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## **INCLUSION OR EXCLUSION – RECRUITING BME COMMUNITY INDIVIDUALS AS SIMULATED PATIENTS**

### **Abstract**

#### **Aim**

To explore perceived barriers to the recruitment and retention of black and minority ethnic community individuals partaking in healthcare education role playing activities using simulated patient scenarios.

#### **Background**

Within the United Kingdom the use of simulated patients as a learning and teaching strategy is gaining momentum in higher education. Simulated patients may be defined as role players who aid in the training of healthcare professionals in communication and diagnostic skills. Cultural differences have been reported to often underpin miscommunication and dissatisfaction in the doctor-patient relationship leading to a large proportion of UK medical schools including cultural competency in their curriculum

#### **Simulated patient**

The term Simulated Patient (SP) is used to describe an individual trained to replicate the symptoms, different behaviour patterns and attitudes that could be demonstrated by a person accessing services within a healthcare environment.

Using simulated patients enables a health care professional to practice skills in the development of diagnostic capabilities, different communication skills, gathering and giving information, identifying the needs of different client groups and working as part of multi professional/interagency team. Through simulation learning can be achieved in a real life setting, with none of the risks associated to the real life situation.

#### **Methods**

A qualitative, exploratory study was conducted with a self selecting, convenience, sample of twenty five participants from Black and Minority communities using one to one and group interviews to elicit data. Ethical approval was successfully received from the University.

#### **Results**

Five broad emergent themes were identified; language; knowledge; power; inequalities and inclusion

## **Discussion**

Participants identified that the simulated patient role could promote inclusion into society through the development of cultural awareness both within and outside cultures. However the term simulated patient was highlighted as being problematic as many people did not understand the term. The inclusion of members of black and minority ethnic communities (BME) as simulated patients was discussed by participants and viewed to be a positive step in the facilitation of increasing social networks; reducing cultural barriers and offering an outlet by which these communities could integrate into society. The sharing of their own experiences developed a feeling of personal achievement through an understanding in others of their own community and values.

## **Key Words**

Black and Minority Ethnic Communities, Simulated Patients, Inclusion, Exclusion, Culture, Language, Power

## **Acknowledgements**

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## **INCLUSION OR EXCLUSION – RECRUITING BME COMMUNITY INDIVIDUALS AS SIMULATED PATIENTS**

This paper presents a qualitative, exploratory study utilising a theoretical framework of culture, diversity, inclusion, citizenship, language and power.

### **Background**

The term Black and Minority Ethnic (BME), is used to determine any member of society who responds to an ethnicity question as alternative to Caucasian. The ethnic origin proportion of the population across England and Wales, as recorded in the 2001 census identified White British as representing 91.3% of the population. South Asian origin (inclusive of Indian, Pakistani and Bangladeshi) 4.4% of the population; Black British (Inclusive of Black Caribbean and Black African) 2.2%; mixed race 1.4%; Chinese 0.4% and other 0.4% (Office for National Statistics, 2001). These most current figures identify that the United Kingdom (UK) is a multi cultural society where members of these communities will at some point seek medical advice. Practitioners will need to be able to understand cultural differences if the care and advice administered is to be effective. Cultural differences have been reported to often underpin miscommunication and dissatisfaction in the doctor-patient relationship leading to a large proportion of UK medical schools including cultural competency in their curriculum (Robins et al. 2001; Dogra et al. 2005). However there is evidence to suggest that cultural issues are not well taught, with Beagan (2003) maintaining that this also applies internationally for reasons that are unclear.

One solution to educating health care practitioners in understanding cultural differences is to use simulated patients. Within the United Kingdom the use of simulated patients, as a learning and teaching strategy is gaining momentum in higher education. Simulated patients may be defined as role players who aid in the training of healthcare professionals in communication and diagnostic skills. Finn (1999) argued that this method was widely used in marketing where simulated patients (also known as standardised clients and mystery shoppers) were routinely used to measure aspects of customer care. Rethans and Seebu (1997) stated that simulated patients could be used overtly (i.e., the simulated patient assumes the role of a patient and the person who is being assessed is aware that this is not a genuine patient) or, covertly (i.e., where the person being assessed is unaware of the

simulated patient's identity or purpose). Both methods have been used in health services for teaching and assessment purposes.

### **Data Collection Methods**

This explorative qualitative research was undertaken to investigate perceived barriers to the recruitment of individuals from black and minority ethnic communities as simulated patients. The aims of the research were:

1. To explore potential applicants' understanding of the role of simulated patients
2. To identify training needs of interested parties from BME communities to support the simulated patient role
3. To investigate potential barriers in recruiting and retaining from BME communities

Data was collected using semi structured; open ended questionnaires, one to one interviews and focus groups using prompts (Appendix 1), with a convenience sample of twenty five self selecting participants. Ethical approval to conduct the study was received from the Schools Research and Ethics Panel within the University. All participants were guaranteed of anonymity and had the opportunity to withdraw from the study at any time. All were offered the opportunity to read the transcripts prior to analysis and were informed that the final report would be made available to the community centres. Informed consent was received from all participants with all interview transcripts and questionnaires stored securely within the University.

Eight community centres representative of the BME communities within the Huddersfield and Bradford districts, West Yorkshire, United Kingdom were identified as sites for the project. Managers of the community centres were approached and presented with an overview of the project. Following the presentation, managers who displayed an interest in the project were left information packs and agreed to make them available to members of the community. It was important to ensure that the community leaders were aware of and supportive of the project to allow cultivation of relationships and to promote the project with potential participants. The early inclusion of the leaders led to them offering their own community centres to undertake the interviews and focus groups. Indeed Pollitt and Beck (2008) suggested

that during the development phase of a project, key stakeholders should be identified and brought on board to the greatest extent possible.

Additionally a web site was developed advertising the project and allowing potential participants to register their interest to become involved in the data collection phase. Posters advertising the research project including the web site address and contact details were displayed in community centres. Demographic information and application of interest were completed electronically via the web site or as a paper copy and posted in a return envelope to the principal investigator. All potential participants were contacted via email or letter and arrangements made for face to face or small group interviews at a mutually agreed time and location. All interviews were tape recorded with participant consent and later transcribed verbatim.

### **Inclusion/Exclusion Criteria**

All potential participants were recruited from a BME community, legally residing in the UK and able to speak and understand English. There was no upper age limit but participants had to be over the age of eighteen. A convenience sample was facilitated by participants indicating their willingness to take part in the study through application via the website or by post. There were elements of 'snowballing' whereby participants recommended inclusion in the project to other members of the BME communities.

Table 1 presents the demographic information of all participants.

**Table I - Demographic information**

<b>Nationality</b>	<b>Identified Ethnic Group</b>	<b>Gender</b>	<b>Age Range</b>	<b>Any Disability</b>
British (3)	Black British	F	20-45	N
British (2)	Black British	M	20-45	N
British	Asian Pakistani	M	46-65	Wheelchair/mobility
British	Asian Pakistani	M	46-65	N
British (2)	White and Mixed other	F	20-45	N
British (2)	Black Caribbean	F	66-80	N
British (1)	Black Caribbean	F	20-45	
British	Black British	F	46-65	N

British (2)	White British	F	20-45	N
Trinidadian (2)	Asian Other	M	20-45	N
British	Other	F	46-65	N
British (2)	Chinese	F	46-65	N
South African	Black African	F	46-65	N
Filipino (2)	Asian other	F	20-45	N
Kurdish (2)	Other Ethnic Background	F	20-45	N

## Data Analysis

Interviews were transcribed by a secretary trained in transcription techniques and the thematic analysis undertaken by a research assistant. Analysis of the data was organised with Nvivo® software with the interviews being typed in Microsoft word documents and then imported to the software, prior to coding and themes being developed.

Content analysis was achieved through the selection of certain words and phrases that were relevant to the study being undertaken, comparing each one and joining them together as appropriate. Five broad emergent themes were identified; language; knowledge; power; inequalities and inclusion. Each theme is presented with a critical discussion of the literature in the context of the theoretical framework.

## Social Exclusion

Social exclusion was defined by McLean and McMillan (2003) as referring to a lack of participation in society, emphasising the multi-dimensional, multi-layered, and dynamic nature of the problem. Definitions of the concept emanate from diverse ideological perspectives, but most share the following features;

(1) *Lack of participation.* Protagonists differ over which aspects of society are important and where responsibility for non-participation resides. Most agree that exclusion is a matter of degree, since individuals may be participating to a greater or lesser extent, and that it is relative to the society in questions.

(2) *Multi-dimensional.* Social exclusion embraces income-poverty

The Government Office for Yorkshire and Humber (2009) in defining social inclusion, suggest that communities who are strong and inclusive lead to better quality of life, stronger sense of identity and belonging, sharing mutual respect and equality. It is further recognised that a cohesive and inclusive community is one where there is a common vision and sense of belonging for all communities; the diversity of people's different backgrounds and circumstances are appreciated and positively valued.; those from different backgrounds have similar life opportunities and strong and positive relationships are being developed between people from different backgrounds in the workplace, in schools and within neighbourhoods.

### **Potential barriers to inclusion**

Culture and ethnicity have often been cited as barriers in establishing an effective and satisfying doctor–patient relationship (Ramirez, 2003). Results of a number of survey studies (Harmsen et al, 2003; Laveist, Nuru-Jeter, 2002) indicated that there was more misunderstanding, less compliance and less satisfaction in intercultural medical consultations compared to intra-cultural medical consultations, even after adjusting for socio- economic variables such as education and income. Health care providers found consultations with ethnic minority patients often emotionally demanding and patients' reasons for visiting unclear and the lack of language understanding between doctors and patients (Jacobs et al., 2003).

Deficiencies in the quality of the intercultural physician–patient relationship compared to the intra-cultural relationship have been identified (Ferguson and Candib, 2002) highlighting that most immigrants and physicians have received little or no formal training in intercultural relations. Many physicians are unable to provide evidence of knowing that culture could have effects in health related domains ( Brant et al, 2000). Indeed many physicians have not learnt about theories of intercultural communication and intercultural communication competence (ICC) as discussed by Gudykunst, (2002) and Wiseman, (2002).

Potential barriers in an intercultural context to communication between physician and patient have been studied and highlighted four barriers: physician and patient may not share the same linguistic background; physician and patient may not share similar values about health and illness; physician and patient may not have similar

role expectations; physician and patient may have prejudices and do not speak to each other in an unbiased manner (Suurmond and Seeleman, 2006).

A literature review of cultural differences (Schouten and Meeuwesen, 2006) discussed the issue of doctor – patient interaction between patients' ethnic background and medical communication, and raised the question to what extent belonging to an ethnic/cultural group influenced the communication process between patients and health care practitioners? Schouten and Meeuwesen, (2006) argued that to pose this question was of vital importance, because in today's multicultural society healthcare practitioners are increasingly confronted with patients from different cultural and ethnic backgrounds. They maintained that divergent beliefs, as well as linguistic barriers often existed between members of different cultures, confronting health care practitioners with the difficult task to deliver good quality care to a wide diversity of patients, each bringing their own unique background to the medical encounter.

It could be argued that the inclusion of members of the BME communities as simulated patients will help to break down barriers thus developing the fundamental skills of medical staff and health care professionals, in relation to communication and cultural appreciation.

## **Language**

During data collection participants identified language and dialect as one of the main barriers preventing some members of the BME communities becoming involved as simulated patients. Hymes (2003) argued that diversity of speech presents itself as a problem in many sectors of life including education, national development and transcultural communication, maintaining that there is no agreement on a mode of description of language in interaction with social life. Two participants explained:

*“I can speak English fluently but other members of my family can't....like my grandmother.....she couldn't be involved but might want to.....so there is already a barrier there” (Female, aged 28 years)*

*“To be honest when you first said it, (the term simulated patient) I didn’t understand it at all, there could be something else that it could be called but I don’t really know what that would be, it seems a bit, I don’t know because if I saw a sign that said that I wouldn’t think of that” (Female, aged 32 years)*

It was acknowledged that although the English language was often a second language and spoken by members of multi cultural societies, regional accents could create isolation within communities as identified by this participant:-

*“There is a problem with different people from different parts of India and Pakistan...they have different accents and we can all speak different languages so just because I am Indian does not mean I can understand others .....*”  
(Female, aged 52 years)

Research has identified that networks based on race/ethnicity create the strongest divides in a person's environment and have many implications for information transfer, attitude formation, and social interaction and experiences (McPherson, Smith-Lovin and Cook, 2001). Indeed diversity of speech can in itself present a problem in many sectors of life including education and transcultural communication with there being little agreement on a mode of description of language in interaction with social life (Hymes, 2003). Interestingly it was accents and different languages spoken within cultures that were identified as potential barriers rather than the inability to speak English. One participant stated:

*‘.....It’s not my dialect that creates the problem it’s the dialect of the English person I’m speaking to.....I have difficulty understanding them and they are born and bred British They cannot see that their own dialect is the issue!’*  
(Male, aged 40 years)

Three female participants discussed the changing role of Asian women in society. They stated that these women *‘socialise almost exclusively with other women of their own culture.....that can create isolation.’* They felt that if they could become a simulated patient they would have the opportunity to highlight to learners, the difficulties that some Asian women experience when attempting to integrate into society.

These discussions relate to the concept of 'social capital' and 'social bonding' where information and co-operation can be developed from social networks. This may provide the platform from which health interventions can pursue a broader agenda of civic engagement through the involvement of lay people in health interventions as described by Hawe and Shiell (2000).

### **Knowledge**

The concept of social capital was highlighted during the interviews with participants as they did not understand the term simulated patient and could not relate its relevance in health care. Once the term had been explained participants stated;

*"I have never heard of it before. .... but you know now that I understand what it is I can see the need for it so keep doing what you are doing"* (Female, aged 80 years)

The fact that the participants were unaware of the role of simulated patients or indeed the term, created an immediate barrier to members of the BME communities undertaking this role. A majority of the participants' believed that in order to be a simulated patient they had to have been a patient in the past or have a medical condition. One participant stated:

*"I cannot be a simulated patient as I have never been in hospital....I am healthy".* (Female, aged 57 years)

In fact one participant believed it referred to science fiction:

*"I think it has something to do with – Star Trek...."*

(Male, aged 26 years)

It is important that the role of the simulated patient and its importance to developing cultural awareness in students from a variety of disciplines is presented in terms that may be understood by all members of communities including those from BME cultures.

## Power

Participants stated that the opportunity to become a simulated patient would offer them a sense of power as they would be able to influence students learning in relation to caring for patients from a variety of cultural backgrounds;

*“If I were to become a simulated patient I would actually be able to teach people why people from my culture cannot be examined by a male.....they would then understand and not judge me”* (Female, aged 24 years)

The extent and distribution of power within a society has two broad perspectives; the extent to which citizens have the power to meet their own needs and wants and the extent to which societies give their citizens freedom from the power of others. The first indicates a lack of power; the second indicates that people are subject to the power of another (Morris, 2002). He concludes that if people are powerless because they live in a certain sort of society, that is, they would have had more power if social arrangements were different then this a condemnation of society. He suggested that we should be evaluating that society and not distributing praise or blame to people. One participant stated that:

*Being involved as a simulated patient would let me support health professionals in understanding the needs of people from my country.....I could also share the roots of my culture with others from within my culture.....*  
(Male, aged 32 years)

Power is exercised by individuals and therefore involves choice and intention; it involves the notion that an individual can achieve or bring about goals that are desirable (Weber, 1968). It is exercised over individuals and may involve resistance or conflict; there are differences in interests between the powerful and the powerless. Power is negative if it involves restrictions and deprivations for those subjected to domination (Weber, 1968). Interestingly a small number of the participants identified that the role of the simulated patient could break down boundaries between cultures especially in relation to caste systems. One lady stated:

*“It would be good if the cultures in my religion understood each other....sometimes we do not understand each other let alone what some one needs or wants from a different country”* (Female, aged 37 years)

Critical social theory has been discussed by Boulos and Rajacich (2003, p. 40) maintaining it is based on the belief that “*meaning and truth are contextualized by relationships, power, social structure and history,*” and its goal is “*to free individuals from the constraints of domination.*” Lancellotti (2007) argued that power within societal institutions contributes to racism and health disparities, and the effects of power structures on the individual, family, and cultures must be acknowledged. She maintained that concepts such as power, domination, autonomy, and freedom are inextricably bound to culture.

## **Inequalities**

Structured inequality involves a process in which groups or individuals with particular attributes are better able than those who lack or are denied these attributes to control or shape rights and attributes for their own ends (Curtis, et al 2004). The difficulties individual members of the BME communities experienced when attempting to undertake the simulated patient role may be related to these differences.

The integration of members of the BME communities as simulated patients could arguably assist to break down these divisions promoting an understanding of the need of communities. It has been suggested that a human characteristic of becoming integrated into society is the feeling of ‘wanting’ to be involved and to gain an identity of that society (Spouse, 2003). One participant stated that the integration of members of BME communities would:

*“Developing a team of simulated patients from black and minority ethnic groups in our community could be more productive, more sustainable as it would be “home grown”, it would reflect the people who live, work and learn here. If we can be given citizenship, a feeling of being included as part of the education and development in recognition of cultural differences, regardless of race, creed, colour, or disability ”. (Male aged 27yrs)*

Yet participants highlighted how they felt uncomfortable when trying to integrate fully into society as their culture “*makes me feel different and makes me feel as though people are watching me.*” One young male participant explained:

*“Reflect the people who live, work and learn here. If we can be given citizenship, a feeling of being included as part of the education and development in recognition of cultural differences, regardless of race, creed, colour, or disability ”* (Male, aged 27 yrs)

## **Inclusion**

*“If people from black and minority ethnic communities were used as simulated patients things might improve for our future generations wanting health care, but only if they can be part of the learning and teaching, if they are included and respected by the ones they are trying to support”* (Female aged 54yrs)

Culture is related to the shared beliefs, values and understandings shared by a particular group with Kendall and Wickham (2001, p. 14) maintaining that ‘culture’ refers to the way of life of a group, including the meanings, the transmission, communication and alteration to those meanings. Whereas Henley and Schott (1999) stated culture is ‘how we do and view things in our group.’ In comparison, culture involves the group’s way of life, particularly its meanings; with the emphasis on the ways those meanings are communicated. Some participants discussed the concept of cultural awareness identifying the advantages and disadvantages as to how it may affect individual involvement in the role.

*“I would like be involved as an SP but I worry that members of my own community will lose their trust in me and I may not be accepted back...”* (Female, aged 35 yrs).

A common theme throughout, was that of participants believing they would have some personal achievement through the development of understanding in others, in turn themselves developing an understanding of the other persons culture. They felt their involvement could bring about specific change and improvement in the delivery of care for people of various cultures. One lady felt that the active inclusion of BME communities as simulated patients would encourage her and others to partake in the role. She stated that:

*“Being included and respected as a respectable citizen through the use of people like me as simulated patients would make me feel more welcome.*

*Some people only want to go to places where they are not standing out as different, they want recognition, demonstration of being included. I would want to feel comfortable by meeting with people like me” (Female aged 80yrs)*

Nairn et al (2004, p. 194) in their review of educational strategies for teaching nursing students multi-culturism quote one lecturer as using the terms *diversity*, *cultural sensitivity*, and *antiracism* interchangeably because *“I cannot distinguish among them in any meaningful way. I tend to question the value of cultural sensitivity training that fails to address power relations and oppression, just as I worry about antiracism training that does not include a focus on cultural similarities and differences”*

A number of participants, identified that there could be a lack of citizenship and inclusion, for the person adopting the role of a simulated patient, who was from a different culture. They identified the need for inclusion as part of the team, stating:

*“I would need to feel included, not in the sense of living here, but as a person who is valued and recognised for who I am as part of the simulated team. To see other people taking on the role, and members of the staff from mine or other ethnic background, would make me feel more at ease, you know, included, a citizen”* (Female aged 23yrs)

Interestingly the words ‘citizenship’ and ‘citizen’ featured in discussions held with the participants. These terms are generally not used in everyday conversations; however participants used them frequently, perhaps reflecting that they interpret this term as recognition of social inclusion, acceptance and respect. Citizenship, like community, can be defined exclusively or inclusively; in the same respect that a community may be defined by reference to a geographical area, or a social or religious group, with the implication that all those outside the group are excluded. Faulkner (2001, p.66) maintained that ‘citizenship’ can be defined by reference to narrow legal criteria of birth, descent or residence. The sometimes restricted or exclusive interpretation of the term citizen has been suggested by Faulkner as being linguistically and technically correct in many circumstances. The version of intention is one of citizenship on a universal basis which extends to all those present in the country or in particular neighbourhoods or institutions; without discrimination or exception and regardless of differences of race, ethnicity, culture, class, nationality. Citizenship, Faulkner (2001, p67) argued is being a recognition of your common humanity.

## **Limitations**

It is recognised that this study was conducted in one region of the UK over a short period of time. However it does offer an insight into the barriers that may prevent BME community members from becoming simulated patients. It identifies and explores that once the term has been explained, members of these communities can see benefits to becoming involved, and that all cultures can learn and benefit from being actively involved in the education of health care practitioners. The authors acknowledge that the lack of awareness of the simulated patient role is not exclusive to BME communities as has been identified in a further study currently being conducted by the authors.

## **Conclusion**

The inclusion of members of BME communities as simulated patients was discussed by participants and viewed to be a positive step in the facilitation of increasing social networks; reducing cultural barriers and offering an outlet by which these communities could integrate into a society. The sharing of their own experiences developed a feeling of personal achievement through an understanding in others of their own community and values.

## **Implications for Practice**

The role of a simulated -patient can provide a 'real life' account and demonstration of issues surrounding culture, diversity and inclusion in society for healthcare training purposes. The integration of members of BME communities into health care education may provide students with an insight into the importance of being able to understand these issues and learning how to effectively communicate within and outside of the practice environment.

The role of the simulated patients from BME communities reflecting the multicultural environment in which we teach and practice, can enhance development of communication skills and cultural sensitivity in the educator and the student learner

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## Appendix 1

### **SEMI-STRUCTURED INTERVIEW QUESTIONS DESIGNED TO GENERATE DISCUSSION WHICH WILL THEN BE RECORDED AND TRANSCRIBED**

#### QUESTIONS

1. From the information given, what are your thoughts about simulated patients?
2. Do you think the terminology used is fitting?
3. What do you think the role is?
4. What type of people do you think become simulated patients?
5. From the information given: How do you think the use of simulated patients may be of benefit in the training in health and social care?
6. How do you think the use of SP's can help in the teaching of certain skills for Doctors, nurses and other health professions?
7. How do you think SP's from different ethnic backgrounds would enrich the educational experience for learners?
8. What do you see as the benefits for members of the public in the use of SP in training and development programmes?
9. Could you be a SP?
10. Do you think members of your community/friends/family would be interested in being a SP?
11. What might the benefits of working as a SP be to you?
12. How do you think SP's from a different culture would be able to identify their cultural needs and differences that a health care provider did not know/understand?
13. What factors might prevent you as an individual from taking up the role of a SP?
14. Are you aware of any cultural issues that might prevent you or other members of your community from taking up the role?
15. If there are issues, how do you think they could be resolved?
16. What would you need in order to support you in developing and practicing as a SP?
17. Are there any other comments you would like to add?