Family Medicine and Community Health
EDITORIAL

Patient-centered care in a multicultural world

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Introduction

To be a good clinician in 2016 is challenging – not only do we have to ensure that our biomedical knowledge is up to date, but increasingly we need to practice medicine within the much broader context of patient-centered care (PCC) in diverse populations. The knowledge, skills, and attitudes required to deliver good PCC in these settings are the same in whatever part of the world we practice. However, PCC presents considerable challenges to us that are highlighted and magnified when we are delivering care to individuals outside our own culture. A particular issue is not only that PCC has yet to be accepted as the 'cultural norm' by patients and clinicians alike, but also increasingly, sophisticated knowledge and skills are required by clinicians to address the complexities inherent in consulting within diverse populations.

How can we build on our current knowledge of best practice in PCC to embrace those challenges and complexities resulting from an increasingly diverse multicultural world?

Patient-centered care

Patient-centered care (PCC) means treating patients as individuals and as equal partners in the process of healing; it is personalized, coordinated, and enabling [1].

Safe and effective care can be achieved only when patients are *present, powerful*, and *involved* at all levels [2]. One problem is that not only can PCC mean different things to different people at different times but, although there is a consensus that this approach should be used for patients with long-term conditions, patient surveys in the United Kingdom, for example, report that we are not delivering PCC nor are we implementing PCC at scale in any meaningful way [3]. In all clinical encounters we should treat our patients with dignity, compassion, and respect.

The major challenge for the implementation of PCC in clinical practice is to "change the conversation" by a "transfer of power" between clinicians and their patients [4]. Our training and our experience may not have prepared us for the "cultural change" which is required – patient "empowerment" challenges the way things should be done in clinical practice, and interventions such as support for self-management, shared decision making, and patient activation, all of which are part of PCC, may not come naturally to us. We need to recognize people's capabilities and their potential to manage and improve their own health rather than seeing them simply as victims of disease or passive recipients of care [5]. It is particularly important to note that PCC is not based on a medical model and should also be *multidisciplinary* – since a person may need more than one sort of health care professional to care for him or her.

There is a great deal of evidence to support the clinical effectiveness of PCC. For

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example, the UK National Voices patient organization has evaluated a large number of systematic reviews (n = 779) to identify the "core facets" of PCC [6]. These core facets are supporting self-management and shared decision making, enhancing experience, improving information, and understanding and promoting prevention.

Evidence-based decision aids are also very useful in improving information to help patients understand the choices that are available to them. Such decision aids provide basic information about conditions, treatment options, likely outcomes, and uncertainties, and there is good evidence that they can be effective if used in the right way (e.g. PANDAs) [7]. However, the acquisition of new knowledge and skills to use such interventions can take us only so far in changing any "disempowering" attitudes we may have acquired during our training. Working with patients in a more patient-centered manner requires excellent listening, communication, and negotiation skills as well as the capability of responding flexibly to a person's individual needs. The use of these skills as part of a collaborative approach can lead to improvements in not only physical and psychological health but also the confidence and skill required to manage one's own health [8].

Cultural sensibility and medical education

PCC is challenging in any medical/clinical environment even without the complexities of clinical practice in a diverse multicultural clinical environment. To practice PCC with someone from a culture very different from one's own is a considerable additional challenge as there may not be many commonalities in terms of norms, values, and communication. It requires more effort on our part to check assumptions we may be making either through the lens of our cultural worldview or through stereotypes we may unconsciously hold of other people.

In medical education, traditionally, a categorical approach to cross-cultural education has involved acquiring fixed knowledge about different cultural groups. This has been called the "cultural expertise" model [9]. However, this approach risks stereotyping a person on the basis of only one aspect of that person's cultural identity [10]. The "*cultural sensibility*" approach to medical education emphasizes the recognition of the dynamic complexity of patients through exploration of our own multifaceted context-dependent cultural identity and experiencing how being stereotyped on the basis of any one of these aspects is limited and potentially harmful [9].

Cultural identity tacitly influences the way we interpret events, interact with others, and live our lives. Although we are mostly unaware of them, our cultural norms have attendant values associated with them that may lead us to make value judgments. A universal core principle underlying health care professionalism is that we must not judge or discriminate against people. This is part of our contribution to reducing health disparities and requires that we acknowledge our attitudes, including our biases and prejudices, toward those who are different from us and whom we perhaps struggle to understand.

The cultural sensibility approach to diversity education recognizes the influence of the clinician's cultural identity on the consultation, which is often not explored in patient-centered consultation skills training. This aspect of diversity education chimes with the patient-centered model of Mead and Bower [11], which has "doctor as a person" as one of its five essential components. By educating physicians to bring their cultural norms to conscious scrutiny, we can teach them to prevent assumptions from prejudicing their clinical practice.

PCC recognizes the central importance of the patient's perspective and the patient's individual illness experience in diagnosis and management. Instead of seeking to learn "facts" about cultural groups, we can safely bridge cultural distance by being *respectfully curious*. Respectful curiosity allows us to connect with patients through active listening and asking questions to uncover the patient's perspective, understand the patient's illness experience, and check our assumptions when we are developing shared management plans. Diversity education facilitates the delivery of PCC by bringing into sharper focus the need for the attributes of self-awareness and respectful curiosity that underlie the skills needed to deliver PCC. It provides the tools to take "care of patients everywhere, from anywhere and whatever differences in background may exist" [12].

In summary, diversity education requires that clinicians understand themselves, and this needs to include their own cultural belonging and sense of self. Through this, they can

identify their own norms, values, biases, and prejudices. This provides an opportunity for reflection on their reactions to violations of their unconscious cultural norms. An approach of *respectful curiosity* allows clinicians to connect with patients who are so different from them that it may be difficult to feel empathy toward them, but through the development of a genuine interest in their unique story, high-quality clinical care can be delivered [13].

Health social movements

In the final analysis, the greatest challenge for us in practising PCC in diverse multicultural populations is the cultural change that is required to implement PCC. Fundamental changes in attitudes in the relationships and conversations between people often requires revolutionary rather than evolutionary change. Revolutionary change usually requires a health social movement [14]. Health social movements have been very effective in the past in transforming the culture of health services provision; for example, the revolution in our care of people with HIV/AIDS (e.g. Dallas Buyers Club, https://www.youtube.com/watch?v=U8utPuIFVnU).

The recently deceased Kate Granger [15] started a very successful health social movement in the United Kingdom with her request that all clinicians start their consultations with "Hello my name is….". In addition to all the cultural and educational interventions outlined herein, we need to do something similar for PCC in diverse populations. Just imagine what a difference it would make if our next patient from a background very different from our own opened the conversation with "What I would like to discuss with you today doctor is….".

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