



Research paper

“Both sides now”—A scale for assessing health care providers’ intercultural communication comfort regarding traditional and non-traditional palliative care

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ABSTRACT

Introduction: Interacting with patients and families from cultures who hold differing views on health and illness involves increased feelings of strangeness and decreased feelings of familiarity. The purpose of this study was the development of the ‘Intercultural Palliative Care Comfort’ (IPCCC) scale and evaluation of its psychometric properties.

Method: The design of this component of the research is scale development. The IPCCC was administered via web survey to 598 clinical staff at one urban acute hospital in New Zealand.

Results: Exploratory factor analyses revealed two primary factors, which accounted for 62% of the variance: Traditional Palliative Care Topics ($\alpha = 0.98$); Non-Traditional Palliative Care Topics ($\alpha = 0.95$). Multidimensional scaling (MDS) was used to triangulate these results. Construct validity was supported.

Conclusion: The IPCCC shows promise in identifying areas of concern particularly in assessing communication comfort in dealing with Non-Traditional (religious and cultural) aspects of culturally safe and culturally competent care.

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1. Introduction

Differences between patient and health professional based on culture can create barriers to effective communication [1]. Culture, within this context, is here defined as “a historically transmitted pattern of meanings embodied in symbols” [2] (p. 89). Culture depends on ‘shared meanings’ which in practice extend well beyond the usual ethnic, racial and gender denotations. A lack of cultural awareness of diverse groups can therefore have profound implications for the quality of palliative care delivery. As noted by Durie [3] “the capacity to embrace other cultures in a confident manner could make the difference between good outcomes and treatment failures.” To help address this need, the current study sought to investigate the psychometric properties of an Intercultural Palliative Care Communication Comfort Scale (IPCCC), trialled in the New Zealand context, whose properties might also be

potentially generalizable to other contexts where overlapping cultural worldviews coexist.

1.1. Communication and culture

Effective communication between health providers and patients lies at the heart of patient-centred care [4]. Communication is likely to be influenced by contexts, settings and patient and provider characteristics (e.g. the doctor-gender preferences of patients) [5]. Gaps in knowledge about different cultures and lack of skills in intercultural communication create barriers to effective palliative care delivery [6]. This is particularly important in a globalized environment where intercultural interactions have increasingly become the norm, not the exception.

Attributions for health and illness reflect a culture’s general value orientations [7]. For example, persons in Western cultures, are often individualistic, and generally believe that the origins of illness are rooted in the individual patient [8]. In contrast, in many non-Western cultures (inclusive of those groups represented in this study) illness is often attributed to societal and/or supernatural conditions [9]. Interacting with patients and families from cultures that differ from self and who hold differing views on health and illness involves increased feelings of strangeness and

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decreased feelings of familiarity [10]. Such situations can produce high levels of discomfort and anxiety [11]. Intercultural communication competence is “the knowledge, motivation, and skills to interact effectively and appropriately with members of different cultures” [12]. Barna [11] indicated that to be competent in intercultural communication, individuals must be able to deal with the discomfort that is one of the barriers to effective intercultural communication.

At a practical level, lack of comfort in intercultural communications can impact on the quality of patient care [13,14]. Research by Ulrey and Amason [15] found a negative relationship between healthcare providers' intercultural communication effectiveness and their levels of anxiety Kai et al. [16] concluded that health professionals' uncertainty in cross-cultural communication contributed to feelings of disempowerment. Disempowerment in turn created hesitancy and inaction in health professionals' clinical approach, to the potential detriment of patients [16]. The impact of this hesitancy comes into sharp focus in end-of-life care. Uncertainty and discomfort may lead to the substitution of stereotypes and assumptions about patient wishes, leaving important issues unaddressed [17]. A study by Frey et al. [6] for example, found that physicians provided limited information about hospice based on the assumption that “they” (Māori, Pacific, Asians) would not use the service.

Identification of areas of uncertainty in intercultural communication is an important first step towards enhancing professionals' experience of working with diversity, as healthcare professionals' discomfort in cross-cultural communication can contribute to ethnic disparities in healthcare access [16]. Thus the availability of an instrument with demonstrated reliability and validity may aid in the development of evidence-based educational interventions that best match the needs of students and healthcare professionals.

1.2. Existing measures

Numerous studies have examined cultural competence in end-of-life communication [18–20]. Competence tools identified within the literature consist of measures of motivation, cultural knowledge and intercultural skills [12,21]. Likewise a number of studies have examined healthcare professional competence in palliative care communication, [22–24]. some of which also examined anxiety (including death anxiety) in palliative and end-of-life communication [25,26]. Only one study was located that included a separate measure of anxiety in intercultural communication [15]. No study has been located which specifically measures health professional comfort in intercultural communication within a palliative care context.

1.3. The New Zealand context as prototype

Aotearoa/New Zealand, historically a bi-cultural society, reflects the worldviews of both European and Māori—partners to *te Tiri o Waitangi*/the Treaty of Waitangi. Māori, the *tangata whenua* (indigenous peoples) of New Zealand, often experience dissonance between the nature of the care and support they would prefer at the end-of-life and the current provision of specialist palliative care services. Like other industrialised societies, New Zealand is also becoming an increasingly multicultural [27]. Although a large proportion of the New Zealand population identify as European (67.6%), it is predicted that over the next two decades the proportion of people identifying as Māori, Pacific and Asian will dramatically increase [28]. Currently the next most populous ethnic groups are Māori (14.6%), Asian (9.2%)—representing East, South East and Southern Asia (e.g. China, Malaysia, Thailand, India), and Pacific Peoples (6.9%)—the majority consisting of

Samoan, Cook Island Māori and Tongan [29]. By 2026 Māori (16%) and Asian (16%) and Pacific Peoples (10%) groups are projected to grow faster than the New Zealand population overall [28]. Moreover, the numbers of older people (65+) within these groups are set to rise sharply over the next twenty years [30]. It has been estimated that 78% of people dying with conditions known to benefit from a palliative care approach are aged over 65 years, with approximately 25% of these in turn being over 85 years [31]. Further adding to this diversity is an increased reliance on overseas trained health professionals. In fact, New Zealand has the highest proportion of overseas trained doctors among OECD countries, and one of the highest for nurses [32].

Identification of areas of discomfort in intercultural communication is a first step to enhance professionals' experience of working with diversity. Raising awareness may encourage self-reflection regarding cultural views and response to discomfort. The availability of an instrument with demonstrated reliability and validity may aid in the development of evidence-based educational interventions that best match the needs of both students and healthcare professionals [33].

1.4. Aim

The aim of the current study was to investigate the psychometric properties of the Intercultural Palliative Care Communication Comfort Scale.

2. Methods

This research utilised data generated from Phase Two of a larger project that explored palliative care need and management amongst inpatients in one acute hospital. Key to appropriate palliative care management in hospital settings is ensuring an adequately trained workforce [34]. Phase Two of the project therefore examined clinical staff education needs regarding palliative and end of life care management, as well as perceptions of barriers to and facilitators of good palliative care provision within the hospital. Included among the barriers explored was comfort with cross-cultural communication. The project received ethical approval from both Northern X and the relevant District Health Board (DHB).

2.1. Study design

The broader research utilised a case study design in one New Zealand acute hospital. The particular District Health Board selected serves a culturally and ethnically diverse population. The design of this component of the research is scale development. Instrument construction and evaluation are presented in two parts. Part One, presents the instrument item selection and scale construction. Part Two presents the psychometric evaluation of the final instrument.

2.2. Measurement

The IPCCC is designed to measure healthcare clinicians' level of comfort in palliative care communication with four distinct cultural groups. The items assess comfort in palliative care related communication with patients who self-identify as belonging to one of four ethnic groups. These groups are representative of the patient population within New Zealand society. Clinicians were asked the following question:

Please rate (not very comfortable to completely comfortable) your level of comfort with discussing the following issues with patients and/or their family who identify themselves as, or who you identify as: (cultural group).

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