



Communicating with patients from minority backgrounds: Individual challenges experienced by oncology health professionals



Kaaren J. Watts ^a, Bettina Meiser ^{a, *}, Elvira Zilliaccus ^a, Rajneesh Kaur ^a, Mona Taouk ^a, Afaf Girgis ^b, Phyllis Butow ^c, David Goldstein ^d, Sandra Hale ^e, Astrid Perry ^f, Sanchia K. Aranda ^g, David W. Kissane ^h

^a Prince of Wales Clinical School, The University of New South Wales, Sydney, NSW 2052, Australia

^b Centre for Oncology Education and Research Translation, Ingham Institute for Applied Medical Research, South Western Sydney Clinical School, University of New South Wales, Sydney, NSW 2170, Australia

^c Psycho-Oncology Co-Operative Research Group, Centre for Medical Psychology and Evidence-Based Decision-Making, The University of Sydney, NSW 2006, Australia

^d Prince of Wales Hospital, Sydney, NSW 2031, Australia

^e Faculty of Arts and Social Sciences, University of New South Wales, Sydney, NSW 2052, Australia

^f Multicultural Health Service, South Eastern Sydney Local Health District, Sydney, NSW 2217, Australia

^g Cancer Council Australia, Sydney, NSW 2000, Australia

^h Department of Psychiatry, School of Clinical Sciences at Monash Health, Monash University, Clayton, Victoria 3168, Australia

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ABSTRACT

Purpose: Oncology health professionals (HPs) are increasingly required to care for patients from minority backgrounds. Yet many HPs have not had formal training in how to communicate effectively in culturally diverse settings. More information is needed about the challenges that oncology HPs face in communicating with minority patients to inform the content of formal training programs. This qualitative study aimed to identify oncology nurses' and oncologists' individual experiences and challenges in communicating with patients from minority backgrounds.

Method: Thirty-eight oncology HPs (21 oncology nurses, 12 medical oncologists, and 5 radiation oncologists) were interviewed individually or in focus groups about their experiences communicating with patients from minority backgrounds. The interviews were audio taped and analysed thematically.

Results: The majority of participants (82%) reported varying degrees of uncertainty and discomfort regarding working with minority patients, with many barriers to communication encountered. Participants perceived that minority patients received less emotional support than majority group patients. They experienced challenges in balancing beliefs about patient autonomy with cultural differences regarding the role of the family. Strategies employed by participants to facilitate interactions included: modifying speech, taking more time in consultations, rapport building, and using nonverbal techniques. **Conclusions:** Oncology HPs encounter many linguistic and cultural barriers when communicating with minority patients. They need formal training tailored to developing culturally competent communication. Oncology nurses and oncologists could benefit from formal communication skills training focused upon cultural competence during their career development programs.

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1. Introduction

Global rates of immigration are increasing worldwide (United Nations Department of Economic and Social Affairs Population Division, 2013). Australia is one of the most culturally diverse nations in the world with more than one in four residents born overseas (26%). In 2011, after the United Kingdom (21%) and New Zealand (9%), in Australia the most common countries of birth for

* Corresponding author. Psychosocial Research Group, Prince of Wales Clinical School, Level 4, Lowy Cancer Research Centre C25, University of New South Wales UNSW, Kensington, NSW 2052, Australia.

E-mail address: b.meiser@unsw.edu.au (B. Meiser).

people born overseas were China (6%), India (6%) and Italy (4%). The most common languages (other than English) spoken in Australian homes were Mandarin, Italian, Arabic, Cantonese and Greek (Australian Bureau of Statistics, 2012). Other developed nations also have substantial migrant populations including New Zealand (23%), Canada (21%), the United States of America (13%) and the United Kingdom (13%) (Australian Bureau of Statistics, 2014). As a consequence, in the health care context, the sociocultural profile of both patients and health professionals (HPs) are changing and are becoming increasingly diverse in these nations. For example, in Australia in 2011, 33% of nurses and 47% of specialist doctors were born overseas compared with 25% and 37%, respectively, in 2001 (Australian Bureau of Statistics, 2013). Health care providers are, therefore, increasingly required to deliver services that are culturally competent given that many of their patients will be from a background different to their own (Butow and Baile, 2012).

Compared to individuals from majority cultural groups, individuals from cultural and linguistic minorities have poorer cancer outcomes including lower survival rates, higher rates of reported side-effects, and poorer patient quality of life (Butow et al., 2013; Chu et al., 2007; Krupski et al., 2005). The disparities in cancer outcomes for minority patients may arise because of language and communication barriers, culturally divergent beliefs and attitudes about cancer and treatment, cultural isolation and alienation, and/or difficulties navigating the health care system (Butow et al., 2011b; Goldstein et al., 2002). Therefore, while cancer presents a major challenge to all people, it is likely that minority patients have unique difficulties in accessing equitable care.

In particular, minority patients with cancer struggle to communicate with their health care team and often do not understand the information imparted to them (Butow et al., 2011b; Kwok and White, 2011). Oncologists often face challenging conversations with patients relating to prognosis, change in care goals, or transition to palliative care (Epner and Baile, 2014). Oncology nurses also play a major role in communicating with patients, and it is widely acknowledged that skillful communication is an important element of providing quality nursing care (Huang et al., 2009). Nurses working with cancer patients who are not fluent in English report deep concerns about patients' lack of understanding of their diagnosis or the complexities of treatment (Richardson et al., 2006). Language and cultural barriers encountered by nurses caring for cancer patients from minority backgrounds can also encourage a short, task-oriented nurse-patient interaction rather than a comprehensive care episode (McKenzie et al., 2015).

However, effective communication with minority patients and their families is not always easy. In several studies, the most common patient characteristic reported to present challenges, reported by 39% of nurses and 43% of physicians working in oncology settings, was dealing with cultural and linguistic differences, communicating through an interpreter, and responding to patients who speak poor English (Fallowfield et al., 1998; Fallowfield et al., 2001). Greater recognition has been emerging of the need for culturally-sensitive communication. Culture influences the way people affected by cancer attach meaning to the disease and how they respond to it (Kagawa-Singer, 2011), and the way patients, families and HPs communicate in the cancer setting (Surbone, 2008). At a minimum, an awareness of the potential for cross-cultural differences is essential to comprehensive cancer care (Butow and Baile, 2012). Cultural competence includes knowledge, skills and attitudes that are needed for effective cross-cultural communication in clinical settings. These can be acquired through training (Surbone, 2008). Yet nurses and other oncology HPs report having little or insufficient training to communicate competently and sensitively with patients from minority backgrounds (McKenzie et al., 2015; Morgan et al., 2015).

There are several e-learning tools available that provide modules designed to teach optimal communication skills for HPs in any setting (MD Anderson Cancer Center, 2016) and cultural competence among oncology HPs (ASCO University, 2015). However, the optimal method for learning communication skills is a simulated environment where learners have the opportunity to engage in role playing challenging interactions with patients or actors (Butow and Baile, 2012). To our knowledge, there are limited experiential and web-based resources available, which are designed to develop culturally competent communication skills specifically targeted to the needs of oncology HPs. The first step in developing the content and format of such training is to identify the individual and organisational challenges experienced by oncology HPs in working with minority patients and then to target training content to address these issues. This qualitative study aimed to identify the confidence of oncology nurses and oncologists in working with minority patients, the barriers and enablers that they experience in communicating with these patients and their families, with a focus on *individual* challenges and the strategies HPs use to overcome these difficulties. The study also aimed to identify the *organisational* challenges and training needs of oncology HPs in relation to working with minority patients including issues related to working with interpreters, and these findings will be reported elsewhere.

2. Methods

Between May and October 2013, oncology nurses, medical oncologists, and radiation oncologists working in Australia were invited to participate in this qualitative study by email through relevant nursing and oncology professional organisations. Because invitations were emailed, it was not possible to ascertain what proportion of HPs elected not to opt in to the study. In addition, EZ presented an overview of the research at oncology grand rounds at a major public teaching hospital in Sydney (New South Wales), where oncology nurses and oncologists were also invited to participate. Written consent was obtained from each participant. The study protocol was approved by the human research ethics committee of the University of New South Wales.

3. Data collection

Depending on the participant's preference, telephone or face-to-face semi-structured interviews or focus groups were conducted (by EZ). After an extensive literature review and expert consultation, an interview schedule was designed to guide the interviews and focus groups, while leaving wording and the sequencing of questions open. The schedule is included as [Supplementary Materials](#). Questions explored participants' understanding and awareness of minority issues, perceived barriers and enablers to effective communication with minority patients, communicating about cancer diagnosis, treatment prognosis and end-of-life issues, working with interpreters, and HPs' perceptions of training needs in this area. Prior to each interview or focus group, participants completed a demographic questionnaire including seven items relating to: country of birth, professional occupation, number of years of experience in oncology, which cultural group the participant identified with, whether English was their first language, and what languages (in addition to English) they could speak and/or spoke at home.

4. Data analysis

Interviews were audio-taped, transcribed verbatim and analysed thematically using a constant comparison approach to develop an agreed set of codes and categories. The analysis was

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