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Challenging ‘cultural filtration’ in medicine

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Equality, diversity and inclusivity (EDI) issues in relation to patient care have been reported from as early as medical school. Indeed, there is evidence that many medical students feel unprepared to care for patients who are from a different cultural background to their own.¹ Like all of us, doctors can be susceptible to implicit bias. This has been defined as ‘... an unconscious, internalized, favourable or unfavourable set of views of particular social groups that strongly influences relationships with patients and members of the health care team’ (p. 1).¹ Moreover, doctors tend to be drawn from socio-economically advantaged groups.² Such relative social privilege can sometimes blind us to the experiences of underrepresented groups. These factors can influence the behaviour of clinicians towards patients, making it less likely that their healthcare needs are effectively met. For example, patients in the United States, identifying as African American, have reported fewer patient-centred behaviours from doctors with higher levels of implicit bias.³ These factors are not just relevant to the patient’s experience of care—there is some evidence that patient (or person) centredness is associated with better clinical outcomes. This observation is probably mediated via better patient engagement with care.⁴ It is likely to be a major driver behind some of the health inequalities observed for minority groups.

Improving ‘cultural competence’ in clinicians could work to reduce these disparities. This requires that varied populations’ cultural rights, diversity, values, beliefs and expectations are acknowledged in the delivery of healthcare.⁵ Cultural competence involves individuals acting appropriately in diverse and inclusive environments and maintaining a neutral curiosity about patient beliefs, needs and preferences for care-relevant issues, so their needs can be understood and met. However, the skill of cultural competence is needed even before the point a patient is referred. This is because individuals from certain ethnic, cultural or subcultural backgrounds may not be referred for appropriate care in the first place. Thus, we introduce our novel concept of ‘cultural filtration’.

We define cultural filtration as the process by which certain demographic subpopulations are less likely to present, be referred, signposted to or otherwise access appropriate healthcare. Thus, such individuals are simply ‘filtered’ out of the care pathway before it has even started. This can be the result of clinicians having insufficient cultural competence. However, in contrast to the concept of cultural competence itself, which is focussed on an individual’s skills and abilities, cultural filtration can operate at several levels within the system. Consequently, metaphorically, certain groups can fail to pass through the relevant ‘mental sieve’ of clinicians, but also those of other professionals, families or even the individuals themselves. That is, this ‘filtration’ can occur simultaneously at more than one point. Therefore this phenomenon may occur at different, interacting levels in the system, including the *individual* themselves; *family/friends*; *other professionals* (e.g. school teachers, social workers, etc.); *clinicians*; and *health services*.

We believe that cultural filtration is likely to be a major driver behind some of the well-documented health inequalities observed between minority and majority groups within the population. In this sense, health inequalities are defined as unfair and avoidable differences in health across different groups within society.⁶ Thus, delays in recognition, referral, diagnosis and treatment can contribute to the generation of worse outcomes in this respect. For example, in the United Kingdom, Black women are more than four times more likely than White women to die during pregnancy or childbirth.⁷ The increased pressure on post-pandemic health services will almost certainly have exacerbated these issues. In some areas accessing healthcare is increasingly relying on the advocacy of the individual, carers or other professionals who know which key phrases may trigger actions (such as acceptance of a referral) from healthcare providers. This phenomenon is becoming most stark in stretched children and young people’s mental health services. For example, on average, Black children tend to be relatively old when referred for neurodevelopment

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assessments, such as those for autism,⁸ with evidence of biased clinician decision making.⁹ Delayed identification of developmental issues can adversely affect a young person's life trajectory, as opportunities for timely medical, educational and psychosocial interventions are lost. It is therefore vital that we develop a comprehensive understanding of where and how this filtration is happening.

Education in the clinical setting is therefore crucial here to ensure we start to implement approaches that can address the harms caused by cultural filtration. Effective training of clinicians means that they can also, in turn, educate others around them (including other professionals such as teachers and social workers), as well as communities in general. We can consider cultural filtration, when it occurs due to clinician-level factors, as the result of a deficit in both semantic and procedural knowledge in the practitioner. That is, the clinician may be unaware of relevant information, for example, how certain conditions present in minority groups. In terms of procedural learning there are socioemotional, interpersonal skills that are essential to challenging cultural filtration. This will involve communicating with patients, carers and other professionals in way that achieves two goals. Firstly, the preferences and healthcare and other relevant needs are accurately elicited from patients and relevant others, such as family members. These can then be taken into account when considering referrals to other healthcare providers and agencies, such as medical specialists and social care. Secondly, such procedural skills are required to support patients, carers and other professionals in shifting attitudes and behaviours that have been acting as barriers to recognising healthcare needs and facilitating access to appropriate care. Communication that supports individuals moving through such a motivational cycle tends to be collaborative in nature (i.e. not directly challenging, unless necessary) and initially 'validating'. For example, techniques informed by the model of intentional behaviour change (transtheoretical model) would be useful to apply here.¹⁰ In this sense, validation is making the person feel that their beliefs or choices are understandable, and logical, even if these appear to be barriers to accessing appropriate care. This also applies to communication with relatives and other professionals who may be unaware that their beliefs and behaviours are preventing access to appropriate assessment or treatment. A more subtle socioemotional skill is an ability to self-reflect. However, this quality is vital to develop if students and clinicians are to recognise their own biases and stereotypes. It is also critical for learners to become aware of any key areas of deficits with working with those from different cultures and areas that need addressing within their specialty. Stigma (including self-stigma) may also play a role in exacerbating cultural filtration effects. This may be particularly the case in relation to sexual or mental health issues. Effective educational interventions implemented by clinical teachers may include emotionally engaging narratives, involvement of those from ethnic minorities with lived experience in education or possibly self-assessment via situational judgement tests. We could then begin to explore this through cross-sectional and longitudinal surveys or vignettes that could be incorporated into situational judgement tests for formative purposes.

In terms of cultural competence generally, there is limited research into what types of interventions may be effective for specific

outcomes and across differing contexts. However, positive effects of interventions are generally reported.¹¹ Nevertheless, there are virtually no staff training or educational interventions that specifically target increased access to healthcare to minority or underserved groups. One of the few examples of such an intervention is the training of staff and the use of motivational interviewing to increase the uptake of HIV testing in Native American populations.¹² Motivational interviewing uses a neutral, collaborative approach to explore and encourage positive change in health related behaviours. This is in keeping with the non-judgmental, curious approach required to attain cultural competence. It is important that we develop more educational interventions that target points of filtration and can demonstrate increased access to healthcare, and ideally improved outcomes, for underserved groups. This will demand more targeted, precise aims than the general enhancement of cultural competency and related knowledge in practitioners.

As resources are even more constrained, due to the prevailing economic conditions globally, there is a risk that Tudor Hart's inverse care law will be exacerbated. This states 'the availability of good medical care tends to vary inversely with the need for it in the population served'.¹³ Indeed, in hard-pressed services, there is little incentive to actually increase demand for care from underserved groups. Thus, it is possible that cultural filtration could turn out to be the most substantial single driver of unequal healthcare outcomes in some contexts. We need to support and develop our workforce to challenge these situations where they are identified.

The term 'cultural filtration' is likely to be beneficial in challenging the inequalities discussed, advancing on the concepts mentioned previously such as 'bias' or 'cultural competence'. The concept is intended to raise awareness and stimulate systematic enquiry into the reasons why certain groups are underrepresented in certain care pathways. Ultimately, it is intended to encourage us to learn more about those individuals 'filtered' out of the healthcare system entirely due to differing cultural needs and presentations. Moreover, *equality of care* is meaningless if it cannot even be accessed, and there is little evidence this source of inequity is being effectively addressed at present.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ETHICS STATEMENT

The authors have no ethical statement to declare.

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