed back after class and gathered around the clinician-educator to ask personal questions. Some even stayed around just to listen in and learn from others' experience.

A constant internal struggle

The 'Not Scared of Sugar™ model of diabetes education was unique and very different from the traditional Western person-centred care model. The participant satisfaction, low attrition and positive outcomes of the program provide a convincing case that this top-down hierarchical diabetes education program was a feasible approach to meeting the needs of the Chinese community. However, it could be challenging for clinicians to move away from traditional practices, reposition themselves in the top-down hierarchical structure and start instructing Chinese people with diabetes. Furthermore, the clinicians involved in 'Not Scared of Sugar™ also highlighted their struggle to teach a passive audience as they were unable to ascertain participants' level of understanding of the information presented.
during the session. Clinicians also experienced exhaustion from the additional workload required to prepare in-depth health information, and reported difficulties providing lifestyle modification instructions in a black-and-white manner when scientific knowledge is constantly evolving.

Conclusion

It is always important to provide culturally tailored diabetes education to people of culturally and linguistically diverse backgrounds to encourage the adoption of healthy lifestyle recommendations while ensuring individuals feel supported in their diabetes journey. To truly tailor diabetes education for Chinese people, reimagining clinicians as instructors is required and it refers to a new way of thinking that repositions clinicians as teachers who hold the authority in the diabetes education classroom. It extends beyond just fostering a top-down hierarchical therapeutic relationship; it shifts the focus from engaging individual learners in self-care decisions so they take ownership of managing their diabetes, to the provision of content-heavy diabetes self-care information. This enables Chinese individuals with diabetes to gain in-depth knowledge about diabetes self-care, in a format that aligns with their learning needs and process of learning.

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References


