Diversity and Equality in Health and Care 2012;9:73–4

Practitioner's blog

Actions speak louder than words

Mary Dawood
Nurse Consultant, Emergency Nursing, Imperial College Healthcare Trust, London, UK

Siobhan O'Sullivan
Staff Nurse, St Mary's Hospital Emergency Department, Imperial College Healthcare Trust, London, UK

Cultural competence in healthcare describes the abilities of systems and individual practitioners to provide care for patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs (Bettancourt, 2002). It is well recognised that language plays a key role in human interaction, and lack of a shared language can be a major barrier to effective communication. This is a particular concern in healthcare settings, where linguistic barriers predispose patients and professionals to high levels of risk. Mutual understanding fosters trust, and both are essential for effective therapeutic relationships. Failure to recognise and acknowledge socio-cultural factors can lead to stereotyping, which can affect clinical decision making (Van Ryn and Burke, 2000).

Cultural behaviours have often been seen as a barrier to effective communication between healthcare professionals and patients. Schouten and Meeuwesen (2006) identified five key predictors of culture-related communication problems, namely cultural differences in explanatory models of health and illness, differences in cultural values, cultural differences in patients' preferences for doctor–patient relationships, racism/perceptual biases, and linguistic barriers. Cultural values and differences in explanatory models of health and illness may be much more subtle, and a greater barrier to communication than language. Such differences and the need for greater awareness and competence with regard to cultural values were highlighted recently in our unit when a young woman visiting the UK from the Middle East fainted while in a supermarket. She was brought to the emergency department by ambulance and was accompanied by numerous members of her family who were holding her and fanning her, and were very reluctant to leave her side.

The patient herself was distressed and dizzy, and despite the fact that there was no major language barrier, the doctor and nurse who were assessing her found it very difficult to obtain an accurate history or picture of what was happening as different members of the family volunteered their various versions of events. The patient's vital signs appeared to be within the normal range but, as she was vomiting, it was decided to give her some pain relief and something to stop her nausea. The family insisted on staying with her throughout. Both the doctor and the nurse who were caring for her found this situation difficult; in their view she needed rest and quiet, and the doctor wanted to examine her more fully. However, they were also very anxious not to upset the patient or her family, so they allowed the relatives to stay.

The patient was reviewed some time later, by senior staff, because she had not settled and her dizziness had worsened. A CT scan of her head revealed a brain haemorrhage. The nurse felt that the patient had not received the appropriate care as quickly as her condition demanded. With hindsight the nurse felt that she had allowed her need to be seen as culturally competent to take precedence over urgent and accurate assessment.

The family were understandably devastated by this news and very concerned that the CT scan had not been requested earlier. They certainly had no appreciation or awareness of the fact that their presence in such numbers or the intensity of their wish to remain with the patient had in any way impeded speedy diagnosis or made it more difficult for the doctor and nurse to do their jobs. As far as they were concerned they were behaving in a normal way by supporting their loved one and making sure that she was not left alone with strangers. The patient was in fact soon referred to the neurosurgeons and recovered, but the nurse was left with a feeling that she had not managed the situation to the immediate benefit of the patient.

Scenes such as this are not uncommon in healthcare settings, where there is often a mismatch between patients' cultural beliefs and practices and western medical imperatives. Delays in delivering appropriate treatment are sometimes due to language barriers rather than cultural issues, and the need to wait for an interpreter, but these are well-recognised and well-documented structural issues that are easily addressed and accommodated. Delivering appropriate care to

patients with diverse cultural needs is more complex, and requires a more empathetic response. Patients with diverse cultural needs are not a homogenous group, and they can be more vulnerable than those who only have linguistic needs. Cultural diversity is vast and infinitely variable; there is no blueprint for practice, and one size does not fit all. Furthermore, cultural diversity can be more stark and apparent in its presentation than language marking out such groups as 'different' and relegating them to the margins of society. Sadly, it is not unusual to see staff shying away, albeit subconsciously, from engaging with such diversity, due to either fear of offending sensibilities or feeling ill equipped to respond in a way that is culturally appropriate but also medically safe.

Cultural competence, which is an essential attribute for any health practitioner, is increasingly employed as a strategy to reduce and ultimately eliminate disparities in healthcare, ensuring quality care for all patient populations. Although life-saving interventions must take priority and must not be delayed in the face of diversity, in a culturally competent organisation these processes should operate in tandem. Bettancourt (2002) suggests that cultural competence can be achieved by focusing on three processes. First, healthcare providers must be made aware of the socio-cultural factors inherent in health beliefs and behaviours. Secondly, they must be equipped with the tools and skills necessary to manage these factors appropriately through training and education. Thirdly, and possibly most important of all, they must be able to empower patients and their carers to be active partners in the medical encounter. Moreover, cultural competence must be seen as a two-way street. The patient described above was probably not well enough to be an active partner in this encounter, but her family were clearly keen to be involved in her care. Misapprehensions on both sides were not managed in an effective way. When there is so much emphasis on language and the importance of interpreters in ensuring equality in healthcare, it is reassuring that staff are identifying more subtle but possibly more prevalent barriers to clinical cultural competence.

REFERENCES

Bettancourt JR (2002) *Cultural Competence in Health Care: emerging frameworks and practical approaches.* Field Report October 2002. New York: The Commonwealth Fund.

Schouten BC and Meeuwesen L (2006) Cultural differences in medical communication: a review of the literature. *Patient Education and Counselling* 64:21–34.

Van Ryn M and Burke J (2000) The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science and Medicine* 50:813–28.

ADDRESS FOR CORRESPONDENCE

Mary Dawood, St Mary's Hospital, Praed Street, Paddington, London W2 1NY, UK. Email: Mary.Dawood@imperial.nhs.uk