Miss Sesi Hotonu
Paediatric Surgery Registrar and RCSEd Scottish Clinical Leadership Fellow

Mr Mark Peter
Consultant General Surgeon and Past Chair, RCSEd Younger Fellows' Committee

Breaking down cultural barriers

Sesi Hotonu and **Mark Peter** explain the importance of bringing cultural competence to the forefront of the clinical encounter

An increase in globalisation and immigration has made the UK population the most ethnically and culturally diverse it has ever been[1]. A recent census revealed that parts of the nation have up to 56% of residents identifying as black, Asian and minority ethnicity (BAME). This statistic varies greatly across the UK, with greater ethnic minority populations concentrated in urban centres such as Birmingham, Leeds and London[1,2]. It goes without saying that there is a need for our NHS to adapt to the needs of our evolving population.

Ethnic diversity brings with it a wide range of languages, beliefs and cultures – an appreciation of this is paramount to the clinician–patient relationship. Good communication is a key pillar of patient safety, improving treatment compliance and patient outcomes, and reducing medical errors and complaints[3].

Health inequalities are prevalent among people in minority groups, who are more likely to occupy lower socioeconomic classes, less likely to seek professional help for health issues and have poor compliance with health interventions.

One potential explanation for this lack of engagement with health services is the lack of trust caused by cultural disparity and paucity of cultural understanding between health provider and patient[4].

COMMUNICATION, COMPLAINTS AND LITIGATION

In 2019 the monetary provision for medical indemnity in the NHS was an estimated £77bn. Given that this figure was reached through an incremental 10% per annum increase since 2015, it is clear that sadly patient claims that justify settlements are on the rise[5].

NHS Resolution, the organisation that coordinates the legal defence of NHS trusts, has found poor communication at the heart of a significant number of claims. Furthermore, a recent survey by the Behavioural Insights Team found that written responses provided by NHS trusts to patients when a complaint is made often contain so much technical jargon it cannot be understood by the lay native English speaker[5].

Furthermore, patients often do not seek monetary compensation for medical error. The same survey revealed the main desire of an aggrieved patient to be a simply worded, open and honest apology; this is often not achieved.

If communication with our English-speaking population is so deficient, it is sobering to think about how much more we fail those for whom language poses an additional barrier. The importance of providing translators for our patients who need them, and appropriate, often additional, time in the consultation to ensure that an adequately translated dialogue occurs cannot be stressed enough.

In areas with a high population of a particular cultural group, information leaflets and resources should be produced in their prevalent language. This is a simple intervention that may dramatically increase patient safety, outcomes and satisfaction with the health service.

CULTURAL COMPETENCE

While communication in a vast array of clinical circumstances is well covered in most modern UK medical school curricula and training programmes, there is currently very little emphasis on attainment of cultural competence.

Cultural competence is an integral part of patient safety and forms one of the key non-technical skills that the practising clinician must have in their arsenal[6]. In a broad sense it is defined as having a respect and understanding of a patient's cultural and personal beliefs, and using this knowledge to make a safe, unbiased clinical decision that involves the patient to the extent of their desire. This is shared decision-making at its best. It is, however, a complex multifaceted skill that must be improved constantly, and it is our professional duty to ensure we educate ourselves on issues relevant to the particular geographic area in which we practise.

It is inevitable that the characteristics possessed by the clinician and the patient will differ in many ways, such as race, age, gender, beliefs, sexual orientation and culture. However, this should not prevent the principles of good medical practice, which places the patient at the centre of the consultation, from being upheld. Every medical encounter should be based on mutual understanding and respect, avoiding prejudices and unconscious bias.

Mezirow's transformative learning theory is central to the development of cultural competence: it encourages learning through reflective practice[7]. Introspective thinking, which involves examining the reasons behind our own biases and beliefs, is the starting point to behaviour change, and to becoming more tolerant and inclusive.

In practice the dynamic four-stage approach to reaching cultural competence described by Teal provides a useful framework for clinical consultations[6]. It involves creating a trusting dialogue with the patient, situational awareness, clinical adaptation, and finally building a cultural knowledge bank that can be drawn on for future interactions (see 'Developing the skills', right).

Cultural competence is a dynamic, lifelong process that is integral to the practice of safe, patient-centred medicine. Just as today's surgeon must keep their technical skills and clinical knowledge current, they must also seek to become and remain excellent communicators, adapting to the community around them.

"Medical encounters should be based on mutual understanding and respect, avoiding prejudices and unconscious bias"

Developing the skills

1. Building rapport

This involves active listening combined with verbal and non-verbal skills to understand the patients' specific needs and to help the them feel comfortable. The skill required to build trust in complex and varied clinical encounters usually grows passively with clinical experience, but active learning is vital in acquiring communication skills. Training in this should begin at the undergraduate level – even a one-day undergraduate workshop can significantly increase undergraduates' confidence and competence in conducting a culturally sensitive consultation[8]. In the busy postgraduate arena, there is good evidence for continuing professional development through e-learning[7].

2. Self- and situational awareness

It's important to be aware of implicit bias caused by cultural differences in the clinician–patient relationship. The clinician must approach each consultation with an open mind and a desire to learn. The clinician also needs to seek feedback on the effectiveness of the interaction[6]. Apart from the conversation content, one must assess non-verbal cues, such as tone of voice, body language and facial expressions, to gauge patient trust and comfort.

3. Flexibility

It is our professional duty to adapt our clinical practice to changing times[3]. Every patient will have social and personal circumstances that are unique to them, and the culturally competent clinician must be able to adapt their approach to best serve the needs of each individual. This difficult skill can be mastered only through practice. Technology, such as web-based translators, can be useful.

4. Knowledge building

Transformative learning relies on the ability to be reflective and adjust one's world view based on new information[7]. Teal describes the importance of shifting the focus from gathering knowledge about particular cultural groups to gathering knowledge about key themes that are applicable to the patient population as a whole[6]. Focusing on individual cultural attributes may lead to the formation or reinforcement of stereotypes. The clinician should focus on broad themes, such as patient attitudes to family involvement in care, religion, beliefs about life and death, and the desire for limited or extensive information, before making a decision about their health.

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