

Transcultural communication and ethnic comparisons in the experience of services

The General Medical Council (GMC) emphasises putting patients at the centre of practice and good communication skills are essential for clinical practice to be patient-centred.¹ Reflecting this, three out of the GMC's 15 'duties of a doctor' specifically relate to communication: namely to listen to patients and respect their views; give patients information in a way they can understand and respect the rights of patients to be fully involved in decisions about their care.² There has been a concurrent increased interest in patient evaluations of both practitioners and services. Patient evaluations of GPs form one component of mandatory 'GP appraisal'. Surveys asking patients about their experience and satisfaction are increasingly used to evaluate services. A number of different measures of patient satisfaction and service experience have been developed.^{3,4} These cover factors seem to be core features of quality of primary care, such as access, technical skills, communication, interpersonal care, patient-centredness, continuity and trust. While overall levels of satisfaction are high, a number of studies have reported less positive experiences and lower satisfaction with primary care services among those from ethnic minorities.^{3,5}

In the Journal this month Ogden and Jain's study of patients' experiences found that Vietnamese patients reported more positive experiences of services than either white or black patients.⁶ The positive findings of the study should be seen in the context in which the study took place. The study setting was a single general practice, which was sufficiently interested in the service they were providing to ethnic minorities to take on a research project in this area. The authors point out that the practice served relatively large numbers of patients from one ethnic group and that there was an in-house interpreter. Thus, the findings may not reflect the experience of Vietnamese patients in other dissimilar settings. However, the

findings in relation to these Vietnamese patients are encouraging in that they suggest that it is possible for GPs to provide a 'satisfactory' service to members of linguistic minorities. While others have proposed that expectations regarding services may influence self-reported perceptions of 'satisfaction', Ogden and Jain's study is the first to provide empirical data to support this hypothesis. The inclusion of reliable measures of patient expectation within satisfaction surveys should go some way towards making the findings of patient 'satisfaction' surveys more transparent. The interpretation of findings relating to 'experience' and 'expectation' regarding services is, however, rendered more complex if one considers the potential role of past experience in shaping expectations. Deficiencies in the provision of interpreting across the NHS are well documented.⁷ Vietnamese responders' lower expectations may be shaped by poorer past experiences in other NHS or public services.⁸ If so, Ogden and Jain's findings could simply reflect that the quality of the service provided by this general practice was higher than that provided elsewhere (and hence expected).

Other factors that may influence experience of services include differences in quality of services, differences in the appropriateness of services, differences in reporting (such as willingness to complain or praise) and differences in health needs. It is of concern that measures which are increasingly used to evaluate services do not take into account the many factors that may influence findings. Equity in service provision is an important concept. In particular, equity in provision can allow for different or greater needs in some groups. If valid conclusions are to be drawn regarding equity in provision, measures developed must consider these additional factors.

In considering the variations in experiences of services a whole range of factors have been proposed as relevant including: ethnocentrism, racism, and the

distribution of healthcare resources.⁹ Communication may play an important role in the perceived quality of services. Good communication skills are considered to be a core feature of high quality general practice. GPs are particularly encouraged to elicit patient views regarding their health and health treatments.¹⁰ Communication skills are now explicitly taught within most undergraduate curricula. Within the multiethnic environment of modern Britain transcultural communication has also received attention¹¹ and some medical schools are seeking to incorporate intercultural communication within communication skills training.

Where the doctor and patient are from a similar cultural background beliefs regarding health or health care may already be shared, or at least known. For example, a white doctor working in general practice in the UK would be familiar with white elderly patients' requests for a 'tonic' and would have some existing understanding of why this might have been requested. They would also have some understanding regarding what was implied when the same patient reported feeling 'under the weather' or having a 'chill' and would know the range of ways in which these kinds of complaints are self-managed. A GP who is a good communicator will draw on such tacit cultural knowledge to frame responses and advice in a way that is both acceptable and understandable to the patient. Mutual understanding thus both predates and ensues from such a consultation.

Such a process becomes more complex when patients are from a different cultural or sub-cultural group to the doctor. Patients from a different ethnic group to the doctor may hold health beliefs that are not familiar to the doctor. Furthermore, patients may be of the same ethnicity as their doctor but hold beliefs that are counter to medical belief system, which they may therefore be reticent to report.¹² Such patients also self-manage complaints and medicines, but

without the doctor understanding the basis on which they are doing this.

In Connell *et al*'s qualitative study,¹³ the key beliefs that influence black African Caribbean peoples self-management of hypertension are outlined. A key role of qualitative studies within health services research could be to inform clinicians about cultural and sub-cultural beliefs that influence health, health behaviour and healthcare seeking behaviour, especially beliefs that may not be familiar to the clinician. Qualitative research can elicit views from patients that they might not raise within the consultation, allowing doctors to understand health and health-seeking behaviour and to tailor their own health advice accordingly. Connell *et al*'s paper is a prime example of how qualitative work could inform clinicians. In principle, this should enable clinicians to tailor their advice in the knowledge of their potential beliefs and practices. Yet the publication of similar findings 17 years ago suggests that such beliefs are deeply held.¹⁴ It also suggests that clinicians may not have addressed the relevant beliefs and practices in their advice to black African Caribbean patients regarding hypertension following the earlier publication.¹⁴ This may partly be a problem of dissemination in that the earlier paper was published in a journal unlikely to be read by most GPs. It may also reflect the difficulty in changing clinician behaviour and influencing patients beliefs and behaviour.

How to encourage clinicians to incorporate research findings into routine practice is a question that is only partially answered. Harmsen *et al*'s paper¹⁵ suggests that interventions regarding transcultural communication need to be directed towards both patient and clinician for change to occur. They report on the findings of their

randomised controlled trial aiming to improve transcultural communication. The intervention encouraged patients to voice misunderstandings and disagreements. It also provided intercultural training comprised of reflecting on one's own culturally determined views and increasing sensitivity and information about patients' cultural beliefs. A benefit in the primary outcome 'perceived mutual understanding' was demonstrated at 6 months as well as one of the secondary outcomes 'perceived quality of care'. These findings are encouraging and suggest that improvements in transcultural communication are possible.

Thus, the studies in this month's Journal^{6,13,15} give some cause for greater optimism regarding transcultural communication and the means to improve this. The ethnically diverse nature of many countries renders effective undergraduate and postgraduate training in transcultural communication important. Some studies suggest that interventions directed towards patients in encouraging greater assertion during consultations improved diabetic control and blood pressure.¹⁶ Future randomised controlled trials could usefully assess the impact of improved transcultural communication on compliance or biological outcomes. Robust evaluation of the links between patient evaluations regarding quality of primary care and compliance or biological outcomes also remain, largely, uncharted territory.⁴

CAROLINE FREE

*Clinical Lecturer in Epidemiology and GP,
London School of Hygiene and Tropical Medicine*

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ADDRESS FOR CORRESPONDENCE

Caroline Free

*Clinical Lecturer in Epidemiology and GP,
London School of Hygiene and Tropical
Medicine, Keppel Street,
London WC1E 7HT.*

E-mail: caroline.free@lshtm.ac.uk

National Programme for IT: the £30 billion question

The National Programme for IT (NPfIT) for health and social services in England has an anticipated cost of around £30 billion. The world's largest ever IT project aims to

provide 'Better information for health, where and when it's needed'. The core strategy is 'to take greater central control over the specification, procurement,

resource management, performance management and delivery of the information and IT agenda'.¹ Its top priorities are listed in Box 1.¹ Few would