Guide to Cross Cultural Communication

**Culture – what is it?**

We all belong to cultures and sub-cultures. Our membership enables us to interact with others in ways which usually means that we share some understanding. Learning about, and respecting the diverse perspectives of others is the essence of patient-centredness, and can help health-care professionals develop supportive, co-operative and more effective relationships with patients. Patients and their doctors approach health care encounters with their own unique communication characteristics, health beliefs, and customs based on their individual backgrounds. These can dramatically influence health care needs, health behaviours, and the necessary sharing of information which will enable an effective outcome from a consultation. Cross cultural communication is a complex subject we will not be able to address all of the issues. We aim to raise your awareness of the need to use effective communication skills to gain an understanding of the patient’s perception of illness, elicit the patient’s expectation of treatment, and educate patients about their illness in a culturally appropriate manner.

Often when we talk about ‘culture’ – we mean the customs and practices of institutions or particular group of people – We can fall into the trap of only thinking in terms of black or minority ethnic groups. However, culture is not something that only other people have. We are all the products of a distinct and unique culture, whether we ascribe to our own culture’s values or not. It’s easy to be blind to the influence of one’s own culture, and to see our own world view as a ‘universal’, ‘natural’ or ‘taken for granted’ and by comparison to see other people and their cultural beliefs and practices as seeming exotic, strange or bizarre.

Some definitions of culture include:

“The norms, values, ideas and ways of doing things in a particular society.”

“All of the means of communication, art, material things and objects that a society has in common. The cultivation of the mind, the civilisation and learning of a society.”

“The ways of life shared by a particular group.”

“The practices that produce meaning in a society.” (Osborne and Van Loon, 1997)

What does culture mean to you on a personal level?

What’s your cultural background?

Consider the first thing that comes to mind. What sorts of things are valued by your culture, at least by the mainstream of opinion within it? For example, does your culture value independence and self-help, or are extended family ties and inheritance more important? Does your culture value youth or is there deference to elders or authority figures? Is thinking about the future (achieving the grades to get into medical school!), valued more highly than earning money to contribute to your family right now. Does spirituality or religion play a part in the way your cultural group thinks about moral issues, or is materialism and individualism more important in shaping opinions? What holidays do you ‘observe’ in your culture? What foods do you eat? Food is a good example of something which is distinctive to a particular culture, and of course there are widely different attitudes to alcohol across cultures.

Usually when people talk about ‘my culture’ they either mean their religion or their ethnic background, though sometimes they might be talking in terms of their social class or some other influence that they feel is more important such as their nationality. In a multicultural society, many people have a mix of cultural influences, and will negotiate their way between the mainstream culture and the culture of their family background. Families and individuals are all different and *within* a cultural group there is likely to be as much diversity as there is *between* different cultural groups. For example it doesn’t follow that because you are a member of a particular ethnic group that you will necessarily be rich or poor, educated or uneducated, religious or secular.

What is important in developing your clinical communications skills is to remain aware of your own assumptions. It would be impossible to learn about all the different cultures you might encounter in medical practice. Instead, we need to become culturally aware, and learn how to ask appropriate questions to obtain information on individual patient’s culture. *Cultural awareness* means seeing a person as individual in their cultural context, and being aware of other influences on their health, such as socio-economic influences and social inequalities.

We all belong to multiple formal and informal cultural groups, defined by geography, religion, age, choice or birth. Cultural groups can be shaped by family (presence or absence of children; carer commitments), community memberships, interests, sexual orientation, languages spoken, professional organisations etc

Some groups and cultures can be more powerful than others. There are different types of power that influence communication between individuals, for example

* Power of expertise
* Personal power
* Professional power
* Resource power
* Power of position.

Whatever your background on entering medical school, you will leave it better educated, better paid and have a higher social status than most of your patients. Sensitivity to the power dynamics that might be at play in an encounter with another person can improve communication and the quality of the information we give and receive.

Definition of culture:

*“Each culture is a texture pattern of beliefs and practices, some of which are coherent and consistent, others contested and contradictory. Culture usually does not compel a patient to believe and behave in a specific way, but rather acts as an implicit and unconscious way to frame or guide individual patients’ decisions.” (Johnson et al, 1995, 153)*

The iceberg model of cultural influences on communication

One way of explaining how differences in nationalities and languages can be experienced as cultural barriers to effective communication is the “iceberg” model. This identifies how some cultural influences may be readily apparent whilst other major influences are hidden and may not be recognised by the health-care professional.

The model suggests that some characteristics are above sea level – age, gender, ethnicity, nationality while others are below sea level – socioeconomic status, occupation, health, previous health experiences, religion, education, social groupings, sexual orientation, political orientation, cultural beliefs, expectations and behaviours etc (Kai, 1999). Even with those characteristics that are above sea level it is difficult to tell which are predominant characteristics in a particular setting at a particular time.

Stereotypes

A stereotype is a standardized conception or image of a specific group of people or objects. Stereotypes can be valuable because they help us to process a lot of information about a general topic. They also help us manage uncertainty. However, we need to be very aware of the dangers when stereotyping people. That is, it is important to deal with the individual in front of you and not with your preconceived ideas about that “type” of person. Most of us like to think we are individuals and so probably feel uncomfortable if we are dealt with otherwise.

What are the first words that come to mind if you think about the following groupings?

* Irish
* British
* Lesbians
* Iraqis
* Homeless
* Teenagers
* Rugby players
* Surgeons

Our first thoughts often echo the stereotype we have of that group. Kai (1999) suggests the following questions when we consider the usefulness of our stereotypes.

Which stereotypes seem justified?

Which and how many are positive?

What are the origins of such stereotypes?

###### What is it like to be different?

Feelings about being in a minority AND being stereotyped…

**Cultural issues in health care**

Patients and their doctors approach health care encounters with their own unique communication characteristics, health beliefs, and customs based on their individual backgrounds. These can dramatically influence health care needs, health behaviours, and the necessary sharing of information which will enable an effective outcome from a consultation.

Cultural insensitivity is widespread. Ineffective communication may be worse in healthcare settings for several reasons. For example, people who are ill may be fearful, uncomfortable, in pain, embarrassed, preoccupied with their illness, etc. This may compromise their ability to communicate. Health-care professionals, on the other hand, may be too focused on “the health problem” and will neglect to interact in a humane way to deliver personal care with sensitivity. As health-care professionals we need to remain sensitive to cultural differences between ourselves and patients and be aware that we bring our own cultural ‘baggage’ to the encounter.

The following questions are designed to develop your cultural self-awareness by prompting you to reflect on your thoughts and feelings. Take some time to think about your answers to these questions

1. Have I made assumptions about this person? If so, are these helpful?
2. Have I dealt with this person as my equal?
3. Have I made an effort to understand their way of thinking about their problem? Did I really hear what they were telling me?
4. Have I made an effort to explain what I intend to do and how I see their problem?
5. Have I sought permission or consent for their co-operation?
6. In what ways have I ensured that the approach to dealing with the patient is compatible with their personal and professional life?

Common issues and barriers in cross-cultural communication (Silverman et al, 2005)

Use of language

* Use of foreign language (i.e. patient and clinician must communicate in a language they are not fluent in)
* Use of slang
* Accent/dialect
* Giving offence through over-familiarity

Use and interpretation of non-verbal communication

* Physical touch
* Body language
* Proximity – closeness/distance
* Eye contact
* Expression of affect/emotion

Cultural beliefs and healthcare

* Interpretation of symptoms – what is considered normal and abnormal
* Beliefs about causation
* Beliefs about efficacy of treatment alternatives
* Attitudes toward illness and disease
* Use of complementary or alternative sources of healthcare
* Gender and age expectations about roles and relationships
* Role of doctor and social interactions related to power and ways of showing respect
* Perceived responsibilities regarding adherence to medical recommendations
* Family life events (e.g. rituals and beliefs with regard to arranged marriages, pregnancy and childbirth, older adult caregiving, treatment of elders, death)
* Psychosocial issues (identifying common stressors, awareness of diversity in family/community supports)
* Role of clinician in mental health

Sensitive issues

* Sexuality – including sexual orientation, sexual practices and birth control
* Uneasiness about some physical examinations
* Use and abuse of alcohol and other substances
* Domestic violence and abuse
* Sharing bad news

Health care practice issues/barriers

* Extent of clinician-patient partnership, extent of family involvement, personal and family responsibility for healthcare and treatment
* Ethical issues in care
* Doctor’s assumptions, stereotyping or prejudices
* Concurrent consulting with a practitioner of complementary or alternative medicine

###### Before turning over take a moment to consider questions you could ask patients who are culturally different to you?

Examples of particular cultural practices that may impact on individual health care

Islam and Ramadan

Islam is the second largest religion in Britain, after Christianity (roughly 2.5 million Muslims in Britain). Ramadan lasts for 29 or 30 days, depending on the sighting of the moon. This is just one of many examples of how a patient’s cultural and religious beliefs could affect their treatment and justifies the importance of communicating and understanding patient’s own beliefs.

Customs in Ramadan

* Fasting from dawn to dusk
* Prayer and meditation
* Iftari, evening feast celebrated with family and friends
* Spiritual activities (Taraveeh- night prayer) (Queshi, 2002)

Fasting Muslims abstain from food, liquids, tobacco, sexual activity and medication (which includes oral, inhalers, or injection) from sunrise to sunset. The sick, pregnant & nursing mothers and children are exempt. If a fasting person becomes ill, they are allowed to end the fast.

Ramadan directly influences the control of diabetes because of the month long changes in meal times, types of foods, use of medication, and daily lifestyle. Doctors who encounter Muslim patients need to understand the practicalities. What might you need to consider?

* A Muslim may be devoted, liberal or secular - How does your patient fit these descriptions?
* Ramadan fasting improves diabetes by lowering blood glucose & HbA1c - Does insulin need to be adjusted?
* Meditation and prayers tend to lower blood pressure – Do other medications need to be adjusted? (e,g, anti-hypertensives)
* Pork-based synthetic insulins and beef insulins are not acceptable to devoted Muslims (Queshi, 2002)

What other examples have you observed where a patient’s cultural beliefs clashed with the medical care that was proposed or provided?

Jehovah’s Witnesses - not accepting blood transfusions

Devout Christians who may be against abortion and who would not want to have antenatal scanning

Learning about, and respecting the diverse perspectives of others is the essence of patient-centredness, and can help health-care professionals develop supportive, co-operative and more effective relationships with patients. This is fundamental to the doctor-patient relationship: it validates the legitimacy and worth of peoples’ backgrounds and provides a more effective basis for better communication. Nevertheless, prejudice, (an unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason). Misunderstanding cultural norms, and inappropriate interpretation of patient’s behaviours collectively lead to poorer health outcomes, and less satisfying doctor-patient communication.

Is patient-centredness transferable across cultures?

There are differences in power, status and gender in professional relationships within and between cultures.

The following questions are adapted from Skelton et al (2001):

Do some cultures want a more patient-centred approach than others?

Do health care interactions in the UK differ significantly when the participants are from different cultures?

Are health care interactions “culture-specific”?

Do health care professionals from minority ethnic cultures have more than one consulting style, which they routinely use with different cultural groups?

Key Skills

The following information is from Kai’s (1995) manual.

Ways of reducing stress in situations where there is no or little shared common language (Mares et al, 1985)

* Allow more time than you would for an English-speaking patient
* Give plenty of verbal reassurance
* Try to communicate some information about what’s going to happen next, even at a very simple level
* Get the patient’s name right
* Try to pronounce the patient’s name correctly
* Keep fuller case notes (this avoids subjecting the patient to repeated unnecessary or complicated questioning)
* Try to ensure that the patient always sees the same staff as far as possible
* Try to find out whether the patient has any specific fears or worries
* Write down any important points clearly and simply on a piece of paper for the patient to take away

Simplifying your English

To avoid confusing, patronising or offending patients it is important to adapt the following advice to individual’s needs (Mares et al, 1985)

* Speak clearly but do not raise your voice
* Speak slowly throughout (but not too slowly)
* Repeat when you have not been understood
* Use the words the patient is likely to know
* Be careful of idioms
* Simplify the form of each sentence
* Don’t speak pidgin English
* Give instructions in a clear, logical sequence
* Simplify the total structure of what you want to say in your mind before you begin
* Stick to one topic at a time
* Be careful when you use examples
* Use pictures or clear mime to help get the meaning across
* Judge how much people are likely to remember
* Be aware of your language (both verbal and non-verbal) all the time

Checking

Checking back should be done throughout the interaction (Mares et al, 1985)

* Try not to ask “Do you understand?” or “Is that alright?” You are almost bound to get “yes” for an answer
* Try also to avoid questions to which the hopeful/desired answer is “yes” – Phrase the question differently
* Ask the patient to explain back to you what he is going to do
* Do not take nods and other gestures or expressions at face value

Working with interpreters

This information is based on Kai & Briddon (1995) and their training manual for health care professionals working with interpreters and advocates.

*Before getting started the interpreter is asked to obtain the following:*

* The name and role of the health-care professional
* Date and time and probable duration of the consultation/interaction
* The name, age and sex of the client
* The context in which the consultation will take place e.g. to obtain informed consent
* The exact language and dialect spoken by the patient
* Whether any reading or written information is required to be translated
* Whether the relative or carer or advocate will be present

When interpreting, the interpreter is asked to:

* Observe confidentiality at all times
* Conduct himself/herself professionally
* Respect the values and practices of the health professional’s organisation
* Be attentive to the needs and wishes of the patient at all times, although the patient does not have the right to misuse the interpreter
* Respect the right of the patient to object to him or her as the interpreter. If this occurs the interpreter must inform the health-care professional
* Be aware that a female patient may be reluctant to share information with a male interpreter and vice versa but may not say this openly. An awareness of this possibility should prompt the interpreter to explore this appropriately
* Respect the rights of parents of children to be involved in care and decisions about the child as patient, but understand the rights of the child as paramount
* Interpret accurately and competently with sensitivity to the circumstances of the interaction
* Be competent in both languages, aware of emotional content, strength and force of words, the double meanings of specific words and be consistent in translation of common words
* Be aware of, and sensitive to, factors which vary among individuals and groups which may be relevant to health care, for example:
	+ Health beliefs and attitudes to illness
	+ Negative experience or fear of health services
	+ Stigma attached to particular problems (e.g. mental health)
	+ Fear of death
	+ Particular problems encountered by refugees and recent immigrants
	+ Socio-economic problems
	+ Fear of attack, harassment and victimization and other stressful situations
* Remain neutral, non-judgmental and not be biased by the class, gender, sexuality, political beliefs, religious beliefs or disabilities of the patient

Practical things to do when working effectively with interpreters (Kai & Briddon, 1995)

* Check the interpreter and the patient speak the same language and the same dialect
* Allow time for pre-interview discussion with interpreter in order to talk about the contents of the interview and the way in which you will work together
* Ask the interpreter to teach you how to pronounce the patient’s name correctly
* Allow time for the interpreter to:
	+ Introduce him/herself to the patient and explain his/her role
	+ Explain that the interview will be kept confidential
	+ Check whether he/she as an interpreter is acceptable to the patient
	+ Introduce you and your role to the patient
* Encourage the interpreter to interrupt and intervene during the consultation as necessary
* Use straightforward language and avoid jargon
* Actively listen to the interpreter and patient
* Allow enough time for the consultation
* At the end of the interaction check that the patient has understood everything and whether he/she wants to add anything
* Have a post-interaction discussion with the interpreter if appropriate

Things to remember

* The pressure on the interpreter
* The responsibility for the interaction is yours as the health-care professional
* Your power as a health-care professional – as perceived by the interpreter and the patient
* To show patience and compassion in a demanding situation
* To be aware of your own attitudes towards those who are different from you – including awareness of racism
* To be aware of your own shortcomings, for example not being able to speak the same language as the patient
* To show respect to the interpreter and his/her skills

Points to check if things seem wrong (Kai & Briddon, 1995)

* Does the interpreter speak English and the patient’s language fluently?
* Is the interpreter acceptable to the patient?
* Is the patient prevented from telling you things because of his/her relationship with the interpreter?
* Are you creating as good a relationship as possible with the patient?
* Is the interpreter translating exactly what you and your patient are saying or is he/she advancing his/her own views and opinion?
* Does the interpreter understand the purpose of the interview and his/her role?
* Have you given the interpreter time to meet the patient and explain what is going on?
* Does the interpreter feel free to interrupt you as necessary to indicate problems or seek clarification?
* Are you using simple jargon-free English?
* Is the interpreter ashamed or embarrassed by the patient or the subject of the consultation?
* Are you allowing the interpreter enough time?
* Are you maintaining as good a relationship with the interpreter as you can?

References and recommended readings

CLARK, W. (1995) Effective interviewing and intervention for alcohol problems (pp 284-293). IN LIPKIN, M., PUTNAM, S. M. & LAZARE, A. (Eds.) *The Medical Interview: Clinical Care, Education and Research.* Ann-Arbour, New York, Springer-Verlag.

FISHMAN, J. & FISHMAN, L. (2005) *History Taking in Medicine and Surgery,* Cheshire, PasTest Ltd.

- a useful source of relevant questions, but many will need adapting to more patient-centred style of interviewing

Hardt E. The bilingual interview and medical interpretation. In: Lipkin M, Putnam SM, Lazare A. eds. The Medical Interview: Clinical Care, Education and Research. NY: Springer-Verlag, 1995; 14 172-177.

HEARNE, R., CONNOLLY, A. & SHEEHAN, J. (2002-Feb) Alcohol abuse: prevalence and detection in a general hospital. *J R Soc Med,* 95**,** 84-87.

Helman CG. Culture, health and illness.2007, 5th edition.London: Wright.

HOCKING, G., KALYANARAMAN, R. & DEMELLO, W. F. (1998) Better drug history taking: an assessment of the DRUGS mnemonic. *J R Soc Med,* 91**,** 305-6.

Kai J. Valuing Diversity: A Resource for Effective Health Care of Ethically Diverse Communities. 1999, Royal College of General Practitioners, London.

Kai J & Briddon D. Working with interpreters and advocates. In, Kai J. Valuing Diversity: A Resource for Effective Health Care of Ethically Diverse Communities. 1999, Royal College of General Practitioners, London.

KNEEBONE, R. L. & NESTEL, D. (2005) Learning clinical skills - the place of simulation. *The Clinical Teacher,* 2**,** (2) 86-90.

LEWIS, T. (2004) Using the NO TEARS tool for medication review. BMJ 329**,** 434.

LIPKIN, M., FRANKEL, R., BECKMAN, H., CHARON, R. & FEIN, O. (1995) Performing the interview (ch 5, pp 65-82 : see pp 73). In LIPKIN, M., PUTNAM, S. M. & LAZARE, A. (Eds.) *The Medical Interview: Clinical Care, Education and Research.* Ann-Arbour, New York, Springer-Verlag.

LLOYD, M. & BOR, R. (2004) *Communication Skills for Medicine (2nd ed),* London, Churchill.

LONGMORE, M. WILKINSON, I. TURMEZEI, T. CHEUNG, C.K. (ed). (2007) *Oxford Handbook of Clinical Medicine (7th ed),* Oxford, UK, OUP.

Mares P, Henley A & Baxter C. Health care in multi-racial Britain. *Health Education Council / National Extension College:* 1985 Cambridge.

NESTEL, D. & TIERNEY, T. (2007) Engaging students in role-play activities: Developing evidence-based guidelines. *BMC Med Educ,* 7**,** 3

Queshi B. (2002) Diabetes in Ramadan. *Journal of the Royal Society of Medicine*. **95**(10):489-490.

Rosen J, Spatz ES, Gaaserun AMJ, Abramovitch H, Weinreb B, Wenger NS, & Margolis CZ. (2004) A new approach to developing cross-cultural communication skills. *Medical Teacher* **26**(2):126-132.

SILVERMAN, J., KURTZ, S. & DRAPER, J. (2004) *Skills for Communicating with Patients (2nd ed) (pp 57-105),* Oxford, Radcliffe Medical Press.

SILVERMAN, J., KURTZ, S. & DRAPER, J. (2004) *Skills for Communicating with Patients*

Skelton JR, Kai J & Loudon RF. (2001) Cross cultural communication in medicine: questions for educators. *Medical Education* 35:257-261.

SMITH, R. C. (2002) *Patient-Centred Interviewing: An Evidence-Based Method (2nd ed),* Philadelphia, Lippincott William and Wilkins.

SNADDON, D., LAING, R., MASTERTON, G. & COLEDGE, N. (2005) History taking (pp 1-37). IN DOUGLAS, G., NICOL, F. & ROBERTSON, C. (Eds.) *MacLeod's Clinical Examination.* 11th ed. London, UK, Elseiver Churchill Livingstone.

WASHER, P. (2009) How to take a medical history (Ch 3, pp18-25). In WASHER, P. *Clinical Communication skills.* Oxford, OUP.

WASHER, P. (2009) Talking with people from other cultures (Ch 8, pp59-66). In WASHER, P. *Clinical Communication skills.* Oxford, OUP.

Zabar S, Hanley K, Kachur E, Stevens D, Schwartz MD, Pearlman E, Adams J, Felix K, Lipkin M, Jr., Kalet A. *“Oh! She Doesn’t Speak English!” Assessing Resident Competence in Managing Linguistic and Cultural Barriers.* Journal of General Internal Medicine. 2006; 21:510–513.