Cultural competence and diversity responsiveness: how to make a difference in healthcare?
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6 Teaching communication with ethnic minority patients: Ten recommendations
Abstract

Introduction
Culturally competent communication is indispensable for medical practice in an ethnically diverse society. This article offers recommendations to teach such communication skills based on the experiences of members of a Dutch NMVO Special Interest Group on ‘Diversity’.

Method
A questionnaire with three open-ended questions on recommendations for training in culturally competent communication was sent to all members (n=35). Returned questionnaires (n=23) were analysed qualitatively with a thematic coding framework based on educational themes emerging from the data.

Recommendations
All students need to be educated in culturally competent communication. Teachers should stimulate awareness of personal biases and an open attitude. Teach the three core communication skills, listening, exploring and checking, and offer practice with a professional interpreter. Knowledge content should focus on mechanisms relevant to various ethnic groups. Offer students a variety of experiences in a safe environment. All involved should be aware that stereotyping is a pitfall.

Discussion
Training in communication skills for consultation with ethnic minority patients cannot be separated from teaching issues of awareness and knowledge. The shared views on the content of these communication trainings are in line with general patient-centred approaches. The development of proper training in this field demands specific efforts of those involved.
**Introduction**

With the increased number of immigrants into the Western world, medical students must prepare for their roles as physicians in a diverse patient population. In the Netherlands, 11% of the population have a non-Western ethnic background (1). This percentage is based on country of birth and comprises first generation migrants and their children (2,3). A relatively large group within this non-Western population were originally labour migrants (mainly from Turkey and Morocco), others came as refugees (e.g. from Afghanistan and Iran) or immigrated from former colonies (e.g. Surinam). The composition of the ethnic minority population is dynamic and ever changing, as exemplified by the recent arrival of labour migrants from Eastern Europe (1), the distribution of first and second generation migrants or the degree of acculturation.

Common causes of communication problems with ethnic minority patients are language barriers, cultural differences in explanatory models of illness, health illiteracy and racism or perceptual biases (4-6). In general, physicians behave less affectively with ethnic minority patients (5,7,8) and check less often whether patients have understood their message (9) than is the case with majority populations.

Cultural competence is generally defined as the combination of knowledge, attitudes and skills necessary for care providers to deal effectively with cultural and ethnic diversity (10). The need for education in cultural competence is widely recognised, but it has not yet been implemented structurally in Dutch medical schools (11) nor in other European countries (12,13). Neither is there consensus on how to implement medical communication training that focuses on patients from an ethnic minority background (culturally competent communication). Many of the existing frameworks and visions on cultural competence describe the contents of the concept at a meta-level (10,14,15). These frameworks can be helpful in defining general objectives of communication training, but do not specify what to teach and how.

In this article, we offer recommendations for the development of medical communication training with respect...
to patients from ethnic minorities. These are based on an investigation of experiences and views of the members of the NVMO Special Interest Group (SIG) on Diversity and will be presented in the context of the available literature. We define ethnic background by country of birth because this is a common practice in The Netherlands and Belgium (2), but our recommendations also relate to communication difficulties resulting from differences in socioeconomic status, cultural background, degree of literacy, religious backgrounds or from discrimination experienced.

**Method**

**Design**

We sent out, by e-mail, a questionnaire to all members of the SIG (N=35) to elicit their ideas about, and experiences in, teaching culturally competent communication in an ethnically diverse context. The questionnaire consisted of the following open-ended questions:

What are your recommendations regarding communication with ethnic minority patients, to: 1. *students*, 2. *educational designers* who are designing training in such communication and 3. *teachers* who teach such communication?

Each of these three items had five information entering fields as response options. Additionally, we asked general items about background (education), academic position, working field, medical institution and demographic characteristics.

As the SIG collaboratively decided on this project, e-mail was used to survey opinions and experiences. Consequently, the identity of the respondents was not anonymous, but in the data-analysis all personal information was left out.

**Respondents**

Thirty-five members (all except CS and VS) were sent the questionnaire and a maximum of two personal reminders in case of non-response, upon which 23 colleagues returned a completed questionnaire. All eight Dutch medical schools and one Belgian medical school were represented (Table 6.1).

**Data analysis**

We used a framework approach (a content and thematic analysis strategy) to analyse the data (16). After having familiarised with the data, VS and CS derived educational themes, which provided a coding framework. Main themes were: educational view, place in the curriculum, teaching objectives, materials and methods, classroom level and danger of stereotyping. All recommendations were independently categorised by VS and CS into these educational themes. Within these broad themes,
clusters of recommendations appeared, which were categorised into subthemes. Recommendations that could not be categorised in a subtheme were assigned to ‘rest’ categories. No qualitative research software was used.

Results of this categorisation process were compared, and differences discussed, until VS and CS reached consensus. We then discussed the recommendations with four other members of our group in order to check the categorisation and search for possible omissions or contradictions in the data. A summarising document, including the recommendations and a short description of every point made was then e-mailed to all our members, inviting them to indicate omissions and information they disagreed with.

All members had the opportunity to react by e-mail, telephone or in person at the next meeting of the SIG. Comments from our members were thoroughly discussed in the meeting and by VS and CS separately, and incorporated into the final recommendations if relevant.

<table>
<thead>
<tr>
<th>Table 6.1 Socio-demographic characteristics of respondents</th>
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<tbody>
<tr>
<td><em><em>Gender (n = 22</em>)</em>*</td>
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<tr>
<td>Female</td>
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<tr>
<td>Male</td>
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<tr>
<td><em><em>Country of birth: outside Netherlands (n = 22</em>)</em>*</td>
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<tr>
<td>Respondent</td>
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<td>Respondents’ mother</td>
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<td><em><em>Educational background (n = 22</em>)</em>*</td>
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<td>Medicine</td>
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<td>Social sciences</td>
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<tr>
<td>Other</td>
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<td><em><em>Current function (n = 22</em>)</em>*</td>
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<td>Researcher</td>
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<tr>
<td>Other</td>
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<tr>
<td><strong>Involved in diversity education (n = 23)</strong></td>
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<tr>
<td>Yes</td>
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<td>No</td>
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<td><strong>Involved in communication teaching (n = 23)</strong></td>
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<td>Yes</td>
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Note: *One respondent left this page blank.

**Recommendations**

All 10 recommendations were structured according to the general educational themes that emerged in the data and that were used for the categorisation process, as
follows: educational view (recommendation 1), place in the curriculum (recommendation 2), teaching objectives (recommendations 3-7), materials and methods (recommendation 8), classroom level (recommendation 9) and stereotyping (recommendation 10).

(1) **Develop a clear view on the content of the training**

The first step is to develop a ‘view’ on what culturally competent medical communication consists of. This view may then function as a starting point for the development of the actual educational programme. The view shared in our group is that communication skills should be part of a larger set of cultural competences and not be taught isolated from awareness and knowledge issues (see recommendations 3-7).

General medical communication and communication with individuals from an ethnic minority background have many similarities. However, some issues are more frequent in or specific for communication with minority patients, e.g. language barriers or expectations for treatment based on health care experiences in the patient’s country of birth. Clarifying these similarities and dissimilarities helps to distinguish what can be taught in regular communication training and what should be addressed in a specific training in culturally competent communication.

(2) **Teach all students**

The group considers culturally competent communication a basic competency for each physician. Therefore, it should be taught in the standard medical curriculum, at all levels and to all students.

By frequently addressing cultural competence issues in communication training, awareness of diversity will become something ‘natural’. Special courses can be developed for students with a specific interest in cross-cultural care.

(3) **Stimulate awareness of cultural and personal biases**

Two awareness issues are especially important in culturally competent communication training. First, teachers have to stimulate students to become aware of their own cultural backgrounds and perspectives. The training must make them aware that culture is not something that only belongs to others, for example by exercises that question students about their own personal and cultural backgrounds. Students are invited to exchange their views and feelings on issues that are not usually part of daily conversations (such as religion or important values in their families) (see Box 6.1 for a practical exercise). This awareness is essential to enable reflection on their communicative behaviour within an intercultural setting.

Second, students must be aware of their personal attitudes (including stereotypes) towards individuals from ethnic minority backgrounds. To raise students’ awareness, they might take an online Implicit Association Test\(^1\) (IAT: https://implicit.
Stimulate an attitude of openness, interest and respect

For effectively applying acquired communication skills, a triad of specific attitudes is a prerequisite, namely openness, interest and respect. These attitudes are essential to understand patients’ perspectives and to prevent students from judging too quickly. Students can practise this ‘respectful curiosity’ by asking questions, even difficult or delicate ones, to their peers or simulated patients.

Students should learn to deal with feelings (such as irritation or powerlessness in case of misunderstandings and language barriers) that might interfere with their openness towards patients. Reflection on these kinds of emotions should be a regular part of the closing discussion after communication exercises.

Box 6.1 Examples of practical exercises.

Example 1 – Reflection on diversity and professional growth: A multicoloured card game

A set of reflection cards (in English, Spanish, Dutch) was designed to stimulate reflection on diversity and professional growth in small groups of medical students. This ‘card game’ is an exercise in listening, asking explorative questions and in understanding one another’s background, values and views. By sharing experiences and views, participants may gain insight into their own personal and professional ‘culture’ and development.

The set consists of over 70 cards with challenging reflection questions, in five categories: 1. personal roots, 2. cross-cultural communication, 3. professional development, 4. death and dying and 5. taboos.

Some illustrative questions per category:

1. Name one rule or moral value you were brought up with that you have now discarded.
2. Have you ever felt discriminated? If so, on what grounds?
3. Name a personality trait of yours that may be a problem in your medical profession.
4. At my funeral, I hope people will say that . . .
5. In your opinion, should a doctor try to avoid crying in front of a patient?

Participants are invited to take turns, answering one of the questions (e.g. by picking a random card or choosing from an open stack).

Three rules should always be respected:

1. Safety and privacy: the ‘interviewee’ may decline any question without reading the card aloud and without explaining why.
2. The ‘interviewers’ show real interest by asking explorative questions, and by not interrupting with their own experiences.
3. No discussion!
Example 2 – Awareness and impact of stereotyping

In a first year course on communication and medical problem solving, one session in small groups addresses stereotyping and prejudices in cross-cultural medical communication. The aim is to challenge students to face their prejudices in order to prevent these from unconsciously affecting their communication with (minority) patients.

1. Students explore their personal cultural backgrounds. Who (according to current definitions) belongs to an ethnic minority? What are the students’ opinions on these ‘labels’?

2. Students engage in a short brainstorm on possible pitfalls in communication with minority patients.

3. The teacher provides some theoretical information on communication with minority patients, stereotyping, and prejudices.

4. Students express and examine some of their personal stereotypes and prejudices freely and uncensored. First, they are invited to come up with labels of (sub) groups in Dutch society, like farmers, ‘Turks’, gays, doctors, women, etc. Then, they are prompted to express their prejudices about some of these groups. Students belonging to a specific group state their prejudices about their own group. Students and teacher compare prejudices and discuss reasons for prejudice.

5. In a roundup, the students and the teacher discuss the possible impact of these prejudices on medical communication. These exercises are followed by a training session with simulated patients.

(5) Listen, explore and check: The three core skills

Preventing misunderstanding when physicians and patients are from different ethnic backgrounds is all the more important because such confusion is then more prevalent than otherwise (17). The most obvious level of potential misunderstandings is language: do both parties understand the words spoken? (see recommendation 6). A next level has to do with interpretation: do both parties give the same meaning to the words used. Due to culturally based differences in expectations, illness-based experiences or different emotions, misunderstanding may also occur.

Students can be taught the necessary skills for preventing misunderstandings such as questioning, listening and observing attentively and checking. The teacher must stimulate awareness that confusion can occur both ways: they can misunderstand their patients and patients may misunderstand them. By asking additional, exploring questions, they may find out whether they were really understood. At the same time, they may discover what is of importance to patients themselves. Transparent
communication can prevent confusion: explain the rationale for the questions that you want the patient to answer.

(6) Practise with a professional interpreter

Students should learn why and when working with professional interpreters is important and be taught specific skills to communicate well with a patient through interpreters. This may be addressed in a session that discusses the pros and cons of working with professional interpreters and where students practise a simulated conversation with an interpreter.

(7) Acquire knowledge at a meta-level

It is an issue of debate as to what kind of knowledge is relevant for culturally competent communication in health care. Knowledge of specific characteristics of cultural groups can easily result in stereotyping, as emphasised in literature and by our members. Nevertheless, our group considers some knowledge aspects important to be taught in communication training, mostly those at a higher level, such as on theories on mechanisms that influence health and health care in patients from ethnic minorities (e.g. Kleinman’s explanatory models (18), migration history of ethnic groups, dynamics of culture). For example, understanding that patients may have particular cultural explanations for their symptoms helps physicians to pick up the cues patients provide during a consultation about their illness perspectives. Qualitative research on patient perspectives and experiences from different ethnic groups as well as books or films on these subjects might serve as valuable input (19,20).

It remains difficult to determine exactly what kind of knowledge of specific cultures should be taught. For students to become sensitive for ‘cultural views’, these should be illustrated with examples of specific groups. Obviously, physicians must be familiar with Ramadan, for example to anticipate risks for diabetic Muslim patients. In order to avoid reinforcing stereotyping, however, it is always important to stress the limitations of this wisdom in the communication with individual patients.

(8) Offer a variety of educational experiences

In working with simulated patients when teaching communication skills, one must make sure that role-plays and communication exercises reflect reality and do not promote stereotypes. The pitfalls of focusing merely on psychosomatic complaints or of providing examples of traditional cultural ideas only instead of showing dynamics in a culture had better be avoided. Cases must have clear learning objectives without all kinds of communication aspects being intertwined, like language barriers as well as cultural and literacy issues. It is considered wise to choose simulated patients from a variety of ethnic backgrounds.
Apart from practising in simulated settings, students may also be offered other examples of educational methods and materials, such as: real-life experiences where they can observe other professionals and meet patients from ethnic minority backgrounds, assignments to write reflection papers, as well as supportive materials such as films and books.

(9) Conditions at classroom level: Safety is crucial

Safety is an important condition for teaching diversity issues. Students should feel comfortable to reflect on their own assumptions and moral values, and to go ‘deeper’ than merely giving politically correct answers.

When one addresses diversity in class, students from ethnic minority backgrounds may have interesting and valuable contributions to what is practised or discussed. They should not be addressed merely because of their ethnic backgrounds, as this might put them in an awkward position. One of our members explained a subtle approach:

I always start to approach background issues broadly and safely. I may ask: ‘Who comes from a rural background?’ And then I move closer to ethnicity or religion related themes.

Reluctant students pose yet another challenge. Some may be unwilling either to reflect on their own backgrounds and behaviours or to modify their regular behaviours when a patient is of an ethnic minority background. Such reluctance might be caused by an unsafe learning environment, and prevented if safety conditions are met, but the political and social context in which this topic is taught might also cause reluctance. Addressing cultural competency as part of the basic competencies that every physician should possess may diminish student resistance. Teachers can be supported in their educational efforts by a specific teach-the-teachers programme.

(10) Stereotyping is a persistent pitfall

Our members frequently warned for stereotyping, which should be in the back of the minds of all involved in developing and teaching medical communication in an ethnically diverse context. This pertains to obvious prejudice as well as subtle stereotyping. Everybody has stereotypes, even unconsciously or unwillingly, and these affect communication negatively (5). Teachers must enable students to examine, and learn to deal with their own stereotypes. Accordingly, teachers should also be prepared to reflect on their own perspectives and assumptions on ethnic diversity.

Discussion

Training in communication skills for health care professionals working with patients from an ethnic minority background cannot be separated from education in issues of
awareness and knowledge. The content of such communication training should focus on skills to prevent misunderstandings and on exploring patients’ contexts. Students must be encouraged to develop their own communication repertoire. Designers, teachers and students involved in these communication trainings should be open to exploring their own attitudes on diversity issues and avoiding reinforcing stereotypes.

Our investigation has its limitations. The recommendations in this article only represent the views of the members of the SIG. Although the SIG represents most of the Dutch expertise in ethnic diversity-related education as well as in medical communication, the views of non-members are not present. The members of the SIG are mostly from ethnic majority background. It might be that teachers from ethnic minority backgrounds have useful recommendations from a different point of view that were not taken into account due to the composition of our group.

Our recommendations result from Dutch and Flemish contexts with regard to medical education, health care organisation and society itself (e.g. regarding ethnic minorities), as well as from our own cultural views. Although the general concepts of culturally competent communication are broadly relevant across contexts, the specific contents of communication training must be adapted to the specific needs of each educator’s context.

The proverbial three-legged stool described by Betancourt (10) as a symbol for the importance of the combination of attitudes, skills, and knowledge in cultural competence education is also reflected in our recommendations on communication training. Our members emphasised that attitudes like openness and respect, and awareness of one’s own background are part and parcel of communication in an ethnically diverse context.

The attitudes and skills described, such as asking explorative questions, listening attentively and being aware of patients’ contexts, are not unique for communication with ethnic minority patients but are important elements of any patient-centred communication approach (21,22). The potential complexity, however, of communication with patients from an ethnic minority group – due to language barriers, cultural distance or influence of stereotypes – asks for distinct qualities (22) or a ‘PLUS’ in the generic patient-centred approach (4,23). It is important for students to explore their expectations about patients as well as their own professional standards and personal ethical limits in order to decide to what extent they can meet their patients’ expectations.

In our recommendations, we have approached the topic of communication very broadly. Medical communication has various functions, ranging from history taking to the breaking of bad news. Influence of patients’ cultural and ethnical backgrounds varies for these functions, and therefore provides different focus points for communication.
training. In history taking, it is important that physicians are well informed of ethnic differences in the prevalence of diseases (15); in breaking bad news exploring patients’ cultural views when talking about health issues is vital.

This article does not discuss recommendations about assessing cultural competence. Probably due to the phrasing of our questionnaire, this issue remained underexposed. Within the cultural competence literature, assessment is a neglected subject (24, 25). Assessment may bring about several pitfalls if not dealt with adequately such as reinforcing a one-dimensional notion of cultures or using assessment tools that lack authenticity (26). To get more insight into the views on assessment, future research with a particular focus on assessment is necessary.

Education in culturally competent medical communication demands specific efforts of both education designers and teachers (more specifically, their willingness to examine their own perspectives regarding diversity issues and their own biases and prejudices). We hope that our recommendations and the pitfalls mentioned provide some guidance and encouragement for those who consider developing education in this field, and contribute to the further development of culturally competent care.

Acknowledgements

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The NVMO SPECIAL INTEREST GROUP ON DIVERSITY was started in 2004, and has since met approximately three times yearly to exchange ideas and experiences related to all kinds of diversity aspects in medical education. The majority of the members are employed by one of the eight Dutch medical schools; two members are from Belgian medical schools in Flanders. All have a special interest in the subject of diversity in medical education, but not all members actually teach diversity-related subjects.

Note

1. The IAT was designed to assess the degree to which an individual implicitly associates certain members in the society (e.g. ethnic minority groups, women, the handicapped, obese individuals, etc.) with certain personal characteristics.
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