CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 2: 2011-2012

OBSTETRICS & GYNAECOLOGY: DEALING WITH DIVERSITY 2
(WOMEN'S HEALTH)

FACILITATORS' PACK V.17 (03/05/2011)

CCS Stage/Level 2 Co-ordinator:
Mandy Williams
Senior Tutor in Clinical Communication

CONTACT DETAILS:
Clinical Communication Skills Assistant
01223 (7)60751
ccs@medschl.cam.ac.uk

Acknowledgements

Many of the ideas, exercises and actual words used in this document have been taken from two excellent sources which have been highly influential in the setting up of this session:

Valuing diversity: a resource for effective health care of ethnically diverse communities, edited by Joe Kai, RCGP 1999

Communication and Cultural Diversity Tutors Guide: St Bartholomew's and the Royal London School of Medicine and Dentistry, Annie Cushing 1999

CULTURAL AND SOCIAL DIVERSITY (OBSTETRICS AND GYNAECOLOGY)

Introduction

The Dealing with Diversity 2 session of the Clinical Communication Skills Theme occurs within Stage/Level 2 of the Women's Health module and has been jointly planned by the O&G department (Attachment Director: Andrew Prentice, University lecturer) and the CCS Team.

This session is the second of a series of three workshops on dealing with diversity in the Clinical Communication Skills Theme. In Stage 1, we start our exploration of dealing with diversity with a seminar exploring the different cultural and disability issues which impact on the medical interview. Here in Stage/Level 2, we move from an attitudinal to a skills approach: students work with simulated patients from culturally diverse backgrounds to enable them to develop practical skills in communicating across cultural boundaries. In Stage/Level 3, we hope that students will work with interpreters to develop their skills in working with patients with little or no English.

This session is one of a coordinated strand of sessions specifically dedicated to the joint teaching of communication and clinical content, both related to learners' current clinical context. Here, the obstetrics and gynaecology department have elected to teach the communication issue of dealing with diversity combined with the content area of heavy, painful periods. Knowledge and communication will be taught hand in hand, validating the central importance of both to successful gynaecological practice.

Aims of the dealing with diversity session:

Aims of the Women's Health module:

1. to provide an opportunity for students to have safe, observed practice in taking the gynaecology/obstetric history
2. to enable students to explore the content area of heavy painful periods and dyspareunia
3. to raise awareness that working with patients from different cultural/ethnic/religious backgrounds may pose particular difficulties because of the intimate nature of the specialty

The students will already have received an introduction to the gynaecological history and a lecture on menstrual disorders. This session aims to cement their learning by providing safe observed practical experience and expand their understanding of the need for sensitivity to each individual patient's beliefs and concerns within gynaecological practice.

Aims of the CCS course:

1. helical reiteration of the students' communication skills learning in the introductory course: initiating the session, gathering information, structuring the interview and building the relationship

2. further exploration of how and where to incorporate the specialist functional enquiry into the structure of the medical interview using the Calgary-Cambridge guide

3. exploration of the communication issue of dealing with diversity with further emphasis on the core skills of understanding the patient's perspective and of building the relationship

At this stage in the students' development, we are concentrating more on information gathering than information giving skills. The two scenarios chosen will provide a history-taking interview format and provide students with an opportunity for helical reiteration of the skills learnt in the introductory course. Using cultural diversity roles it will allow us to highlight some of the specific communication challenges of dealing with diversity and emphasise the importance of the core skills of exploring the patient's perspective and building the relationship. Setting the scenario within obstetrics and gynaecology enables us to explore the need for sensitivity with regard to personal and sexual questions and the need to explore the ideas, beliefs and expectations of each individual patient. The need to take into account cultural issues without stereotyping the individual will be explored.

Objectives of the cultural and social diversity session:

Helical review and refinement from Stage/Level One
At the end of the session, you will be able to:
Initiate an interview by:
- establishing a supportive environment and initial rapport
- developing an awareness of the patient's emotional state
- identifying as far as possible all the problems or issues that the patient has come to discuss
- establishing with the patient a mutually agreed agenda or plan for the consultation
- developing a partnership with the patient, enabling the patient to become part of a collaborative process

Gather information by:
- exploring the disease perspective so as to obtain an adequate "medical" history
- exploring and understanding the patient's perspective so as to understand the meaning of the illness for the patient
- ensuring information gathered about both frameworks is accurate, complete and mutually understood
- ensuring that the patient feels listened to, that their information and views are welcomed and valued

Structure the consultation by:
- summarising, signposting, sequencing and timing

Build the relationship by:
- developing rapport to enable the patient to feel understood, valued and supported
- ensuring reduction in potential conflict between doctor and patient
- encouraging an environment that maximises accurate and efficient initiation, information gathering and explanation and planning
- ensuring the development and maintenance of a continuing relationship over time
- involving the patient so that he understands and is comfortable with the process of the consultation

New skill acquisition
At the end of the session, you will have:

Gained further skills in gathering information to enable you to**:**
- incorporate the specialist functional enquiry into the structure of the medical interview as shown in the Calgary-Cambridge guide, using appropriate skills and timing

Explored the communication issue of cultural and social diversity by:
- identifying and practicing those communication skills that need particular emphasis in working with patients from ethnic minorities
- looking at key specific skills in cultural diversity, for example:
  - awareness of the possibility of differences in nonverbal communication patterns
  - how to avoid assumptions, stereotyping or patronising
  - how to value, explore and understand cultural differences (related to social, religious, and health practices and beliefs)
  - how to be sensitive to the patient's wish to be interviewed with a family member or by a female or male doctor
- exploring the danger of stereotyping the individual or making assumptions, and the need to consider that there is as much variation within as between cultures
- further exploration of the core skills of understanding the patient's perspective and of building the relationship

Incorporating the specialist functional enquiry into the structure of the medical interview as shown in the Calgary-Cambridge guide, using appropriate skills and timing

Our aim for this component of the session is to enable students to practice the gynaecological functional enquiry as laid out below, within the context of a collaborative medical interview – how and when to ask the following questions are as important as what questions to ask:

The gynaecology functional enquiry (provided by Andrew Prentice):

1. **Menstrual history**
    a. Frequency and regularity of menstruation: how often, are they regular, when was the start of the last one?
    b. Duration of menstruation: how long do they last?

2. **Other bleeding from the genital tract**
    a. Bleeding between periods
    b. Bleeding after intercourse

3. **Symptoms associated with menstruation**
    a. Dysmenorrhoea: are they painful?
    b. Heaviness of menstrual loss: are they heavy?
        i. Flooding
        ii. Passing clots
        iii. Frequency of changing protection, need for double protection, need to change overnight
        iv. Interference with normal lifestyle

4. **Other gynaecological symptoms**
    a. Vaginal discharge
    b. Galactorrhoea – discharge from the breast
    c. Menarche – age at onset of first menstruation
    d. Dyspareunia – pain on intercourse, where is the pain?
    e. Post-coital ache

5. **Cervical Smear history**
    a. Date of last smear
    b. Whether normal or abnormal
    c. Any previous abnormal smears

6. **Drug history**
    a. In particular contraceptive history
    b. Any drugs taken
    c. Any allergies

Format of the dealing with diversity session:

Each three hour session will be co-facilitated by a member of the O&G department and by a communication facilitator. **If for any reason the specialist from the O&G department does not attend the session, please report this to the CCS office by recording it on the facilitator feedback form.** Two simulated patient cases will be presented in each session.

The group will be divided into six small groups. In the rotation the sessions will occur in Weeks 1, 2, 3, 4, 5 & 6 (students attend one session depending on which group they have been allocated too). The sessions will occur on a Tuesday afternoon from 14:00-17:00 and will be held in the clinical skills unit if possible.

Please arrive 15 minutes before the start of the session.

Please note that student packs now contain the following information:
Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish by 16.50 to allow time for this and student evaluation/feedback.

Students' written feedback on the sessions will be made using the CAMS system

Recording equipment will be used in all sessions

Special care in facilitation in this cultural and social diversity session:

The need for support of ethnic minority participants:
When facilitating your sessions, please take time to consider how best to meet the different needs of ethnic minority participants. An increasing proportion of medical students are from differing ethnic backgrounds. Although ethnically diverse, it is worth noting that many share and sometimes identify strongly with a similar cultural background and range of experiences of those of colleagues, for example in privileged social class and education. Therefore take care with normal ground rules and ensure that learners are not pressurised to contribute or respond in a way that makes them feel uncomfortable. Think about:

- how are ethnic minority participants likely to feel during the session?
- how can you make sure that ethnic minority participants are able to voice their responses and opinions and reactions and are able to intervene if racist or derogatory remarks are made?
- in what way will you be able to reinforce positive things about people with differing backgrounds to reduce stereotyping and culture blaming?
- how can you support participants if others are hostile or racist either personally or in general will you have a closer relationship to people in your own ethnic group to others – will this be difficult for you?
- how to deal with conflict, anger, general discomfort, silence

Plan
Three hour session 2-5pm

2.00 Introduction: 5 mins

- Welcome, introduce your self and your co-facilitator, explain how this session fits in with their overall learning
- Brief round of names
- Outline a temporal plan for the session, explain the joint O&G and CCS aims and signpost methods for the session
  A plan of the session is provided as a PowerPoint so that they can keep a structure in their heads of what happens when. An PowerPoint of the objectives is also included
- Emphasise the point of safe practice rather than being judgemental
- Emphasise equally the cultural, communication and O&G content areas of the session

Part One: Skills in communicating across cultural boundaries / the gynae history
Aims for the facilitators:
To remind the students re their learning in Stage 1 re diversity
To explore the difficulties of the gynae history
To explore the skills required in interviewing someone from another culture

2.05 Names: Patient experiences of gynaecology 10 mins

Tell students you are going to ask each person to introduce themselves and tell us (without mentioning names) about a friend or relative who had a gynaecological problem and that person's experience of dealing with it. Summarise with an overview of their experience: how wide, if representative (mention if they don't TOP, infertility, dyspareunia, contraception, PMT, HRT, incontinence, prolapse, culposcopy, hysterectomy, discharge – all difficult areas for the patient)

2.15 Difficulties in taking the gynae history 10 mins

OK let's turn this round to us as doctors

1. Have you all watched outpatients in the gynae clinic? What have you seen so far? What have you done yourself
2. Brainstorm problems that they might have themselves in taking the gynae history – difficulties they have had or could anticipate experiencing in communicating with patients if they were the doctor
3. Look at handout of functional enquiry questions. What questions would be difficult to ask? Tick those which they would personally find difficult
4. What questions would they like to practice?

2.25 Difficulties and skills in cross cultural communication 20 mins

Let's return to the cultural diversity part of this session. We need to return to thinking about this – some time since you started this in phase 1 and looked at some of the issues that might occur.
What have you seen now? What experiences have you had already of working with patients from a different culture from their own – free discussion

Can we briefly go over again the issues you need to consider in interviewing patients from different cultural backgrounds. Brainstorm problems working and communicating with those from other cultures. **Do this fast** - help with overhead of five headings as below (without the details filled in)

Use of Language

- English as a second language
- Use of slang
- Accent/Dialect
- Giving offence through over-familiarity etc

Non-verbal communication

- Physical Touch

- Body language
- Proximity: Closeness/distance
- Eye Contact
- Expression of Affect/Emotion

Cultural Beliefs and health care

- Interpretation of symptoms - what is considered normal & abnormal
- Beliefs about causation
- Other sources of health care that this cultural group will seek
- Gender expectations about roles and relationships
- Role of doctor and social interactions related to respect, power and patient adherence to medical recommendations
- Family Life Events (i.e. Rituals and beliefs around Arranged Marriages, Pregnancy & Childbirth, Older Adult Care giving, Death)
- Psychosocial issues (Identifying common stressors, awareness of diversity in family/community supports)
- Role of doctor re: Mental Health Counselling (Assessing, diagnosing and treating common mental health issues

Sensitive issues

- Sexuality: including sexual orientation, sexual practices and birth control
- Discomfort performing some physical examinations
- Use and abuse of alcohol and other substances
- Domestic violence & abuse
- Sharing Bad News

Medical Practice Issues/Barriers

- Extent of Doctor/Patient Partnership and Responsibility for healthcare and treatment
- Ethical Issues in Care
- Doctors assumptions, stereotyping or prejudices

But remember, equally important to avoid stereotyping people by making assumptions about their cultural background – highly dangerous, as much variation within a cultural group as between. Need to see people as individuals with their own perspectives and cultural context. Overall, two slightly conflicting communication problems – how to avoid making assumptions about a patient based on their ethnicity and how at the same time to value and be willing to explore and understand cultural differences that might make a considerable difference to how you care for them.

Re-visit the **plan of stages of the interview** on the CC guide on the wall, and review **disease and illness**.

Explain that the communication areas in cultural settings that you need to consider even more than usual are **building the relationship** and **understanding the patient's perspective – remind them that the concept of the patient's perspective originally came from cross-cultural work.**

2.45 – 3.00 Tea	**15 mins**

Part Two: Experiential skills training

3.00 Communication Simulated Patient 1:	**1 hour**

Here we present **two simulated patients** who come with the same name and referral letter. One patient though has the symptoms of dysfunctional uterine bleeding, is second generation, educated and more assimilated. The other has the symptoms of endometriosis and has a more traditional, less assimilated background. We start with the patient with endometriosis.

The nature of the cultural issues that arise might include unhappiness seeing a male student, difficulty in use of language, difficulties in discussing menstrual or sexual function, concerns re vaginal examination

etc. effects on life such as being unable to pray during prolonged periods, cultural attitudes to fertility, hysterectomy or sterilisation, individuality versus stereotyping.

Get started as soon as possible with the first role to maximally use the simulated patient. Here the patient has the symptoms of endometriosis and has a traditional, less assimilated background.

Facilitator to set up communication session:

- describe the specific scenario in enough detail to orientate the group (setting, information already known, **show GP letter** etc.)
- specifically explain who the learners are and what their role is in the scenario (i.e. medical students in gynaecology out-patients)
- get the students to discuss the general issues that the role provides first, before the student sets their own objectives as below
- explain that the interviewer can stop and start and break for help whenever they would like
- when the learner rejoins the group, provide communication skills feedback on the interview so far.

We want to use this role to bring out cultural aspects of communication. In this role, they are:

- **unhappiness seeing a male student or doctor**
- **difficulty in use of language**
- **prolonged periods prevent praying**
- **live in extended family**
- **mother in law's wish to have a grandson - concern re fertility**
- **difficulties in discussing periods or sexual matters even with a female**
- **concerns re vaginal examination etc.**

To enable this to happen, the actor will play the role as follows:

Start off quietly and take a little time to get confidence. If it is a male medical student this is even more difficult for you. If the medical student asks you, "what problems brought you to the hospital today", answer; 'well, my periods have been very heavy and I've been getting a lot of pain'. Stop there smile and look away. See where the student then goes and be happy to tell him/her your story if asked to elaborate. You find discussing periods difficult even with a female but try.

Start with the bleeding and then go onto the pain. Then in a while give a big cue:
'and its causing problems at home……'

Stop and only continue about this if the student picks up this cue and asks you what problems you have been having. Then say:
'I can't go to the temple to pray when I am bleeding so much…..'

If asked, explain why that is so in your religion. Also say that this causes friction between you and your husband. Please do not mention the issue of having only one child and the pressure on you to have more unless asked about your wishes about having more children by the doctor.

At some point half way through this first case, after one or two role-plays and soon <u>after</u> the issue of bleeding preventing praying has arisen, break and say: now let's think about what cultural issues may be around – there are two sources:

- **picking up cues already - e.g. use of language, non-verbal - how is that influencing things - what do you have to do to cope with it; praying and bleeding**
- **what we know about a cultural group - if you had some knowledge of the cultural group in question or worked closely with it, what could you know about a lady called Meena Patel that could be helpful to you here (and we say some if they don't know) - what religion would she be, where might she come from, what cultural issues might be relevant here e.g.**
    - **religion**
    - **social situation – extended family**
    - **concern re fertility - mother in law's wish to have a grandson**
    - **attitudes to hysterectomy**
    - **unhappiness seeing a male student or a male doctor**

- **difficulties in discussing periods or sexual matters even with a female**
- **concerns re vaginal examination etc.**

So are there areas this might trigger you to want to know about - and if so, how do you address them without making assumptions or giving offence - they could then try first open questions about effect on life, ideas, concerns and expectations without assumptions, then if necessary try bringing up specific areas such as religion or fertility in a non-judgemental fashion 'you mentioned that you have a three year old child, would you like to have more?' followed by if necessary 'I hope this is OK to ask but sometimes problems with periods and having children can cause difficulties in families - has that been a problem for you at all?'

Chunk the role-playing and feedback into small aliquots. Although the flow of the interview is truncated this way, you can get many more participants involved and the feedback on communication skills works much better. You can remember what happened in each small bit, give more focused feedback, use the actor's feedback better, use the tape more and do re-rehearsal of different approaches much more. This latter makes the students see the importance of working with the simulated patient - instead of being on trial, they really discover how to do the stages of the interview and find different ways to do so.

Stop each person at a pre-determined point e.g. at the end of the introductions and establishing rapport. Again after taking an open history and before asking detailed questions. At each stage do good well paced communication skills teaching. It will be much easier to do revisiting the intro course stuff if we break it down into sections and get everyone involved - five minutes or so each rather than 40 minutes for one!

It will be essential to balance their exploration of the disease aspects within the interview with their exploration of the patient's perspective. Overall, we need to work with effective ways of gathering information about both disease and illness.

Remember to:

- look at the micro-skills of communication and the exact words used
- practise and rehearse new techniques after suggestions from the group
- make sure to balance positive and negative feedback
- bring out patient centred skills (both direct questions and picking up cues) as well as discovering facts
- utilise simulated patient feedback

Ask each student:

- What would be the particular issues for you here (try to get the participant to hone them down)
- What are your personal aims and objectives for the role-play
- What would you like to practice and refine and get feedback on
- How can the group help you best
- How and what would you like feedback on

Emphasise to the "doctor" that OK to stop and start whenever. Take time out or start again, as required. Re-play a section or re-play the whole lot, or just stop when help needed.

Feedback

- Start with the learner –
  how do you feel?
  can we go back to the objectives? Have they changed?
  how do you feel in general about the role-play in relation to your objectives?
  tell us what went well, specifically in relation to the objectives that you defined?
  what went less well in relation to your specific objectives?
  or "you obviously have a clear idea of what you would like to try."
  would you like to have another go?
  what do you want feedback on?
- Then get descriptive feedback from the group
- Use the recordings
- If participants make suggestions, ask prime learner if they would like to try this out or if they would like the other group member to have a go. Try to get someone else to role-play a section if they make a suggestion for doing it differently. "Would anyone else like to practise?"

- Bring in the simulated patient for insights and further rehearsal: ask actor in role questions that the group has honed down

As the session proceeds, ensure that equal emphasis is given to the problem of cultural diversity and gynaecological history taking. Bring in the co-facilitator to discuss the content of the case near the end.

Facilitator to get the group to see how knowing the patient's ICE will help the patient and the doctor to manage the illness

4.00 Communication Simulated Patient 2:	**50 mins**

This patient has the symptoms of dysfunctional uterine bleeding, is second generation, educated and is more assimilated. We use the same letter.

In the second case, let the students take more of a gynae history and then break again to discuss what is happening but this time it will become clear that the patient's concerns will be more appropriate than a cross-cultural approach. This will help the discussion of avoiding making assumptions.

In this role, we can shift the focus to the communication issues of how to pick up cues and explore them, how to acknowledge the patient's perspective and how to be empathetic. To help, the role-player will change from a confident approach when sex is mentioned and will falter and say it is embarrassing to discuss it. She then will need careful drawing out with:

- **empathetic statements**
- **acknowledging**
- **silence and space**
- **gentle exploration of her concerns**

Thus we could really teach on picking up cues and how to handle them, a problem we discovered in the end of Stage/Level 1 OSCE.

4.50 Endings	**10 mins**

Rounds of what learnt

Handouts, feedback sheets

Look at handout below with students.
Map these to the C-C guide skills, esp. building relationship and patient's perspective. Explain how many of these are skills we use in all consultations, not just with those from obviously different ethnic backgrounds, but how they need applying in more depth and intensity here:

Individual feedback if appropriate

Your evaluation of the session
There is a feedback form provided for your comments on the session as a whole and to feedback on any student who is struggling and requires extra help in any way. If a student has been referred for help on more than 2 occasions in any one stage/level of their clinical studies, they will be contacted by the Senior Tutor in Clinical Communication and offered an appropriate programme of remedial support.

Please inform the student that you are being referred for support but that they will only be contacted on receiving the third referral. If they have any concerns about this they should be advised to contact Mandy Williams (mw480@medschl.cam.ac.uk), Senior Tutor in Clinical Communication.

It is important that you state why you are highlighting a student for help and what you have observed. This will assist the team in ensuring appropriate and timely support is provided.

We would also like you to identify any student who is clearly performing at a high level and you would like to nominate for the CCS prize

Cultural and social diversity

Key core skills

These skills relate particularly to the skills of

1. *building the relationship*
2. *understanding the patient's perspective during the information gathering phase*
3. *utilising the patient's perspective during the explanation and planning phase*

- checking pronunciation of name and how the patient would like to be addressed
- **demonstrating interest, concern and respect**
- **picking up verbal and nonverbal cues**
- **discovering the patient's ideas, concerns and expectations of medical diagnosis and treatment**
- non-judgmental acceptance of ideas and beliefs
- sensitivity to feelings and emotions
- empathy
- sensitivity with the clinical examination
- clarity in giving information
- checking understanding
- relating explanations to patient's illness framework
- negotiating approach to management
- checking if concerns have been addressed

<u>Key areas needing special care:</u>

- awareness of the possibility of differences in nonverbal communication patterns
- willingness to explore and understand cultural differences (related to social, religious and health practices and beliefs)
- avoiding making assumptions, stereotyping or patronising
- sensitivity to the patient's wish to be interviewed with a family member or by a male or female doctor
- interviewing more than one patient at a time
- willingness to understand different family and marital relationships
- offering choices for example the examination of female patient by a doctor of the same sex
- offering the help of an interpreter and handling an interpreter in the interview
- understanding social and community networks

Here are some examples of phrasing to help you achieve a balance between exploring and valuing cultural differences and avoiding making assumptions (although remember, your non-verbal behaviour and your ability to pick up cues are even more important):

In general, if your initial questions would work equally well for the majority culture, you are on the right track - asking questions about the individual patient or the patient's family rather than about their culture helps personalise rather than label:

- "What effect is all this having on your life and on those around you?"
- "Can you tell me a little about yourself and your family" – then for instance you could ask any of the following: "where do you live…...who is at home with you….where was your family home…what are your parents' background…..do you practice a religion yourself?"
- "You tell me that your body hurts all over…do you have any ideas about why this might be?

When you don't know the patient or relative and are unsure whether to shake hands:

- observe the person's response
- apologize if they seem offended - you didn't mean to offend.
- make sure to do something else instead to build the relationship

Ask permission if you wish to ask a sensitive question

- 'Would it be alright to ask you about this or not?'

Ask what would help

- 'I need to ….. is there anything that will help you with this?'

Explain why

- 'This may be difficult for you, the reason I need to ask you / do this is……"

- ‘Sometimes people have their own explanations for things and it helps to understand patient’s views.’
- ‘I know that sometimes women would prefer to be examined by a female doctor – is that important for you?”
- “I can understand that it must be frustrating for you that I can’t understand you as well as you would like. Would it help if we had an interpreter?”

If say you are dealing with a gynaecology problem, you might want to ask:

- “I know that problems with fertility can cause tensions in families, has that been true at all for you?”
- “Sometimes, people’s family or religious backgrounds are very important when discussing gynaecological problems – is that so for you?”

Then follow according to the patient’s response:

- “You mention that you are from Afghanistan. I don’t know anything at all about Afghanistan culture..... are their strong views about hysterectomy in Afghan culture? ”
- “I’d like to know what sort of treatment you were expecting..... or hoping for. From what little I know of Chinese culture, it might be quite different from what we offer here, and I’d like to help”.

HANDOUT I

Referring GP:
Dr. Alison Evans
Cherry Hinton Medical Centre,
Cambridge

To:
Mr. Andrew Prentice
Consultant Gynaecologist
Addenbrooke's Hospital

Date: three months ago

Re Mrs Meena Patel, 23 Maple Close, Cherry Hinton, Cambridge

Age 35

Hospital number 374910

Category: in turn

Dear Mr. Prentice,

Thank you very much indeed for seeing this 35 year old woman who presents with heavy painful periods over the last year. I have treated her with both tranexamic acid and mefenamic acid but her periods remain a problem.

She is finding the symptoms difficult to bear and I would be grateful for your further assessment and advice regarding further management.

Thank you very much,

Best wishes

Yours sincerely

Dr. Alison Evans

HANDOUT II

Commentary on the content of the first case (provided by Andrew Prentice)

The first patient is suffering from **endometriosis**. The most common symptom associated with this condition is *painful periods* (dysmenorrhoea) but other painful symptoms may be associated with the condition such as *lower abdominal pain* (pelvic pain) at other times of the month and *pain during and/or after intercourse* (dyspareunia and post coital ache). The pain on intercourse is deep inside and is not prevented by having intercourse in different positions. Pain at initial penetration is not a feature of endometriosis. Patients with endometriosis may or may not have heavy periods. Patients complaining of heavy periods may pass clots, may soak through their sanitary protection (flooding), may have to change protection frequently or get up at night to change, and may even have to resort to extraordinary means to protect themselves (towels, baby's nappies). For a proportion of patients excessively heavy periods may interfere with lifestyle.

Painful periods in patients with endometriosis may start a few days before the onset of the period itself. Painkillers that can be bought in a pharmacy – paracetamol, aspirin or ibuprofen, may relieve it. Women using the *combined oral contraceptive pill are less likely to have endometriosis* and also are less likely to have painful periods. Women with endometriosis may not always have had painful periods and a typical history is of initially periods that were not painful but that lately the periods have become painful and the severity of the pain is increasing – may no longer respond to simple painkillers, interfering with normal life, having to take time off work, making physically sick with the pain. Painful and heavy periods may be more common in women who use an IUCD (the coil). It is important to establish whether the patient wishes to have more children as infertility may be a feature but also because some of the treatments are contraceptive or sterilising – it would therefore be useful to decide whether your family was complete or if you wished more children or if you have had difficulty in becoming pregnant.

Women with endometriosis may have a *regular or irregular menstrual cycle* – regular means anything from 21 days to 35 days from the start of one period to the start (first day of bleeding) of the next (average 28 days). Regular cycles do not vary by more than 7 days from month to month. Irregular cycles are usually but not always longer than 35 days and will vary more than 7 days from month to month. It would be unusual for a patient with this condition to complain of either bleeding between periods or bleeding after sexual intercourse.

More rarely patients may have other complaints due to the condition. Pain on opening the bowels at time of the period only. Passing blood from the back passage - again at the time of the period only. Otherwise it is unlikely that women will complain of any bowel or urinary tract symptoms.

A commonly believed misconception is that once you have had a baby you cannot have endometriosis. This is not true. One of the conditions that may be confused with endometriosis is pelvic infection – in pelvic infection periods would not be painful but intercourse would. In addition it is likely that there would be excessive offensive vaginal discharge. In the patient with endometriosis it is unlikely that there would be any complaint of discharge – a small amount of white discharge or an increase in the amount of discharge in the middle of the month is normal but equally it would be common for a woman to say she has not noted any problem. Discharge from the breast would not be a feature of the condition

HANDOUT III

Commentary on the content of the second case (provided by Shazia Malik)

The second patient has 2 distinct problems. She is suffering from the physical problem of menorrhagia and also from a psychosexual problem. The management of these problems is related in this patient as we need to examine her in order to assess her pelvis and she may find she is unable to allow this at this point.

Menorrhagia is defined as a menstrual blood loss of 80ml or more on average per menstrual cycle. In practice, this can only be measured objectively in the research setting as it involves collecting used sanitary protection and using the alkaline haematin method to measure the blood lost. We are therefore usually limited to more subjective assessment, such as asking about clots, flooding, limitation of lifestyle and symptoms of anaemia. Some units use a pictorial chart (Higham chart) to try to get a clearer idea of the amounts lost per cycle. Many women resort to using double protection but this patient is limited to using pads alone as her vaginismus prevents her from using tampons. Her periods are regular, so she is likely to be suffering from ovulatory dysfunctional uterine bleeding. She may however have for example submucous fibroid or endometrial polyps causing her heavy periods and we should look for such a cause as first line medical therapy has failed to improve her symptoms.

Women with vaginismus can find that this affects several areas of their lives. If they are unable to have sexual intercourse, then not only does this mean that they are unable to conceive but also their relationship with their partner can become strained. They may be suffering from depression as a result of the primary problem causing the vaginismus and also secondary to its effects on their relationships. This patient has insight into the cause and consequences of her problem and has already sought professional help.

This case requires excellent communication skills from the doctor in order to instil confidence in the patient. The doctor must be able to discuss sexual matters comfortably and also mustn't rush the patient. Someone trained in psychosexual counselling would be best suited to this, and we have special clinics for this. In this case, one could decide with the patient how to deal with each problem and in which order. The treatment of her vaginismus is likely to take sometime to resolve and may require counselling as well as physical measures such as the use of vaginal dilators.

Although this is one of the patient's concerns, ovarian cysts do not usually present with menorrhagia. They often present late, either acutely with pain due to torsion or rupture, or with vague symptoms such as abdominal bloating, frequency of micturition or even as an incidental finding. It would be easy to do a pelvic ultrasound in this case, but to assess the endometrial cavity we need to do an outpatient hysteroscopy and take an endometrial biopsy. This may not be possible because of her difficulties with being examined vaginally. We might need to consider a hysteroscopy under GA in day surgery, and could defer both the vaginal examination and cervical smear until then. If she has a submucosal fibroid or polyps, these could be dealt with at the same time. If no cause is found for her menorrhagia, we need to think of how to manage it. Dealing with the vaginismus is essential before she can try for a family, so a Mirena IUS in the interim for her heavy periods could be considered, as fertility returns to normal pretty much as soon as it is removed. Ablative treatments are not suitable in someone who wishes to try for a pregnancy.

CULTURAL ISSUES

The communication skills needed for exploring cross-cultural issues are a special case of the core skills used in understanding the patient's perspective (in gathering information and in explanation and planning) and in relationship building.

Many of the concepts which helped formulate the disease-illness model (as discussed in Chapter 3 of the Skills book) came originally from anthropological and cross-cultural studies. Multicultural interviews were viewed as an extreme example of all medical encounters and the lessons learned were later applied to doctors and patients working within a single culture. Here we are reversing the process and exploring how the core skills of discovering the patient's illness framework apply to the specific difficulties of the cross-cultural situation where doctors and patients often hold differing cultural perspectives.

Increasingly we encounter ethnic complexities and mobility of peoples throughout the world. **Johnson and colleagues (1995)** have said that "each culture is a textured pattern of beliefs and practices, some of which are coherent and consistent and others contested and contradictory". They suggest that doctors must explore a patient's health beliefs and views of their symptoms and illness in every medical interview. If doctors ignore this advice, they risk making assumptions, value judgements and stereotyping patients. This can lead not only to conflict but also inaccuracy.

Johnson and colleagues also make the following points which doctors may find useful to keep in mind when consulting with a patient who comes from a different culture from their own: a person's culture provides her with ideas about health and illness, notions about causality, notions about who controls health care decisions and how steps in seeking health care are made. They have also developed a useful explanatory model which sets out common differences between Western-trained physicians and traditional ethnic patients. This approach is supported by a cross-cultural study by **Chugh et al (1993).** Their main findings were that there were a number of barriers to patient satisfaction, to doctors giving diagnosis and treatment and to patients receiving it. The barriers were related to the patient's cultural experiences, ideas, beliefs and expectations as well as language difficulties.

Myerscough (1992) and **Eleftheriadou (1996)** give some excellent and detailed information about a number of problems related to culture commonly encountered by Western physicians. Examples given include: the importance of the family structure and life-style, women's roles, attitudes towards women and their children, dress, religion, food and fasting, and life and death.

Some knowledge of the different ethnic cultures in which a physician practices is useful and in some cases it is vital. But the core skills of understanding each individual patient and their particular health beliefs, whichever culture they come from, remain essential. Some knowledge and familiarity undoubtedly gives the doctor confidence and may allow some "short cuts" to be made. But labelling the patient with the attitudes and outlook of a whole race or culture may be just as damaging as not being sensitive to cultural issues at all; the doctor's objective must be to find out each individual patient's unique perspective and experience of illness. This is just as important when both doctor and patient share the same culture.

Why doctors need to concern themselves with Cultural Issues?

Interpretation of Symptoms:
Whether a person interprets a symptom as 'abnormal' may be culturally determined e.g. diarrhoea may be common in some populations and even visible parasites in the stool may not be considered pathological by them. In western culture working class elderly are more likely to accept visual problems as 'natural' and not seek medical care than members of the middle class.

Beliefs about causation:
Conditions which doctors may attribute to psychosocial problems may be thought to be due to organic causes by some patients who resist interpretations of emotional causes and stress.
Illness may be attributed to wrongdoing, indiscretions, offending someone or failing to honour social obligations in some cultures. Additionally some people and cultures may be more fatalistic about illness and hold no concept of personal health behaviours and lifestyle causing illness.
Explanations for symptoms may relate to alternative paradigms such as the blood being too much, too little, too thick, too thin or 'stagnant'. Imbalances of 'hot' and cold'; eating the wrong foods; being in draughts, etc. Doctors' prescriptions or advice may not match what the patient considers the cause and this will affect their compliance.
How to ask about beliefs? Don't expect patients to be able to tell you - link this with power, age, and expectations.

Doctor-patient interactions:
In the UK doctors usually deal with the individual patient when an adult. Some cultures will expect the family to be involved or even primarily interacting with the doctor and making the decisions on behalf of the patient.
Poorer patients from rural backgrounds are likely to see the extended family as much more significant than upper or middle class patients from industrialised cultures where people are more socialised to be self reliant.
In some cultures people may be more used to accepting orders and directions from those they consider superior and want to be told what to do by a doctor, whilst in other cultures patients may want more involvement, choice and their views to be taken into account in decisions.
It may be particularly difficult to talk about some subjects with certain cultural groups although these may be very important for good clinical practice. Over-sensitivity on the part of the doctor could lead to the risk that she or he does not obtain important information from the history or examination.
Doctors' prior experience that some cultures manifest psychological distress in physical symptoms could lead to the risk of overlooking real organic disease when it occurs.

Steps people take in seeking care:
In any culture most people self-medicate, consult with family members or other trusted lay people before entering the formal health care system. People may be consulting simultaneously with an alternative healer and a western-trained doctor.
They may have different expectations from each of these practitioners and they may be reticent to disclose to any of them that they are attending another practitioner or taking other medications and remedies.

How to discover these issues:
Establishing a relationship of trust, open-mindedness and respect will be important to attempt to discover such information. It may be possible to learn a lot from patients. However, cultural issues themselves may make it difficult for a doctor (or medical student) to discover some of these issues. Patients may not be prepared to talk about them. Health advocates can provide invaluable insight into understanding patients and in helping patients understand doctors and the health care system, above and beyond just language translation.

Cultural and social diversity session– simulated patient role one

Name: Meena Patel **Age:** Thirty-five

Setting:
You are waiting in the gynaecology out-patient clinic waiting room at Addenbrooke's Hospital to see a doctor. You have been waiting for about twenty minutes and you are by yourself: your husband is not happy about you attending the clinic without him but is unable to get time off work. This is your first out-patient appointment at the hospital. It has been a three month wait for this appointment since your doctor (a woman, Dr Evans) wrote off to the hospital for you but you were not unduly concerned by the wait. You are waiting patiently.

You have already been asked by the clinic nurse if you would mind seeing a student doctor before seeing the specialist and you have agreed slightly reluctantly – you inwardly felt you would rather not and showed this non-verbally – you would have been even more reluctant if the student was male but you felt you could not say that.

Clinical details:
For the last year, you have had heavy painful periods, increasing in severity. The heaviness was the main problem at first but increasingly it is the pain too.

Your periods are reasonably regular but over the last year they are occurring more frequently, lasting 8 to 9 days and coming every 23 to 27 days. And they are increasingly heavy: you pass clots and soak through your sanitary protection. You have to change protection frequently and sometimes get up at night to change. The bleeding is getting in the way of your prayers. You only have a little white discharge mid-cycle between your periods as you have always had.

The pain starts a few days before the onset of the period and builds up. It goes a few days after your period finishes. Prior to this, your periods were no more than a little painful but over the last six months the severity of the pain is increasing – they no longer respond to simple painkillers such as paracetamol or Nurofen, and are interfering with your normal life: you are having to take time off work because of the pain, which makes you physically sick – you actually vomit. The pain is like a period pain, a low down dragging pain, but it now spreads through to your lower back as well. During your period only, you have also started to get a deep internal pain when you open your bowels.

You also always get pain deep inside when you make love, not as your husband enters you but deeper. This occurs throughout the month. This puts you off sex which your husband is not too happy about.

You have no bleeding between your periods or after intercourse. You have had smears in the past which have been fine. You have one child, a girl now aged three, born via forceps delivery and have had no miscarriages. You want to have another child although most of the pressure here comes from your mother-in-law who lives with you and would like you to have a son. You had a coil inserted soon after the birth of your child which you have not had removed as yet. Your current problems don't coincide with the insertion of the coil as all was fine for the first two years. Your GP has given you a drug called something like Cyclokapron in the past to see if it would control your periods but although it did make the periods a little less heavy, it didn't help the pain (it doesn't matter if you can't remember the name). He also gave you something else for the pain but that didn't work either.

Past medical history:
Any previous operations: no operations in the past
Any previous illnesses: no serious illness, you get headaches quite a lot
You get some constipation at times but it isn't really a problem
Would you have had any illnesses as a child in Kenya – malaria, TB etc?

Tina – we need to explain your own limp here! Would you be prepared to use your own story or to make up something else to fit this?

Self medication:
Nurofen, paracetamol

Family history:
Any family history of

Heart disease: your mother has heart disease, you don't know quite what; it gives her chest pain and makes her short of breath and she takes tablets for it

Serious illness: there is quite a lot of diabetes in your aunts' and uncles' generation but not your parents

Smoking: you do not smoke
Alcohol: do you drink any alcohol?

Social history:
Cultural background: your background is that you are Guajarati speaking and a Hindu, originally from kenya. You moved here at the age of eighteen, seventeen years ago. You spoke a little English when you came but you are not fluent by any means and prefer to speak Guajarati.
Occupation: you went to work for Phillips electronics and still do – the job suits you well as it involves predominantly manual and visual dexterity rather than spoken English.
Married: could you fill this in as seems appropriate please: name, occupation etc.
Children: you have one child, a girl now aged three, and you want to have another child although most of the pressure here comes form your mother-in-law who would like you to have a son.
Where do you live: you live in a suburb of Cambridge; you live with your parents-in-law in an extended family
Type of housing: again, please tell me what sort of housing you are in, rented, own, council, good quality or not?

Patient's framework:

- **Ideas and thoughts:**

What do you think might have caused your problem: probably just what women get as they get older but it is does seem worse than everyone else
What have they told you so far: possibly fibroids (don't know what they are really), 'hormonal upset'

- **Concerns:**

What are you concerned about: your main concern is the heavy bleeding and the pain and how to get rid of it although you are also worried that you might not be able to get pregnant (although at one level this might get your mother-in-law of your back). So the sort of questions in your mind relate to could you get pregnant now if you had the coil removed or is there something wrong, how long after having the coil removed would it take to get pregnant etc
Have you any underlying fears: worried in the back of your mind that it could be cancer of the womb
A*ny practical problems*: you are concerned that you are missing time at work and that might cause problems with the company; you cannot pray or go to the temple during your periods, so this is becoming a problem for you

- **Expectations:**

What are you hoping for: a diagnosis, what is it? Also and most importantly relief of the pain, preferably with tablets, and not too much in the way of embarrassing tests. If hysterectomy or other treatments that might make you infertile are mentioned, you would be very reluctant

- **Feelings:**

How are you feeling about all this: anxious at being by yourself

- **Behaviour:**

You are not confident with doctors and any interview with a professional can be difficult: you can feel easily put down if they don't make you welcome at first. You are hesitant in your use of English and often have difficulty following things if they are not clear. You often feel the need to ask questions to understand things but you would be reluctant to ask the doctor questions if they were rushed or didn't make space for you or didn't seem understanding. You might then look a little quizzical but still answer 'yes' when you meant 'no' to 'are you happy about that?'. If the doctor was kind or helpful, you would voice your concerns or questions

Initially, you avoid eye contact for some of the time as this is a normal pattern of deference in your culture – it is not meant to represent rudeness

The major cultural issues which might affect your behaviour here are:

- Unhappiness seeing a male student or a male doctor
- Difficulty in use of language
- Prolonged periods prevent praying
- Mother in law's wish to have a grandson - concern re fertility
- Difficulties in discussing periods or sexual matters even with a female
- Concerns re vaginal examination etc.
- Attitudes to hysterectomy

Presenting symptoms or problem:

Please start off quietly and take a little time to get confidence. If it is a male medical student this is even more difficult for you. If the medical student asks you "what problems brought you to the hospital today", answer; 'well, my periods have been very heavy and I've been getting a lot of pain'. Stop there smile and look away. See where the student then goes and be happy to tell him/her your story if asked to elaborate. You find discussing periods difficult even with a female but try.

Start with the bleeding and then go onto the pain. Then in a while give a big cue:

'and its causing problems at home…….'

Stop and only continue about this if the student picks up this cue and asks you what problems you have been having. Then say:

'i can't go to the temple to pray when I am bleeding so much…..'

If asked, explain why that is so in your religion. Also say that this causes friction between you and your husband.

Please do not mention the issue of having only one child and the pressure on you to have more unless asked about your wishes about having more children by the doctor.

Cultural and social diversity session– simulated patient role two

Name: Meena Patel **Age:** thirty five

Setting:
You are waiting in the gynaecology out-patient clinic waiting room at Addenbrooke's Hospital to see a doctor. You have been waiting for about twenty minutes and you are by yourself. This is your first out-patient appointment at the hospital. It has been a three month wait for this appointment since your doctor (a woman, Dr Evans) wrote off to the hospital for you but you were not unduly concerned by the wait, in fact you were quite pleased it has taken so long. You are waiting patiently.

You have already been asked by the clinic nurse if you would mind a student doctor talking to you before seeing the specialist and you have agreed quite happily (it is being examined by the specialist that you are worried about – this might delay things further).

Clinical details:
For the last year, you have had heavy regular painful periods, increasing in severity. It is the excessive bleeding that is your main problem.

Your periods are reasonably regular, lasting 7 days and coming every 28 to 30 days. They have always been on the heavy side but quite manageable. But over the last year they are increasingly heavy and are now getting impossibly so. For the first two days, you pass only a dribble but then you have two absolutely awful days after which it tails off. On the worst two days, you pass big clots and soak right through your sanitary protection – you use sanitary towels but not tampons. Sometimes you flood right through with blood staining your underwear and down your legs you have to change protection very frequently and need get up at night to change. You can't play badminton one week out of three. The main difficulty is your work. How are you meant to attend meetings when you feel you are sitting in a pool of blood? You are frightened to stand up at times in case you have stained your clothes. Your GP has given you a drug called Tranexamic acid to see if it would control your heaviness but it didn't really work.

Three months ago you did have some spotting mid-cycle for a few days but otherwise you have no bleeding between your periods. You are not really having intercourse so you don't know if you would bleed after sex. You have a little white discharge mid-cycle between your periods as you have always had.

You have always had painful periods which you control with tablets called Ponstan Forte from your doctor which you take one three times a day when you have the pain. It is a little worse lately but as it only occurs on the first day of bleeding, you can cope. You have no pain at other times of the month.

You have had smears but not recently as you have avoided vaginal examinations. You managed to get your GP not to examine you before this referral by always saying that you were bleeding at the time. You have no children but the 'clock is ticking' and your husband wants to start a family. You love children but cannot face pregnancy (see below). You are not having sex but would use the sheath if you did – the contraceptive pill in the past caused you bloating and breast tenderness.

Past medical history:
Any previous operations: appendicectomy aged 14
Any previous illnesses: no serious illness ever, you keep fit and play badminton
You tend to get headaches when stressed or working too hard
You get sinus infections if you get a cold and use Otrivine nasal spray then

Medication:
Ponstan forte as above

Family history:
Any family history of
Heart disease: no
Serious illness: there is quite a lot of diabetes in your aunts' and uncles' generation but not your parents; mother had a hysterectomy and both ovaries removed for what turned out to be benign ovarian cysts a few years ago; otherwise both parents well

Smoking: you do not smoke
Alcohol: you enjoy wine with your meals but not excessively

Social history:
Cultural background: your background is that your parents are Guajarati speaking and Hindu, originally from India. They moved to England in the sixties – your father is a doctor who trained in India and is a GP in a practice in the midlands where you were brought up. Your mother was a housewife and you have 2 brothers. You were born in England and educated at a local grammar school where you got on very well both socially and academically. You hardly understand any Guajarati and on the two occasions that you have gone back to India with your parents you have felt completely at sea. Your parents encouraged their children to be English although they themselves went to the temple and kept up their religion. You feel 'caught between two cultures', basically English but clearly visibly different. But you are confident and to the outside world very assimilated. If asked 'where do you come from', you would be suspicious that someone meant India and was labelling you by your colour and would answer 'derby'.
Occupation: you went to university and studied history and economics and now work as a producer for a local BBC radio station in Cambridge
Married: you are married to Geoffrey, a very sweet, white, accommodating chartered accountant, very English in background, who loves you dearly. You are definitely the more out-going. Your parents accept Geoffrey although you know they would have preferred you to marry within their culture. They can't have it both ways! But they don't understand why you have not had children and you know they blame Geoffrey for it – they don't know the real reason lies with you
Where do you live: you live in a nice suburb of Cambridge with a big mortgage

Patient's framework:
- **Ideas and thoughts:**

What do you think might have caused your problem: probably just what women get as they get older but it is does seem worse than everyone else. You wonder if you have fibroids or an ovarian cyst like your mother
What have they told you so far: your GP mentioned 'dysfunctional uterine bleeding' which he said was very common and in effect too much lining of the womb. You might need a d and c

- **Concerns**:

What are you concerned about: your main concern is the bleeding and how to prevent it getting in the way at work and at play
Have you any underlying fears: you are worried about having a vaginal examination

- **Expectations:**

What are you hoping for: you are very ambivalent, you almost didn't come – you know you need to get this looked into but can't cope with what that might involve.

- Feelings:

How are you feeling about all this: you look composed and accepting in the waiting room, but underneath you are in a little distress.
- **Behaviour:**

You are normally confident and easy with professionals. You have perfect English, are socially adept and composed and have a quick mind. You are assimilated and, because of your father, understand a bit of the medical world. Normally you would be forthcoming, friendly and be sure to mention what you hoped to achieve in an interview. Today you are just slightly more hesitant and faltering than usual and this betrays your nervousness to you. But you are still pretty composed and look in control - someone meeting you for the first time would still think you were relaxed. Basically you come across as unembarrassed and quite jokey about discussing gynae problems in general and the doctor would think you were modern in your approach and might be surprised at your eventual unwillingness to discuss your sex life – you would in fact discuss other people's sex life easily but not your own problem.

The major issues which might affect your behaviour here are:
- No difficulties in discussing periods or any other gynae symptom except great embarrassment about discussing your inability to have sex - you feel pathetic and ashamed of your problem here
- Concerns re vaginal examination
- Concern about wanting to have children

Presenting symptoms or problem:
Please start off reasonably confidently. It doesn't matter to you if the student is male or female. If the medical student asks you "what problems brought you to the hospital today", answer: 'well, as i am sure dr Evans has said to you in her letter, I've been getting a lot of bleeding and my periods have been more painful and I'd very much like your help in sorting it out.' stop there and smile. See where the student then goes and be happy to tell him/her your story if asked to elaborate, as long as you skirt round sex itself. Once you get going, freely and happily discuss your bleeding pattern with some humour and panache. Falter though if either bleeding or pain with sex is mentioned – say it is embarrassing to talk about that sort of thing. Eventually say that it hurts too much to have sex so you haven't for a year or two really. If handled sensitively, volunteer bits of the following story:

You were quite sexually active as a teenager and at university. You had quite a few relationships and had an abortion in your first year at university. You had a brief depression after this treated by the university practice with anti-depressants and you then recovered. You thought you had got over it quite well and put it to the back of your mind but recently as the thought of having a family has become more pressing, it has increasingly played on your mind. You met and married your husband some years later and at first sex was fine but increasingly in the last few years, you have been having difficulties with sex - you try but it is very painful and you tense up immediately. You have stopped even trying now. You know that it is to do with feeling guilty about the abortion - you feel you are not fit to bring children into the world after having got rid of one – this is not a cultural belief but a personal one. Your husband understands and has tried to help. You had some counselling privately but to no avail. You know that a vaginal examination will be painful for you but you equally know it will be necessary. It is actually admitting the problem that is most painful.

HANDOUT IV

Common Issues/Barriers in Cross Cultural Communication

Use of Language

- English as a second language
- Use of slang
- Accent/Dialect
- Giving offence through over-familiarity etc

Non-verbal communication

- Physical Touch
- Body language
- Proximity: Closeness/distance
- Eye Contact
- Expression of Affect/Emotion

Cultural Beliefs and health care

- Interpretation of symptoms - what is considered normal & abnormal
- Beliefs about causation
- Other sources of health care that this cultural group will seek
- Gender expectations about roles and relationships
- Role of doctor and social interactions related to respect, power and patient adherence to medical recommendations
- Family Life Events (ie. Rituals and beliefs around Arranged Marriages, Pregnancy & Childbirth, Older Adult Caregiving, Death)
- Psychosocial issues (Identifying common stressors, awareness of diversity in family/community supports)
- Role of doctor re: Mental Health Counselling (Assessing, diagnosing and treating common mental health issues

Sensitive issues

- Sexuality: including sexual orientation, sexual practices and birth control
- Discomfort performing some physical examinations
- Use and abuse of alcohol and other substances
- Domestic violence & abuse
- Sharing Bad News

Medical Practice Issues/Barriers

- Extent of Doctor/Patient Partnership and Responsibility for healthcare and treatment
- Ethical Issues in Care
- Doctors assumptions, stereotyping or prejudices

HANDOUT V

Incorporating the specialist functional enquiry into the structure of the medical interview (the Calgary-Cambridge guide) using appropriate skills and timing

One aim for this session is to enable students to practice the gynaecological functional enquiry as laid out below, within the context of a collaborative medical interview – how and when to ask the following questions are as important as what questions to ask:

The gynaecology functional enquiry:

7. **Menstrual history**
    a. Frequency and regularity of menstruation: how often, are they regular, when was the start of the last one?
    b. Duration of menstruation: how long do they last?

8. **Other bleeding from the genital tract**
    a. Bleeding between periods
    b. Bleeding after intercourse

9. **Symptoms associated with menstruation**
    a. Dysmenorrhoea: are they painful?
    b. Heaviness of menstrual loss: are they heavy?
        i. Flooding
        ii. Passing clots
        iii. Frequency of changing protection, need for double protection, need to change overnight
        iv. Interference with normal lifestyle

10. **Other gynaecological symptoms**
    a. Vaginal discharge
    b. Galactorrhoea – discharge from the breast
    c. Menarche – age at onset of first menstruation
    d. Dyspareunia – pain on intercourse, where is the pain?
    e. Post-coital ache

11. **Cervical Smear history**
    a. Date of last smear
    b. Whether normal or abnormal
    c. Any previous abnormal smears

12. **Drug history**
    a. In particular contraceptive history
    b. Any drugs taken
    c. Any allergies

HANDOUT VI

Cultural and social diversity

Key core skills

These skills relate particularly to the skills of

4. *building the relationship*
5. *understanding the patient's perspective during the information gathering phase*
6. *utilising the patient's perspective during the explanation and planning phase*

- checking pronunciation of name and how the patient would like to be addressed
- **demonstrating interest, concern and respect**
- **picking up verbal and nonverbal cues**
- **discovering the patient's ideas, concerns and expectations of medical diagnosis and treatment**
- non-judgmental acceptance of ideas and beliefs
- sensitivity to feelings and emotions
- empathy
- sensitivity with the clinical examination
- clarity in giving information
- checking understanding
- relating explanations to patient's illness framework
- negotiating approach to management
- checking if concerns have been addressed

Key areas needing especial care:

- awareness of the possibility of differences in nonverbal communication patterns
- willingness to explore and understand cultural differences (related to social, religious and health practices and beliefs)
- avoiding making assumptions, stereotyping or patronising
- sensitivity to the patient's wish to be interviewed with a family member or by a male or female doctor
- interviewing more than one patient at a time
- willingness to understand different family and marital relationships
- offering choices for example the examination of female patient by a doctor of the same sex
- offering the help of an interpreter and handling an interpreter in the interview
- understanding social and community networks

Here are some examples of phrasing to help you achieve a balance between exploring and valuing cultural differences and avoiding making assumptions (although remember, your non-verbal behaviour and your ability to pick up cues are even more important):

In general, if your initial questions would work equally well for the majority culture, you are on the right track - asking questions about the individual patient or the patient's family rather than about their culture helps personalise rather than label:

- "What effect is all this having on your life and on those around you?"
- "Can you tell me a little about yourself and your family" – then for instance you could ask any of the following: "where do you live…...who is at home with you….where was your family home…what are your parents' background…..do you practice a religion yourself?"
- "You tell me that your body hurts all over..do you have any ideas about why this might be?

When you don't know the patient or relative and are unsure whether to shake hands:

- observe the person's response
- apologize if they seem offended - you didn't mean to offend.
- make sure to do something else instead to build the relationship

Ask permission if you wish to ask a sensitive question

- ‘Would it be alright to ask you about this or not?’

Ask what would help

- ‘I need to ….. is there anything that will help you with this?’

Explain why

- ‘This may be difficult for you, the reason I need to ask you / do this is…….”
- ‘Sometimes people have their own explanations for things and it helps to understand patient’s views.’
- ‘I know that sometimes women would prefer to be examined by a female doctor – is that important for you?”
- “I can understand that it must be frustrating for you that I can’t understand you as well as you would like. Would it help if we had an interpreter?”

If say you are dealing with a gynaecology problem, you might want to ask:

- “I know that problems with fertility can cause tensions in families, has that been true at all for you?”
- “Sometimes, people’s family or religious backgrounds are very important when discussing gynaecological problems – is that so for you?”

Then follow according to the patient’s response:

- “You mention that you are from Afghanistan. I don’t know anything at all about Afghanistan culture..... are their strong views about hysterectomy in Afghan culture? ”
- “I’d like to know what sort of treatment you were expecting..... or hoping for. From what little I know of Chinese culture, it might be quite different from what we offer here, and I’d like to help”.