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# The Challenges of Cross-Cultural Healthcare — Diversity, Ethics, and the Medical Encounter

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*Difficulties in the provider-patient relationship arise from many sources, and pose various challenges to the integrity of the medical encounter. When these issues are especially sensitive or important to the patient's health and well-being, a complete breakdown in the therapeutic relationship may result. The goal of the emerging field of cross-cultural healthcare is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds. We should weave the concepts of cross-cultural care into the ethics of caring if we truly hope to have a positive impact on the health status of diverse patient populations.*

With each passing day, the United States population becomes more diverse. It is expected that people of color (African Americans, Hispanics, Asian/Pacific Islanders, Native Americans, and Alaskan Natives) will grow from a current 28 percent of the population currently, to over 40 percent of the population by the year 2030. Other immigrant populations, including those from the former Soviet Union, Yugoslavia, and West Africa, will further add to this diversity.

Demographic changes anticipated over the next few decades will directly impact all facets of our society, including healthcare delivery. As providers we must successfully manage medical encounters with patients from very different social and cultural backgrounds from our own. The goal of the emerging field of cross-cultural healthcare is to improve providers' ability to understand, communicate with, and care for patients from diverse backgrounds.

## Naming the Challenge

What challenges occur in the cross-cultural encounter? Perhaps the first and most obvious challenge is the language barrier that exists between providers and patients. Over 31 million residents of the United States do not speak English as their primary language (Census 1993). This

figure represents 14 percent of the total U.S. population, and ranges as high as 36 percent of the population in some states. It is not difficult to imagine how frustrated patients and providers become when they are unable to communicate with each other. We have only to think about the personal and confidential information that must be exchanged in an effective clinical encounter.

Social and cultural differences between patient and provider are a second challenge that, if not handled correctly, will adversely affect the clinical interaction. Given that the unique perspectives of

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both provider and patient are greatly influenced by the social and cultural factors that define each person, one can easily imagine how different world views can undermine the trust and cooperation necessary for a successful healing and therapeutic relationship.

Assume, for example, that the provider understands "disease" as a pathophysiologic process, while the patient sees his or her "illness" as a unique manifestation of disease composed of physical, psychological, social, and cultural factors. Such a patient may have a different understanding of the cause, severity, and prognosis of an illness, the treatment he or she expects, and how the illness will affect his or her life. This conceptualization, or "meaning," of the illness can be described as the patient's explanatory model (Eisenberg 1977, Kleinman et al. 1978).

Failure to elicit a patient's explanatory model, especially if he or she has a sociocultural background that is unfamiliar to the provider, may lead to a sense of dependence and dissatisfaction on the part of the patient, and to frustration and misperceptions about the patient on the part of the provider. In essence, divergent health beliefs and different interpretations of illness pose significant difficulties in the medical encounter.

A third challenge in the cross-cultural healthcare encounter is the fact that manifestations of a patient's illness are directly linked to that individual's social environment. Exploring the patient's support systems and persistent stressors, migration history, educational background and literacy, socioeconomic status, and subsequent control over his or her environment is critical to delivering quality care. In sum, language barriers and failure to understand the disease/illness dichotomy or to elicit the patient's social context can lead to difficult and often frustrating cross-cultural encounters.

### **Difficulties in Context**

Specific examples of how cross-cultural encounters can lead to significant ethical dilemmas occur when informed consent is required for a major test, procedure, or operation; when the truth about terminal diagnoses is told (or not told); and when attitudes toward the role of physicians and the medical system arise in the context of previous patient mistrust. The ethical issues surrounding the concept and process of informed consent have been extensively studied (Arnold et al. 1995, Vollman and Winau 1996, Cross and Churchill 1982,

Savulescu and Momeyer 1997). Providers may have personal biases that lead to coerced consent, or they may unintentionally influence patients by not realizing the effect of certain phrases or concepts (Vollman and Winau 1996). Patients may lack a true understanding of the risks and benefits of a procedure due to lack of information, misinformation, or different conceptualizations of risk. A patient's rational judgment may be distorted as a result of stress during a crisis situation, or other outside pressures.

Sociocultural differences such as language barriers and illiteracy influence and add additional layers to the complexity of obtaining informed consent. An undereducated patient may not be able to read and understand the detailed, university-level language of the typical informed consent form. In fact, some studies have shown a level of noncomprehension as high as 59 percent for a standard informed consent document in urban public hospitals (Williams 1995). Communication styles, the desire to avoid disrespecting the physician, underlying mistrust of the healthcare system, and spiritual beliefs about the body and its purpose are other more subtle sociocultural issues. The following is an example of how these issues affect the process of informed consent.

Mr. L is a seventy-two-year-old Navajo man who has been healthy and rarely seen a medical doctor. He has smoked for years and recently noticed a white lesion on the base of his tongue. He presented to the Ears, Nose, and Throat clinic and was informed that he needed a biopsy of the lesion. The procedure was described as being simple with no major risks, and he was handed an informed consent document, which he signed without reading.

The biopsy revealed that the growth was malignant and he was told that he needed major curative surgery. He was again given an informed consent form, but this time he was instructed on all the potential complications of surgery (e.g., reacting badly to the anesthesia; bleeding; infection; or death). He was shocked and refused to sign. Later that

evening he explained to his family what had happened. The doctor had described several potentially terrible outcomes of this operation and was therefore not to be trusted. He had willed these bad outcomes to occur through his negative words.

This patient would likely be perceived as being "difficult" by the provider. From her perspective, Mr. L did not seem to realize that the risks of the surgery were much less than the risk of allowing his cancer to spread. Mr. L was, however perfectly rational within his cultural context. Certain Navajos consider it inappropriate to make mention of any negative future events because voicing them is akin to wishing for their occurrence (Carrese and Rhodes 2000).

It has been suggested that healthcare providers use a different approach in these situations. Rather than listing the risks of certain outcomes, for ex-

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ample, the provider can explain that these complications have occurred in a certain fraction of other people who have had this procedure. This tactic puts the information in an impersonal context, which is much more acceptable (Carrese and Rhodes 2000). Although the provider may not know how every patient prefers to have a procedure explained, he or she can explore how a particular patient, within a particular sociocultural context, best prefers to have this information presented.

Another ethical hot-button issue in cross-cultural healthcare is that of "truth-telling," the revealing of terminal diagnoses or other bad news. The healthcare system in the United States and other Western countries places great emphasis on the autonomy of the patient. The Patient Self-Determination Act secures this right legally for all patients in the United States, but its applicability to patients of various cultural backgrounds has often been debated (Refolo 1992, Ersek 1998). Many studies in countries such as Japan, China, and the United Arab Emirates have demonstrated that doctors in these countries are much more likely than U.S. physicians to withhold information from patients about terminal diagnoses, and that their patients are more likely to prefer this withholding (Elwyn et al. 1998, Pang 1999, Harrison et al. 1997).

Even in the United States, patients of certain cultural backgrounds may be more likely to prefer this approach (Blackhall et al. 1999). In these situations the patient's family members are told the diagnosis and are responsible to determine whether or not to reveal the information to the patient and, if so, how best to do so. In essence, certain cultures have a more family-centered approach to decision making, as compared to cultures with a greater focus on the individual as decision maker. Other factors are differences in beliefs about the power of hope and the negative consequences associated with losing hope, the role of the physician and paternalism, and the way social roles change with aging. The effect of some of these issues in the generation of difficult provider-patient encounters is exemplified in the following vignette.

Mrs. Y, a sixty-six-year-old Japanese American woman who came to the United States with her family twenty years ago, presented to the emergency room with a history of fever for three days and spontaneous bruises that had appeared on her legs. She had hypertension and hypothyroidism, but had otherwise been healthy. Her family, fearing a serious diagnosis, asked the doctors to reveal the results of any of the tests to them, not to the patient directly. They would then discuss whether she should be told the diagnosis or

whether it would be in her best interest to withhold the information.

Blood tests showed that she had a very aggressive leukemia. The situation created a great deal of conflict among the healthcare providers. Most, including the doctors, felt that they were obliged to tell her the diagnosis. They felt that it was her right to know, particularly if she would require chemotherapy, and that the family was being unreasonable. A few, including her nurse who was Korean, felt that the family members were within their rights to withhold the information as they knew what was best for her, and understood how she might react to this life-threatening condition.

Mrs. Y is a perfectly competent woman of sixty-six years and should, as far as staff is concerned, know her diagnosis and make decisions for herself. To staff, the family is making this situation difficult and challenging. While most healthcare providers think it is imperative to tell patients their diagnoses, they can also fail to appreciate the other side, which in Mrs. Y's case is the family's perspective. If the provider can determine that the patient really does prefer to let his or her family make decisions, then the patient can waive the right to know. He or she can choose to leave decisions about their diagnosis in the hands of their families.

The provider-patient relationship is predicated on the underlying tenet that the provider will always look out for the patient's best interest. The patient must therefore trust the provider's ability to carry out this mandate. When trust is lacking for any reason, the medical encounter becomes strained and extremely difficult. Mistrust can be generated in many ways in cross-cultural encounters, but often arises from fear of prejudicial treatment based on race or ethnicity. Clearly, these fears have a basis in reality; the Tuskegee Study of Untreated Syphilis, for example, left a legacy of fear and mistrust within the African American community that was recently validated by studies showing striking disparities in care between races (Gamble 1997).

Nor is mistrust limited to African American patients. A recent survey found that Latinos were significantly more likely than whites to feel that they are treated unfairly by providers or their medical system (Kaiser Family Foundation 1999). Previous bad experiences, poor communication, disrespectful treatment, socioeconomic discrimination, and the current market-driven healthcare environment magnify these fears for all patient populations. As a result, providers have a responsibility to build trust through rapport, good communication, patient participatory decision making; and by respecting patient needs, fears, and concerns. They must also confront their own prejudices and biases and explore how these prejudices affect their interactions with patients.

The consequences of devaluing sociocultural differences in the medical encounter can be severe. Perhaps the consequence that catches the most at-

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tion is the presence of racial/ethnic disparities in health. Significant disparities in access to care, utilization of services, and health outcomes exist between majority and minority Americans. These disparities have gained national attention, and the *President's Initiative on Race and Healthy People 2010* has focused on eliminating disparities in cardiovascular disease, diabetes, cancer screening and management, HIV/AIDS, infant mortality, and immunizations. This initiative makes us aware that differences may exist in the quality of care, depending on who is sitting across from the provider. In addition to being a quality issue, many have raised this disparity as a health and human rights issue.

The connection between effective cross-cultural care and the elimination of racial/ethnic dispari-

ties is now being explored. This connection is based on the hypothesis that poor communication between provider and patient — complicated by bias on the part of the provider, mistrust and varied preferences on the part of the patient — may be partially causative of health disparities.

## Solutions

There are no simple solutions to the ethical challenges and dilemmas inherent in the cross-cultural provider-patient encounter. Difficulties that arise from different perspectives are complicated by the firmness to which these perspectives are adhered to by each party. In this context, the concept of negotiation is a fitting approach to the problem. Negotiation occurs when two or more parties, each with a different set of expectations, agendas, values, and concerns, yet with certain common goals, work together to reach a mutually acceptable agreement.

Each of the cases previously described yield potential for negotiation. For example, Mr. L may have agreed to the operation if the provider had first explored how he wanted therapeutic options and possible complications presented to him. Similarly, if the provider had asked Mrs. Y how she wanted to receive the results and who should be responsible for her care before beginning the diagnostic work-up, both the staff and the family may have felt more comfortable. Alternatively, Mrs. Y could have disagreed with her family and asked to know her diagnosis.

For successful negotiation, it is crucial that each side understand the other's perspective. Effective communication, open-mindedness, and respect are essential. Since the physician is generally in a position to determine the course of the encounter, he or she must assume responsibility for effective communication. In cross-cultural encounters this responsibility includes exploring the patient's cultural beliefs and values as they relate to the particular medical issue at hand.

Techniques of cross-cultural communication include exploring core cross-cultural issues, understanding the meaning of the patient's illness,

and determining important aspects of the patient's social context, all of which have been described elsewhere (Carrillo et al. 1999). Having some basic knowledge of the patient's culture may be helpful, but no one can become an expert in the hundreds of cultures that make up the fabric of our world. Healthcare providers must become adept at exploring these issues with the individual patient and using his or her explanation to direct the ensuing negotiation.

## The Ethics of Caring

Finally, whereas medical ethics has attempted to balance the principles of beneficence, autonomy, and justice as a framework for addressing dilemmas, the ethics of caring has arisen as a more salient approach for the medical environment (Branch 2000, Carse 1991, Gilligan 1982). The ethics of caring has attempted to refocus on the doctor's responsibility to the individual patient, and away from the less empathic, principle-based method focused solely on fairness and equity. This approach fits well with the challenges we face in attempting to care for cross-cultural patient populations. It becomes very easy to grow frustrated with those whose language and health beliefs we do not understand. In these instances, we may stray from the ethics of caring and assume the more distant posture that stresses principles over empathy.

An orientation to caring incorporates attributes of attentiveness, honesty, patience, respect, compassion, trustworthiness, and sensitivity, into all acts of behavior. We should interweave the concepts of cross-cultural care into the ethics of caring if we truly hope to have a positive impact on the health status of our diverse patient populations. Ultimately, if we are to maintain high standards of healthcare delivery, we must be prepared to meet the challenges that our nation's increasing diversity poses, while simultaneously benefiting from the strengths its diversity provides.

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