Communication in cross-cultural cancer care

Care involving health professionals and patients of differing culture and ethnicity is becoming more common in developed countries, including the UK. There is little evidence on the influence of ethnic diversity on clinical encounters in cancer care. Although cancer in general is less common in minority ethnic groups, its incidence is expected to rise in coming decades linked to lifestyle changes, such as those around diet and smoking (Wild et al, 2006).

Also, some cancers (notably prostate cancer in men with African heritage, and mouth cancers in South Asian people) are more common or have a worse prognosis and possibly a different natural history in some ethnic groups (National Cancer Intelligence Network, 2009).

Advice
There is no specific guidance on multicultural practice or the value of interpreters.

National Institute for Clinical Excellence (2004) cancer service guidance on supportive and palliative care states the importance to practitioners of developing communication skills. It suggests that professionals may lack the necessary skills to be able to communicate effectively with people whose preferred language is not English or Welsh and those from minority ethnic backgrounds and traditions.

Health professionals tend to perceive patients’ needs to be similar across ethnic groups.

Similar training needs are noted for communication with people who have hearing, sight, speech or combined sensory disabilities, and those with learning disabilities.

New evidence
A qualitative study explored health professionals’ experiences of caring for cancer patients from diverse ethnic communities (Kai et al, 2011). Data was analysed from 18

BOX 1. COMMENTARY: EVIDENCE BASE FOR COMMUNICATION SUPPORT

Mark RD Johnson, director of the UK Centre for Evidence in Ethnicity, Health and Diversity at the Mary Seacole Research Centre, De Montfort University, Leicester, and specialist adviser on ethnicity, equality and diversity, NHS Evidence, says:

“There is increasing recognition of the need to address issues of inequality in cancer care for minority ethnic groups, and Kai and his colleagues (Kai et al, 2011) have done the professionals a service in documenting some of the challenges involved here.

Their paper provides at least, and at last, an authoritative evidence base for an often-felt experience, and demonstrates as well, how additional expenditure (up front) on language support might be required to reduce longer-term costs or increased risks.

It is possible, on the basis of the data they present and other evidence (Centre for Maternal and Child Enquiries, 2011) to question whether interpreted “family” consultations should really be classed as “interpreter mediated” – the risks of poor translation or selective information transmission are high.

A clear distinction also needs to be drawn between consultations that are conducted through an appropriate professional interpreter and those where a bilingual professional is involved.

Using a child as a linguistic go-between, which is sometimes done, also raises issues of child protection.

Clearer guidelines on communication across languages are required. Few health professionals are trained to work with interpreters, even when they are available.

Kai et al’s paper highlights and provides high-quality qualitative evidence, robustly collected and assessed, to support their conclusions.

With continuing migration, the UK population is increasingly diverse and, as the NHS chief executive has stated, diversity sensitivity is “mission critical”.

A key element in health services provision is communication for care planning and to achieve concordance (or even medication adherence).

It is also important to note that Kai’s informants stated that they found working across cultures was stimulating and rewarding, and it enriched their practice.”
focus groups involving 106 participants from both primary and acute care. The results showed that health professionals perceived patients’ needs to be generally similar across ethnic groups, whatever their background.

However, they encountered a range of challenges, particularly involving third-party interpreting. The health professionals felt that relatives’ approach to ownership of information and decision making could hinder assessment, informed consent and discussion of care with patients.

Using independent trained interpreters did not necessarily solve the problems raised. The findings suggest that bilingual workers might underestimate psychological concerns, and there is a need to support them in handling complex information and breaking bad news.

Even when English was spoken by both parties, gauging non-verbal communication and cultural differences in expression and perception could lead to misunderstanding. Language interpreters also play a role as cultural awareness mediators.

The study suggests a need for increased awareness and understanding of cultural and individual variations in concepts such as patient centeredness, patient autonomy, and how families might approach disclosure and decision making. The researchers conclude that the extent to which these concepts may be ethnocentric and lack universality deserves wider consideration. NT

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References


