Communication and health in a multi-ethnic society

Mark Robinson


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Communication and cultural diversity have become key focus areas as the health service engages with goals of health improvement and equity. This timely and unique book provides a rigorous and challenging review of recent research, with a particular focus on health communication interventions concerning service users who may lack fluency in English. The book shows that meeting the needs of all health service users, including disadvantaged groups, depends on both structures and processes of communication.

Communication and health in a multi-ethnic society:
• clarifies issues surrounding ethnic and cultural diversity, racism and communication;
• identifies barriers to effective communication;
• evaluates interventions aimed at enhancing healthcare communication;
• recommends priorities for service development, practice and research by focusing clearly on the evidence.

This book will prove invaluable to healthcare and medical students, academics, practitioners, service managers and policy makers concerned with improving health services for minority ethnic groups.

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COMMUNICATION AND HEALTH IN A MULTI-ETHNIC SOCIETY

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Introduction

Background and context of research

This book examines existing research into communication between health care providers and minority ethnic health care users who lack fluency in English. The book should be of value to academics, researchers, and students in health care and also the sociology of health, and to health service practitioners and leaders. It takes account of research conducted within health care disciplines, while complementing this with perspectives derived from the sociology of health and communication. The strong dual focus on empirical research and on communication sets it apart from other books focused on minority ethnic users and health, which have tended to have a less empirical flavour (Robinson, 1998), or to focus more generally on ethnicity (Ahmad, 1993).

The book does not exhaustively explore the full range of barriers to health care facing minority ethnic patients. Many members of minority ethnic groups in the UK do not lack fluency in English; an increasing number are born and raised here. Yet many of the communication barriers they face doubtless overlap with those of non-fluent speakers, for example concerning institutional and attitudinal rather than strictly linguistic factors; however, not all the research touching on their needs is covered here. At the same time, the scope of the book remains wide-ranging, and it includes research conducted in several countries where English is a national language, widely used in health care, particularly the US, Canada, and Australia, as well as the UK. As a result, a considerable diversity of minority ethnic groups and health care contexts is considered. Some facets of the research are rather context-dependent, indeed the robustness of communication research may require context-sensitivity, yet many aspects of each study should have broad application wherever minority ethnic users not fluent in English strive to have their communication needs understood and met. Given that the number of interventions in this area remains small, a strength of this study should be the broad scope it offers for making careful comparisons.

The primary focus is on empirical evidence of barriers to
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communication, and of interventions aimed at enhancing communication, involving minority service users who are less than fluent in English. However, the book cannot consider all minority ethnic community groups in English-speaking countries, since relevant interventions have not been carried out involving many such minorities. A substantial amount of research in the UK has focused on South Asian minority ethnic communities, whereas the needs of others, such as Polish, Vietnamese, and new migrants, including asylum seekers, are as yet relatively under-researched. User groups with particularly complex needs and affiliations such as minority ethnic people with disabilities, and older people also seem relatively under-represented. Men's concerns may also receive less attention than women's concerns in the pages that follow.

What is not in doubt is that for many members of under-represented groups, including new migrants whose importance for the health service is bound to increase, issues of communication are central. Lack of fluency in English is one of the most significant among several interacting factors influencing the health care experiences of these service users and an understanding of the current evidence, with its strengths and also its weaknesses, is likely to be of increasing importance to health service practitioners and academics.

During a period of major reforms, the health service in Britain has been subject to important debates about accountability and accessibility to users. UK government policy documents have supported action to address the needs of minority ethnic users. For example, the government White Paper *Saving lives: Our healthier nation* (DoH, 1999a) set a framework and provided an action plan for health improvements, especially for the “worst off” (p 1, para 1.2) which carries implications for communication needs. The Department of Health (DoH) circular *Clinical governance* (DoH, 1999b) explicitly linked an agenda for continuing professional development with reducing health inequalities and targeting minority ethnic service users and carers. The document *The vital connection: An equalities framework for the NHS* (DoH, 2000) emphasises setting and maintaining equality standards and prioritises promotion of education to meet the needs of culturally diverse communities. The document *Making a difference* (DoH, 1999c) set out a “new vision” (p 6) for nurses, midwives and health visitors in the NHS, explicitly requiring these practitioners to target the most vulnerable in the community, including some minority ethnic groups, who are least likely to access and use the service.

Rhetorical recognition of the importance of cultural and ethnic
diversity to the delivery of an equitable service does not mean that the health service and health practitioners meet the needs of minority ethnic patients effectively (M. Johnson, 1996). Recognising and meeting the needs of all service users depends on structures and processes of communication. In fact, relationships between understanding needs, service development, and communication processes, are often mutually informing and require conceptual and empirical attention. In that general context a number of issues, linked to communication, concern non-fluent minority ethnic health care users specifically. The main body of this book examines the evidence concerning these issues and explores implications for practice and for policy.

Issues, where evidence is available concerning non-fluent service users, relate to:

- equal opportunities for access and participation for service users who may not be fluent in English, among diverse client groups;
- organisational constraints on the provision of communication support in the health service;
- unease about institutional racism;
- attitudes and practices of some health care professionals;
- concerns about the use of material resources.

A first concern is that a service which aims to provide equal opportunities for health for all requires equitable processes supporting access and participation for diverse and marginalised client groups. A further problem, as later chapters show, is that structural and organisational constraints in the health service disadvantage users who lack fluency in English. The constraints include the quality of mechanisms for planning, implementing and monitoring ethnically sensitive service development (Monach and Davis, 1996).

Another issue is that health service reforms are occurring in a period of increasing awareness of institutional racism and concern to understand and challenge the mechanisms which support it. The MacPherson Report (1999) defines institutional racism in terms of the systematic differential treatment of people by organisations because of their race, and emphasises that the definition rests on the effects of organisational practice, and not intentions. With the 2000 Race Relations (Amendment) Act public authorities in the UK now have a strengthened statutory duty to examine discriminatory practices and promote racial equality. Discriminatory practice can happen in any kind of care work,
but it becomes particularly possible where language barriers exist, and when health professionals are stretched to their limits.

Also, a related and enduring concern is that the attitudes and practices of some health professionals to minority ethnic service users remain unacceptable (Rocheron et al, 1989; Murphy and Macleod Clark, 1993). Stereotyping or over-controlling behaviour, in relation to assumptions about cultural difference and language deficit, may contribute to instances of two-way miscommunication, and a reluctance to request or use appropriate language support resources (Gerrish, 2001). A further problem is that the provision of material resources to meet the education or information needs of minority ethnic service users is woefully inadequate in many places. There are not enough appropriately translated materials and not enough materials in appropriate media, for example visually formatted (Arora et al, 1995; Karim, 1996).

The book highlights these concerns by assessing the available evidence. At the same time, gaps in the research are discussed. The majority of interventions under-emphasise the contexts of communications between service users and providers. Too little is known about the socio-cultural environments within which people’s needs are felt and expressed, and which influence the effectiveness of communications. The diversity of sub-cultures is flattened out in interventions, so that, for example, the focus on minority ethnic women and health is not often matched by a sharp interest in socio-economic differentials, nor by a focus on such specific groups as people with disabilities, nor, indeed, on men. Equally there is a need to understand better the specific and dynamic work contexts where practitioners’ perceptions occur as they communicate.

Addressing such a range of issues is a central challenge for health providers. The variable quality and limited quantity of relevant empirical research aimed at enhancing communication perhaps reflects the continued marginalisation of minority ethnic service users’ concerns. This book therefore sets out to be both descriptive and evaluative, and to offer a useful guide to the evidence for practitioners, health educators, researchers in the field, students, service users and service managers.

Aims

The primary aim of this book is to evaluate the research evidence relating to communication between adult minority ethnic service users who lack fluency in English and health care professionals, so as to inform practice and service development, and to identify the most pressing
research issues. A large, central section of the book focuses on reviewing empirical studies that have aimed to enhance health communications with minority ethnic clients who lack fluency in English. Earlier sections more briefly identify barriers to effective communication. Empirical studies of barriers are reviewed in a wide range of areas, including those of consultation and needs assessment for service development, health professionals’ communication practice, bilingual services, health education programmes and materials, service organisation and management, and training of health professionals. The Introduction also highlights important conceptual issues for research in key areas concerning ethnicity, racism, culture and communication. The effectiveness of actions taken to enhance communication depends in part on whether the issues have been adequately conceptualised for operational research or for service development. It also depends in part on whether barriers which have been identified are adequately confronted through the interventions. A central argument of the book, in fact, is that overcoming barriers and enhancing communication with minority ethnic service users requires the development of an adequate conceptual and empirical toolkit for understanding the issues and tackling them.

**Methods**

**Advisory panel**

A panel of advisors contributed to the planning of the review and provided feedback on the focus and direction.

**Study protocol**

A study protocol or structured plan was developed with a set of objectives for the review and specific criteria for the selection of papers for review. The set of objectives is shown in Appendix I.

The objectives were met by a review of healthcare literature which includes:

- a summary review of conceptual frameworks relevant to the research;
- a summary evaluative review of empirical ‘barrier’ studies;
- a structured review of interventions.
The review of interventions both describes the range of interventions that have been carried out, and evaluates their quality. The conceptual review provides an underpinning for evaluation of the way key concepts are used operationally, and how this affects the validity of the research. The barriers review underpins evaluation of how adequately the interventions address the range of major barriers to communication.

**Selection of studies for the review**

The conceptual review includes some work from health care, sociology and linguistics. Interdisciplinary work is emphasised since health service research and development has been influenced by specific conceptual frameworks indebted to other disciplinary fields.

A set of necessary criteria, shown in Appendix 1, was devised to select the empirical studies for review. For reasons of feasibility, studies eligible for inclusion in the electronic database search dated from January 1989 to March 2000, English language only. However, where the studies in the review cite earlier studies of central importance, these were also considered. Some background research published since that date is also included.

**Search strategy**

A search strategy was developed with the assistance of the advisory panel and of librarians at the University of Leeds. Both electronic and hand searches were carried out. Search terms and a list of databases used are shown in Appendix 1, and a sample search in Appendix 3.

**Results of the literature search**

**Papers identified**

As a result of a pre-screening process a total of 25 interventions, 62 empirical barrier studies, and 47 concept studies were collected for review.
Development of data extraction form

A data extraction form was developed to collect descriptive and evaluative information about the intervention studies. Headings are shown in Appendix 2.

Some of the criteria for evaluating qualitative, interpretative research differ from criteria for evaluating quantitative, positivist research, despite specific challenges for the evaluation of 'hybrid' studies using multi-method designs.

The healthcare field abounds with material on developing criteria for quantitative research. However, many quantitative studies have paid relatively little attention to service user perspectives, and provide little information about processes and contexts. They are then not always suitable for addressing a range of health communication issues that are multi-dimensional, and concern subjective or inter-subjective meanings. On the other hand, it has been argued that good qualitative research attends to the interpretation of subjective meaning and the adequate description of social contexts, and that in such cases adequacy needs to be assessed at the level of meanings which can help to explain why something happens or is the way that it is (Popay et al, 1998). Therefore, criteria for the evaluation of qualitative research were developed, drawing on existing theoretical and empirical work (Mays and Pope, 1995; Lemmer et al, 1999; Newman, 1999). These criteria are applied in relevant parts of this book.

Presentation of review findings

All selected research studies were reviewed. A brief review of key conceptual issues precedes a summary review of barriers to communication, and then the detailed review of interventions.

The review of barriers focuses on the following central issues, identified from the empirical studies:

- stereotyping
- language and miscommunication
- the adaptation of prevailing practice models to transcultural communication contexts
- assessment of minority ethnic user needs by community consultation
- gathering and use of information about individual patients’ communication needs
• bilingual support
• practitioner education
• provision of material resources.

The review of the intervention studies includes the following areas:

• evaluation of service organisation
• ethnic matching, and service matching
• ethnic monitoring
• bilingual services – advocates, linkworkers and interpreters
• training – health care professionals and staff
• training interpreters and implementing an interpreter service
• health education programmes
• material resources and media.

Issues arising from the study

The concluding section highlights key findings and focuses on the implications of the study for research, for evidence-based practice, and for health service development. It emphasises what has been achieved, and what remains to be achieved in understanding and acting on urgent issues for enhancing communication between health service providers and minority ethnic service users who are not fluent in English.

Conceptual issues

In any empirical research inconsistent and confusing operational use of the concepts leads to flawed interventions. The process of conceptual clarification can therefore be helpful for evaluating research and development in health care settings. The brief summary here of current debates on ethnicity, racism, culture and communication is intended to inform the subsequent review of empirical research on communication involving minority ethnic health service users who are not fluent speakers of English.
Ethnicity

Definitions of ethnicity

Definitions of ethnicity in health research are problematic – for example, the words culture and ethnicity are not always clearly distinguished when used together. The concept of ethnicity is fiercely debated (Annandale, 1999). A review of the theoretical literature on ethnicity suggest two persistent tendencies – to define ethnicity in ‘primordial’ terms and in ‘instrumental’ ones (Smaje, 1996, p 141). Both tendencies view ethnicity, with varying emphasis, in terms of boundaries and continuities. The former views ethnicity as, in the last resort, a social construct by which people gain a fundamental orientation to the world (in the sense of ‘ethnic identity’). The latter views ethnicity as a social construct instrumental for accessing resources (Smaje, 1996, p 141). Operational definitions may also relate ethnicity to a cluster of other concepts that supply criteria for the differentiation of social groups. The criteria may include: language (viewed as a distinct language or as a distinct dialect), common origin (or ‘homeland’ from which the group migrated), common religion, common history, and culture (Law, 1996, pp 43-4).

Significant developments in the theorisation of ethnicity include structural-materialist views of competing material interests of social classes impacting on definitions of ethnicity (Smaje, 1996, p 145). Alternatively, with the notion of situational ethnicity, individuals can adopt ethnic labels in different contexts for different purposes (Smaje, 1996, p 141). There is considerable interest from situational and post-modern perspectives in how ethnicities are produced and reproduced, defined and redefined through discourses and social practices involving relations of power and resistance (Law, 1996, p 44).

Ethnicity and health

The use of ethnicity in health research has been characterised by different approaches according to research aims and the paradigm used.

Approaches that focus on ethnic identity and the meanings surrounding this may operationalise ethnicity in terms of cultural and group affiliations (Nazroo, 1998, p 710). Research into culturally sensitive professional practice, for example, which includes communication, sometimes uses concepts of ethnicity in this way. However, the studies
do not always acknowledge the thorny conceptual issues of equating cultural knowledge and sensitivity with untheorised ethnic categories. Some of the research is vulnerable to criticisms of ‘racialisation’ (Ahmad, 1993, p 19). Racialisation involves the assumption that populations can only meaningfully be divided into ‘ethnic’ or ‘racial’ groups, taking these as primary categories for explanatory purposes to the exclusion of other factors. This danger is highlighted for the use of ethnicity in research into communication and culture in health care.

On the other hand, much research has not explicitly theorised ethnicity, but the operational categories have still been criticised for over-generalisation and simplification, and for relying on externally imposed categories without taking adequate account of user categories (Nazroo, 1998, p 713). This applies not only to epidemiological research but also much of the research into communication. The interpretation of data is flawed if based on the assumption that such categories are homogeneous, rather than socially constructed in ways that may obscure differences of history, language, geography, and socio-economic position (Nazroo, 1998, p 713). The use of ethnicity as an independent variable in research is criticised if it leads to claims made on the basis of descriptive correlations that ‘ethnic differences’ from assumed white ‘norms’ cause inequalities of outcome in health where there may be multiple causes (Law, 1996, pp 156–7).

Recently, attempts have been made to plot an escape from the research and development traps outlined above. Suggestions include assigning individuals to ethnic categories on the basis of sufficient data, consistency, and dealing with complex realities like ‘dual heritage’ or ‘mixed parentage’ (Nazroo, 1998, p 713). One option is to provide respondents with better opportunities and more relevant choices to provide descriptions of their own ethnicity. Also, if ethnicity is treated as an explanatory variable it becomes important to ask not only what it is used to measure, but how its interaction with other potential influences is treated.

**Ethnicity and communication**

Communication research in particular has been subject to the criticism that definitions of ethnicity tend not to be based on theories, and that social constructs are treated as self-evident social realities, or as unproblematic geopolitical classifications (Leets et al, 1996, p 115). A sizeable proportion of studies fail to report how they measure ethnicity at all (Leets et al, 1996, p 130).