

Original article

Health-care professionals' perceptions of interacting with patients of South Asian origin attending early inflammatory arthritis clinics

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Abstract

Objective. The aim was to explore the perceptions of rheumatology health-care professionals (HCPs) of interacting with patients of South Asian origin attending early inflammatory arthritis clinics.

Methods. We used face-to-face semi-structured interviews, designed in partnership with a clinician partner, to interview 10 HCPs involved in the running of early inflammatory arthritis clinics across seven centres in the UK. Data were recorded, transcribed by an independent company and analysed using inductive thematic analysis.

Results. Three emerging themes were identified that characterized consulting experiences of HCPs: varied approaches were used in early inflammatory arthritis clinic; the challenges for rheumatology HCPs in managing and delivering information to patients of South Asian origin in early inflammatory arthritis clinics; and moving towards good practice, the views on managing future patients of South Asian origin in early inflammatory arthritis clinics. Overall, HCPs found that they required additional skills to support the engagement and management for patients of South Asian origin living with inflammatory arthritis. The HCPs felt that they were less effective in addressing self-management issues for this patient group, and they found it difficult to determine adherence to medication. In such consultations, HCPs perceived that their own limitation of inadequate training contributed towards poor consultations.

Conclusion. For the first time, our data demonstrate that the management of patients of South Asian origin in early inflammatory arthritis clinics is under-served. To address this, HCPs have identified training needs to improve knowledge and skills in engaging with and supporting patients of South Asian origin. These findings provide a good direction for future research.

Key words: rheumatology, health-care professional interaction, early inflammatory arthritis

Key messages

- Health-care professionals play an active role in managing patients of South Asian origin but lack confidence.
- Tailored training programmes may improve the confidence of health-care professionals in interacting with patients of South Asian origin.
- The training needs to address both consultation skills and the establishment of culturally sensitive services.

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Introduction

Today, rheumatology departments around the world are seeking to promote a health-care system that is patient centred, in which the patients are actively involved in their treatment plan [1]. From a patient's perspective, the ideal health-care setting that includes educational input about their disease together with help from a multi-disciplinary team is favoured [2]. Because of this, the

traditional ‘one-size-fits-all’ approach should be abandoned. Internationally, RA is one of the most common forms of inflammatory disease and has become increasingly morbid and costly [3]. The disease significantly impacts on every aspect of a patient’s life, particularly on work patterns, which adds to the financial burden [4, 5]. Effective disease management can be achieved by seeing the patient in early inflammatory arthritis clinics. Early detection, initiation of treatments and positive patient engagement can control disease activity significantly [6]. However, few patients with RA achieve the control needed to avoid complications. Furthermore, minority ethnic populations are disproportionately at high risk of poorly controlled RA [7]. Lack of awareness about RA, delays in seeking medical help at the onset of symptoms and lack of educational resources, in addition to differences in knowledge and health beliefs about RA, contribute to poor outcomes [8, 9].

There are marked differences between RA in ethnic groups around the globe in terms of adherence to medication and perceptions of RA being a curable disease [7, 9]. The world is increasingly becoming a global village, and across chronic conditions, health-care professionals (HCPs) see more culturally diverse patients than ever before, with many different cultures, languages and traditions living together as multicultural societies [7, 10–13]. Like other parts of the world, the UK has a minority ethnic population of 7.9%, with Indians being the largest minority group, followed by Pakistanis [13]. Consequently, together, South Asians make up an overwhelming majority of the ethnic minority population of the UK. Similar to other diseases [10, 11], in RA, cultural factors influence beliefs, behaviour, perceptions and emotions, all of which have been reported to have important implications for health and health care [7, 9]. Many challenges stem from the consultation process. Patients of South Asian origin with RA are reported to favour discussions about disease causation and a treatment plan with a wider understanding that conceptualizes their thinking [14]. Sometimes, this approach may be viewed as ‘difficult’ by HCPs and may lead to negative judgements [14]. Psychological theories have widely captured patients’ process of rationalization about having long-term conditions and treatment [15].

Despite these theories aiding HCPs’ understanding of patients’ perspectives, some rheumatology HCPs who deal with minority ethnic populations are presented with challenges in engaging with patients of South Asian origin attending early inflammatory arthritis clinics. It is important to explore these perspectives, because engaging with patients at an early stage provides a platform for a long-term relationship and optimizing the best clinical outcomes [16]. Our recent study that explored South Asian patients’ experiences of attending early inflammatory arthritis clinics highlighted that there was room for improvement of the care delivered to this population [17]. In that study, patients made useful recommendations for future clinics. In order to implement the lessons learnt from the patients’ perspectives, we

wanted to widen our understanding of clinical experiences. Currently, there are limited data that document the experiences of rheumatology HCPs dealing with minority ethnic patients. In the present study, we explored rheumatology HCPs’ perception of interacting with patients of South Asian origin attending early inflammatory arthritis clinics and aimed to understand the facilitators and barriers to effective clinical interaction among minority ethnic populations, with consequent global lessons.

Methods

Theory is interchangeably used in qualitative research [18]. We began from the position that rheumatological conditions have public health dimensions [19]. The disease onset strongly shows patterns of cultural influences and social determinants of health [19, 20]. To explore the interactions of HCPs with patients of South Asian origin, our orientation of theory centred on thematic analysis. Thematic analysis is known as a method in its own right that is not bound to any theoretical framework, complementing the pragmatic approach that we took in this study [21]. Pragmatism is guided by the researchers’ desire to produce socially useful knowledge and takes a bottom-up approach [21].

An in-depth, qualitative interview study involving 10 rheumatology HCPs across seven centres in the UK, including a mixture of consultants, registrars and specialist nurses, was conducted. We used thematic principles because they allow the researcher to collect data for the purpose of generating a framework to understand the HCPs’ experiences [18, 22]. The reporting of this study falls in line with consolidating criteria for reporting qualitative research [23].

Using purposive sampling, we recruited HCPs from White British, Afro-Caribbean and South Asian backgrounds, those who spoke South Asian languages and those who did not, and a mixture of genders (Table 1). The recruitment of HCPs took place from academic linked hospitals and general hospitals. This enabled us to explore a broad range of HCPs’ experiences in serving South Asian populations in early inflammatory

TABLE 1 Demographic data of health-care professionals interviewed

Characteristics	Female	Male
Age, years		
25–40	3	2
41–55	2	3
Self-identified ethnicity		
White British	3	1
Afro-Caribbean	2	0
Indian	1	1
British Indian	1	1
Role type		
Rheumatology doctors	4	2
Clinical nurse specialist	4	–

TABLE 2 Topics discussed in interviews

Topics
1. Current role in early inflammatory arthritis clinic.
2. Experience of giving information to patients from South Asian background in the early inflammatory arthritis clinics. Examples of questions: How do you tend to deliver disease-related information to patients of South Asian origin? Do you think the way this is done currently facilitates medication adherence and patient motivation? Do you assess patients' health or illness beliefs? What information do you use to assess those?
3. Views on future development and improvements in early inflammatory arthritis clinics. Examples of questions: How culturally sensitive do you think these approaches are? What can aid a better patient engagement in your view? What resources might help?

arthritis clinics. A semi-structured interview schedule, designed and developed with a clinician partner, was used to conduct 10 interviews with rheumatology HCPs who were involved in the running of early inflammatory arthritis clinics (Table 2). Ethics approval was granted by the South West-Frenchay Research Ethics Committee (Reference 234815). Rheumatology HCPs were contacted by email via a regional rheumatology mailing list and were invited to take part in qualitative interviews, lasting ~45 min, on their experiences of interacting with patients from a South Asian background in early inflammatory arthritis clinics. Those who expressed an interest were interviewed (for details, see the Results section). Written informed consent was obtained from each HCP before interview. Interviews were conducted by K.K., an experienced researcher with rheumatology expertise. K.K. is also of Indian origin. Eight interviews were conducted face to face and took place in the hospital rheumatology department where the participant practised; and two were conducted over the telephone. Interviews were audio-recorded, anonymized and transcribed verbatim by an independent transcription company.

Data analysis

Given that our study was not based on grounded on another phenomenology framework, data were analysed using a form of thematic analysis. Analysis began shortly after initial data collection. An iterative coding procedure, in accordance with principles of inductive thematic analysis, was used [22]. An analysis approach appropriate to applied health services research, enabling investigation of issues while simultaneously allowing for identification of newly emergent ideas in the data, was used [22]. For all interviews, the progressing analysis informed subsequent data collection. At the end of each interview, a summary of findings was discussed with HCPs for agreement. Interviews continued until the main data categories were saturated and no new insights were apparent. The team included diverse expertise: a

rheumatologist (A.A.), health psychologist (R.S.), research partner (E.P.) and health literacy expert (J.A.) and all contributed different expertise to data analysis.

Rigour was achieved through a process of reflexivity and by documenting all analytical decisions, leaving an audit trail. The first author (K.K.) systematically analysed all the transcripts to establish themes grounded in the data. In this process, transcripts were read and reread line by line. The clinician research partner (E.P.) independently coded three transcripts to develop reliable and inclusive themes informed by multiple perspectives. The triangulation process and discussion of the coding framework took place between the researchers (K.K., A.A., R.S., E.P. and J.A.), who compared codes to solve any differences. This process allowed researchers to validate trustworthiness of the data. All transcripts were checked for the emerging new codes identifying data saturation. The team further read and analysed random selection to confirm interpretation of codes. Codes were grouped into categories discussed and revised by the team and then were grouped into themes. Coding categories that lacked concordance were discussed and absorbed into the coding framework. The core themes extracted and presented here focus on HCPs' perceptions of interaction with patients from a South Asian background in early inflammatory arthritis clinics. Initially, 182 codes were identified, which were then grouped into 35 categories and finally combined into three overarching themes. The final report was sent to participants, who did not make any changes.

Results

Ten rheumatology clinicians (six rheumatologists and four nurses), from seven academic linked and National Health Service (NHS) hospitals across the UK, took part. In total, 18 were approached to take part in the study. However, owing to work commitments eight HCPs were unable to fix a time for interview. The declined population included five men and three women. Of the 10 who took part, there were seven women and three men, ranging in age from 29 to 62 years (mean 45.6 years) and qualified from 8 to 35 years (mean 20.3 years). Suitable quotes were selected to illustrate the findings. These are presented in Table 3. The three predominant themes enhanced our understanding of HCPs' perceptions of interacting with patients from South Asian backgrounds in early inflammatory arthritis clinics. See Fig. 1 for a thematic diagram of HCPs' perceptions of interacting with patients of South Asian origin in early inflammatory arthritis clinics and supporting the management of RA.

Varied approaches used in early inflammatory arthritis clinic

Rheumatology HCPs in the study described their roles. The doctors viewed their aim of consultation being focused primarily on diagnosis, assessing physical symptoms and function [Quote (Q) 1]. The clinical nurse

TABLE 3 Health-care professionals' quotes

Quotes relating to: **varied approaches used in early inflammatory arthritis clinic.**

- Q1. My role is to diagnose patients and recommend treatment. If they need extra encouragement, then the nurses normally do that. **[White British, consultant, female]**
- Q2. I mainly see patients to educate them and monitor their drugs, inform them about disease process and DMARD therapy and how we will aim to treat. I educate about the lifestyle changes patients need to make. **[British Indian, clinical nurse specialist, female]**
- Q3. I would say certainly there are complex issues to deal with and one has to take a holistic approach, but who is the person best to do this? That's the question. **[White British, registrar, female]**
- Q4. I do feel it's really tricky to engage with patients from South Asian background in the inflammatory arthritis clinics. Particularly the women. I don't have the same feeling for the men at all, but the women can be very different and do perceive RA to be burdening more than others. **[White British, consultant, female]**
- Q5. I tend to start off by saying, what is it that you would like to achieve? For some, it might be just making chapatti is important; for some, it might be looking after the grandchildren. But at least this gives me an idea of what the goal is, and I like to make it personal to them. I think if we can find someone who works with a goal then that becomes easier to work with. **[Indian, consultant, female]**
- Q6. I don't tend to do the goal setting as I don't know much about the culture really. I tend to ask how they are feeling, and that sometimes gives me enough to know if the condition is controlled or not. I don't use a framework, and perhaps I should because we do use a framework for our young adolescents and that works well. This is a good point: why don't we use this for South Asians? **[White British, consultant, male]**
- Q7. There isn't a formal tool that we use or anything like that; it is more what patients express. We normally would like to discuss this with patients. **[British Indian, clinical nurse specialist, female]**
- Q8. The leaflets are not good at getting across the harm and benefit balance. I think that most leaflets have been developed with White patients and therefore might not have the input of South Asian or ethnic groups. I suspect that section in the information leaflets is missing. Leaflets, they don't have reflections from Black minority ethnic groups views on board. I know they revise these sometimes, may be every year or so, but they are mainly done by White patients. So there you go, how we can make things more cultural sensitive. **[Afro-Caribbean, registrar female]**
- Q9. You see, what we found is that showing patients their problem with joints through an ultrasound helps patients to really get to grips with the condition. Maybe this is more than words can describe. Pictures or making it real with a scan might convince this population. **[White British, clinical nurse specialist, female]**
- Q10. I think we don't get to find this (referring to Apni Jung project) information; there needs to be more education about these resources. We don't have enough time in clinic. **[White British, consultant, male]**
- Q11. I do get concerned about the level of support that there is for South Asian patients really. I mean, if we look at the diabetic care there is a vast amount of information, and we in rheumatology have very little. On reflection, we can't blame the patients' disengagement. We have leaflets, which are all in English. We don't have any cultural understanding other than our own experiences. It does need improving. We are producing more and more medications, but patients or certain groups are not willing to take the general things, so how will they take the other advanced ones? **[White British, consultant, female]**

Quotes relating to: **experience of managing and delivering information to patients from South Asian background in early inflammatory arthritis clinic: rheumatology health-care professionals' challenges.**

- Q12. I know some of them want the cure, and maybe that's why they don't like to take all these medications, because they know it will never go away. Some of them do have more pain, and it is repeated in consultations. **[Indian, consultant, male]**
- Q13. I think we only learn from our clinical experience about some problems but not sure how to deal with them. I do note there are very embedded health beliefs, and when patients present in clinic we are not sure how to deal with those and, in fact, to address them. Clinics take longer and extra time. **[White British, consultant, female]**
- Q14. I feel there is a framework to discuss with family; then it gets decided what will happen. It is really sad that they don't view the importance of exercising joints. My patients just don't attend the physio appointments. I know this because there is a letter dedicated to say the person never turned up so options are limited. **[Afro-Caribbean, consultant, female]**
- Q15. We include the physiotherapy in our consultations. We have found that, in this way, our patients will understand the holistic approach and who is who in the team. For South Asian patients, we note they are more likely to attend the appointments for physio if they knew their role in self-managing. **[British Indian, consultant, female]**
- Q16. Sometimes the information is not taken seriously, and this is more of a problem with the non-English speaking. Then my view is, well, if you are going to listen to what I have to say then you should at least seek all this from somewhere. So, I am aware that this goes on a lot at the beginning of this journey, and it is long time for having the disease. **[White British, clinical nurse specialist, female]**
- Q17. I would say, certainly more hierarchy in the ethnic groups. They do view the doctor to be a lot more important. So, if our nurses see a patient and they are not very convinced then they will call me in to discuss this further with the patient. But when a doctor comes in they might be more serious to take the advice. So occasionally, we are asked to add extra visits. **[Indian, consultant, female]**
- Q18. To be fair, I can understand the patients' perspective and try to get them to engage, maybe better than my White colleagues. I speak Punjabi and Hindi, so sometimes speaking in own mother tongue can help as well. It makes that connection with patients. They are open to more about their plans. For example, like I said, if they are not taking 15 mg of methotrexate then they will tell me what they are doing, like taking the other stuff from India or something. **[Indian, consultant, female]**
- Q19. I grew up in an environment where there were very few ethnic populations. I now work in here, and I don't really know what the expectations are from disease, and sometimes it is hard to unpick these things. **[White British, registrar, female]**
- Q20. I think, as health professionals, there is only so much you can do to help others. I mean, South Asian patients, particularly non-English speaking, decide not to take on what we say; therefore, there is not much I can do about that. **[White British, consultant, male]**

(continued)

TABLE 3 Continued

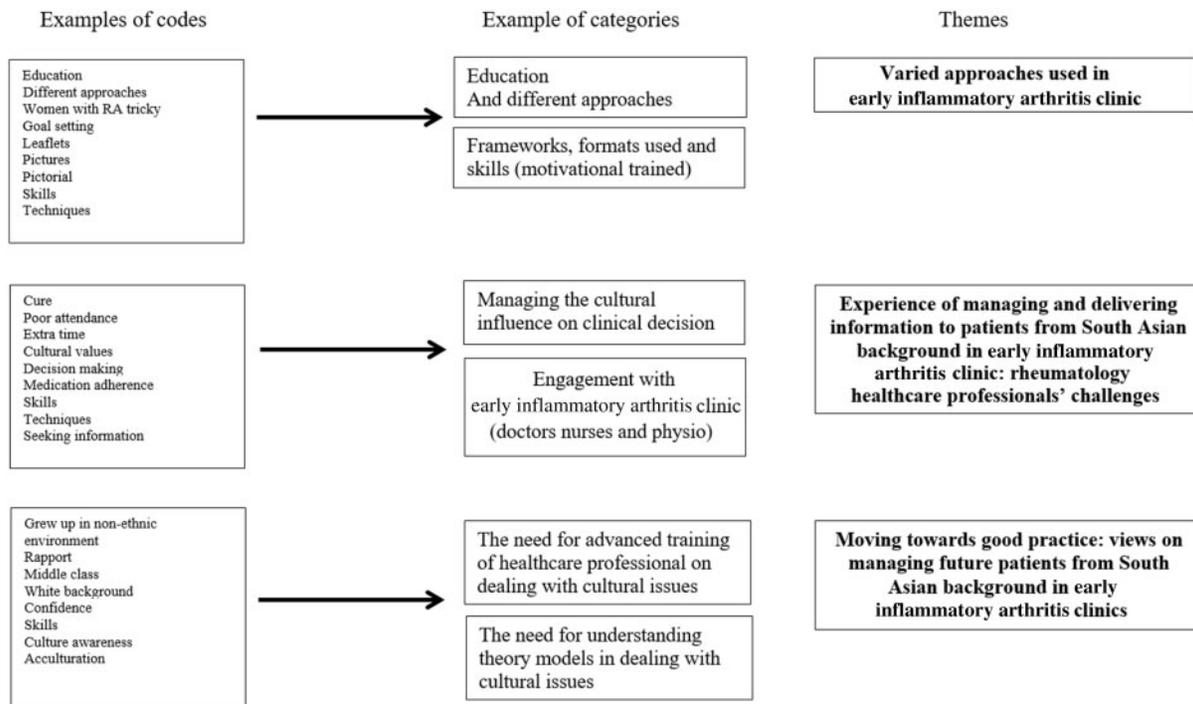
- Q21. There is a lot of weighing up and down going on. There is also a lot of discussion with family, and it takes some time for patients to decide about medication. Sometimes you never know what the patient or family want so just have to go with the flow. Sometimes this causes more discussion and more appointments. I find sometimes it is very challenging and frustrating to know how to move forward. **[White British, consultant, female]**
- Q22. I find a big difference in generations, like the more acculturated ones will understand our viewpoint, but first generation are not always on board. **[White British registrar, female]**
- Q23. I think, to a certain extent, we do lack knowledge about how to deal with ethnic minority populations. I mean, do we even know how to address some of the things? I bet some of us don't really get to the bottom of a consultation. I do think we need to improve this if we are to move forward. **[White British, consultant, female]**
- Q24. There might be the fact that people are not happy to take long-term medication. I can normally tell that from their body language. We can only tell them what we know and give them what is best to control, and this doesn't match their expectation. I feel that ethnic groups might not see the benefits so easily. Medications are toxic, and to be honest they are, but in a White patient you might hear, oh well at least I tried it, but here there might be more thinking going on. **[White British, consultant, male]**

Quotes relating to: **moving towards good practice: views on managing future South Asian patients in early inflammatory arthritis clinics.**

- Q25. It is all about rapport building, but I don't think I can or ever have achieved with a patient from an ethnic background simply because I have limitations on my part and a fear of not fully consulting about their health beliefs. So, a lost opportunity really. **[White British, consultant, female]**
- Q26. We are all very busy, and in order to move forward we should champion someone for each department who can update every about research in this area and resources around. Like this Apni Jung with NRAS, some know and I meet still a lot of people who don't know about it. **[White British, consultant, female]**
- Q27. I think, in years to come, we do need to understand a lot more during consultation. Rheumatology training is all about how to manage the disease, but sadly less on how to manage the person. So, if you could get this onto the rheumatology training for registrars and others then that would be great. **[White British, clinical nurse specialist, female]**
- Q28. I think that's something we can learn in these training sessions. Coming from White backgrounds, we don't always allow the discussions. I am a typical middle-class person who has little knowledge about different cultures. The things I have learnt are what I have picked up along the way. I think learning more about these models might be more useful, in that training for people like me and being verified by people, maybe like you, who know the research would be a great resource. **[White British, consultant, female]**
- Q29. We know how to take good medical history but not how to use models in clinic that can explore patients; in this case, minority ethnic patients' views about engagement. To feel that confidence in clinic, it would be good to know more, and more techniques like motivational interviewing skills. I would like to hear South Asians' views or heritage they bring to consultation. **[White British, consultant, female]**
- Q30. We know that there is a need to move forward and do things differently with South Asian patients but fear also, if we employed new skills, would they work? **[White British, clinical nurse specialist, female]**
- Q31. I think we should have a programme for professionals, as cultures and beliefs are very different, and trying to make sense of these can be a job. We only need to look at other specialities, like cancer, they do. . . **[Afro-Caribbean, registrar, female]**
- Q32. A framework to explore illness beliefs. I think someone like yourself, who might be used to these concepts, can maybe use these in clinic, but a lot can't do this. So, I think something on that will be useful, like how to use self-efficacy with patients. **[White British, clinical nurse specialist, female]**
- Q33. We could be better at this, but since we are limited in our full understanding of what really motivates patients or expectations then we are not perhaps getting the whole story or patient on board. We have limited time in the day. We should have support from British Society for Rheumatology really to do these things. **[Afro-Caribbean, consultant, male]**
- Q34. The only way we are going to improve this situation is if we train and gain more skills on how to manage ethnic minority patients in clinic. I think Arthritis Research UK or British Society for Rheumatology should support things like this really. We try our best to follow clinical pathways, but something is missing. One thought is, should clinicians go on compulsory cultural training if you are appointed in a hospital that has so many minority ethnic patients? **[White British, consultant, female]**

specialist described their role more broadly, where they included a focus on educating patients and providing them with information on lifestyle changes (Q2). The doctors were familiar with a model of care that emphasized a holistic mind and body interaction and recognized RA as a complex disease, with a range of psychological, social and physical sequelae, but questioned whether the needs of patients were addressed adequately (Q3). The HCPs acknowledged that the patient-perceived burden of having RA would impact patients from a South Asian background in many different ways (Q4). Some doctors reported the use of goal-setting techniques with their patients; however, this approach was used only by a few doctors from minority ethnic backgrounds (Q5). The accounts of doctors from

a White background described less sophisticated management approaches that were not embedded within behavioural theoretical models (Q6). Although the clinical nurse specialists described playing a broader role in early inflammatory arthritis clinics, they too were less likely to use strategies that motivate patients at an early stage in the patients from minority ethnic backgrounds (Q7). Both doctors and clinical nurse specialists tended to use standard leaflets to help support their discussions during consultations. There was recognition that the leaflets presented a limitation for non-English-speaking patients (Q8). Only one centre used visual representation to communicate disease-related information. The HCP at this centre expressed the view that the visual representation material helped in engagement with the

Fig. 1 Thematic diagram of health-care professionals' experiences of interacting with patients of South Asian origin

problem and need for treatment, particularly for patients with a lower level of literacy (Q9).

Within their varied approaches used to engage patients from a South Asian background, there was a lack of knowledge about resources available that could assist HCPs in educating patients of South Asian origin (Q10). Only a few centres were aware of the National Rheumatoid Arthritis Society (NRAS) Apni Jung webpage (our fight against rheumatism; www.nras.org.uk/apnijung). The reason for this was cited as lack of time to signpost and, for some, lack of knowledge about this project. The HCPs recognized that RA could be a demanding condition, with an impact on patients' emotional wellbeing and quality of life; however, they were less likely to undertake structured behavioural approaches. The HCPs concurred on the perceived lack of shared management of RA in patients of South Asian origin and that the condition was not subject to the same level care as other long-term diseases, such as diabetes. Specifically, patients' needs for information, decisions to take medication, support for self-care and coping were problematic (Q11). Systems for adequately supporting these needs were perceived as lacking in early inflammatory arthritis clinics.

Example quotes from HCPs:

Q4. I do feel it's really tricky to engage with patients from South Asian backgrounds in the inflammatory arthritis clinics, particularly the women. I don't have the same feeling for the men at all, but the women can be very different and do perceive RA to be burdening more than others. [White British, consultant, female]

Q6. I don't tend to do the goal setting as I don't know much about the culture really. I tend to ask how they are feeling, and that sometimes gives me enough to know if the condition is controlled or not. I don't use a framework, and perhaps I should because we do use a framework for our young adolescents and that works well. This is good point: why don't we use this for South Asians? [White British, consultant, male]

Experience of managing and delivering information to patients from a South Asian background in the early inflammatory arthritis clinic: rheumatology health-care professionals' challenges

The HCPs considered consultation for widespread pain to be higher among patients of South Asian origin compared with the indigenous UK population. They reported that it was not common for patients of South Asian origin to consult with symptoms but present these as new at every visit, possibly in the hope of obtaining alternative medication or a cure (Q12). The HCPs were familiar with the concept of illness belief models that some patients of South Asian origin hold, and they recognized their own limitations in informing these with their patients during clinic consultation. The HCPs reflected on their experiences and noted South Asians take longer to make decisions about their treatments; therefore, they require more time and sometimes extra clinical visits (Q13). The HCPs expressed that despite their effort in supporting self-management, some patients of South Asian origin validated information with families and did not always attend the multidisciplinary team appointments. An example of this

was physiotherapy (Q14). The HCPs expressed difficulties associated with engaging some patients and often noted that their approach and methods were not effective in engaging patients of South Asian origin attending physiotherapy appointments. Only one centre included physiotherapy treatment as part of the consultation supporting patients to understand the role of the multidisciplinary team and the purpose of involving different HCPs in their care (Q15).

The HCPs suggested that providing information in English to non-English-speaking patients of South Asian origin on RA and treatments was not often seen as useful. Moreover, HCPs felt that non-English-speaking patients of South Asian origin did not actively seek information about their RA and management (Q16) and that HCPs should provide some additional support to facilitate this. Some consultants reported their experience of hierarchy amongst first-generation patients, where patients viewed a doctor's opinion to be more valuable than that of other HCPs (Q17). The HCPs who were from the same ethnic background as the patient found that communicating in the patient's native language helped to build better rapport and enabled such approaches as goal setting to be implemented much more effectively (Q18). In contrast, HCPs who were from White origin backgrounds expressed challenges in engaging with some Asian patients, particularly those who were non-English speaking (Q19). Owing to cultural barriers, some doctors from a White origin background acknowledged difficulties in managing patients of South Asian origin. This mirrored the accounts of doctors who believed there was little they could do to help with RA management and were consequently reluctant to consult fully with patients (Q20). The manner in which patients of South Asian origin present and express their concerns was perceived to be culturally influential during the consultation process. Many HCPs reported that patients of South Asian origin present more frequently (Q21). The HCPs described circumstances in which clinical presentations were florid, posing challenges and frustration for the HCPs to treat and manage patients (Q21). The HCPs found that second- and third-generation South Asians presented differently from non-acclimated South Asians and were similar to patients from a White British background (Q22).

The difficulties associated with managing patients of South Asian origin living with RA pose personal challenges for HCPs, causing some HCPs to question their training and value to the community (Q23). Adherence to medication was also noted and difficult to determine during consultation. The HCPs reported feelings of their own limitations and lack of knowledge and skills when patients repeatedly failed to adhere to previously prescribed medication, and it was acknowledged that a focus on disease cure was prioritized by patients (Q24). The HCPs reported that building a strong doctor-patient relationship was important; however, this was perceived to take a long time with patients of South Asian origin for HCPs who were from a White origin background.

Example quotes from HCPs:

Q12. I know some of them want the cure and maybe that's why they don't like to take all these medications because they know it will never go away. Some of them do have more pain, and it is repeated in consultations. **[Indian, consultant, male]**

Q19. I grew up in an environment where there were very few ethnic populations. I now work in here, and I don't really know what the expectations are from disease, and sometimes it is hard to unpick these things. **[White British, registrar, female]**

Moving towards good practice: views on managing future patients from South Asian background in early inflammatory arthritis clinics

The HCPs in this study discussed the concept of a collaborative relationship between the clinician and the patient and noted this to be the cornerstone of more effective patient engagement. However, owing to their own lack of awareness about different cultural values and how to tackle some health beliefs held by minority ethnic populations, they lost the opportunity to explore these and were unlikely to apply goal-setting techniques during consultations (Q25). A few doctors suggested having departmental champions who could act as ambassadors for updating on health diversity agendas, because some were not fully aware of updated research on ethnicity in rheumatology practice (Q26).

The accounts of most HCPs from a White origin background indicated self-reported low levels of expertise and confidence in the management of patients from minority ethnic backgrounds living with RA, which they blamed on lack of training opportunities (Q27). This appeared to be more apparent for those HCPs who might have trained in non-ethnically diverse environments but now worked in hospitals serving a large minority ethnic population (Q28). In contrast, HCPs of South Asian origin felt that they were at an advantage in communicating with patients of a South Asian origin.

During the interview, many HCPs of White British origin reflected and recognized the need for development of culturally specific skills that could better assist them in engaging with the minority ethnic populations in consultations. All HCPs said that having the skills to apply theory underpinning illness health beliefs and self-management would be useful to strengthen their confidence in managing minority ethnic populations better (Q29). The HCPs stated that it would be helpful to try new approaches, which might offer more to both the patients and the HCPs, given the time constraints to see patients. A concern experienced by many HCPs was in relationship to using new skills competently in minority ethnic patients, and how to respond if complex psychological difficulties emerged in a consultation (Q30). A clear sense emerged that formal training would be the start of a learning process for managing patients from minority ethnic backgrounds. The HCPs described how they could use theoretically driven strategies to support minority ethnic populations and enhance shared care decision-making in clinical practice after training (Q31–Q34).

Example quotes from HCPs:

Q31. I think we should have a programme for professionals, as cultures and beliefs are very different, and trying to make sense of these can be a job. We only need to look at other specialities, like cancer, they do... [Afro-Caribbean, registrar, female]

Q28. I think that's something we can learn in these training sessions. Coming from White backgrounds, we don't always allow the discussions. I am a typical middle-class person who has little knowledge about different cultures. The things I have learnt are what I have picked up along the way. I think learning more about these models might be more useful in that training for people like me and being verified by people, maybe like you, who know the research would be a great resource. [White British, consultant, female]

Discussion

This is the first study to present the perspectives of rheumatology HCPs' perceptions of interacting with patients of South Asian origin attending early inflammatory arthritis clinics. We have documented different approaches used by HCPs in engaging patients from minority ethnic backgrounds, but only a very few consultations were based on any underpinning behavioural change theory. There were many challenges described by HCPs, and signposting to specific resources that could have allowed patients of South Asian origin to better engagement was not always optimized. Educational materials currently available to non-English-speaking patients of South Asian origin were also presented as challenges by HCPs.

We have found two key directions from HCPs that affirm future steps. Firstly, all HCPs may require a better understanding of implementing health-related theory models and skills, such as motivational interviewing, into their consultation when engaging with patients of South Asian origin. In our study, HCPs identified the need for training and reflected that theoretical models could be used better to guide consultations. Theory-based interventions with advanced skills have been tested and recommended to improve the patient-clinician relationship [24], allowing the opportunity to generate an improved engagement and increase the likelihood of wide adoption of self-management by patients [25]. In our previous study, in which experiences of South Asians attending early inflammatory arthritis clinics were explored, we reported a massive impact of RA on patients' psychological status [17]. The psychological burden and tension were reported to increase owing to lack of effective interaction with HCPs to manage RA. The results of HCPs' experiences of interacting with patients of South Asian origin affirm the reasons for lack of interactions in clinics. Our data suggest an opportunity to help embed skills in clinical practice and develop advanced techniques to move forwards. Transfer of training theory proposes that higher levels of shared care decision-making might increase the likelihood of successful outcomes [24]. This was found in research into brief cognitive-behavioural training for clinicians working in cancer [26], where clinical consultation was based on necessity and

needs of patients, and HCPs trained to address concerns effectively, maintain skills and build confidence. In our study, HCPs in one centre identified the creation of advanced techniques and used different modes of communication, whereby use of diagrams and showing pictures of joints during US consultation was found to be particularly useful for non-English-speaking patients. That centre used this approach to communicate disease-related information to patients with lower literacy levels and perhaps less acculturated in the western systems. This extends our understanding that going beyond traditional consultation styles may reap meaningful rewards. For example, pictorial or visualizing types of materials can be helpful to communicate disease-related information [27]. Surprisingly, visualization during consultation was used in only one centre, although previous studies have shown that this method of engagement helps patients to reduce their treatment-related concerns that lead to non-adherent behaviours, particularly among patients of South Asian origin living with RA [7]. Moreover, other specialities have shown that visualization when used within self-regulation theory [28, 29] assists patients in rationalizing their disease process and understanding the long-term need for treatment [30, 31]. This is particularly helpful for engaging minority ethnic populations, who have been known to seek a cure for the disease and often lack motivation to adhere to treatment [32]; moreover, they were reported to have frequent hospital visits in our study.

Secondly, HCPs who were not from minority ethnic backgrounds strongly recommended advanced cultural competency training for rheumatology practitioners. Our findings resonate strongly with those of previous researchers [33], who have shown that HCPs consulting with minority ethnic populations are not always equipped with appropriate training to address the culturally sensitive issues and how these drive clinical decisions [34, 35]. Cultural competence training in specialities such as diabetes has been shown to improve patient outcomes [10, 36]. A systematic review of 34 studies by Beach *et al.* [37] found that training clinicians improved knowledge in 17 of 19 studies skills and attitudes in 21 of 25 studies. Likewise, another systematic review [38] found that five studies showed that cultural competence training of HCPs resulted in improved patient satisfaction and better understanding of the treatment plan [39]. Others noted an improvement in clinical variables in diabetes [39]. This was echoed by another systematic review [40], in which 13 studies of HCPs and diabetic patients concluded that cultural competence training increased clinicians' knowledge about and awareness of dealing with culturally diverse patients and cultural sensitivity. Moreover, cultural awareness has been highlighted in areas such as general practice [41].

Our study has limitations. We recruited a relatively small sample size, which might not have enabled us to reach data saturation. However, we were able to explore a broad overview of the rheumatology HCPs' perspectives of interacting with South Asian patients attending

early inflammatory arthritis clinics across seven centres in the UK. Alternative methodology, such as the use of focus groups, could have enabled a more in-depth analysis of each clinic, which might have offered useful insights of patient journeys and experiences. Having conducted our interviews face to face and over the telephone could have introduced some unintentional bias. Nevertheless, we elucidated the views of HCPs and captured their experiences regarding what would help them to conduct effective consultations in early inflammatory arthritis clinics across the UK.

Conclusions

It is clear that rheumatology HCPs, particularly those from non-South Asian backgrounds, believe that they need an advanced understanding of cultural skills training and currently find consultations difficult when dealing with minority ethnic patients. Moreover, all HCPs may require a better understanding of theory-related health models to enhance consultations. The training needs to address both consultation skills and the establishment of culturally sensitive services. These findings provide a good direction for future research. Our study provides an example that can be used internationally for all rheumatology departments that treat patients from a variety of ethnic backgrounds. The issues identified here should provide an example for all health-care professionals working to develop culturally competent staff and deliver culturally appropriate services to all patients.

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