WEARING THE SAME T-SHIRT DOESN’T MAKE YOU A TEAM! THE CHALLENGES OF MULTICULTURAL HEALTHCARE TEAMS...with particular focus on patient safety.

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And here is a team in the making...

And one that has made it!
Our ideal healthcare world...

Culturally Competent and Safe Organisations

CCS teams

CCS individual HCP

CCS patient care
So, what does the literature say about multi-cultural healthcare teams...other than T-shirts?

Quite a lot on Cultural Competence

Quite a lot about teams

Quite a lot about patient safety

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The Papadopoulos, Tilki & Taylor model of transcultural health and cultural competence (1998)

CULTURAL AWARENESS
- Self awareness
- Cultural identity
- Heritage adherence
- Ethnocentricity
- Stereotyping
- Ethno-history

CULTURAL KNOWLEDGE
- Health beliefs & behaviours
- Anthropological, Socio-political, Psychological & Biological understanding
- Similarities and differences
- Health inequalities

CULTURAL SENSITIVITY
- Assessment skills
- Diagnostic skills
- Clinical Skills
- Challenging & addressing prejudice, discrimination and inequalities

CULTURAL COMPETENCE
- Empathy, Appropriateness
- Interpersonal/communication skills
- Trust, Respect, Acceptance
- Barriers to cultural sensitivity

Anna Reynvaan Lecture - 19.05.11
Bruce Tuckman's 'Forming Storming' Team Development Stages Model - 1965

forming → storming → norming → performing

Patient safety

AND WE HAVE...

• **WHO - World Alliance for Patient Safety** (established in 2004)

• **The NHS National Patient Safety Agency** (established in 2001)

• **The USA National Quality Forum** (established in 1999)
But still we fail

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Cultural Competence

Safety

Teams
I WILL DISCUSS:

• The **need** for culturally competent and safe healthcare teams

• The **challenges** related to developing culturally competent and safe teams

• The **characteristics** of culturally competent and safe teams

• The **implications** of culturally incompetent and unsafe teams
An Organisation with Memory (DoH 2000) reported that every year...

- 400 people die or are seriously injured in adverse events
- Nearly 10,000 people are reported to have experienced serious adverse reactions to drugs
- Around 1,150 people who have been in recent contact with mental health services commit suicide
- Nearly 28,000 written complaints
- The NHS pays out around £400 million a year to settle negligence claims
SOME MORE FACTS

• There is a long history of international doctors working in the NHS and also of recruitment of nurses from overseas.

• In 2002–2003 more than half of the nurses newly registered with the Nursing and Midwifery Council (NMC) had trained outside the UK.

• EU legislation and policy promotes mobility of people and some EU countries have seen an increase of health staff from the EU (mainly from East to N. West)

• Thus, the globalisation of healthcare has meant that multi-professional healthcare teams are now also likely to be multicultural healthcare teams, with the potential for further barriers to effective healthcare practice.
Many non UK qualified doctors find a distinct difference in the ethical framework of practice in the UK e.g:

- emphasis on individual autonomy and patients' rights,
- confidentiality and informed consent,
- Shared decision making model

Many non UK qualifiers identified concerns about communication on entering practice in the UK (language, dialects etc)

Also concerns about lack of knowledge regarding social, cultural and behavioural norms of host country

Recognition of the ethical, legal and cultural context of the UK health care does not happen until doctors are in practice

Need for training.
Smith et al (c2007) report that overseas-trained nurses are over-represented in cases of clinical malpractice reported to the Nursing and Midwifery Council (NMC), and argue that this is related to insufficient diversity awareness [of the host country]....
The importance of inter-professional practice in health and social care is now recognised.

**Barriers to successful inter-professional practice include:**

- different professional cultures resulting from education and training
- Different communication styles, working methods, time and pace of work, decision-making practices, dealing with conflict, and ways of measuring success
- Expectations of team behaviour linked to traditional hierarchies
Now let’s add the cultural dimension...

- Individual values, attitudes, perceptions and patterns of behaviour may be different among individual members of multi-disciplinary multicultural teams.

- Must acknowledge that managing the cultural diversity that exists in health care poses many challenges.
The complex dynamics

Policies
- Professional codes
- Personal agendas
- Culture of organisation

Inter-professional Multicultural teams

Team dynamics & values
- Individual cultural background
- Personal & professional values
- Decision making & care
- Decision making
- Care

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Johnstone and Kanitsaki (2006)

- Patients of minority cultural and language backgrounds are disproportionately at risk of experiencing preventable adverse events while in hospital compared with mainstream patient groups,

- Contributing factor is the failure of patient safety programmes to recognise the critical relationship that exists between culture, language and safety and quality of care.

- Culture is an influencing factor in shaping people’s perceptions and experiences of health and health care, whether they are the providers or recipients of care.

- They stress that “Patient safety policy ... must contain explicit and substantive mention of the complexities and implications of the mediating variables of culture and language in the clinical encounter” (p387).
We cannot assume that because a person is highly skilled in her/his discipline s/he will be an effective member of a team

**Education and employment institutions’ level:**
- The complexities of team working need to be given more attention during initial training and through continuous professional development

**Team level:**
- Teams must also take time to reflect on how they function and how they can develop better understanding of each other with particular attention to those members new to the country

**Individual level:**
- Each individual has a responsibility to develop good team ‘habits’
He suggests five fundamental dimensions to national culture. These can be summarised as:

1. **Hierarchy** – Hofstede calls this dimension 'power distance'; it relates to the extent to which individuals within a culture accept unequal distribution of power. At one end of this continuum are cultures that value hierarchy. In these cultures, the emphasis is placed on leader status; individuals will expect the team leader to provide direction and make decisions. Individuals within these cultures tend to be accepting of rules and questioning authority may be discouraged.

At the other end of the continuum are cultures that place a lot of emphasis on team involvement, with wide consultation and group decision-making being common. Questioning authority is likely to be accepted or even encouraged in these cultures.
• 2. **Ambiguity** - This dimension, labeled by Hofstede as ‘Uncertainty Avoidance’ deals with the degree to which individuals feel comfortable with ambiguity. At one end of the continuum are cultures that **encourage risk taking**; in these cultures individuals are likely to feel very comfortable trying new and different ways of approaches things. 

• At the other end of the continuum are cultures that **place more value on routine**, regulation and formality. Individuals in these cultures are likely to prefer tried and tested ways of doing things rather than taking risks with unknown methodologies.
3. **Individualism** - This dimension relates to the extent to which the individual values self-determination. In an individualistic culture people will place a lot of value on individual success and the need to look after oneself.

At the other end of the dimension are **collectivist cultures** in which individuals will place more value on group loyalty and serving the interests of the group.

4. **Achievement-orientation** – One end of this dimension is masculine and the other end is feminine. A culture at the masculine end of the continuum will be very achievement-oriented, valuing things such as success, achievement and money. At the other end of the continuum are cultures that place more value on aspects such as quality of life, interpersonal harmony and sharing.
5. **Long-term orientation** – This dimension was a later addition to Hofstede’s work. At one end of the continuum are cultures that **focus on long-term rewards**; at the other end are cultures that are more concerned with **immediate gain**.
How may patient safety be compromised by culturally diverse teams?

Mrs Andrews is an 82 years old Scottish woman suffering from dementia is being nursed on the ward for a chest infection. While there she is refusing to eat. Her caring daughter becomes concerned and asks to discuss her mother’s care with the doctor. It so happened that earlier in the day the medical team discuss Mrs A’s plan of care. The team consists of:

- A 50 year old male English consultant
- A 55 year old male Indian registrar
- A 30 year old female English junior doctor
- A 30 year old female qualified nurse from Sierra Leone
- A 25 year old male student nurse from Russia

- Both the qualified nurse and the student nurse have been living in the UK for a short period of time.

Let us analyse a few aspects of this scenario using the Hofstede framework.
Hierarchies

Emphasis on team
English
Junior DR

Hierarchy

Values
Hierarchy
Indian Registrar

Expect each team member to make a contribution in the discussion and participate in the decision making.

Views the consultant as the leader and respects his decisions. Expects others ‘below him’ to comply with his decisions.
Risk taking
male student nurse
from Russia

Values Routine
female qualified nurse
from Sierra Leone

Ambiguity

Direct in expressing his views and challenging common practice

Secure in routines and happy to go along with decisions made on common practice

But how would they behave when caring for Mrs A on their own?

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Both ‘English’ doctors would view the death of Mrs A as a failure in their part. The young Russian student wants to gain different experiences which will help him complete his course.

These two professionals come from collectivist cultures; group goals are more important than personal goals.

But how would they behave when caring for Mrs A on their own?

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Mrs A. represents a challenge to them and they both wish to succeed for different reasons.

Mrs A. represents a challenge to them and they all wish to agree a plan of action although some may insist in involving the family whilst others think this is not necessary as they are the people who know best.
Different appreciation of time and urgency. Mrs A will benefit from a team that has time to reflect on discussions and understand each other better.

Want to see the team working efficiently and responding to Mrs A’s needs as soon as possible.
A GOOD TEAM IS LIKE AN ORCHESTRA...
• We talked about the differences between members of teams...now let’s talk about the similarities. Are there any universal values/virtues we should be cultivating?

• Can we draw any of these from the orchestra metaphor?
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SUCCEED TOGETHER

Common Purpose

PRACTICE TOGETHER

Individual skills

LEADERSHIP

Common Language (music)
Aristotle said...

Almost 2.5 thousand years ago the Greek philosopher Aristotle (384 BC – 322 BC) espoused that the following five virtues will make us and our colleagues happy (or help us flourish). Possessing these virtues can only impact positively on our patients:

- **Compassion**
- **Courage**
- **Friendship**
- **Self love**
- **Forgiveness**

Each member of the team must cultivate the habits of these virtues by practicing them. Teams must practice and practice and practice these habits together. Team leaders who encourage the development of these habits have successful teams which deliver high quality care to patients.

I propose that people from all cultures desire these to some degree.
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Forming
Cultural awareness

Storming
Cultural knowledge

Norming
Cultural sensitivity

Performing
Cultural competence

Friendship

Self love

Forgiveness

Courage

Compassion

Translating evidence into safer and culturally competent care

Measuring harm

Understanding causes

Identifying solutions

Evaluating impact

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• Let us build healthcare worlds which prepare and support healthcare teams to be **culturally competent in order to provide safe and compassionate care.**

One person cannot whistle a symphony... BUT a **T.E.A.M.** can...

**Together Everyone Achieves More**

**Thank you!**