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Teaching intercultural communication skills in healthcare to improve care for culturally and linguistically diverse patients

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ABSTRACT

Objective: To provide recommendations for adequately training healthcare providers in intercultural communication skills.
Discussion: We discuss three main recommendations concerning intercultural communication skills training. First, we give an overview of the fundamental skills in which healthcare providers should receive training, such as self-awareness and adaptability. Second, we briefly discuss how such training should be delivered, and focus on different language support methods, including those that work with different types of interpreters and digital tools. Third, we discuss how within-group differences can be taken into account to prevent stereotyping. To illustrate these recommendations, we provide certain examples of existing good practices and interventions.
Conclusion: In today's superdiverse societies, delivering culturally and linguistically sensitive healthcare tailored to the needs, values, and preferences of individual patients is a prerequisite for good quality healthcare communication. To achieve this goal, there is a need for clearer recommendations for affirmative action, guidelines, policy, and support for the topic of diversity sensitivity in healthcare, such as evidence-based interventions, than is currently the case. That is, structural changes on a system level are urgently needed to support healthcare providers to implement diversity sensitivity in their daily clinical work.

1. Background

Due to increased migration, there are currently about 282 million international migrants worldwide, which is three times higher compared to 1970 [1]. This unprecedented increase has led to such complex societies that the notion of superdiversity was introduced [2] to ensure justice to the newly emerged demographic and social patterns. These patterns surpass traditional group-based categorizations of ethnicity, which are, for instance, based on the country of birth, and take into account the dynamic interplay of a multitude of variables that exist on an individual, social, and system level affecting how people function in a certain society at a specific time. This diversity, which takes into account the multi-layeredness and complexities within migrant subgroups, has not yet been widely taken up in the field of intercultural health communication, even though adequate intercultural communication in healthcare has grown to be an increasingly challenging task in such superdiverse societies. Previous research has already abundantly indicated that medical consultations between healthcare providers and migrant and ethnic minority patients tend to lead to worse communication processes and outcomes compared to those between healthcare providers and patients belonging to the same majority groups [3]. For instance, migrant and ethnic minority patients ask fewer questions, have a reduced understanding of their illness, are less adherent to treatment recommendations, and have higher rates of misdiagnoses compared to ethnic majority patients [3–6]. In addition, healthcare providers have indicated a need for more training to acquire the cultural skills and knowledge required to enable better care delivery to migrant patients [7]. Factors contributing to the challenges in intercultural communication are individual patient-related factors, such as specific health and illness beliefs [8], individual provider-related factors, such as a conscious or unconscious bias toward minority patients [9], and social and system-related factors, such as a lack of interprofessional dialogue and the financial resources required to call in professional interpreters to mitigate possible language barriers [10]. To promote health outcomes for migrant and ethnic minority patients and reduce existing health inequalities, such as their lower levels of access to healthcare and poorer

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health behavior [11], it is crucial to improve the intercultural communication process by training all categories of healthcare providers in intercultural communication skills while taking into account the dynamic interplay of variables put forward by the concept of superdiversity. In the following sections, we will elaborate on three main recommendations based on theoretical and empirical knowledge about how to adequately train healthcare providers in intercultural communication skills and improve the intercultural communication process and its outcomes for culturally and linguistically diverse patients.

2. Recommendations

2.1. What should we teach to improve healthcare providers' intercultural communication skills?

Communication with culturally diverse patient populations should be patient-centered and culturally competent. Patient-centered care is commonly understood as care that considers individual patients' needs, values, and preferences to arrive at a collaborative and egalitarian alliance between healthcare providers and patients where power and responsibility are shared [12]. Although there is debate regarding what the concept of cultural competency should entail, most definitions do incorporate the "ability to work and communicate effectively and appropriately with people from culturally different backgrounds" [13, p. e120].

Based on the concepts of patient-centeredness and cultural competency, various frameworks and models have been developed, which include the cultural competency framework [14] and the culturally competent communication model [CCC; 15]. The CCC formulates four fundamental elements of culturally competent healthcare required to meet the core goals of medical communication, namely, fostering a relationship with the patient, gathering and providing information, and responding adequately to patients' emotions [16]. Specifically, healthcare providers need to be trained in numerous basic verbal and nonverbal communication skills, situational and self-awareness, adaptability, and knowledge about cultural issues [15]. Basic communication skills include showing empathy and respect, attentively listening, obtaining sociocultural aspects of patients' illness experiences, and eliciting patients' preferences, which are, in essence, part of patient-centered care. Self-awareness refers to healthcare providers being aware of their own cultural identity, beliefs, and biases to enable a sound understanding of their own expectations and behaviors. For instance, the beliefs people have about end-of-life care are to a large extent based on cultural values and being made aware of this may contribute to a better understanding of other perspectives on this topic, which can ultimately improve the intercultural communication process. While self-awareness is a precondition for delivering culturally competent care, situational awareness, which is quite similar to the concept of mindfulness [17], is needed to be able to properly respond to the needs of a given patient at a specific time. That is, healthcare providers should be aware of all the nuances of the interaction with the patient, such as attending to the patient's tone of voice, using silence, and other para-lingual and nonverbal communicative elements, and adjust their behavior accordingly to fulfill the needs that underlie these patient cues. Similarly, as individual patients within migrant and ethnic minority groups may display a wide variation in their expectations and beliefs, healthcare providers should be able to tailor their communicative behaviors to the beliefs and expectations of the individual patient. For instance, even though shaking hands may be interpreted as a polite welcoming gesture by some Muslim women, it may also be perceived as a sign of disrespect by other Muslim women. Finally, of particular importance is the notion that rather than acquiring knowledge about specific migrant group characteristics, which may lead to stereotyping, healthcare providers should obtain knowledge about how stereotyping works, how it may impact the interaction and how to counteract it. Furthermore, to be alert to possible cultural differences, healthcare providers need to know about cultural issues, such as beliefs about gender and family roles, power and authority, verbal and nonverbal communication modes, religious beliefs, and explanatory models of illness and health. For instance, many health concepts, such as pain and depression, do not have a direct translation into another language and/or are not expressed and understood in the same manner across different cultures [18]. Therefore, clinicians should always strive to explore patients' explanatory models of illness and health, which refer to the culture-bound explanations one gives to an illness episode and acceptable treatment options [8], to ensure that mutual understanding with the patient is achieved.

To achieve effective healthcare communication with culturally diverse patients who do not speak their clinician's language or not sufficiently, several language support methods are available to overcome the language barrier (see for a brief overview, [19]), of which working with professional interpreters and intercultural mediators is the gold standard. These professionals are preferably integrated into the medical healthcare team and are specifically educated to provide medical interpreting services. Previous research has shown that compared to non-professional interpreters, professional interpreters provide a better service in terms of translation quality [e.g., 20]. Training should entail both interpreters and healthcare providers and students of these disciplines working with each other.

However, in some circumstances, the use of different types of non-professional interpreters, such as family members, friends, or bilingual healthcare staff, and the use of technological tools may be the preferred, or the only option, to overcome language barriers [21–23]. A clear advantage of using digital translation tools, such as Google Translate and DeepL, is their cost-effectiveness and the possibility of quick and spontaneous implementation in daily clinical practice [22]. The use of such tools can improve patients' and healthcare providers' satisfaction as well as the quality of care [24]. However, considering the high number and diversity of applications on the market and the sometimes questionable translation accuracy and other ethical concerns raised by using such tools, there is both an urgent need for further scientific research and the development of standardized evaluation and implementation criteria, including training for healthcare providers on how to make adequate use of translation apps [22]. This is also needed for other types of multilingual tools that are increasingly being developed and used to assist healthcare providers and patients in bridging language and cultural divides, such as audiovisual multilingual patient educational narratives, online decision aids, animations, and question prompt lists. While research indicates that such tools seem to have some clear benefits, such as increased patient understanding and involvement [25], a systematic and evidence-based approach to implementing such tools in clinical practice is sorely needed, as current guidelines on dealing with language barriers do not currently take these into account sufficiently.

2.2. How should we address healthcare providers' intercultural communication skills?

To adequately teach the aforementioned intercultural communication skills, it is essential to systematically integrate cultural competency training in both undergraduate and postgraduate medical curricula in all medical and paramedical specialties in a longitudinal and scaffolded manner, guiding students at different levels step by step toward enhanced knowledge and skills. In addition, more research is required to assess such training as there is a lack of evidence about the positive effects on patient health outcomes besides positive effects on patient engagement [26]. Although there has been an increased interest in the general topic of diversity and related intercultural communication skills in recent years, the majority of medical schools does not, or only superficially, address cultural diversity and competency training in their curricula [27]. A welcome exception is the "IPIKA-Interprofessional and Intercultural Work in Medicine, Nursing and Social Services- project" [28], an integrated trans-professional program aimed at various medical

disciplines, which comprises six 2-day modules during which participants learn to broaden their own perspective and ability to build respectful and trusting relationships with patients through dialogue. In alignment with the CCC model, the project emphasizes that healthcare providers must learn to communicate in an empathetic manner and enables them to develop and implement their own professional action points to counteract the health communication deficits that currently exist for many minority patients. Topics include relationships between migration, flight, culture, and health; working across language barriers and using professional language mediators and digital communication and translation applications; dealing with stereotypes, possible actions against discrimination and racism in everyday clinical life; ethical issues in intercultural contexts; de-escalation and conflict management; and interprofessional cooperation. An important recommendation of the project is that communication in the trialogue with interpreters and patients should be professionalized.

A good example of such training is the well-evaluated project UZ Interpreting Sessions at Ghent University [29,30], whose goals include creating more awareness among future healthcare providers regarding the need for intercultural and interlanguage mediation and appropriate ways of including interpreters in the consultation. In alignment with the recommendation to deliver such training in a longitudinal and scaffolded manner, the program provides both immediate expert feedback and the possibility for repeated training. Content-wise, it strives to create awareness among medical students about the different options of linguistic and cultural mediation (e.g., non-professional and professional interpreting, remote interpreting, and cultural mediation) and the preconditions, advantages, and possible disadvantages related to these options. On the future interpreters' part, the training aims to create an understanding of the specific setting of medical consultations and the expectations they may face in this situation. Interpreting students are informed of the structure of the medical consultation according to the Calgary–Cambridge model [31] and the different goals providers try to achieve at different stages of the care process and the strategies and resources they deploy.

Despite its clear drawbacks, an often-used method to overcome language barriers in medical encounters involves working with different types of non-professional interpreters, such as family members and friends of patients and bilingual healthcare staff [32]. Hospital-based bilingual staff is usually familiar with institutional procedures and medical issues and healthcare providers face fewer organizational difficulties in setting up an encounter mediated by staff members than in organizing a professional interpreter. Similarly, patients with limited language proficiency often bring along family members or friends to the medical consultation to help overcome the language barrier. However, such non-professional interpreters can be overwhelmed by the task of mediating in medical settings as they lack specific lexical knowledge in both languages and are unaware of the discourse structures of the medical consultation and the typical challenges and possible solutions of mediating in this setting [33–36]. Although training patients' family members or friends does raise serious practical and ethical concerns (but see for an example [37]), bilingual hospital staff who can regularly act as interpreters could be more easily trained. Meyer et al. [38] argue that such training should be based on authentic examples of interpreter-mediated medical consultations to illustrate important scenarios and allow for a discussion of how to deal with potential pitfalls. They further emphasize that non-professional interpreters need to know the structures of different types of discourse (e.g., medical interviews, briefings for informed consent, and briefings of diagnostic findings) and understand the physicians' goals. Possible training methods include role play, simulation, forum theater, and observational tasks. Following training, it is also important to recognize their contributions by, for example, reducing their overall workload.

2.3. How should we address within-group differences and prevent stereotyping in culturally and linguistically discordant consultations?

Culturally and linguistically diverse patients are often perceived as the "other." This so-called "othering" describes people as different or not belonging to the majority group due to differences based on social or structural processes and thereby potentially excludes them from healthcare [39–42]. It is closely related to stereotyping, which, subsequently, can lead to discrimination. While overt displays of discrimination are legally prohibited, more subtle covert forms of discrimination in healthcare are frequently reported by migrant and ethnic minority patients [43] as they experience racism and disrespect and perceive unfairness in obtaining the treatment they need. Several studies, the majority carried out in the US, indicate that healthcare providers' (unconscious) biases toward the "other," such as perceiving them as less intelligent, likable, and adherent to treatment, not only negatively influence the intercultural communication process but also directly contribute to health inequalities due to providing unequal treatment [44,45]. In addition, ethnic minority and migrant patients not only encounter bias and discrimination during medical interactions but these also occur when their access to healthcare is hampered. Prevalent underutilization of interpreting services by the healthcare system and a lack of patient education materials in the patients' mother tongues are significant barriers to accessing healthcare for ethnic minority and migrant patients who do not speak the dominant language of the country they inhabit. Not properly addressing this language barrier is known to lead to a host of negative consequences, among which are the underutilization of care, missed appointments with clinicians, feelings of fear and despair, and less adherence to treatment plans [5].

Possible ways to prevent stereotyping and its negative impact and take into account within-group differences are to increase intercultural openness and diversity management in health care [46]. To promote culturally competent healthcare systems, various components and strategies at different levels can be deployed that are known to contribute to culturally competent healthcare systems. At the individual level, these include incorporating culturally specific concepts, linguistic and cultural adaptation by healthcare staff, the use of linguistically and culturally appropriate materials, and employing more healthcare providers from diverse cultural and ethnic backgrounds. At the organizational level of the institution, components of culturally competent healthcare include integrating language and cultural mediation into care processes, further developing human (bicultural or multilingual) resources, and continuing education and training of healthcare staff in cultural competencies. A good example of such an institutional-level intervention has been the European migrant-friendly hospital pilot project [47], which incorporated various interventions to encourage culturally competent staff in the hospital to improve the quality of healthcare (communication) for migrant patients. On an individual level, recent training programs, carried out predominantly in the US, have focused on addressing the negative impact of healthcare providers' implicit and unconscious bias on the delivery of care to migrant and ethnic minority patients, with some states in the US having made such training compulsory [48]. However, evidence of the effectiveness of training to reduce the negative effects of implicit bias is mixed at best, and may potentially backfire if either not implemented well, for instance by insufficiently qualified trainers, or when incorporating elements that will lead to increased anxiety and avoidance by participants. Elements that do seem promising, albeit with the provision that more research is needed to replicate results, are exposure to counter-stereotypical exemplars, formulating intentional strategies to override or suppress biases, and identifying the self with the "other" [49]. For instance, exposing healthcare providers to examples that contradict their (implicit) stereotypes regarding certain patient groups, such as giving counter-examples of African-Americans who are medically compliant, may help reduce bias.

3. Conditions for inclusive and diversity-sensitive healthcare: concluding remarks

In today's superdiverse societies, delivering culturally and linguistically sensitive healthcare tailored to the needs, values, and preferences of individual patients is a prerequisite for good quality healthcare communication and patient outcomes. However, various barriers to implementing diversity-sensitive healthcare exist, including a lack of incentives, such as more appreciation of healthcare providers who treat migrant patients and more time to do their job, a lack of financial resources, and organizational difficulties. Furthermore, providers often lack clarity regarding implementation and insufficient conviction about the need for diversity-sensitive measures. Therefore, there is a need for clearer recommendations for affirmative action, guidelines, policy, and support for the topic of diversity sensitivity in healthcare, such as evidence-based interventions for the implementation of solutions. Increased effort should also be directed toward inclusive and resource-oriented approaches based on a thorough understanding of patients' socioeconomic realities, such as their living conditions and employment status. Linguistic and culturally sensitive health communication wherein healthcare providers adopt a diversity-sensitive communication approach in which both culture-specific needs and individual differences within cultural groups are acknowledged, will enable them to tailor both the content and form of their communication to the individual patient's needs, thereby increasing the quality of healthcare for vulnerable populations. Structural changes on a system level, within healthcare organizations, for instance, by providing incentives to healthcare staff to provide culturally sensitive care, and in society at large, are urgently needed to support healthcare providers to implement diversity sensitivity in their daily clinical work.

CRediT authorship contribution statement

Conceptualization: **Barbara Schouten**. Writing – original draft: **Barbara Schouten, Linn Manthey, Claudio Scarvaglieri.** Writing – review & editing: **Barbara Schouten, Linn Manthey, Claudio Scarvaglieri.**

Declaration of Competing Interest

None.

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