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# Modern Medicine in a Multicultural Setting

by Dorothy Rasinski Gregory

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*In dealing with patients from other cultures, we often find that our "ethical" focus on autonomy, beneficence, nonmaleficence and justice fails to help solve a dilemma or answer a question. A broader view of autonomy, one that includes the person's culture—the values and belief system within which that person functions—is in order.*

Examining the faces encountered while walking down the streets of any American city or hearing the variety of languages spoken by passengers on public transportation is convincing evidence that we are a multicultural, multiethnic society. One of the most critical areas in which the interface of cultures is encountered is in the health care setting.

In its infancy, bioethics was largely a white, Anglo-European, Judeo-Christian enterprise, and the ethic pursued conformed to the belief system of that group. Gradually health care workers have realized that what is ethical and appropriate for members of one community may not conform to the needs and expectations of everyone who is a recipient of health care in the nation today; particular values, beliefs, and practices of other cultures have been neglected in bioethics theory and literature. Bioethicists need to be cognizant of the rich variety of cultures influencing the health care encounter.

## Culture

What is meant by culture? A shorthand definition is the social experiences of a group, experiences which lead to the value and importance its members place on certain elements of our lives. These experiences are not stagnant but evolve and develop over time. Culture includes nationality, language, dress, method of adornment, food preferences, customs, rituals, music, art, and religion. It encompasses the role of the individual and the family (or group) in decision making, the importance of women, how the group defines success

and the value placed on time and money. Subcultures may be influenced by place of residence (whether rural or urban), educational level, occupation, socioeconomic status, religious affiliation, gender, sexual orientation, primary language, and level of achievement.

The provider should inquire about the group's, and especially the individual's, understanding of the elements of disease causation, the role and meaning of life and death, and what particular practices or rituals the group (or the individual) has adopted to treat symptoms, to respond to illness, and to prepare for particular changes in life or death. This information may be very important in making health care decisions.

When cultures mix in a health care setting there is potential for bias on both sides: the side of the provider and the side of the patient. In becoming culturally competent, health care professionals need to understand their own values and beliefs first, then understand these against the background of the mainstream. It is often easier to treat patients with a similar background to the health care professional's because both parties share and understand, at least to some degree, the same belief system. In working with people from differ-

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ent cultures, it is difficult to meet their health care needs effectively without understanding their values and beliefs. This will become increasingly important in view of recent population trends. These data indicate that by the year 2000 almost forty percent of the population of this country will be immigrants or first generation Americans, and by the first half of the next century, half of the population will be people of color.

### **Differing Perspectives**

For many years the approach of American medicine has been to diagnose a disease and then to treat it accordingly. The term "disease" is the diagnostic label a physician affixes to the constellation of a patient's symptoms, history, clinical signs, and laboratory and imaging data.

Patients, on the other hand, are seeking treatment for an "illness," a condition that interferes with their ability to carry on their normal activities and relationships. That illness may have nothing to do with the disease which the physician diagnoses and attempts to treat. It is understandable, then, that treating the disease may have little or no effect upon the illness that worries the patient or disturbs his normal routine.

This discrepancy is magnified in the treatment of an individual whose culture is different from that of the provider and, consequently, whose perception of disease or illness causation may vary greatly from that of the health care professional. For example, a physician may diagnose abdominal pain, prescribe symptomatic treatment and assure the patient that the x-rays and CAT scans are negative, chemistries in order, and the biopsies normal. If the patient's diarrhea and other symptoms continue because of guilt or grief over a troubled relationship, a situation about which the physician knows nothing and makes no inquiry, the patient's problem is magnified. And if the patient happens to be of Haitian or Caribbean background and believes that his symptoms are secondary to someone's having placed a hex upon him, the potential for escalation of that problem is enhanced. A patient would probably not offer such information without being asked, particu-

larly if the patient is new to this country, but such information is critical to treating him effectively. The physician must elicit it carefully and nonjudgmentally.

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The patient's perceptions and understanding affect his compliance with medical recommendations, as well as the ability of the providers to tailor those recommendations to the patient's belief system. The meaning of life, the meaning of illness in the context of a particular life, the causation of illness, as well as the meaning of death in the context of one's overall existence play a vital role. In many cultures, illness (or disease) is not considered to be the result of metabolic, physiologic, infectious, or malignant pathophysiology as Western medicine maintains. Illness may be perceived to arise because of the activities of an evil spirit, a hex, curse, or a food imbalance, or perhaps as punishment for past sins or evil practices. Patients from such cultures may have difficulty in understanding or accepting prescriptions since they seem to have little relationship to the factors which patients feel have caused their problems.

### **Eliciting Information**

Assuring good communications between the patient and caregiver is especially important when significant culture differences exist. In such situations, the provider should be attentive to body language and facial expressions as well as to the verbal exchange. Phrasing questions in nonjudgmental and open-ended ways will generate trust and make patients feel respected.

Patients' perceptions about the causes of illnesses may be based on generations of tradition and folk wisdom. A young woman, recently arrived in the United States from Mexico, was hospitalized for treatment of gram-negative septicemia secondary to a urinary tract infection. A Mexican American nurse discerned that the patient believed her illness occurred because she had offended a spirit residing in her home by sweeping dust onto it inadvertently. The upset spirit caused the fever and other symptoms in retaliation for the offense. After appropriate antibiotic therapy and fluid replacement, blood and urine cultures were negative. The fever and malaise, however, persisted. Only after the patient was reassured that family members had scrubbed the affected corner of the house and placed offerings there to appease the spirit, did her fever leave and general health return. Although health care providers might not always understand how emotional states influence recovery, visible effects of belief systems on a patient's clinical status cannot be discounted.

### **Meaning of Life and Death**

Different cultures have varying ideas about the meaning and role of death in the life of the individual or of the family or group. Many cultures view life as being controlled entirely by God. Among these groups the suggestion that a treatment modality such as a ventilator, intravenous fluids, or dialysis be withdrawn, even though clinically ineffective, would be considered an inappropriate option since to do so would be interfering with God's will. Recognizing the patient's or surrogate's autonomy would require continuing treatment since in these cultures, doing anything to hasten death, for whatever the motivation or degree of the patient's suffering, is unacceptable. Orthodox Jews, for example, believe that the spark of life must be nourished and protected under all circumstances. Adjusting the pillow under the head of a patient in a coma, if that adjustment might alter respiration and induce respiratory arrest and death, would be prohibited. The meaning of beneficence as applied within such a belief system would be altered considerably from that in other cultures.

In a recent study at the University of Miami Medical School, 142 patients were questioned about their desire for certain levels of care in a variety of states, including coma with little chance of recovery, persistent vegetative state, dementia, terminal illness, and AIDS (Caralis et al. 1993). In response, 14 percent of the nonHispanic whites, 37 percent of African Americans, and 42 percent of Hispanics wanted to be kept alive, no matter how ill. Moreover, 11 percent of nonHispanic whites, 37 percent of African Americans, and 41 percent of Hispanics would not stop life support under any circumstances. In a coma with little chance of full recovery, the majority of all three groups desired at least some form of medical intervention.

Those responsible for discussing with patients their wishes about the appointment of a surrogate decision maker or an advance directive about life-prolonging treatment must be aware that a patient may have strong beliefs about the meaning of forgoing treatment. In approaching the patient, the caregiver should choose language that indicates respect for the patient's beliefs and culture.

### **Alternative Methods**

Care and sensitivity must be exercised in eliciting information about nontraditional health care practices.

Many Asian families believe in acupuncture and herbal medication to control symptoms and ward off disease. Information about previous use of these modalities may not be volunteered when seeking care from a practitioner of Western medicine. The provider should ask whether or not the patient has had treatment by an acupuncturist or herbalist in the past, whether or not he has employed such a modality in this case, and how well the patient responded to that type of intervention. Even though Western medicine does not understand the mechanism of action behind acupuncture, many physicians have seen the remarkable results achieved, particularly in surgical procedures performed with acupuncture and without anesthesia. As long as herbal medicine and acu-

puncture are not harming a patient, they should be allowed to continue, especially if the patient feels them helpful. Such collaboration serves both autonomy and beneficence, and cements the physician-patient relationship.

### Language Problems

A difference in language between patient and provider raises another set of concerns. Physicians and other health care providers must be aware of the importance of language, even if the patient speaks and understands English. Scientific jargon is confusing in itself, but when the patient's familiarity with English is limited, technical terminology is even more intimidating and threatening. By stopping frequently in the conversation and inviting questions, the provider can access the patient's understanding and facilitate her grasp of the situation.

The use of a family member as interpreter between a physician and patient who don't speak the same language requires caution. A middle-aged Chinese lady, visiting her son in the United States, had the sudden onset of heavy vaginal bleeding. The son took her to the hospital, but among Chinese females, it is inappropriate to discuss problems involving the female genitalia, particularly with a male family member. The woman, consequently, told her son she had a stomachache; the son, in turn, described his mother's ailments in those terms to the physician. It was only after an examination and a consultation with a female gynecologist that the caregiver determined the exact nature of the problem. In addition to problems such as these, using a relative as interpreter sometimes brings nuances to the translation that obscure the real message.

The cultural connotation of words can also cause problems in communication. In certain cultures it is inappropriate to say the word "cancer." The term conveys to the patient that he is about to die and that he should resign himself to the fate that will befall him in a brief period of time. Asking family members to translate and convey such information to the patient may result in their saying what they feel the patient wants to hear or

what may be culturally appropriate for the patient to hear, without restating what the physician has actually said. This is particularly true among certain ethnic Russian and Asian groups. Even if the physician tells the family member or translator that the cancer can be controlled or remission achieved by surgery, chemotherapy or radiation, the message to the patient may be that "death is imminent." Consequently the patient may refuse all treatment, even if the family member or translator had stated that good treatment options were available.

Another communication issue occurs in cultures in which information is only given to, and decisions are only made by, the oldest male in the family. Among certain Middle Eastern groups, all decisions must be made by the father, even if the patient is an adult, unmarried female. In such patriarchal societies, it is considered inappropriate to pass information to the female. Under these circumstances, physicians may have difficulty seeking "informed consent" for treatment from a patient who has been considered by her family to have no right to receive the information, let alone to make the decision. When an Iranian woman, a college and professional school graduate, developed a breast lesion, she chose to make her own treatment choices. However, her father, a retired attorney, and other family members adhered to traditional Iranian customs and resented the fact that the physician did not involve them in the decision making. The physician, after eliciting and documenting the patient's wishes, discussed and explained his actions with the patient's family. He spoke respectfully of their usual practices, then explained that in the United States it is important that physicians proceed according to the wishes of the patient. In this case, the patient had specifically requested that she be the recipient of the information as well as the decision maker. Such discussions should be carried out with sensitivity and then documented in the medical record.

In some cultures the physician is honored, respected and never contradicted. When a physician accustomed to practicing Western medicine

provides information to a patient or a patient's family as a prelude to seeking consent for treatment, the encounter may give the family the impression that the physician has little or no confidence in his abilities or in his recommendation for further treatment since he appears to need their "permission" to proceed. Such an interpretation of the physician's actions may cause the family to doubt the physician's competence in treatment decisions. In cases like this, the physician, using background information from the patient's medical record as a guide, needs to tailor her approach to the demands of the situation.

When one moves to another country, the new community influences that person's culture in varying degrees; after many years, rituals and customs may gradually be adapted, acculturated and assimilated into the American mainstream. For health care providers, this can cause even greater confusion, and they need to choose cautiously the suitable, considerate approach to patients of varying cultural backgrounds.

### **Health Care Customs and Practices**

It is important to distinguish custom and cultural ritual from abuse. A Vietnamese mother brought her son to an emergency room for treatment of a fracture. While the boy was being treated, his younger sister sat in the waiting area. A nurse, noticing a series of round, red lesions on the girl's arm, questioned whether or not she had been burned. A Vietnamese colleague explained that such lesions were often marks of "coining," a common Vietnamese practice of massaging away fevers and aches with a heated coin or piece of metal that draws blood to the surface of the skin. The Vietnamese nurse then talked with the young girl to ascertain that this was the case. Had caution not been taken, an erroneous report of child abuse might have been made, causing unwarranted distress to everyone involved.

As immigrant populations and the cultural diversity of our society swells, health care providers are becoming increasingly familiar with differentiating customs from signs of abuse and with working with parents whose child-rearing prac-

tices from their homelands sometimes conflict with Western concepts of good parenting.

Sometimes health care providers discover that patients for whom they have prescribed medications are not getting better. Upon making inquiries, it is discovered that the patients are not taking the medication or following the recommended procedure because it has not been appropriately blessed by their shaman or curandera. In the southwest, for example, a Native American patient, newly diagnosed with diabetes, returned to the public health hospital with blood sugars out of control because she had not taken her insulin at home. Only after the tribal shaman had blessed the insulin and syringes and given her permission to follow the doctor's treatment, was she willing to continue with the health care provider's recommendations to control her disease. Taking care to involve the appropriate person from the patient's culture can facilitate compliance. This strengthens the physician-patient relationship and confirms that the physician is an individual to be trusted, one who respects the patient and her background.

### **Solutions**

The AMA Department of Adolescent Health has recently described five components of cultural competence for health care providers. These include:

- awareness and acceptance of how cultural differences can affect the delivery of effective health care
- the ability to recognize how one's own culture affects behavior and attitudes
- the awareness that misunderstanding and misinterpretations can occur when a provider from one culture interacts with a patient from another
- enough knowledge of each patient's culture to anticipate barriers and an awareness that cultures are often too complex to be fully understood
- the ability and willingness to adapt and

refine one's own skills to provide culturally competent care

Several examples of educational strategies to promote cultural competencies have been tried and proven effective. Medical students and house officers at several medical schools, including University of California/Irvine, have established courses and seminars dealing with cross-cultural issues in health care. Continuing medical education and nursing in-service programs that deal with cultural beliefs and practices have been instituted around the country. Kaiser Permanente of Northern California, for example, has successfully mounted a program dealing with the various cultures it serves. Community-wide programs sponsored by bioethics networking groups that utilize health care professionals from a variety of ethnic backgrounds, respected elders or religious leaders from ethnic communities, and faculty from local colleges and universities as resources are also effective means of education. In addition there are increasing numbers of articles in medical and bioethics literature dealing with multi-cultural aspects of health care delivery.

### Conclusion

There are elements of power and control in health care which may intimidate patients, even when the cultures are not diverse. The health care providers possess the knowledge, skill and information; they order the tests, the procedures and the medications. The patient, on the other hand, is in a dependent, vulnerable position. In culturally diverse situations this disparity is even more pronounced.

The development of cultural competency not only closes this gap and sharpens one's communication skills, but also fosters tolerance and patience. In the process it creates better physicians and providers. It extends the patient-doctor relationship to several levels, including the visual, the verbal, and the attitudinal.

Health care ethics is about empowerment, about permitting a patient to participate in his or her health care and to exercise control to the extent that he or she wishes. It is also about respect

for patients as unique individuals with their own beliefs and values.

Consider the words of Sherwyn M. Woods, M.D., Ph.D.:

...the overriding ethical obligation of the physician, namely, that it is an abomination to undertake the care of a patient, if one's prejudice, beliefs, or convictions diminish, in any way, the ability to deliver every ounce of dedication to the task. No rationalization, religious or otherwise, can modify that obligation (Woods 1994).

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