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## **Exploring Health Care Workers' perceptions and experiences of communication with Ethnic Minority Elders**

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### **Abstract**

**Purpose:** There is a recognition in Europe and in the Western world of a demographic shift in the ageing population. While the overall ageing of the general population is growing, the numbers of immigrants getting old in their host countries is also increasing, thereby increasing the racial and ethnic proportion of older people in these countries. This changing landscape calls for understanding of issues related to health care provision, policy and research regarding ethnic minorities. Communication is seen as a key factor in understanding

the needs of ethnic minority elders. The purpose of this study was to explore health care workers' (HCWs) perceptions and experiences of communication with ethnic minority elders (EMEs). In this paper, the term health care worker includes qualified nurses and health care assistants

**Design:** A descriptive qualitative study design using semi-structured interviews was employed. Ten health care workers, who had ethnic minorities in their care were individually interviewed to explore their perceptions and experiences of communication when caring for ethnic minority elders.

**Findings:** Analysis of data revealed various barriers of communication including Cultural differences, and stereotyping of older people. Facilitators of communication included appropriate training of HCWs and appropriate use of interpreters.

**Limitations:** Only homes and agencies willing to take part in the study gave permission for their staff to be interviewed. Therefore views of staff in homes who did not give permission may not be represented.

**Practical implications:** The diversity of older people needing care in nursing homes and in the community calls for training in culturally sensitive communication for effective provision care provision for EMEs.

**Value:** Training of HCWs in culturally sensitive communication is required for good communication in practice.

**Key words:** communication; minority elders; health care workers; experiences; interview; cultural competence

## **Background**

Globally the ageing population is on the increase (United Nations (UN) 2017). The UN (2013) estimates that the percentage of older people (aged 60 years or over) rose from 9.2 percent to 11.7 percent in 2013 and this increase will reach 21.1 percent by 2050. In Europe the number of persons aged over 65 is projected to rise from 16.0% in 2010 to 29.3% in 2060 (Creighton 2014). Increased longevity and migration have contributed significantly to the diversity in the ageing population (Coleman, 2010, Nguyen, 2011). This picture is similar in the UK where the ethnic minority population increased from 8% to 16.5% between 2001 and 2011 (UK Census 2011). This trend is expected to continue (Runnymede 2010). More over a report from the Government Office for Science (2016) states that over 70% of UK population growth between 2014 and 2039 will be in the over 60 age group, an increase from 14.9 to 21.9 million people. This change in demographics has resulted in a range of demands on health and social services, not least the increase in the proportion of ethnic minority elders (EMEs) who need care (Langer & Langer, 2009, Sharma, 2015). Several researchers (Johnson et al, 2004 Manthorpe, 2010 and Philipson, 2015) have reported difficulties of communication between EMEs and HCWs. This will require a better understanding of EMEs' experiences of later life.

The UK, health care services endeavour to offer easily accessible, reliable and relevant information to enable people to participate fully in their own health care decisions, and to support them in making that choice, including information on the quality of clinical services (DH 2010) Fulfilling this duty requires effective, culturally sensitive communication and engagement between healthcare workers and

EMEs (Mold, Fitzpatrick & Roberts, 2005, Langer & Langer, 2009, Likupe, 2011). The need for more research into communication with EMEs is now well recognized (Manthorpe, 2010, Phillipson, 2015). Culture in the context of this paper refers to ways in which people in different societies live together, their practices, values religion and even the way they talk to each other (Burnard and Gill 2009)

AS the number of older people who require health and social services in the UK continues to increase (Age UK 2017). Similarly there is an increase in the number of ethnic minority elders who need care in various settings, presenting a challenge for both health care providers and policy makers. Mentes, Salem & Phillips (2017) explain the importance of nurses acquiring “cultural competence” in relation to communication so that they can be able to discuss sensitive issues with ethnic elders in an acceptable manner.

However, most of the research on communication between HCWs and EMEs has been conducted in Canada and the United States of America (USA). The main lens through which this has been explored has been the Social-Environmental theory described by Hendricks and Hendricks (1986), Szreter & Woolcock (2004) and Street Jr and Epstein (2008). This theory posits that older people are influenced by their social environment in adapting to successful ageing. The social environment includes the physical environment as well as the individual’s social world. Culture and social norms are particularly important as they define roles fulfilled by older people and attitudes towards ageing (Holmes & Holmes 1995). Therefore, interaction with older people differs according to the particular roles and norms of different cultures. In common with Canada and the USA, the UK has a diverse population with an increase in ethnic minorities through various waves of immigration (The Global Migration Observatory 2014).

Limited research has been conducted into communication needs, facilitators and barriers among HCWs and EMEs, Mold, Fitzpatrick, & Roberts (2005). However, Johnson's et al. (2004) reported poor communication between white physicians and African American patients than that between white physicians and white patients. Similarly Gerrish (2001) found that patients who spoke little or no English were: disadvantaged in their care as they could not understand and follow treatment instructions, psychological support for these patients was limited, and that identification of patients' needs in such circumstances was questionable.

Moreover Sims (2010) who interviewed 56 African American women aged 40 to 70+ about their perceptions, expectations and beliefs about the role of cultural difference in a predominantly white health care setting. The women reported that mostly they received different treatment from white HCWs and that stereotyping shaped their treatment by HCWs. Stereotyping is "a cognitive representation of a group... often framed in traits-specific characteristics that we expect a certain group to possess" (Harwood 2007,p50) Johnson et al (2004) assert that culturally sensitive communication skills programs that are patient centred and focus on building rapport, benefit patients in general, and ethnic minorities in particular.

In the case of the UK the Winterbourne report (DoH 2012), cited poor communication as a contributory factor to the poor care of patients at winterbourne View. Other reports of elder abuse, in nursing homes include DeHart, Webb & Coleman, (2009) and Walsh et al, (2011) Communication issues may be accentuated when it comes to interaction between HCWS and EMEs if the elder is not able to speak

or understand English (Walsh 2011). This study set out to explore HCWs' communication with EMEs in selected nursing and care homes and in the community in one of the cities in the North East of England. The city, in common with many European cities, has seen a large influx of ethnic minorities in recent years and it was thought that this research would be able to illuminate any problems experienced by HCWs during the communication process with this population. In addition the results could be used to inform policy makers of the importance of culturally appropriate communication in the delivery of health care.

### **Aim**

To explore health care workers' (HCWs) perceptions and experiences of communication with ethnic minority elders (EMEs).

### **Objectives**

1. To identify barriers of communication between HCWs and EMEs
2. To identify factors that facilitate communication with EMEs
3. To draw conclusions and make recommendations for service improvement

### **Ethical considerations**

The relevant Research Ethics Committee granted ethical approval for the research under reference number 13/WA/0096. After being provided with written information followed by a verbal explanation about the study, participants indicated their voluntary participation by signing a consent form. No one declined to be interviewed.

### **Study Sample**

Working from a list of care and nursing homes in the city's telephone directory, service managers were approached by telephone by the researcher to seek their involvement in the study. A snowball approach was then used to identify those individual HCWs in these institutions who had EMEs directly in their care. These were targeted as they had the experiences that the researcher wanted to study. Purposive sampling is directed by the question being asked. It involves application of specific criteria to ensure that the selected sample will answer. The criteria used in this study was that the HCW had to have the experience of caring for an ethnic minority elder for at least 6 months. This yielded a sample of 10 HCWs from 5 institutions (2 nursing homes, 2 care homes and 1 social care agency). HCWs were aged between 23-55 years; mean age 35 years with caring experiences between and 1-20 years. A summary of participants' biographic information is presented in table 1. Insert table 1 here

Participant	Age	Setting	Qualification	Experience (yrs)	Ethnicity
1	21	Community	HCA	1	S Asian
2	39	Nursing home	RGN	15	Black African
3	55	Community	HCA	20	White British
4	35	Community	RGN	10	White British
5	21	Nursing home	RGN	3	Black African

6	25	Nursing home	HCA	1	White British
7	26	Care home	HCA	4	Black African
8	30	Care home	HCA	2	Black African
9	25	Community	HCA	1	White British
10	40	Nursing home	RGN	15	White British

**Note that Black African in the UK refers to persons identifying themselves as originating from Africa by birth.**

Table 1. Sample characteristics

### **Data collection method**

The qualitative approach as described by Sandelowski (2000 and 2010) was adopted for the study using Semi-structured interviews with HCWs, which lasted between 30 to 50 minutes. The interviews were recorded and later transcribed verbatim by the first author who has worked in this sector previously. This method was suitable because semi-structured interviews encourage participants to talk about their experiences while the flexibility allows for responses to be fully probed and explored (Fielding & Thomas 2016, Legard, Keegan & Ward, 2003). Moreover this method ensured collection of rich data from the small sample that could provide the experiences required to achieve the aims of the study. A range of probes including verbal and nonverbal were used during the interviews to explore HCWs experiences of communicating with minority ethnic elders. Interviews were carried out in the participants' preferred place, some were carried out at the place of work, others at the participants' home. This would participants to be relaxed and did not feel pressured (King & Horrocks, 2010). Participants were also reminded that they were free to stop the interviews any time without it affecting their jobs.



Interviews started with the question: “please tell me your experiences of caring for and communicating with minority elders.” Subsequent questions and probes were related to the discussion from this question.

### **Data analysis**

A thematic approach using an iterative and interpretive technique was adopted in analysing the data (Spencer & Ritchie, 2003). Data collection and analysis was conducted by the first author and the other authors discussed the results and analysis with the first author to verify the results. Saturation (this is where more interviews could not yield new information) of information was reached before data collection could be stopped (Glazer & Strauss, 1967). The preliminary analysis involved extraction of emerging themes following reading and listening to the tape recorded conversations. This process enabled the researcher’s thoughts to move forward and backwards which involved assigning data to refined concepts, refining and distilling abstract conceptions, assigning meaning and generating themes and concepts. Data analysis was a continuous process from data collection so that codes and themes from the first interviews were subsequently used to reflect and reframe probing questions for the whole period of data collection. Each interview was examined for content and its meaning, labels were assigned to the data and similar ideas were grouped together before commencing the process of interpreting the meaning of data. Tables 2 and 3 depict examples in the process of theme extraction and formation using Spencer and Ritchie’s (2003) analytic hierarchy framework.

Theme	CATEGORY OF STATEMENTS
Cultural differences between HCWs and EMEs	Statements about different forms of respect, forms of dress and address and beliefs
Language problems and limited time to interact	Statements about need for interpreters, patients have problems speaking English, cares having little time to listen and understand patients' wishes.
stereotyping	Statements about ethnic elders always liking that having a negative attitude toward ethnic elders and statements about treating elders as individuals. Statements about need for cultural training.
pre-existing health conditions amongst EMEs, such as poor	Statements about communication being impaired because of existing conditions related to old age, statements about having to raise ones voice to be heard and statements about having to face the elder and form words properly.

eyesight and deafness	
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Table 2. Examples of themes and category of statements supporting themes

Table 3. Example of a thematic chart

<b>Respondent characteristics</b>	<b>Cultural differences</b>	<b>Limited time to interact</b>	<b>Stereotyping</b>	<b>Researchers notes</b>
Female nurse white	Found it difficult to understand elders' culture as ethnic elders' culture different from her own. Form of address different, different verbal and nonverbal meanings.	Always rushed of her feet to find time to sit down and have a chat with the elder. Difficult to understand some elders' accents.	Most elders are deaf and some of them cannot see well. If they are from India or somewhere like that then you expect them to dress in that way and prefer their own food from their countries.  Ethnic elders are not asked what they want most of the time,	Found cultural difference difficult to understand.  Have less time to find meaning to have meaningful interaction with elders, particularly difficult with minority elders as more time to listen and understand accents.  Elders stereotyped as having

			people assume that if they are from that county then they should be treated in a certain way.	existing conditions, behave in a certain way and have similar preferences.
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Several participants were asked to go through the transcribed data and the themes to confirm that their thoughts were accurately represented (Denzin & Lincoln, 2008).

## **Findings**

Data in this study revealed the following to be barriers of communication: cultural differences between HCWs and EMEs, limited time to interact, stereotyping of EMEs by healthcare workers and pre-existing health conditions amongst EMEs, such as poor eyesight and deafness. Findings are reported below as themes and supported by verbatim quotations from HCWs. A discussion of the findings in relation to previous research follows. The theme formation process is discussed in data analysis section above and is presented in tables 2 and 3

Factors that facilitate communication were: access to appropriate cultural communication training and development for HCWs, availability of an interpreting service and the amount and quality of time available to interact with EMEs

### ***Cultural differences between HCWs and EMEs***

Cultural understanding is one of the factors which promotes individualized care. HCWs indicated that often they and the people they cared for were from different ethnic backgrounds and culture. This caused problems in understanding each other's cultures and values in terms of religion, form of personal address and manner of speaking.

They (EMEs ) want to be respected, for example personal space the way you look at them, the way you address them and their values and norms and want you observe that when you look after them (HCW1).

Other aspects identified as cultural differences by HCWs were cultural identity and dignity in acknowledgement of cultural values. For example, HCWs stated that EMEs preferred to be addressed by their titles and not by their first names and indicated that elders might find being addressed by their first names as disrespectful. However, culture is not static; it changes at the individual level as well as at the group level. HCWs explained that, although respecting individual wishes and preferences is key to good communication, a good understanding of the elders' culture and cultural values is important as it gives the HCW a starting point on which to base care.

### ***Limited time available to interact***

Health care environments are usually busy and some HCWs felt that nursing homes and residential homes are such busy environments that sometimes, staff may have less time to communicate properly with EMEs. This is especially so when they have difficulties understanding the elder.

In my experience, I've seen that nurses are too busy. You'd find that if a patient doesn't speak English, that patient might suffer more because the nurses would think he is wasting much of my time. The nurse does not have time to sit and listen or find an alternative form of communication as she is not able to give time and the patient is just left (HCW10).

### ***Stereotyping***

Stereotyping of older people by HCWs, first as having physical deficits and second as ethnic minorities from a particular culture and therefore needing a specific form of care was felt to be a barrier to communication. HCWs felt that if elders felt stereotyped, they may choose not to cooperate with them in their care giving efforts resulting in effective care. HCWs further explained that stereotyping of EMEs could upset EMEs and result in poor care as HCWs could assume that EMEs preferred to be cared for in a particular manner and by members of their own ethnicity. Conversely other HCWs felt that it was important to have some

knowledge of preferences of EMEs from different cultures in cases where there were communication difficulties and it was difficult to get interpreters.

If you say the Indians are always like that then you go to that person with that attitude... you find you are creating a communicating problem with them (HCW 9).

If you had some knowledge of their culture then you may have an advantage (HCW 5).

### ***Pre-existing Health conditions***

Common physiological conditions associated with ageing were cited by HCWs as barriers to communication. Poor eyesight and deafness were singled out as especially problematic.

HCWs said that if the elder had hearing problems then it was particularly difficult to communicate with them as they had to raise their voices to be heard. This was compounded if the elder had sight problems as they could not lip read and therefore other forms of communication had to be employed.

Most of the patients' communication can be impaired because of conditions. You need to make sure that you talk to them face to face so that they can see you if they can't hear properly (HCW 7).

### **Factors that facilitate communication**

#### ***Cultural training***

HCWs associated cultural training with obtaining information about other cultures and skills to be able to care for elders from different cultures. Some HCWs felt that they did not have sufficient training to care for EMEs and said that it would be helpful if cultural training was provided for them at work.

I think education definitely and some background knowledge if the elder comes from a different culture and community should be taken into account. (HCW 6).

#### ***Availability of interpreters***

HCWs viewed Interpreters as indispensable in improving communication with EMEs who were not English speakers. HCWs considered that language could sometimes act as a barrier to communication if the ethnic elder and the HCWs did not understand each other. However it was acknowledged that interpreters could not be in the home or in the community all the time in the same way as the health care worker is with the elder almost all the time and they need to know how to communicate with them. They were also aware that some elders may not want family to interpret for them as they would want to protect their privacy:

You may need an interpreter to help you to communicate with them. The problem comes because interpreters cannot be with the patient 24 hours and caring is 24 hours. Whereas you as a nurse, you need constant communication with that patient. So, that can be a bit challenging as well (HCW 5).

### ***Individualized care***

HCWs were in agreement that although knowledge of culture is important, ethnic elders should be treated as individuals, as no two people are the same. Cultural knowledge should be used as a guide only and the elders wishes need to be respected. Moreover, culture is a dynamic concept and things are always changing.

You know now some people have adapted to a different type of culture. So, even those patients despite of their ethnicity you need to address that difference on assessment and in the plan of care so that you don't actually take a patient for granted you know (HCW 1).

### **Discussion**

A number of important issues have been highlighted in this study regarding communication between HCWs and EMEs. These are: cultural differences between



HCWs and EMEs, limited interaction time, stereotyping and the effect of pre-existing health conditions. An important and unique finding in this study is that HCWs regardless of age and experience recognised the need for training in culturally sensitive communication in order to meet the needs of EMEs in their care.

Stereotyping of EMEs by their HCWs was also a significant finding in this study. HCWs in the present study reported that older people are often stereotyped as having physical deficits, and that EMEs are stereotyped to a particular culture. The assumption being that they therefore require a specific form of care and prefer to be looked after by “their own” without establishing their individual differences. The concept of respect here is key. Stereotyping of older people by younger people as discussed by Ryan et al. (1995) in the Communication Predicament Model of ageing is viewed as a form of lack of respect. In this model younger people stereotype older people for the way they look and speak. This stereotype influences the young person’s communication with the older individual. This study suggests that the EME may experience a ‘double jeopardy’ in the Communication Predicament Model, which could mean that barriers of communication are accentuated.

In this study, differences in culture resulted in misunderstandings about what constitutes respect. Culture here “refers to how people behave and interact.., their religious views (or lack of them) and practices... and even the way they talk to each other” (Burnard & Gill, 2009 p 3). Culture and communication are interlinked in that how well one communicates depends on how one behaves, and non-verbal communication seems to be a key factor that can influence the way one communicates with others from a different culture (Burnard & Gill 2009).

The form of address in some cultures discussed by Harwood (2007), of using honorific terms such as “sir” or “madam” is the norm in traditional African and South Asian

cultures (Nussbaum et al 2000). Some HCWs suggested that form of address may impact on the dignity that the EME feels is accorded to them. This may have implications for the co-operation that the elders may give in their own care if they perceive those providing care as not being respectful of their culture and values. However, culture is dynamic. For example research by the Centre for Ageing Better in the UK (2015) found that regardless of age, gender and ethnicity, health, financial security and social connections were key aspects of a good quality of life in later life. Therefore, consideration of these dimensions is essential in the care of older people. Language was also perceived as an important part of cultural understanding. Lip reading and good sight was thought to be particularly useful to EMEs if language and accent were problematic. HCWs noted that both verbal and non-verbal communication could have different meanings in diverse cultures. One HCW acknowledged that non verbal communication may have different meanings in different cultures and it would be helpful if HCWS could have some knowledge of these.

In relation to respondents' reference to the impact of limited interaction time between HCWs and EMEs, it acknowledged by the RCN (2012) that staffing levels are an important factor affecting the amount of time devoted to residents in nursing homes; leading to nurses feeling that they often fall short of their expectations. Against this backdrop the lack of a shared background as discussed by Holmes & Holmes (1995) further compounds this time pressure, as conversations are likely to take longer. This issue was substantiated in this study by the comments of HCWs.

Having discussed the above factors as barriers to communication, HCWs identified several factors that could enhance communication between HCWs and EMEs. These were: cultural training, availability of interpreters and individualized care.

Cultural training could help HCWs become aware of cultural differences and motivate them to be conscious of their own behaviour, attitudes and beliefs. It could also help them to build

problem solving skills during interactions with EMEs (Langer & Langer, 2015, Williams et al., 2003, RCN, 2004 and 2010). EMEs may have unique cultural needs as identified in this study. Therefore, culturally sensitive communication training needs to be the focus in the delivery of healthcare to EMEs, as cultural barriers have been cited as a significant and common factor in caring for minority and immigrant patients (Yehieli, Grey, & Vander-Werff, 2004, Harwood, 2007 and Likupe, 2014). Cultural competence in communication refers to the ability of being able to interact with people from another culture and doing so effectively. Culturally competent individuals have a good working understanding of the history, socioeconomic background, language, and other factors affecting a particular culture (Yehieli, Grey, & Vander-Werff, 2004).

Being able to understand and speak a common language is an important aspect of need assessment in the care giving process. In the UK, most of the EMEs now found in care and nursing homes were born abroad (Runnymede, 2010). Some elders may therefore not be able to speak English fluently and may also have difficulty understanding the English language. These elders may need interpreters to make their needs known. Using relatives to interpret was seen as inadequate or even undesirable by participants in this study as it could limit how much information was given by elders because of confidentiality issues.

### **Limitations**

The small sample (ten HCWs) in this study means the results are limited in application to the homes and community in which the study took place. Moreover the results reflect the views of those people who had time and were willing to be interviewed. Important information may have been missed from homes that did not give permission for the study. In addition HCWs came from the community and from care homes. There may therefore be some differences in their communication with

EMEs. However, in spite of these limitations the findings indicate that cultural competence in communication is an important attribute for HCWs to acquire in order to deliver culturally competent care.

### **Conclusion**

This study has provided an insight into factors that act as barriers and factors that act as facilitators to communication between HCWs and EMEs. It has shown that at the heart of good care is an effective relationship between EMEs and HCWs. This relationship needs to be based on mutual respect in terms of culture and values. Stereotyping of elders by HCWs based on age and ethnicity has been found to impede communication and care of the elder. The study has also revealed that EMEs may not get optimum care in nursing/care homes and in the community if barriers of communication are not removed. This study has also identified a gap in the cultural knowledge of HCWs and the care that they are required to provide.

### **Recommendations**

The results of this study indicate that training in culturally sensitive communication that is appropriate to the local population should be every managers concern; this may include training HCWs to ask EMEs how they would like to be addressed for example (Age UK, 2012). Cultural communication training needs to address the needs of EMEs with impairments, such as those in hearing and sight. In addition institutions should be encouraged to recruit staff who are open minded and willing to train in culturally sensitive communication. Educational institutions should provide an informed curriculum which enables HCWs to provide culturally competent care using culturally sensitive communication at the individual level. HCWs must be trained to recognise individuality of EMEs to avoid stereotyping in care provision which, may result in the delivery of culturally unsuitable care.

Since communication is a two way concept, we recommend that future studies should seek views of EMEs.

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