Cross Cultural Communication: Patient's and Surgeon's Perspectives

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"The greatest problem with communication is the illusion that it has occurred."
- George Bernard Shaw

Diversity:

Mosaic is an art form which involves fitting small pieces of different types of materials such as rock, shell, tile, or glass. All these together create a pattern that is an artistic expressive seen in many cultures all over the world. In the same way human diversity is a mosaic representing people from a variety of backgrounds, styles, perspectives, values, and beliefs that is expressive of many global cultures.

When someone says diversity…what comes to mind? Is it differences in language, race or ethnicity? Diversity is more than skin deep, there are many facets to it, such as our age, gender, sexual orientation, ancestry, mental abilities and physical abilities. Many of these characteristics are aspects of diversity that we are born with. Then you add the layers of diversity such as geographic location, education, work income, family status, communication style, organization role and level, religion, which influences who we are. This is what makes each of us unique and different. All these facets affect communication as every encounter is an opportunity for cultural communication.

Culture:

Our belief systems, values, practices and assumptions that we are born with and acquire, define our culture and determine how we will interact and interpret the world. When we communicate with people who are culturally similar to us we have a sense of familiarity and security. Where there are differences it is an opportunity to acknowledge and respect differences, and value cross cultural communication. Cultural Competence in a clinical setting becomes evident when there is the ability of the patient and surgeon to establish interpersonal and working relationships that supercede cultural differences. To be able to communicate cross culturally in a medical setting one needs to have effective health communication and be aware of health literacy. This is the dissemination of understandable and usable information that concerns itself with health[1].

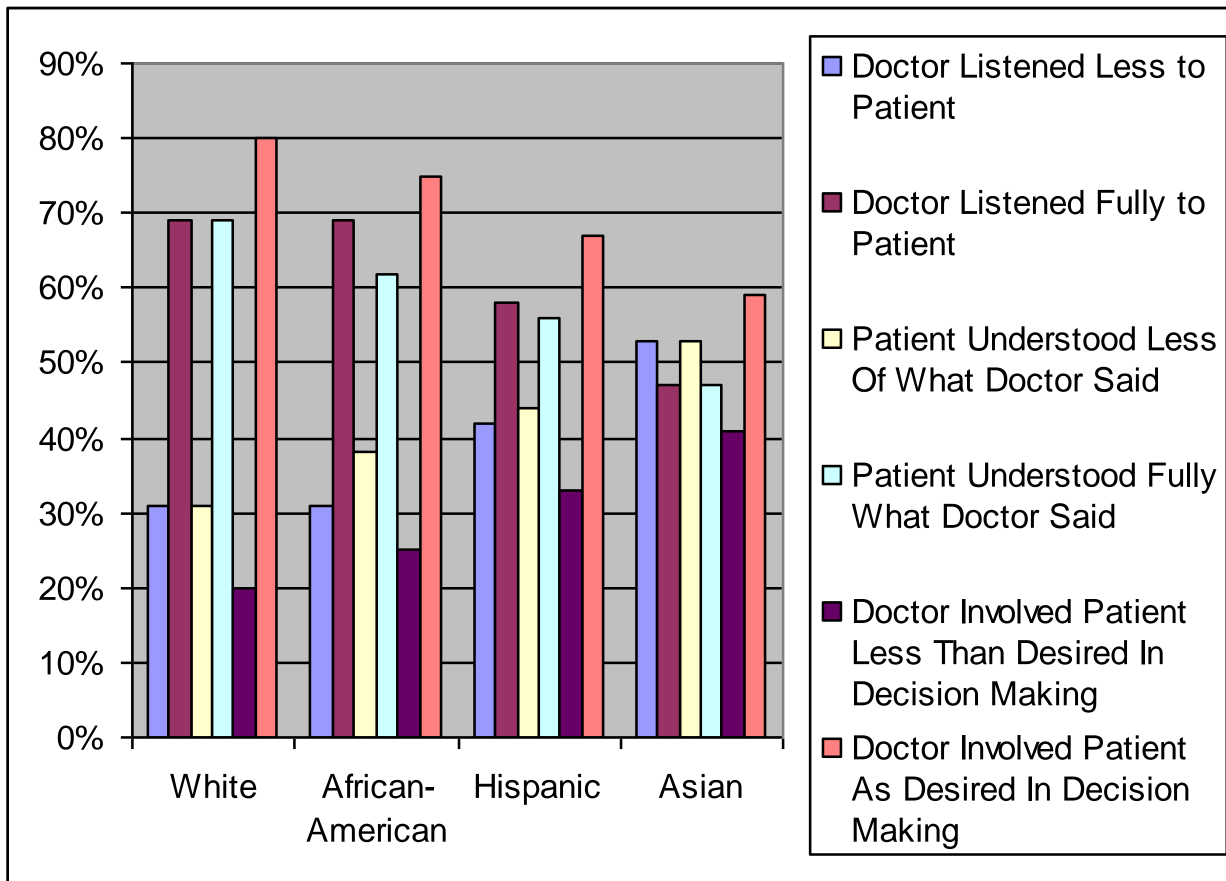
In focus groups done with different ethnic groups, patients said they wanted to have doctors who were competent, and showed respect. The need was not to have a doctor of the same culture but one who was caring. These are universal needs of any group.

What do patients say?

6,299 White, African American, Hispanic and Asian patients were interviewed on their health care experience in the United States[2]. Hispanic and Asians had different perceptions of the care they received than Whites and African American. They were more likely to feel that doctors did not listen to everything they had to say, and did not understand everything the doctor had to say. They also felt that the doctors did not involve them as they wanted, in decision making about their care and doctors did not spend adequate time with them. On the other hand African Americans felt that they were treated unfairly and disrespectfully. The questions that arise are what are the expectations of the different ethnic groups, of health care and what and how is it communicated to them. The gap is often differences in

[1] Calderón JL, Beltrán RA, MD, MBA , Pitfalls in Health Communication: Healthcare Policy, Institution, Structure, & Process, Medscape General Medicine. 2004;6(1):e7
[2] Johnson, RL et al, Racial and Ethnic Differences in Patient Perception of Bias and Cultural Competence in Health Care, J Gen Intern Med 2004 19(2) 101-110

communication. The effect of unconscious bias also comes into play also, both from patients as well doctors.



What do surgeons want?

Any surgeon will respond that from their perspective they want to see improved health, adherence to treatment regimen, and quality care for their patients. There is also the professional satisfaction in being able to communicate effectively and see the impact of it in improved health outcomes and patient safety.

How effective communication helps:

There are several benefits how communication improves health outcomes[3]. Patients make better decisions leading to appropriate use of services; they are more compliant to interventions and better apt to better self care. A positive patient and surgeon communication fosters better relationships which is vital for the healing process.

How poor communication hurts:

Poorer access to care, poorer quality of care, and poorer health outcomes. Studies suggest that functional health literacy is a more sensitive indicator of clinical health outcomes than the patient's simple ability to read words and according to this article[4] "Clinicians routinely underestimate the prevalence of limited health literacy among their patients and frequently overestimate the ability of individual patients to understand the information they provide to those patients. Awareness of the prevalence of limited health

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[3] Lockyear, PLB, Physician-Patient Communication: Enhancing Skills to Improve Patient Satisfaction http://www.medscape.com/viewprogram/3679, 2006 December 9

[4] Clinical Review, Medscape Nurses, November 2007

literacy in a clinician's practice, however, can allow the clinician to modify communication methods to match the needs of patients." The majority of adults (53 percent) had intermediate health literacy. About 22 percent had basic and 14 percent had below basic health literacy according 2006 National Center of Education statistics in their 2003 release of the National Assessment of Adult Literacy (NAAL) health literacy results[5]. Many patients complain that their physician does not explain their medical condition in words they could understand. Once the appointment is over, patients with inadequate health literacy may not know when to return or how to follow up on the visit[6]. Physicians and surgeons should be cognizant that often most patients are unwilling to admit that they have literacy problems. Literature reviews[7] show that 40% of patients do not adhere to treatment regimens e.g. if instructed to not to eat after midnight or 12 hours prior to surgery may interpret that it is alright to eat candy, chew gum or think alcohol is clear liquid. Many also misinterpret common instructions e.g. only 36% correctly interpreted every 6 hours. 50% leave doctors office not knowing what they have been told.

What do surgeons need to be effective?

Qualified interpreters, transcreated materials that are appropriate to the culture, qualified bi-lingual bi-cultural staff and providers, diversity and cultural competency trainings, easy carry on tools on PDAs and pocket cards.

Communication skills in the future may be monitored as part of quality control. Good skills lead to greater satisfaction with each encounter and overall practice efficient and safe. We need to adopt the change from physician knows best and patients accepting recommendations, to shared decision making.

What is ineffective?

Providing written materials at 12th grade level; deficient literacy occurs in 40% of persons over age 65, languages or learning challenged people, socially deprived and recent immigrants to US. Illiteracy rates among non-English-speaking Americans remain high. Various estimates indicate that 56% of Hispanic-Americans cannot read and 34% of Native Americans read at the 5th grade level or below[8]. Providing written materials in their native language appears to be of little use for many of these patients. In addition, even patients who are bilingual may not feel comfortable discussing sensitive issues using the English language. Many of these patients may not have a telephone, so even a toll-free telephone number may not be effective. Teenagers are not routinely reached with written information, but with other forms of communication such as television, radio, and their peers. Written information may be ignored, and teenagers may feel threatened or uncomfortable in the health care system, especially if they have an embarrassing medical problem.

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[5] Kutner M, et al Health Literacy of America's Adults Results from the 2003 National Assessment of Health Literacy http://nces.ed.gov/pubs2006/2006483.pdf, September 2006

[6] Safeer R S, Keenan J, Am Fam Physician 2005;72:463-8.

[7] Atreja A et al, Strategies to Enhance Patient Adherence: Making it Simple, Medscape General Medicine. 2005;7(1):4.

[8] Andrus MR, Roth MT, Pharmacotherapy 22(3):282-302, 2002

Recommendations:

Integrate patient-centered and culturally-appropriate communication into clinical practice.

Use simple everyday language, have patients repeat instructions, arrive at common understanding, provide information that the patients find pertinent. Encourage patients to share in decision making, and communicate with families, practice the 5As of communication: assess, advise, agree, assist, and arrange.

Understand patients by gathering information of their culture, respecting the cultural differences, and valuing the cross cultural encounters. Treat patients as they want to be treated not as you would want to be treated.

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