A patient-centred approach to diversity

The link between culture and health is well established (Napier et al, 2014). This would imply that, as part of their practice, clinicians need to incorporate the patient's culture as an integral part of the assessment. The challenges for diversity education in medical undergraduate curricula are now well rehearsed (Dogra et al, 2010, 2016). A recent national meeting of all UK medical schools (Dogra et al, 2016) found that ongoing issues include a lack of conceptual clarity, how the concepts should be framed to be clinically relevant, and staff engagement and development. This was also reflected in postgraduate medical education (Bentley et al, 2008) and reinforced at the national meeting at which the major colleges were present.

Reassessing diversity education

To address these challenges the authors propose that diversity education and with whom the responsibility for its delivery lies needs to be reassessed. Dogra (2003) described two approaches to diversity education from the philosophical stance through to curriculum development, delivery and evaluation. The more widely practiced and traditional approach is that of 'cultural expertise' where training focuses on providing information about different groups based on one characteristic – usually ethnicity.

The second approach of 'cultural sensibility' argues that patients are a combination of different characteristics and that there is a complex interplay between internal and external factors to produce unique beings with their own sense of self, and having a very personal culture. Dogra (2003) also emphasized the need for learners to be aware of their influences, biases, values and prejudices as all these shape their world view including how to deliver high quality care. The cultural sensibility approach moved away from a knowledge-based approach to a skills-based approach, with an emphasis on acknowledging that unless we ask we cannot know others, and that people should be treated as individuals not as members of groups.

To engage clinicians who are increasingly overwhelmed with increasing mandatory training, any diversity training should be clinically focused and aim to refine clinical practice.

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Educational approach

The educational approach should be the recognition of broad psychosocial issues that can affect the way individuals perceive health and access health services rather than information about specific groups. Studying the health needs of particular groups, without understanding how the different groups that people belong to intersect in any particular context, risks oversimplifying the complexity of individual experience and treats groups of people in any category as homogenous groups.

For example, when considering the needs of 'Indian' patients, the assumption may be that the needs of Indian men and women are the same. This also does not take into account that an Indian man with a disability may have very different needs from one without a disability. At times the man may identify as a man, at others as having a disability and at others as being Indian (none of these are homogenous in themselves).

Recognizing multiple factors

A clinician may inadvertently apply stereotypes thinking that he/she is providing culturally appropriate care because he/she has accounted for ethnicity but he/she may fail to account for other diversity factors. The cultural sensibility approach to diversity education can be explored by clinicians reflecting on their own individual complexity and the limitations of being defined by any one aspect of their identity. There is also a need to recognize the relevance of the context in which information is presented or received.

Acknowledging difference is important. Difference between the doctor and patient is potentially present in all encounters and not just those where ethnicity differs. The focus is on self-reflection and awareness – the interaction between two individuals which generates effective, shared understanding and dialogue. When the doctor and patient do not speak the same language this may be a barrier. However, it is all too easy to focus on the issue of language and forget that the factors leading to miscommunication and misunderstanding are present even when the spoken language is shared.

It is also important to emphasize that diversity is an integral part of the whole consultation process and different aspects of it may be relevant at different times. For example, having a knee operation may have very different meanings to a patient depending on his/her job, and gender may be a less relevant factor in this situation. In this way the overlap between the principles of cultural competence and patient-centred care become apparent (e.g. as discussed by Saha et al, 2008). Both have at their core the ability of the health-care provider to relate to the patient as a unique person, understand the patient's perspective, approach the patient's health holistically, and develop shared management goals.

Clinicians' views about diversity can challenge patient-centred care but can also enhance it. Training students to consult with patients who are diverse from them has been shown to improve their patient-centred skills (Ho et al, 2008).

Mead and Bower's (2000) model of patient-centred care resonates with cultural sensibility in that both recognize that doctors as people are active participants in the consultation process. In consultations, the unique individuality of both the patient

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and clinician come into play and affect the outcome of the encounter. How each responds to the other is dependent on many variables as discussed above. However, the influence of clinicians' individuality is often not recognized or explored in clinical training.

Diversity education requires that clinicians understand themselves and this needs to include their own cultural belonging and sense of self. Through doing this, they can identify their own norms, values, biases and prejudices. They can then consider their possible reactions at an unconscious level to violations of these cultural norms. For example, a clinician with a cultural norm of eye contact indicating attention and respect may unconsciously react angrily to a patient who is not making eye contact by assuming that the patient is not paying attention and is therefore being disrespectful. However, there may be several explanations for the patient not making eye contact, including a range of emotional contexts (such as anxiety, discomfort, embarrassment, shame), diagnostic reasons (depression, anxiety or autistic spectrum disorder) or cultural belief that direct eye contact is disrespectful. It may be more helpful to show respectful curiosity and ask about the behaviour rather than make an assumption that the reason for the behaviour is already known.

An approach of respectful curiosity allows us to connect with our patients even where their values, norms and approaches are so distant to our own that we cannot use the usual approach of imagining what it might be like in another's position to feel empathy towards them. Through genuine interest in their unique story we can demonstrate care.

Diversity as an integral part of education

If this approach towards diversity education is accepted it becomes clear that diversity education is not the remit of identified individuals but an integral part of clinical work, so something all clinicians should and can be teaching. Doctors need to move towards a process of teaching diversity that goes beyond seeing patients as unidimensional beings and clinicians as objective and divested participants. The clinical skills of self-awareness and respectful curiosity that help to uncover patient perspective and develop shared management plans, are relevant to all consultations, whatever the cultural distance between clinician and patient (Bansal, 2016). For effective, safe and rewarding clinical practice with an increasing diverse patient population, a patient-centred approach is needed but simultaneously recognition of what is brought to the conversation and how clinicians' perspectives influence the clinical consultation. **BJHM**

KEY POINTS

- The educational approach to diversity education, including contents and delivery, needs to be reviewed.
- Doctors and patients are multidimensional beings with multiple influences.
- Clinicians need to be aware of their own perspectives and how these influence the care they deliver.
- Diversity education needs to be integrated with clinical education to lead to more patient-centred care.

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