PedsCases Podcast Scripts

This is a text version of a podcast from Pedscases.com on **"Cross-Cultural Communication – CPS Podcast."** These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

Cross-Cultural Communication – CPS Podcast

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Introduction

Hello everyone, my name is Dr. Sarah Johnson, a second year Paediatrics resident at the Stollery Children's Hospital at the University of Alberta in Edmonton. This podcast was produced by PedsCases and the Canadian Paediatric Society (CPS).

With this discussion, we aim to summarize the new CPS practice point on cross-cultural communication: tools for working with families and children. I am joined today by the lead author of this statement, Dr. Ladha. Dr. Ladha is an Assistant Professor and General Paediatrician at the University of Alberta with an interest in health disparities and social pediatrics, and I am grateful to have the opportunity to interview her regarding this important topic.

If you are interested in learning more after this podcast, please check out the CPS website kidsnewtocanada.ca.

Learning Objectives

Before we begin, here are the objectives for this podcast:

1) Define cultural competence and cross-cultural communication.
2) Describe and apply the LEARN model for cross-cultural communication.
3) Review different forms of communication, including using interpreters.
4) Describe changes that can be made to your clinical practice to optimize cross-cultural communication.

Defining Cross-Cultural Communication

Dr. Johnson: So, Dr. Ladha, can you tell our listeners why it is important for us to understand cross-cultural communication, and how a patient or their families' culture may impact their health?

Dr. Ladha: Cultural competence, which is the basis of cross-cultural communication, is important in establishing mutually trusting, collaborative, and effective patient-provider relationships. Cultural competence includes being aware one's own values and how they may impact the provision of care, as well as exploring the patient's cultural background to achieve a better understanding of how it may impact their health and management of illness.

For example, when I first started practicing, I saw a patient in clinic that needed to be sent to hospital. She wasn't sick enough to need an ambulance, but did need to be taken straight to the hospital for monitoring, treatment, and possible admission. I asked the family if they felt comfortable taking their child straight to the hospital, and assessed their understanding of the relative urgency of the situation. When I was assured that they agreed with the plan and would take her to the emergency room, I discharged them. When I followed up by calling the emergency room later, I learned that it had taken them over an hour to get there (despite it being a 10-minute drive away) because they didn't own a car and had taken two buses! In my haste to get her to the hospital, I hadn't assessed her socioeconomic background which is a large part of culture and communication. Cross-cultural communication doesn't just apply to treating patients from a different country or a different ethnic background than your own. It applies to EVERY patient encounter.

The LEARN Model

Dr. Johnson: Thanks Dr. Ladha, that reminds me of a clinical case that I have come across – a young Indigenous man (we'll call him Jo) came into the emergency room with a general feeling of being unwell, along with a racing heart, and tingly fingers. How about I use the LEARN model to go through this scenario with our audience.

In the CPS statement, the LEARN model is described as a way to facilitate cross-cultural communication. This is an acronym that stands for Listen, Explain, Acknowledge, Recommend, and Negotiate. It was developed in 1983 by Drs. Berlin and Fowkes, and creates a good framework in which we can ensure we are working with our patients in a culturally sensitive manner.

Listen: Allow time for the patient to describe their concerns, and what they hope to gain from the visit. If there seems to be differences between how you and your patient understand the illness process, explore these differences.

Jo had arrived to the hospital with his mother. He was worried that there was something serious wrong with him and wanted an assessment. He thought he could be having a panic attack but wasn't sure.

Explain: Provide an explanation of your own perception of the health condition, keeping in mind that the patient's understanding of health and illness are influenced by their cultural, ethnic, socioeconomic, and educational background.

After a full history and physical exam, I explained to Jo that I did feel he was having a panic attack, and it sounded like he had some elements of generalized anxiety as well. Jo's mother was not surprised as it ran in their family, and she had dealt with it in the past as well.

Acknowledge: Identify areas of similarity as well as differences between your understanding of the illness and treatment options and your patient's understanding, ensuring that you acknowledge and carefully consider their views.

Recommendations should be a collaborative process involving the patient and possibly their family or community at large, depending on their cultural background.

While we were all on the same page in terms of the diagnosis, we had different ideas around treatment. I initially provided Jo and his mother with my list of community resources, and talked at length about counselling, psychiatry, and medications. It wasn't until the very end of the interview that his mother mentioned some of the things that had helped her anxiety in the past, such as going to talk to one of the community elders, and attending smudging ceremonies. I was glad Jo's mother brought up these possibilities, as I hadn't expanded my questioning to find out what their experiences and expectations around treatment might be. It was important for me to ask about their family's experiences with anxiety, what had worked for them, and what expectations they had around treatment prior to counseling them on their treatment options.

Negotiation refers to the process of discovering a treatment plan with your patient that incorporates both your and your patient's goals, and that includes consideration of the patient's background and culture.

At the end of the visit, Jo, his mother, and myself decided that he would integrate some of my recommendations, as well as some of the strategies that had worked for his mother. He left the emergency room with plans to follow up with his family physician.

Dr. Ladha, do you have some examples of how you use cross-cultural communication in your daily pediatric practice?

Dr. Ladha: I think it is important as a provider to pay attention to both verbal and non-verbal cues in patient interactions. Traditionally, western cultures use more direct, verbal means of communication. In many other cultures, people rely heavily on silence or non-verbal cues in order to relay meaning or messages. Paying attention to family's non-verbal cues such as body language, tone of voice, and pauses or silences can help the provider to better assess the family's understanding and comfort level with a particular course of treatment or plan.

Interpreters are another key aspect of facilitating cross-cultural communication. Interpreters should be non-family members who are cultural, not just language

interpreters. What I mean by this is that they understand the cultural background of the patient they are translating for so that they can understand and convey nuances in meaning. Even when using interpreters, it is important to make eye contact and speak directly to your patient and their family, and book extra time and repeat visits to ensure trust building and a better understanding of the medical and social issues.

Relevant Practice Points

To finish off this podcast, here are some of the practice points listed in the CPS statement:

- Try to identify cultural differences in yourself and your patients. Be self-aware of biases and values that you may be bringing to medical encounters.
- Use a trained interpreter rather than a family member to translate when needed.
- Build awareness of differences in communication style (for example verbal and non-verbal) that may influence care.
- Consider the role of silences in each patient encounter. They may represent discomfort with a topic or uncertainty about a question being asked. Paying attention to nonverbal cues can help determine whether a differential power relationship is hindering communication.
- Building trust and understanding helps empower families and optimize patient care.
- Booking longer and repeat visits with the same interpreter can forge trust and understanding around child and youth health issues and management plans.
- Devise a tailored treatment plan that involves the patient's immediate family, extended family or other community members, as appropriate.
- Recognize that a 'high-context' communication style may be a family's cultural norm and stay attuned to tone, body language and other nonverbal cues.
- Assess the literacy levels of patients or families and adjust the use of written materials accordingly.

Ok that should be all for our podcast today, thank you so much for your insight on this important topic Dr. Ladha!