

**NATIONAL HEALTH SERVICE CORPS EDUCATIONAL PROGRAM  
FOR CLINICAL AND COMMUNITY ISSUES IN PRIMARY CARE**

**CROSS-CULTURAL ISSUES IN PRIMARY CARE MODULE**

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## **SUBTOPIC 1**

### **AN INTRODUCTION TO CULTURALLY APPROPRIATE MEDICINE**

#### **TIMELINE (60 minutes)**

5 min	Introduction/Ice Breaker
5 min	Review of Objectives
15–30 min	Optional Experiential Exercise (see "Overview of Module")
5 min	Review of Case and Medical Issues
30 min	Discussion of Cultural Questions and Complications (or extend to 45 or 60 minutes)
10 min	Review and Final Questions
5 min	Closure

#### **SECTION 1 LEARNING OBJECTIVES**

Target Group: Physicians in training and in practice, nurse practitioners/trainees, physician assistants/trainees, certified nurse midwives/trainees, mental health care professionals/trainees, and other health professionals/trainees.

By the end of this discussion, participants should:

1. Understand the concept of culture and cultural filters as they apply to medical care in culturally diverse populations
2. Understand how culture works to create differences in disease explanations
3. Understand how culture molds beliefs about medical treatments

## **SECTION 2 ICE BREAKER**

This exercise is designed to allow participants to express the ways in which they identify themselves in relation to their racial, ethnic, and/or cultural heritage. It can be useful for participants to explore their feelings and reactions to being asked to self-identify in this way.

The facilitator selects one of the questions below. Each participant then shares his or her responses. It can be useful for the facilitator to use butcher paper, chalkboard, or white board to record participant responses. The participants can later use this information about their own identities and experiences to contrast and gain awareness about cultural orientations and their assumptions about themselves and other groups.

- What racial, ethnic, or cultural groups (e.g., socioeconomic class, religion, profession, age group, gender, and community) do you belong to?
- What experiences have you had with people from ethnic groups, socioeconomic classes, religions, professions, age groups, gender or communities different from your own?
- What personal qualities do you have that will help you establish interpersonal relationships with persons from other cultural groups? What personal qualities might be detrimental?

Source: This exercise is adapted from Axelson (1985).

## **ADDITIONAL ICE BREAKER**

### **Developing Cultural Competency**

#### **How Culturally Competent Care Relates to Environmental Conditions**

Environmental conditions can have a variety of "hidden" impacts on patient health, compliance with health provider recommendations, and overall health outcomes. Sometimes, a patient's experience and environment are so different from those with which a provider is most familiar, that the provider can "filter out" significant considerations or influences. For example, someone who is at the end of a pay cycle and does not have established credit may not be able to afford medications or the suggestion to "drink lots of fruit juice." Someone who is caring for a chronically ill family elder may not be able to follow a recommendation to "get lots of rest" or "get out every day to exercise or do something relaxing." People who have minimal reading skills may go to great lengths to hide their shame that they cannot read much or may have difficulty remembering key instructions (especially at a stressful time). People may have strong beliefs about what promotes health, for example using or avoiding certain foods.

Discuss a variety of environmental conditions (5 minutes), how they might impact health and health care (5 minutes), and how health provider awareness and cultural competence might positively impact health outcomes (10 minutes). Conclude the discussion by summarizing key points identified (5 minutes). Take a few minutes to discuss participant reactions to this exercise (5 minutes). (30 minutes total, or more if time allows)

Ask participants the following questions, record responses on newsprint, and periodically stop to identify and summarize key issues as the discussion progresses.

- What are environmental conditions that might be "hidden" from a health provider's "view" (e.g., physical conditions, emotional conditions, religious or spiritual conditions)?
- How might such conditions impact health, health care, and patient compliance with provider recommendations?
- How might health provider awareness and cultural competence positively impact health outcomes?
- What are some of the key ways that culturally competent care and environmental conditions can be seen as related? (Use the responses generated above to develop an overall summary of the group's discussion.)

### SECTION 3 OVERVIEW

Culture includes dynamic patterns of shared knowledge, beliefs, experiences, attitudes, behaviors, and language skills among a given population. Culture has a direct impact on patient and provider decision making in health care (see handout Glossary: An Introduction to Culturally Appropriate Medicine).

The practice of culturally appropriate medicine can ease health care delivery, improve patient adherence to therapeutic regimens, and minimize confusing communication. Three conditions that make the practice of culturally appropriate medicine more challenging are:

- Cultural filters: shared cultural experiences, perceptions, and beliefs (our "world view") "filter" information in or out as patients and providers make decisions about health care; we use filters to "screen in" information that fits with our experiences, beliefs, and understandings and to "screen out" information that does not fit.
- Somatic conditions: conditions that involve a physical manifestation of a mental/emotional/spiritual state, and may include beliefs about its treatment.
- Culture-bound syndromes: sets of behaviors that, within a given culture, are recognized by a common name and evoke a shared understanding about the elements of the syndrome.

Traditional medicine beliefs exist in all cultures, including the cultures with which people identify. People sometimes identify medical conditions that do not match those found in modern medical reference, yet these conditions are real to them and can have a direct impact on health care and outcomes. Beliefs about health conditions and treatments can move people to seek out or to reject care in ways that do not make sense to those with different cultural experiences and beliefs.

## SECTION 4 CASE STUDIES

### Case 1

A 33-year-old, energetic professional working three jobs presents to the office. Nine months prior to this visit he was in a motor vehicle accident. His car skidded on some ice and was totaled. He sustained only some bruised ribs and a bruised knee. He was out of work for about one week, and then he went back to all three jobs.

Four months prior to this visit, he was in his second motor vehicle accident. Once again, his car was totaled. This time the patient was not using a seat belt and sustained major injuries. These included multiple forehead lacerations, severe rib contusions, and a severely contused right knee that was eventually diagnosed as having a partially torn anterior cruciate ligament.

Today he presents with bilateral aches in the knees. The ache is worse when he bends, runs, or climbs stairs. There is no effusion; all ligaments are intact. The physical therapy and six-week rest prescribed for the right knee have worked; no laxity is noted. The patient's thigh musculature is back to normal.

1. Why is this person working three jobs? Should you explore the repeated accidents?
2. What questions would you ask this patient? Do you find that there are certain useful ways to begin conversations (e.g., asking about family well-being)? What experiences have you had with various cultures that might apply to situations like this one?
3. What cultural filters might you, as a practitioner, have operating as you begin to assess this case?

## Case 2

We now find out that this patient is a health care provider working 80 hours a week. The three jobs he had at the time of his accidents were medical director of a clinic that serves minority population groups, faculty member at a medical school, and president of a board of health.

1. How did your thinking shift when you found out that this patient was a health care provider? What new cultural filters might you now be operating as you continue to assess and manage this case?
2. This case can be said to present the problems of a "workaholic" (an example of a culture-bound syndrome), a condition that does not correspond with medical diagnostic categories and is not found in all cultures. What does the term "workaholic" mean when applied in a clinical case?

### Case 3

We now find out that the patient in this case is a Native American. He decides to consult with a Native American healer who uses an approach and ways of talking that have developed from Native American traditional beliefs and practices. The Native American healer says:

When are you going to wake up and listen to what the Spirits have to tell you? You got hit in the right knee. The knee is the center of humility. The right side is your masculine side. You are being told that you need a dose of masculine humility. Now your left knee is hurt. Your left is your feminine side. You need to strengthen your feminine side to walk in balance.

The healer instructs the patient to slow down, focus on his family, and develop his spirituality so that he will stop missing the spiritual messages that are sent to him. He also tells the patient to quit his social drinking. The patient takes the advice and finds it more helpful than any of the Western medical practices that were recommended.

1. Would your medical practice recommendations now differ if you encountered a patient who is a member of a cultural group with roots in Native American, African American, Hispanic, Asian/Pacific Islander, or other groups who either may not be familiar with allopathic or osteopathic medical beliefs/practices or who would feel more comfortable if his/her own beliefs and traditions could be incorporated into treatment? Why or why not? What cultural filters do you think might be useful to consider? How could you determine to what extent the patient is familiar, and is comfortable, with Western medicine beliefs?
2. If the case scenario immediately above does not generate a culturally appropriate set of responses for a patient from a different cultural group, ask participants to provide suggestions from their own cultural roots that would help solve this case if the patient were from their culture.

## SECTION 5 SUGGESTED ANSWERS

### Case 1

1. *Why is this person working three jobs? Should you explore the repeated accidents?*

What other arenas might be explored? What might be the psychological considerations of this case? Is debt or some other social problem a possible cause? Should substance abuse be explored as a possible factor? Could it be useful for the provider to explore the social conditions of the patient?

2. *What questions would you ask this patient? Do you find that there are certain useful ways to begin conversations (e.g., asking about family well-being)? What experiences have you had with various cultures that might apply to situations like this one?*

The discussion leader should allow or encourage participants to explore issues such as substance abuse, family violence, and stress at home. How could you ask questions to address these issues sensitively while demonstrating concern for the patient? What might be some culturally competent ways to begin such a conversation? Could there be interview approaches that might work across a variety of cultures or if you unexpectedly need to respond to a member of a not-yet-familiar culture?

3. *What cultural filters might you, as a practitioner, have operating as you begin to assess this case?*

Examples of cultural filters that might be operating when assessing and treating another health provider include expectations about similar experiences and beliefs about how to approach given conditions, agreement about the meaning of professional language, and so on.

## Case 2

1. *How did your thinking shift when you found out that this patient was a health care provider? What new cultural filters might you now be operating as you continue to assess and manage this case?*

One way to explore this case is to consider the phrase, "physician, heal thyself." Health care providers should never forget that sometimes they are patients.

2. *This case can be said to present the problems of a "workaholic" (an example of a culture-bound syndrome), a condition that does not correspond with medical diagnostic categories and is not found in all cultures. What does the term "workaholic" mean when applied in a clinical case?*

Every profession has its own set of experiences, values, beliefs, and practices—its own culture. Ask participants to discuss the enculturation they have experienced as health care providers, their need for control of their own bodies and minds, and the power of the health professions culture in influencing and determining their behavior.

Treatment is most powerful when it is congruent with a patient's cultural background and beliefs. In what ways is it easier for health care providers to treat problems among patients who are also health care providers? In what ways might health care providers attempt to align treatments to fit the experiences and beliefs of people who work in different occupations or are from different cultural groups?

### Case 3

1. *Would your medical practice recommendations now differ if you encountered a patient who is a member of a cultural group with roots in Native American, African American, Hispanic, Asian/Pacific Islander, or other groups who either may not be familiar with allopathic or osteopathic medical beliefs/practices or who would feel more comfortable if his/her own beliefs and traditions could be incorporated into treatment? Why or why not? What cultural filters do you think might be useful to consider? How could you determine to what extent the patient is familiar, and is comfortable, with Western medicine beliefs?*

Some patients may deal with this type of problem effectively by returning to or incorporating beliefs from their cultural roots. Is it feasible to suggest or make provision for a patient to work with two or more healers? How might you respond to collaborating with a traditional healer? How might you begin such a collaborative relationship? How might your cultural filters operate to evaluate the potential for effectiveness of non-Western approaches and treatments? How might you view the similarities and differences between Western and traditional approaches?

2. *If the case scenario immediately above does not generate a culturally appropriate set of responses for a patient from a different cultural group, ask participants to provide suggestions from their own cultural roots that would help solve this case if the patient were from their culture.*

This case can help participants see that not all patients or practitioners talk about or interpret disease in ways that Western medicine has found useful.

## SECTION 6 SUGGESTED READING

1. Cross-cultural medicine. *Western Journal of Medicine: Special Issue*. 1983;129(6). Cross-cultural medicine: A decade later. *Western Journal of Medicine: Special Issue*. 1992;157(3).  
These two special issues introduce cultural beliefs and practices of many ethnic communities in the United States, including African American, Hispanic, and Native American.
2. Culture. *The New Physician*. 1992;41(7).  
Provides succinct description of the importance of culture in modern medical practice.
3. Lester N. Cultural competence: A nursing dialogue. *American Journal of Nursing*. 1998;98(8):26–33; Lester N. Cultural competence: A nursing dialogue, 2. *American Journal of Nursing*. 1998;98(9):36–42.  
A two-part series that explores the nurse-patient relationship, culture, and transcultural nursing.
4. Levine MA. Exploring cultural diversity. *Journal of Cultural Diversity*. 1997;4(2):53–56.  
Companion article to "Out of the Comfort Zone." Provides professor and student insights about planning and experiencing a clinical experience in a developing country. Reports on the need to understand relationships between culture and health.
5. Like RC, Steiner PR, Rubel AJ. Recommended core curricular guidelines on culturally sensitive and competent health care. *Family Medicine*. 1996;28:291–297.  
Offers insight and ideas about designing curricula that strengthen cultural competence.
6. Novack DH, et al. Calibrating the physician: Personal awareness and effective patient care. *JAMA*. 1997;278(6):502–509.  
Proposes curriculum of four core topics for reflection and discussion: physician's beliefs and attitudes, feelings and emotional responses in patient care, challenging situations, and self-care.
7. Pachter LM. Culture and clinical care: Folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271(9):690–684.  
A practical approach to evaluating patient-held beliefs and behaviors that may interfere with biomedical recommendations. References specific beliefs and more general insights.
8. Schulman KA, et al. The effect of race and sex on physician's recommendations for cardiac catheterization. *New England Journal of Medicine*. 1999;340(8):618–625.  
Reports research suggesting that management of chest pain is influenced by patients' race and sex.

9. Shapiro J, Lenahan P. Family medicine in a culturally diverse world: A solution-oriented approach to common cross-cultural problems. *Family Medicine*. 1996;28:249–255.  
A practical guide to responding effectively to cross-cultural challenges in medical practice.
10. Stewart M, et al. *Patient-Centered Medicine: Transforming the Clinical Method*. Kansas City, MO: Society of Teachers of Family Medicine and Sage Publications; 1995.  
Presents a six-component model to assist health providers to strengthen their relationships with patients, including conceptualizing illness and encouraging a whole-person philosophy.
11. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*. 1998;9(2);117–124.  
Proposes cultural humility, a life-long commitment to self-evaluation and self-critique and developing mutually beneficial partnerships with communities on behalf of individuals and groups.
12. Ventres WB. Cultural encounters and family medicine: Six lessons from South America. *Journal of the American Board of Family Practice*. 1997;10(3).  
Explores issues related to cross-cultural experiences, family practice education, internship and residency, empathy, and international educational exchange.

## **SECTION 7 HANDOUTS/OVERHEADS**

## **HANDOUT 1: GLOSSARY**

### **AN INTRODUCTION TO CULTURALLY APPROPRIATE MEDICINE**

**Affirmative Action:** Affirmative action, as a concept, is not based in statutes or legislation. It has its origins in case law, i.e., decisions handed down by judges in court cases. In such cases, an employee sued his/her employer for some form of discrimination, often in the areas of hiring and promotion. An employer's poor history of hiring and/or promoting men of color and women implied that discrimination was present. It was in such cases that affirmative action requirements were often placed upon employers. The objective was to make the employer's work force more representative of the general population in its geographic area. It ensured that employers took positive steps to attract, promote, and retain women and minorities if they were underrepresented in the company's work force.

**Behavior:** Any observable response given by a person.

**Communicating Respect to Patients:** A practice of continually and consistently showing respect for patients and their culture (e.g., ask patients for their opinion or for their ideas about what might be happening), commonly cited as a primary ingredient of culturally appropriate health care.

**Communication:** The transmission of common understanding through the use of symbols. The term communication is derived from a Latin word that means "common." In other words, unless a common understanding results from the transmission of the symbols (verbal or nonverbal) there is no communication.

**Cross-Cultural Coaching:** Coaching to enhance one's awareness, knowledge, and skills to effectively work within another culture.

**Cultural Ally:** A person who shares diversity-supporting values and actions with others, whether they are present or not. Being a cultural ally is an ongoing strategic process in which we look at our personal and social resources, evaluate the environment we have helped to create, and decide what needs to be done.

**Cultural Competence:** A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. Cultural competence can also be thought of as a process of learning that leads to an ability to effectively respond to the challenges and opportunities posed by the presence of social-cultural diversity in a defined social system. It helps people avoid stereotypes and biases and promotes a focus on the positive characteristics of diverse cultural groups.

**Cultural Competence Continuum:** A number of competencies and a range of effectiveness work together to form a continuum of cultural competence. The practice of culturally appropriate medicine can ease health care delivery, improve patient adherence to therapeutic regimens, and minimize confusing communication.

**Cultural Competence Models:** A systematic approach to developing cultural competency (e.g., may focus on teaching participants about others or themselves, may focus on organizational culture or individuals, etc.).

**Cultural Filters/Lenses:** Shared cultural experiences, perceptions, and beliefs (our "world view") "filter" information in or out as patients and providers make decisions about health care. Filters are used to "screen in" information that fits with our experiences, beliefs, and understandings and to "screen out" information that does not.

**Cultural Sensitivity:** An awareness of the nuances of one's own and other cultures.

**Cultural Values:** The social principles, goals, or standards that are shared by a cultural group; may be emotionally charged and considered personal (e.g., religion, sex, and politics).

**Culturally Appropriate:** Demonstrates sensitivity to cultural similarities and differences and effective use of cultural symbols to communicate a message.

**Culturally Competent Evaluation:** Methods and instruments that are consistent with the cultural norms of the group or groups being served. Evaluation instruments can be chosen according to the needs of a culture or a specific group or groups targeted for interventions.

**Culturally Competent Mental Health:** Involves service providers who are specially trained in specific behaviors and attitudes, coupled with policies that recognize, respect, and value the uniqueness of individuals and groups whose cultures are different from those associated with mainstream America. This includes an awareness and respect of the importance of the values, beliefs, traditions, customs, and parenting styles of the people they serve.

**Culturally Competent Organization:** An organization that values the people who work there, understands the community in which it operates, and embraces its clients as valuable members of that community. The culture of the organization promotes inclusiveness and institutionalizes the process of learning about differences.

**Culturally Competent Program:** A program that takes a variety of steps to develop and strengthen cultural competence, such as including multilingual, multicultural staff; offering

culturally appropriate services; displaying culturally relevant artwork and magazines; showing respect and increasing consumer comfort with services; and accommodating needs of consumers (e.g., hours, transportation).

**Culturally Competent Systems of Care:** Systems that provide appropriate services to children and families of all cultures; they respect the uniqueness of cultural influence and work within a family's cultural framework.

**Culture-Bound Syndromes:** Sets of behaviors that, within a given culture, are recognized by a common name and evoke a shared understanding about the elements of the syndrome.

**Environmental Conditions:** Conditions of day-to-day life and surroundings. Many people in America and throughout the world live without things that the majority of Americans take for granted (e.g., source of adequate heat and food, adequate and safe supply of water, adequate sanitation and sewage disposal, access to washing facilities, blankets). Differences in living conditions can directly impact health and choices about the most effective approaches to health care.

**Equal Employment Opportunity (EEO):** Equal employment opportunity legislation was enacted to prohibit discrimination on the basis of race, color, religion, sex, national origin, age, disability, or veteran status. It has since been updated to include sexual orientation. EEO attempted to provide applicants and employees with equitable treatment in an organization's human resources practices, including recruitment, hiring, training, compensation, and promotion.

**Ethnic:** Belonging to a common group, often linked by race, nationality, and language and with a common cultural heritage and/or derivation.

**Ethnic Cultures:** Having ties to a common history, ancestry, and geographic origin.

**Ethnicity:** Refers to belonging to a group with unique language, ancestral, and often religious and physical characteristics. Broadly characterizes a religious, racial, national, or cultural group.

**Ethnocentrism:** The belief that one's own group or cultural view is superior to all others. It occurs when we use our own cultural biases or culturally biased information to interpret another's beliefs or behaviors.

**Gender:** Refers to whether a person is male or female. It is preferable to the term "sex," which can have other meanings.

**Gender Roles:** Gender-specific roles ("being a man" and "being a woman") that are supported and encouraged by a given cultural group and can vary among different cultures (e.g., in some cultures, women are the primary health providers, and certain health issues are not traditionally discussed with men).

**Golden Rule:** Treating others the way we want to be treated. Often the ethnocentric standard behind the idea that we should treat everyone the same.

**Non-Western Medical Treatment Modalities:** Alternative or complementary modes of treatment outside "traditional" Western medicine. Use of such modalities can reflect cultural norms, which, in the great majority of cases, are not especially dangerous and may be useful.

**Norms or Guidelines:** Group norms, guidelines, or ground rules—established and accepted by the group—can promote conditions where people feel safe enough to openly share their thoughts and feelings and can promote an understanding and agreement about conditions that could best support working together.

**Platinum Rule:** Treat others the way they want to be treated.

**Race:** Term commonly used to refer to major subdivisions of the human family, distinguished by form of hair, color of skin and eyes, stature, bodily proportions, etc. Many anthropologists believe there are three primary groups, Caucasoid, Negroid, and Mongoloid, and believe that environmental conditions such as climate were the driving force that produced the physical features associated with different races.

**Somatic Conditions:** Involves a physical manifestation of a mental/emotional/spiritual state and may include beliefs about its treatment.

**Traditional Medicine:** Beliefs held by individuals within a culture regarding the causes and appropriate treatment for various conditions. People sometimes identify medical conditions that do not match those found in modern medical reference, yet these beliefs are real to them and can have a direct impact on health care and outcomes. Beliefs about health conditions and treatments can move people to seek out or reject care in ways that do not make sense to those with different cultural experiences and beliefs.

**Western Culture Medical Model:** Experiences, beliefs, and views about the practice of medicine that, while influenced by a variety of traditions, are largely based on European and Western perspectives and scientific principles. Western approaches may differ greatly from approaches that are effective in other cultures (e.g., concepts of mental disorders vary greatly).

## **SUBTOPIC 2**

### **ISSUES OF ETHNOCENTRISM**

#### **TIMELINE (60 minutes)**

5 min	Introduction/Ice Breaker
5 min	Review of Objectives
5 min	Review of Case and Medical Issues
30 min	Discussion of Cultural Questions and Complications (or extend to 45 or 60 minutes)
10 min	Review and Final Questions
5 min	Closure

#### **SECTION 1 LEARNING OBJECTIVES**

Target Group: Physicians in training and in practice, nurse practitioners/trainees, physician assistants/trainees, certified nurse midwives/trainees, mental health professionals/trainees, and other health professionals/trainees.

By the end of this discussion, participants should:

1. Understand the concept of ethnocentrism as it applies to medical care in culturally diverse populations
2. Explore how ethnocentrism and incongruent expectations affect medical care
3. Learn about the clinical effects of ethnocentrism and stereotypes

## **SECTION 2 ICE BREAKER**

This exercise is designed to support participants to develop new awareness, knowledge, and skills about how racial, ethnic, or cultural experiences can influence day-to-day beliefs and behaviors. This exercise can go on to explore ways that participants' experiences and beliefs can act to filter out, or "reject," another's experiences and beliefs.

The facilitator selects one or two of the questions below (including Question 1) and asks participants to brainstorm their responses. It can be useful for the facilitator to use chalkboard or white board to record participant responses. The participants can refer to this information throughout the study module and can later use their insights to gain awareness about the relationship between their own cultural orientation and the cultural orientation of others.

1. What are some of the things that you know about your family and cultural history for the past three generations?
2. What is a common saying or proverb that you remember your parents or grandparents using?
3. To whom do you go first when you need help?
4. What kinds of food do you feel most comfortable eating on a daily basis? Are there any types of food you avoid?

Participants can be encouraged to share their responses and discuss how these responses reflect their own cultural heritage. For example, in Question 2 the saying "the early bird gets the worm" might describe how a successful immigrant population regards hard work. When people describe the food they eat in response to Question 4, they are often describing important parts of their cultural heritage.

### SECTION 3 OVERVIEW

Culture is the basic set of beliefs, knowledge, experiences, attitudes, and behaviors that individuals learn as they grow up. Cultural learning begins in infancy, and new elements are added at each stage of life as existing elements are reinforced. The result is that cultural viewpoint is so much a part of identity that it shapes people's ideas about what it means to be human; anything that falls outside this definition is often considered "less than" human.

Once learned, culture becomes reality; it is the main window through which the world can be perceived. To question, doubt, or attack someone's culture is to question, doubt, or attack that person's innermost self.

Ethnocentrism is the belief that one's own cultural view is the superior or most prominent view. It occurs when we use our own cultural biases, or culturally biased information, to interpret another's beliefs or behaviors. It has three main consequences:

- If we lack information needed to make sense of a cross-cultural situation, we use our own beliefs, perceptions, and experiences to make meaning, make sense, or interpret the situation. We view others as we view ourselves, and we may be surprised if they turn out to be different. We may not "see," in full or in part, key elements of a situation.
- If we do not have much experience with individuals from a certain cultural group, we are likely to prejudge them based upon hearsay, culturally biased information, stereotypes, and emotional reactions.
- If we lack an awareness of the ways in which we are treated in society in relation to our race, gender, or age (i.e., if our experiences differ from those reported by others), there is a tendency or need on our part to reinterpret reality for others. In a sense, we try to see others as we see ourselves or everyone else rather than to see others for who they really are.

Ethnocentrism can be detrimental to a patient's health. Miscommunication and its corollaries—stereotypes and disrespect—can lead to a breakdown in the critical elements of delivering health care to patients of a different culture. If a provider filters out, disregards, or rejects an attribute of a patient's culture (language, beliefs, habits, behavior), the patient may become confused or take personal offense and be less able or likely to adhere to treatment recommendations.

## **Risk Interpretations and Informed Consent**

The dominant U.S. culture contains a large number of rules about informed consent and a clear discussion of potential harm that can result from medical procedures. This bias to fully inform the patient is not universally shared in other cultures. In some cultures, people might experience excellent care yet be minimally informed about the details of their treatment. In some cultures, the extended family is informed before the patient. Consequently, the U.S. process of informing patients may actually create problems and confusion.

In some cases, patient confusion is a problem of interpretation and the words used to express risks in other languages. Because many cultures have strong sanctions against appearing ignorant or against questioning a professional's recommendations, patients may automatically respond "yes," when asked if they understand a provider's explanation of risks.

**REMEMBER:** It can be very useful for interpreters to ask patients to express, in their own words, what they understand has been said.

## **Communicating Respect to Patients**

The most common advice given by providers who are successful in delivering culturally appropriate health care is consistently to show respect for patients and their culture. One way is to ask patients for their opinion during the clinical experience. The following questions can improve communication and convey respect in patient encounters (Klineman 1988).

1. What do you think caused your problems? Why do you think it started when it did?
2. What do you think your sickness does to your body? How does it work?
3. How severe is your sickness? How long do you think it will last?
4. What are the main problems your sickness has caused you?
5. Do you know others who have had this problem? What did they do to treat it?
6. Did you discuss your problem with any of your relatives or friends? What did they say?
7. What kinds of medicines, home remedies, or other treatments have you tried for this sickness? (Ask about quantity, dosage, frequency, and how the treatments were prepared.) Did they help? Are you still using them?
8. What type of treatment do you think you should receive from me? What are the most important results you hope to receive from this treatment?
9. Do you think there is any way to prevent this problem in the future? How?
10. Is there any other information that might help us design a treatment plan?

## SECTION 4 CASE STUDIES

### Case 1

A 25-year-old woman from the Middle East comes in with her husband. She wears a dark dress and a veil covering all of her face except her eyes. Her husband speaks for her. She has received prenatal care from a gynecologist in her native country. You note that she has all the appropriate lab work and a sonogram, but no pelvic exam has been done.

The patient is also complaining of a rash on her scalp. When you ask her to remove her veil, she does not do so.

Upon pelvic exam, you notice surgical scars at the top of the labia.

1. What are some of the issues that might be addressed (including gender issues) by a provider who wants to communicate respect in relation to patients who practice Islamic beliefs?
2. How do you tend to deal with cultural values with which you are not familiar?
3. Have you had an opportunity to learn about some of the cultural issues that surround female circumcision?
4. How might you feel about or react to this practice? Discuss ways to address cultural differences that are very different from your own and that might provoke your emotional reactions, biased judgments, or conflicted feelings.
5. What might you say or do to respond to the patient and her needs in this situation?

## Case 2

Mrs. Nguyen, a recent immigrant from Vietnam, pregnant with her first child, receives routine testing for thalassemia. She is identified as an alpha-thalassemia carrier. Her health care provider tells her that her husband must be screened and that the couple requires genetic counseling. She hesitates and then agrees.

Her husband delays having his blood tested. He claims he feels well and believes his wife's anemia is related to poor nutrition.

After five weeks, the husband agrees to testing. It is confirmed that he too is an alpha-thalassemia carrier. Quickly, amniocentesis is performed, but there is a five-week delay before results are known (testing of fetal blood requires DNA analysis, which is a time-consuming process).

Before five weeks elapse, Mrs. Nguyen is phoned by a laboratory representative and told that the fetus is "normal," because chromosomal studies are unremarkable. She is befuddled when told by her practitioner that her baby may still be abnormal, because chromosomal studies are not definitive for alpha-thalassemia major. Indeed, two weeks later, DNA studies confirm alpha-thalassemia major—a diagnosis that will lead to an intrauterine fetal demise, stillbirth, or neonatal death.

Mrs. Nguyen is told that the medical treatment of choice is abortion. She hesitates because she has now felt fetal movement for weeks and cannot understand how a diseased baby could be so active. She directs her provider to "do what you think is right."

When presented with a form requesting her informed consent for an abortion, she balks at the notion that her own life and well-being could be threatened by the procedure.

1. What Western concepts of physiology and medicine complicate communication between patient and clinician in this case?
2. How do cultural concepts of fertility, parenthood, and the role of women affect Mrs. Nguyen's decision making? Why did she hesitate to get tested?
3. How might this couple view the clinician-patient relationship? How does their view differ from Western models?
4. How do medical-legal considerations (e.g., the concept of informed consent) affect cross-cultural communication between provider and patient?

5. What could you, as the provider, have done to improve this couple's experience with Western medicine?
6. Discuss Western medicine's insistence that the patient accept the biomedical model (in this case, to insist that the mother understand the genetic concepts behind the problem).
7. Explore the imposition of Western ethical and legal standards upon persons with differing views of medicine and healers (e.g., the interpretation of informed consent to a person unfamiliar with this concept).

### Case 3

A 40-year-old Native American man comes in to your clinic for a routine history and physical. His past medical history is benign except for substance abuse. His physical exam is completely normal.

Upon questioning, he relates the following history. He started drinking with his friends on the reservation at about age 13. By age 15, he was drinking heavily and smoking pot. After high school, he joined the military and was involved in heavy pot smoking. He also was introduced to heroin and coke. After the service he got heavily involved with these drugs. He got strung out and was so depressed that he came back to the reservation.

On the reservation, he met some old-timers who helped straighten him out. He states that the Native American Church really helped him. With further inquiry, you learn peyote is used weekly by the patient in the church services. (Peyote is a mescaline-rich psychotropic drug contained in a type of cactus.) He states he has now been clean for 15 years and is a productive member of society.

1. How do you feel about the use of peyote? How might you ask questions to learn more about the Native American Church and its relationship to alcohol and drug abuse?
2. Once you discover that the members of this Church use peyote, would you need to explore whether the patient's behavior is legal? If so, how might you do so?
3. Would you need to explore whether there is a potential problem of addiction with the patient's use of peyote?
4. How might a provider's personal or cultural opinion of peyote use affect his or her treatment and management of this patient?
5. How does participation in the Native American Church fit with Western medical concepts of addiction and alcohol treatment? What conflicts might be set up by intervention in this case?

## SECTION 5 SUGGESTED ANSWERS

### Case 1

1. *What are some of the issues that might be addressed (including gender issues) by a provider who wanted to communicate respect in relation to patients who practice Islamic beliefs?*

Islamic cultures often maintain a far stronger separation of male and female roles than do most European-based cultures. Women and men are usually judged by different sets of standards for their behavior, and women are much more restricted in the activities that are considered appropriate. Explore ways in which these differences can be respected.

2. *How do you tend to deal with cultural values with which you are not familiar?*

The easiest way to learn is to ask. However, it can be important to approach a person who feels comfortable speaking on behalf of his or her family or cultural group. Cultural values may be emotionally charged (religion, sex, and politics are personal in nature in many cultures); therefore, seek out someone with whom you have an established relationship, not a patient who may misunderstand your desire to learn. In this case, it may be helpful to ask one or more members of an Islamic, Arab, or African culture.

3. *Have you had an opportunity to learn about some of the cultural issues that surround female circumcision?*

Female circumcision, or female genital mutilation, is practiced among Muslims, Christians, and others in parts of at least 28 countries in Africa, the Middle East, and Asia. The practice ranges from removing some of the clitoris to removing all of the clitoris, the labia minora, and the labia majora, and then suturing the sides together so that only a small hole is left for urine and menstrual flow. In the same way that male circumcision in America was long considered by many as essential to hygiene and health, female circumcision is considered appropriate by most but not all men and many but not all women in the cultures in which it is practiced. An uncircumcised female is believed to be immoral (that is, believed likely to engage in extra-marital relationships). However, the practice offends many people from Europe, America, and elsewhere who consider it brutal. Some countries have outlawed the practice, some states in America have passed laws that can make it a felony, and several groups view this practice as a form of child abuse. Women and girls affected by this practice increasingly are found in urban areas and among some immigrant communities in the United States. Within the cultures affected, some in America have

spoken out against this practice and others who continue it.

4. *How might you feel about or react to this practice? Discuss ways to address cultural practices that are very different from your own and that might provoke your emotional reactions, biased judgments, or conflicted feelings.*

Western culture often views this practice as one that relates to a woman's human and reproductive rights as well as her health. How might health providers become aware of and manage culture-based emotional reactions that might affect their capacity to respect and respond with dignity to a person with different, disturbing, and possible illegal cultural practices?

5. *What might you say or do to respond to the patient and her needs in this situation?*

Because the presenting complaint is unrelated to the clitorrectomy, the best way to handle it may be to be discreet. Do not do or say anything about the condition until you have explored it through other avenues. You may want to seek out written information and talk with health care providers in your area who are familiar with these practices to learn how they deal with female circumcision. How might you comply with medical-legal considerations in ways that acknowledge and respect different experiences and cultural concerns?

## Case 2

1. *What Western concepts of physiology and medicine complicate communication between patient and clinician in this case?*

Many recent technological advances in medicine are not generally known by people in developing countries—or even by many people in our own country. How does this fact affect ways that a highly technical and "invisible" condition could be discussed with a patient?

2. *How do cultural concepts of fertility, parenthood, and the role of women affect Mrs. Nguyen's decision making? Why did she hesitate to get tested?*

In many cultures, health decisions are made within the context of the family. When asked, this patient indicated that she feared her husband would view her as "abnormal" and unfit for child bearing. This is a culturally valid reason for him to abandon her. She also claimed that it would be difficult to explain to her husband exactly what her problem entailed. It may be useful to be aware that, for many patients, hope about the future and a good outcome is an essential ingredient for adherence to treatment. How might health providers ask questions to elicit this kind of awareness or understanding?

3. *How might this couple view the clinician-patient relationship? How does their view differ from Western models?*

This couple has a much stronger cultural belief in the knowledge and infallibility of the provider than prevails in most Western countries. They are less likely to ask questions or directly challenge the clinician's statements. If they disagree, they tend to do so by delays and other forms of indirect resistance.

4. *How do medical-legal considerations (e.g., the concept of informed consent) affect cross-cultural communication between provider and patient?*

The patient's guilt engendered by allowing the abortion is compounded with concerns that her own health, including her future fertility, may be compromised by a third-trimester abortion. She would not be presented with these options in her former country. In the litigious United States, protection of patients' legal rights can be very intimidating to individuals whose sole experience is with other medical systems (Surbone 1992). How might health providers comply with medical-legal considerations in ways that acknowledge and respect different experiences and cultural concerns?

5. *What could you, as the provider, have done to improve the couple's experience with Western medicine?*

One approach is to try to prepare yourself by seeking information about the cultures that you are most likely to encounter in your current or prospective practice location. You might invite speakers to discuss different sets of values and beliefs or use case conferences to share different perspectives.

6. *Discuss Western medicine's insistence that the patient accept the biomedical model (in this case, to insist that the mother understand the genetic concepts behind the problem).*

Do patients need to know the theory behind their condition, or do they simply need to know the consequences? Our culture tends to emphasize both. What might be the medical, personal, and cultural implications and consequences of (a) having an abortion or (b) carrying the pregnancy to term and dealing with the potential sequelae (spontaneous abortion, stillbirth, neonatal death, etc.)?

7. *Explore the imposition of Western ethical and legal standards upon persons with differing views of medicine and healers (e.g., the interpretation of informed consent to a person unfamiliar with this concept).*

The litigiousness of U.S. culture has produced the concept of defensive medicine (practicing in a manner designed to avoid or win malpractice lawsuits). Other cultures do not share this orientation, and people from such cultures may find it very confusing to be told every possible complication and low-probability condition that could result from treatment. They may feel that clinicians make the best professional judgments possible, and that patients should not have to make decisions for which they do not have the background to make.

### Case 3

1. *How do you feel about the use of peyote? How might you ask questions to learn more about the Native American Church and its relationship to alcohol and drug abuse?*

The Native American Church is a well-established religious tradition that involves ceremonies, counseling, and the sacramental use of peyote. The Church places a high value on maintaining or re-establishing family relationships, social responsibility, and a harmonious existence. The Church requires abstinence from drinking. Members may attend frequently or only when they feel the need to re-establish their participation in the "Peyote Road."

2. *Once you discover that the members of this Church use peyote, would you need to explore whether the patient's behavior is legal? If so, how might you do so?*

In the past, the U.S. government has recognized the Native American Church and has provided special legal dispensation for its practitioners to possess and use peyote. Recent court decisions have made this issue more complicated. The general practice has been to allow Native American practitioners a great deal of leeway regarding this issue within tribal reservations.

3. *Would you need to explore whether there is a potential problem of addiction with the patient's use of peyote?*

The most significant indicators of addiction are described in *DSM-IV*. The most common are interference with social and work relationships, physical problems manifested when the amount of drug being consumed is reduced, and a loss of control over the amount used and the time spent using the drug. In general, ritual use of peyote is not associated with addictive behavior. Substance abuse relapses are more likely to be triggered by use of over-the-counter or prescription medications that contain alcohol or narcotic derivatives or by situational conditions such as traumatic or chronic stress or pain.

4. *How might the provider's personal or cultural opinion of peyote use affect his or her treatment and management of this patient?*

The discussion might focus on different situations that providers may encounter where their opinions may differ from patients' opinions and practices. How can providers remain effective in managing such cases?

5. *How does participation in the Native American Church fit with Western medical concepts of addiction and alcohol treatment? What conflicts might be set up by intervention in this case?*

The main alcohol abuse treatment in the United States is the 12-step program requiring self disclosure. Not all cultures encourage or allow people to make negative statements about themselves and their families in public. The Native American Church allows people to avoid alcohol use without this type of self disclosure.

## SECTION 6 SUGGESTED READING

1. Borkan JM, Neher JO. A developmental model of ethnosensitivity on family practice training. *Family Medicine*. 1991;23:212–217.  
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2. Burstyn L. Female circumcision comes to America. *Atlantic Monthly*. 1995;276(4):28–35.  
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3. Calabrese JD. Spiritual healing and human development in the Native American Church: Towards a cultural psychiatry of peyote. *Psychoanalytic Review*. 1997;84(2):237–55.  
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4. Cross-cultural medicine. *Western Journal of Medicine: Special Issue*. 1983;129(6). Cross-cultural medicine: A decade later. *Western Journal of Medicine: Special Issue*. 1992;157(3).  
These two special issues introduce cultural beliefs and practices of many ethnic communities in the United States, including African American, Hispanic, and Native American.
5. Hispanic Health Issue. *JAMA*. 1991;235(2).  
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6. Like RC, Steiner PR, Rubel, AJ. Recommended core curricular guidelines on culturally sensitive and competent health care. *Family Medicine*. 1996;28; 291–297.  
Offers insight and ideas about designing curricula that strengthen cultural competence.
7. Manson SM. The wounded spirit: A cultural formulation of PTSD. *Culture, Medicine and Psychiatry*. 1996;20(4):489–498.  
Explores relationships among traumatic stress, combat, alcohol, and American Indian culture.
8. Novack DH, et al. Calibrating the physician: Personal awareness and effective patient care. *JAMA*. 1997;278(6):502–509.  
Proposes curriculum of four core topics for reflection and discussion: physician's beliefs and attitudes, feelings and emotional responses in patient care, challenging situations, and self-care.
9. Pachter LM. Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271:690–694.  
A practical approach to evaluating patient-held beliefs and behaviors that may interfere with biomedical recommendations. References specific beliefs and more general insights.

10. Shapiro J, Lenahan P. Family medicine in a culturally diverse world: A solution-oriented approach to common cross-cultural problems. *Family Medicine*. 1996;28:249–255.  
A practical guide to responding effectively to cross-cultural challenges in medical practice.

## **SECTION 7 HANDOUTS/OVERHEADS**

## **HANDOUT 1: GLOSSARY ISSUES OF ETHNOCENTRISM**

**Assumptions and Biases:** Ideas that one takes for granted or supposes to be fact; a mental tendency, prejudice.

**Communicating Respect to Patients:** A practice of continually and consistently showing respect for patients and their culture (e.g., ask patients for their opinion or for their ideas about what might be happening), commonly cited as a primary ingredient of culturally appropriate health care.

**Connecting with Assumptions:** An ongoing process of becoming increasingly aware, continually learning, and developing skills to effectively encounter and respond to assumptions; involves learning to continually recognize our own assumptions, beliefs, prejudices, and emotional "triggers."

**Cross-Cultural Conflict:** Conflict that emerges primarily out of a misperception regarding another's cultural values or conventions.

**Culture:** The way of life of a people. It is not innate but learned; the various facets of a culture are interrelated. Cultural groups have enough significant differences from the dominant society to have their own way of life. Cultures contain all of the ways in which we are different.

**Ethnocentrism:** The belief that one's own group or cultural view is superior to all others. It occurs when we use our own cultural biases or culturally biased information to interpret another's beliefs or behaviors.

**Perceptions:** The process by which individuals take in information and attach understanding and meaning to it.

**Perceptions, the process of:** Perceptions of the world are formed to a large extent when people are children. Families, friends, schools, and communities have a fundamental impact on who we become as adults. Many people are raised in homogeneous communities and tend to gravitate toward people like themselves. Also, people tend to be uncomfortable with differences they don't understand and screen out evidence that contradicts existing perceptions. Often, we are unaware of the perceptions we have adopted and accept them as facts without ever questioning their validity.

**Prejudice:** Seeing differences as weaknesses. Suspicion, intolerance, or irrational hatred of other races, creeds, regions, occupations, etc.

**Stereotype:** A fixed and distorted generalization, often formed in childhood, made about all people in a certain group. It is a rigid judgment that does not take into account the individual and the "here and now."

**Stereotyping:** The act of applying a fixed and distorted generalization to all members of a particular group; making a rigid judgment that doesn't take into account the individual and the "here and now."

### **SUBTOPIC 3**

#### **LANGUAGE AND COMMUNICATION IN HEALTH CARE**

##### **TIMELINE (60 minutes)**

5 min	Introduction/Ice Breaker
5 min	Review of Objectives
5 min	Review of Case and Medical Issues
30 min	Discussion of Cultural Questions and Complications (or extend to 45 or 60 minutes)
10 min	Review and Final Questions
5 min	Closure

##### **SECTION 1 LEARNING OBJECTIVES**

Target Group: Physicians in training and in practice, nurse practitioners/trainees, physician assistants/trainees, certified nurse midwives/trainees, mental health professionals/trainees, and other health professionals/trainees.

By the end of this discussion, participants should:

1. Understand the impact that language differences have on the delivery of medical care
2. Identify situations in which there is a need for appropriate language adjustment between the provider and patient
3. Understand and be able to employ the basic principles of medical interpretation
4. Identify potential areas in which problems in conceptual transfer of medical information may interfere with patient adherence to treatment
5. Understand cultural differences in the interpretation of medical risks and risk statements

## **SECTION 2 ICE BREAKER**

This exercise is designed to provide opportunities for participants to develop awareness, knowledge, and skills related to communication across cultures. Each person in the group selects a partner. The pairs then role play how a provider might greet a patient identified as being of another culture and how the provider can communicate sincerity and respect to that patient without using words. It could be useful to include a role play situation in which the patient does not speak the provider's language, and no interpreters are available.

The role plays should not take longer than one minute.

It can be helpful if at least one or two people try to show how they would communicate respect to a patient who is deaf, using no sounds at all.

The discussion leader should point out if/when someone uses a technique that only works when two people speak the same language or share the same cultural assumptions. (A classic example of how cultural assumptions can affect communication is that nodding one's head "yes" or "no" can have opposite meanings in different cultures.)

## **SECTION 3 OVERVIEW**

Communication is the basis of good health care. If the health professional and patient cannot communicate, the encounter will be difficult and may result in problems such as misdiagnosis, misunderstanding, nonadherence, and recidivism. Providers should make every effort to ensure that patients are spoken to in their native language and dialect. Dialects can differ in ways that deeply affect understanding.

### **Using Medical Interpreters**

The challenge of communicating is much greater when the patient and professional do not share a language. Many cases require interpreters.

Successful interpretation requires skill on the part of both the health professional and the interpreter. One of the most common problems is using an interpreter who has not been trained to create conceptual transfer rather than verbatim translations. The interpreter must make sure that concepts are communicated effectively in both directions. In the clinical setting, the transfer is often from technical clinical concepts in one language to acceptable social terminology (that conveys the clinical meaning) in the second language. Optimal conditions for effective translation involve an interpreter familiar with the technical concepts, preferably in both languages, and who knows how to express them in terms the patient will understand.

The following are guidelines for working with medical interpreters, adapted from Randall-David (1989:32–33).

1. The provider should meet with the health care team members who serve as interpreters on a regular basis to review interpreter roles and procedures and provide in-service training.
2. The provider should speak in short units and ask short questions. Interpreters will have difficulty interpreting long, involved statements without forgetting something important.
3. Avoid technical terminology, abbreviations, and professional jargon (or explain them thoroughly).
4. Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and metaphors.
5. Encourage the interpreter to translate the patient's words as much as possible rather than paraphrasing or polishing with professional jargon. This approach will give a better sense of the patient's concept of what is going on, his or her emotional state, and other important information.
6. During the interaction, look at and speak directly to the patient, not the interpreter.
7. Listen, even though you do not understand the language, and look for nonverbal cues.
8. Be patient. Interpretation takes time when done right.

9. Have the interpreter ask the patient to repeat as accurately as possible the information that has been communicated to see if there are gaps in understanding.

Randall-David provides an excellent model for choosing appropriate interpreters for different types of medical encounters, as well as pitfalls to avoid if at all possible, including using family members, children, or individuals of a different gender to interpret in a situation that involves intimacy and issues of family hierarchy (based on the patient's culture).

## **Nonverbal Communication**

Good nonverbal communication skills can enhance clinical encounters. They can build rapport and communicate positive emotional messages (such as respect, caring, and concern). The following are potential areas of cultural difference in nonverbal communication.

**Silence**—Some cultures are quite comfortable with long periods of silence; others consider it appropriate to speak before the other person has finished talking.

**Physical Distance**—In general, Americans of European descent prefer to be about an arm's length away from another person, while Hispanics prefer closer proximity and Asians prefer greater distance. Provide a patient with a choice by inviting him or her to "sit wherever you like."

**Eye contact**—Some cultures advise members to look people in the eye (European Americans), while others consider this disrespectful (African Americans), or a sign of hostility or impoliteness (Asians, Native Americans). Observe the patient when talking and listening to get cues regarding appropriate eye contact.

**Emotional expressiveness**—This behavior varies greatly from one culture to another. Some cultures value stoicism, while others encourage open expressions of emotions such as pain, joy, and sorrow. Asian Americans may smile or laugh to mask other emotions.

**Body movements**—Some cultures consider finger pointing or foot pointing disrespectful (Asian), while others consider vigorous handshaking a sign of aggression (Native American) or a gesture of good will (European American). Observe the patient's interactions with others to determine what body gestures are culturally appropriate. When in doubt, ask (Randall-David 1989:33–34).

**Touch**—Physical contact is another important form of nonverbal communication. Some individuals need the comfort of touch to feel they are being healed, while others are offended by the same contact. The etiquette of touch is highly variable from culture to culture, or even within cultures. It may be all right, for example, to touch children but not

adults. In some cultures, it is appropriate to touch someone of the same sex but not of the opposite sex, in others, the reverse may be true.

Even general rules about touch regarding gender, age, status, or occupation may differ for specific locations. A touch that is acceptable in private may be obscene or incorrect in public. It is best to get a thorough briefing on touch in any culture that will be commonly encountered in your clinical practice.

### **The Invisible Person Syndrome**

One of the strongest ways of showing disrespect in cultures all over the world is to behave as if someone does not exist. Doing this says, "You are nothing, unworthy of notice." It means you are an unwanted object, not a person; something to be talked about rather than someone to be talked with. The following are key issues in this area.

- In some cultures, a health professional's failure to introduce himself or herself and shake hands when entering an examining room indicates extreme disrespect.
- Talking to the nurse or someone else in the room as if the patient were not there or is incapable of understanding what is going on can be disrespectful.
- Joking and laughing with someone else in the room in a language that the patient does not understand will often be taken as a form of disrespect.

### **Treating Adults Like Children**

When explaining technical conditions, some practitioners have a tendency to treat adults from other cultures as if they were children. Approaches that tend to create conditions of adherence to therapeutic regimen are those that change medical concepts into nontechnical, adult concepts.

### **The Feeling of Linguistic Isolation**

When everyone around you is speaking a language you do not know, a common reaction is to feel you are being talked about, made fun of, or belittled. This feeling can be especially acute if you are in an emotionally tense setting such as a medical clinic. Health providers can create conditions that tend to counter stress and negative perceptions. Such conditions might include a secure, confident, and supportive atmosphere. Also, patients will appreciate correct use of any words or sentences you may know in their language.

### **Technical Talk**

It is common for the patient and practitioner to share social languages but to encounter a mismatch when using "medical talk." Practitioners sometimes fail to remember that their technical language, which is important for communicating precise information to other health care professionals, is not shared by most patients. Communication will proceed much more smoothly if the provider translates technical words into plain and simple language that is appropriate for the age, gender, and background of the patient.

## SECTION 4 CASE STUDIES

### Case 1

Ana G. is a 32-year-old woman from El Salvador who complains of recent right knee pain and a two-year history of headaches. A 17-year-old niece acting as her interpreter accompanies her.

Ana G. states that her knee pain is diffuse and hurts primarily at night. Her headaches occur two to three times a week, usually starting in the late afternoon. The pain is sometimes throbbing, but she experiences no nausea or visual change. She gets mild relief from Tylenol.

When asked, she states that she moved to the United States two years ago to work and send money to her family. She works as a housekeeper and lives with relatives. She attends church weekly but has little other social contact. She says she is not depressed.

Her exam is unremarkable. You prescribe treatment including a nonsteroidal anti-inflammatory drug and Extra Strength Tylenol. You counsel her to use pads when on her knees during work.

Ana G. returns four weeks later. She is alone and an interpreter is called. Ana G. states that her knee pain is better but the headaches have become more frequent. She has been having problems with insomnia and she missed work twice last week.

Upon further questioning, she becomes tearful and reveals that her husband in El Salvador is dying of cirrhosis. Her four children live with him and their grandmother in a rural area. She does not want to return to El Salvador now because she needs to work here at least one or two more years to have enough money to bring her children to the United States. Her aging mother wants her to visit, but Ana knows she will be unable to leave if she sees her children again. She says she doesn't know what to do.

1. What are some potential problems with using a family member or friend as an interpreter?
2. How could you approach Ana G.'s intensified headaches?
3. What obstacles might you encounter in making a referral for counseling? How might you overcome them? Many cultures feel that mental illness is a stigma, and their members may somaticize emotional problems as a result. How can you handle this possibility in a culturally competent way?

## Case 2

A 25-year-old Asian woman presents at the acute care clinic. Because she cannot speak English, she brings her 10-year-old daughter to interpret.

Her daughter explains that her mother's "stomach aches" and that "it hurts where she pees." The pain has been constant for two weeks and is unrelated to eating. She had an operation one year ago after the birth of her fourth child so that "she wouldn't have any more babies." She "bled" two weeks ago. She is not taking any Western medicine but has seen an herbalist in the past week who prescribed some tea, which hasn't resulted in any relief.

On exam, the woman rocks back and forth in the sitting position, rubbing her lower abdomen. She is afebrile, BP is 100/68, HR 80, RR 20. She moans when asked to lie down in the supine position. Her abdomen is scaphoid and moderately tender on palpation but demonstrates no rebound tenderness. There is a periumbilical scar and ecchymotic areas in the supra pubic region. The skin is oily, and there is an odor reminiscent of camphor and peppermint.

A pelvic exam is moderately painful. There is some mild cervical motion tenderness and some mucoid vaginal discharge. Cultures are obtained. A wet mount reveals a few clue cells, but the sniff test is not definitive, and no organisms are identified. A urinalysis reveals 5–7 RBCs and 2–3 WBCs. A urine pregnancy test is negative. The patient is started on erythromycin and Flagyl after receiving an injection of ceftriaxone.

1. What might the description "Asian woman" tell you? What doesn't it tell you?
2. How does the use of the daughter as interpreter help or hurt your ability to care for this patient? Discuss the use of child interpreters, especially when dealing with problems related to reproductive organs. Is this an appropriate approach? Are there circumstances where it is unavoidable? What are the possible negative consequences of this approach? What other approaches might be used?
3. The gender of the provider is not identified. How might the approach or outcomes be different if the provider were a man? A woman?
4. What are some clues that this patient has used non-Western modalities of medical treatment? What are some things you could say to this patient if you were interested in exploring these modalities and the patient's cultural beliefs?

## SECTION 5 SUGGESTED ANSWERS

### Case 1

1. *What are some potential problems with using a family member or friend as an interpreter?*

In some cultures, social hierarchy concerns may cause a family member to give an incomplete history and thus compromise the patient. The family member who is interpreting may feel uncomfortable about relating certain information and consequently may edit the information given to the provider. A trained interpreter, on the other hand, will give both a linguistic and a cultural interpretation of the patient's history.

2. *How could you approach Ana G.'s intensified headaches?*

This situation calls for a more complete medical history, including Ana G.'s possible exposure to solvents or fumes during work. Explore her health beliefs or explanatory models of illness to gain the information you need. Ask questions such as the following:

- What do you think caused your headaches?
- Why do you think your headaches became worse recently?
- How do your headaches affect your work life? Your home life?
- What worries or fears do you have about your headaches?
- What do you think your headaches do to you?
- Are there treatments you know of that you would like to try?

3. *What obstacles might you encounter in making a referral for counseling? How might you overcome them? Many cultures feel that mental illness is a stigma, and their members may somaticize emotional problems as a result. How can you handle this possibility in a culturally competent way?*

Many cultures view a recommendation of counseling as a diagnosis of "craziness" (which may be viewed as a permanent condition). These cultural views are slowly changing in the United States but not in some other cultures.

Some people may benefit from opportunities to experience counseling that includes an education and skill-building or support group focus (e.g., explore new ways to reduce stress and resolve complex problems of day-to-day life, support of others with similar issues) in addition to a medical focus (e.g., prescribing medication).

In Ana G.'s culture, women commonly sacrifice for the family, and loyalty to family often takes precedence over individual needs. Her situation therefore may not be viewed as a problem in the same way it might in another culture. How might you deal with this difference? Two suggestions are:

- Ask the patient if there is a family member available with whom she would like to discuss these issues.
- Be aware of ways that the Latino culture's emphasis on loyalty to family is helpful to your patient. If Ana G. accepts the view that her improved happiness means she'll be able to work more regularly and thus help her family more, she may be more open to participating in health education, support groups, or counseling.

## Case 2

1. *What might the description "Asian woman" tell you? What doesn't it tell you?*

It can be important to be aware of potentials for stereotyping and to remember that there is diversity within ethnic groups. If we automatically link expectations about culture and beliefs to someone who has a certain appearance, we may miss opportunities for useful and effective communication. People can change their cultural orientation as they encounter and respond to experiences, beliefs, perceptions, personalities, behaviors, world views, and practices of a new or different culture. It can be important for caregivers to seek to know something about the specific background of each patient as much as possible.

2. *How does the use of the daughter as interpreter help or hurt your ability to care for this patient? Discuss the use of child interpreters, especially when dealing with problems related to reproductive organs. Is this an appropriate approach? Are there circumstances where it is unavoidable? What are the possible negative consequences of this approach? What other approaches might be used?*

The use of child interpreters can be extremely problematic. Sometimes it is unavoidable (in an emergency or when no one else can be found who speaks the patient's language).

A child lacks the adult vocabulary and life experience needed to comfortably and effectively interpret medical conditions. Many concepts are simply not discussed with children, and children do not understand them well enough to adequately interpret them. Even routine functions can sound frightening. This is especially true of processes dealing with internal organs or sexual history; children may not even be aware that some of these processes exist.

In addition, it is extremely difficult for a child to interpret information about life-threatening conditions. If the child understands the threat to the parent, he or she may become distraught and unable to communicate anything other than fear. If the child does not understand the threat, he or she may not be able to convey the importance of a medical procedure that the parent would rather avoid. If there is an urgent need to rely on a child or other untrained interpreter, especially a family member, try to be aware of ways to phrase questions to reduce fear and stress. Also, a caring person who has the skills and time to debrief a critical incident can do much to reduce stress and trauma that may occur.

If you want to role play the difficulties of using a child as an interpreter, set up a three-way conversation in which you sit in one room and ask a child to pass medical information to someone sitting in another room. Have the child run back and forth between the adults,

conveying information and relaying questions. Make sure to use common medical terminology.

You might want to write down your statements and have the other adult write down exactly what the child says. Compare notes after the exercise.

After this exercise, you will likely find ways to avoid using children as interpreters. (This exercise does not even take into account the problems of finding the correct translation for concepts that may not be directly comparable in two languages.)

The use of family interpreters is not recommended even if they are adults, because the patient-physician relationship is compromised. An uninvolved community representative, ideally one who is bilingual and bicultural, is familiar with the medical beliefs and practices of both cultures, and is comfortable with the role might be called on in emergencies if a trained interpreter is not immediately available.

Trained medical interpreters are the most effective and appropriate first choice. The interpreter should be familiar with the structure and nuances of each language used. Ideally, translations are pre-tested with the target audience before using them in clinical situations.

3. *The gender of the provider is not identified. How might the approach or outcomes be different if the provider were a man? A woman?*

In many cultures, it is easier for a person to communicate about delicate subjects with someone of the same gender. You might want to discuss cases in which this is true and cases in which people successfully communicate across this barrier. It can also be important to be aware that some cultures equate the health provider role with a specific gender.

4. *What are some clues that this patient has used non-Western modalities of medical treatment? What are some things you could say to this patient if you were interested in exploring these modalities and the patient's cultural beliefs?*

A very high percentage of individuals from all cultures and all economic levels try home remedies that are acceptable and endorsed within their cultural system but not prescribed by the clinician. Recent studies suggest that a clear majority of Americans have sought or would consider seeking alternative or complementary modes of treatment outside "traditional" Western medicine. Understanding something about each patient's belief system can strengthen the approach and effectiveness of treatments.

You might want to open this inquiry by acknowledging that many patients use such modalities, for example, "Many patients try a variety of approaches before seeking medical attention. I am interested in learning about different approaches, including those that might work together with the approaches I have found useful. To do so, I sometimes read or talk with people about different approaches or consult with other caregivers in the community. What have *you* tried so far?" Depending on the response, you might continue: "Many people try treatments that they've learned from family or friends or that have been passed through the generations. What about you?"

After a patient describes a particular modality, it is important to acknowledge the use of such modalities as normal behavior, which, in the great majority of cases, is not especially dangerous and may be useful. Tell your patient that you appreciate the opportunity to understand him or her better. When making recommendations, explain how you might combine medical therapy with traditional remedies.

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## SECTION 7 HANDOUTS/OVERHEADS

## **HANDOUT 1: GLOSSARY**

### **LANGUAGE AND COMMUNICATION IN HEALTH**

**Accent:** A distinguishing manner of pronunciation and speaking. Everyone has an accent.

**Child Interpreter:** A child who is called upon to interpret communication between a non-English speaking person (often a family member) and a health care provider in an emergency or when a trained interpreter who speaks the parent's language cannot be found. This practice can be problematic, since a child lacks the adult vocabulary and life experience needed to comfortably and effectively interpret medical conditions.

**Communicating Respect to Patients:** A practice of continually and consistently showing respect for patients and their culture (e.g., asking patients for their opinion or for their ideas about what might be happening), commonly cited as a primary ingredient of culturally appropriate health care.

**Cultural Assumption:** In communication, the assumption that a word, phrase, or gesture has the same meaning across cultural lines. A classic example of how cultural assumptions can affect communication is that nodding one's head "yes" or "no" can have different meanings in different cultures.

**Dialect:** Can involve a form of language that is unique to a specific locality or group. Dialects can differ from the standard language in ways that deeply affect understanding and complicate translation.

**Family Interpreters:** A family member who is called upon to interpret communication between a non-English speaking person and a health provider in an emergency or when a trained interpreter who speaks the patient's language cannot be found. This practice can compromise the patient-physician relationship.

**Invisible Person Syndrome:** Pretending that someone does not exist or acting as if he or she is not present; one of the strongest ways to show disrespect in cultures all over the world.

**Linguistic Cultural Competence:** Involves understanding the importance of the use of language and terminology and striving for terminology consensus so that communication can be more effective.

**Linguistic Isolation:** When people around you are speaking a language you do not know. A common reaction—one that can be especially acute if you are in an emotionally tense situation—is to feel you are being talked about, made fun of, or belittled. Awareness and respect can create conditions that tend to counter such negative perceptions and stress.

**Medical Interpreters:** Interpreters that translate communication effectively in both directions; they transfer technical clinical concepts in one language to acceptable social terminology (that conveys the clinical meaning) in the second language. Ideally, this process involves conceptual, rather than verbatim, translations.

**Multilinguistic Resources:** Resources selected to meet the needs of multilingual communities (e.g., use of skilled bilingual and bicultural translators whenever a significant percentage of the target community is more comfortable with a language other than English; printed and audio visual materials).

**Nonverbal Communication:** Nonverbal messages can be transmitted without use of words and can include silence, eye contact, use of physical space and movement, comfort with proximity and distance, and touch. They can be used to build rapport and communicate positive emotional messages (such as respect, caring, and concern).

**Non-Western Medical Treatment Modalities:** Alternative or complementary modes of treatment outside "traditional" Western medicine. Use of such modalities can reflect cultural norms, which, in the great majority of cases, are not especially dangerous and may be useful.

**Reflective Listening:** Listening for content, feelings, and assumptions and reflecting—or mirroring back—what you think the content, feelings, and assumptions were; a way to strengthen effectiveness of cross-cultural communication.

**Social Language:** Language that is appropriate for the age, gender, and background of the patient. Communication can proceed more smoothly if the provider translates technical words into plain and simple social language.

**Technical Language:** Language important for communicating precise information to other professionals, but this language is not shared by most people. Effective communicators translate technical words into plain and simple language that is appropriate for the age, gender, and background of a patient.

**Two-Way Communication:** Involves responsibility on the part of both the person sending the message and the person receiving the message to strengthen effectiveness of communication.

**Uninvolved Community Representative Interpreter:** Ideally, someone who is bilingual and bicultural, is familiar with the medical beliefs and practices of both cultures, is comfortable with the role of translating and representing community beliefs and values for others, and is willing to be called upon if a trained medical interpreter is not immediately available.

## **SUBTOPIC 4**

### **ENVIRONMENTAL CONDITIONS AND CULTURALLY COMPETENT MEDICAL CARE**

#### **TIMELINE (60 minutes)**

5 min	Introduction/Ice Breaker
5 min	Review of Objectives
5 min	Review of Case and Medical Issues
30 min	Discussion of Cultural Questions and Complications (or extend to 45 or 60 minutes)
10 min	Review and Final Questions
5 min	Closure

#### **SECTION 1 LEARNING OBJECTIVES**

Target Group: Physicians in training and in practice, nurse practitioners/trainees, physician assistants/trainees, certified nurse midwives/trainees, mental health professionals/trainees, and other health professionals/trainees.

In the course of this discussion, participants should:

1. Explore environmental constraints to health
2. Explore common barriers to health problem prevention
3. Discuss cultural aspects of preventive health interventions
4. Explore non-clinical approaches to solving medical problems

## **SECTION 2 ICE BREAKERS**

(either ice breaker can be used)

### **1. Environmental Conditions and Health Care**

Many patients do not have access to the same resources and living conditions as their providers do. These differences in living conditions can directly impact health and choices about the most effective approaches to health care. This exercise is designed to offer opportunities for participants to strengthen awareness, knowledge, and skills in these areas.

In this exercise, the discussion leader asks participants to brainstorm the things in their home that make their life healthy and comfortable. The discussion leader uses chalkboard or white board to record responses. Many people will fail to list important items such as adequate heat or well-vented wood stove and safe chimney, access to heating fuel, blankets, running water and hot water, adequate plumbing and flush toilets or outhouses that are appropriately located, electricity, food and food storage containers, a can opener, pots and pans, refrigerators, lead-free paint and pipes, access to washing machines, a stove, showers and bathtubs, soap and towels, a clock, smoke detectors and fire extinguishers, a water-tight roof, safe stairs and floors in good repair, window screens, absence of insect and rodent infestations, safe use of poisons and agricultural chemicals, locks that work, and a phone. These are items that many people take for granted.

After all participants respond, the facilitator adds the items above (if they have been omitted) and prompts the group to discuss the ways that these conditions can contribute to health (e.g., refrigeration for food and medicine, bathing facilities to wash off agricultural chemicals, shelter and heat to stay warm and dry, etc.) This may lead to a discussion about assumptions that providers may make about patient resources when providing health care recommendations (e.g., "take with food" or "drink lots of fruit juice and get plenty of rest").

### **2. Uncommon Medical Problems**

Community health care in the United States is growing more complex because of the country's increasing connections with other countries. This ice breaker asks participants to list diseases they might encounter when working with groups that are culturally different from their own.

The discussion leader may want to name a group that would be encountered locally or explore conditions among groups that participants are likely to encounter in their practices. The leader can discuss some of the less common diseases that may be found in special populations.

The goal is to encourage participants to think in useful ways about preparing to encounter conditions that are not routine in their training or practice, without making negative judgments about the patients and cultures they will encounter.

The following chart/handout offers a useful way to present the task of considering health risks and diseases of different population groups.

POPULATION	HEALTH RISKS—DISEASES
African American	
Hispanic	
Asian American	
Pacific Islander/Native Hawaiian	
American Indian/Alaska Native	
European American	
Low Income or Economically Disadvantaged	
Other:	

## **SECTION 3 OVERVIEW**

The issues surrounding the delivery of culturally competent health care include the patient's environment and other special conditions relevant to culturally diverse groups. The most common conditions that relate environment to cultural health processes include:

- Economic conditions
- Local environmental hazards (which are found more often in poor communities than in wealthy ones)
- Culturally specific dietary conditions
- Sanitation conditions
- Housing conditions

### **Living Conditions**

Many people, including disproportionate numbers of disadvantaged populations and cultural minorities, cope with living conditions that do not include things that many people in America believe are essential. Clinicians who are fully aware of the conditions in which their patients live are better prepared to understand how these conditions can place constraints on the delivery of health care.

For example, if a patient does not have a refrigerator available, prescribing drugs that require refrigeration might be impractical. Appointments may have to be scheduled to accommodate local transportation conditions. Providers may need to help people learn how to better protect their health when they lack hot water, toilets, or screens on their windows.

It can also be useful to consider dietary conditions and circumstances, for example, the extent to which a patient (e.g., refugee, immigrant, males in some cultures) has knowledge of Western foods and nutritional values, preparation skills, refrigeration and cooking fuel, and so forth. Access to transportation and gas, a grocery or farmer's market, or an affordable and familiar restaurant can also be key factors. These kinds of conditions can combine in ways that result in inadequate nutrition and can lead to poor health or chronic health problems.

## **Barriers to Health Care**

The primary barriers to health care delivery for economically disadvantaged cultural groups in the United States have been repeatedly confirmed over the past 20 years. They include:

- The time it takes for patients to get an appointment
- The distance patients must travel to a health care facility
- Language and cultural barriers
- The times during which health care facilities are open
- The cost of health services
- Patients' loss of income if they miss work to use health services
- Patients feeling uncomfortable with practitioners and staff
- Patients' lack of knowledge about which provider to go to about their condition
- Patients' fear of what clinicians might find upon examination
- Lack of understanding of the Western health care system
- Rejection of personal health promotion beliefs

## SECTION 4 CASE STUDIES

### Case 1

A 45-year-old African-American female presents complaining of general malaise, weakness, rapid fatigue, and poor appetite. She also has been told by those who know her that her "eyes appear yellow." She denies any history of IV drug use or ETOH use. She has not received any blood products.

Additional history reveals that she has two children, ages 10 and 12 years. They also have been feeling unwell and have experienced nausea and vomiting. This is the second family in the last two weeks that has presented with these symptoms.

The patient's workup includes:

- A physical exam, which reveals an ill-appearing female in no acute distress whose sclera is grossly icteric; abdominal exam reveals hepatomegaly
- Lab results: CBC-WNL; U/A positive bilirubin; LFTs elevated

1. Define or suggest additional environmental situations that may have clinical significance.
2. If the medical history reveals risk factors and exposures of an environmental nature, how might you prevent further transmission of this disease?
3. Recent health status research indicates there is still a considerable gap between the working and living conditions experienced by many minority individuals and those experienced by the majority of workers in the United States. What are the health provider's responsibilities for creating community-responsive efforts to address this problem?

## Case 2

An obese, 38-year-old female, gravida 5, para 5, AB 0, presents complaining of low back pain, bilateral knee pain, frequent urination, headaches, shortness of breath, and generalized weakness.

Accompanying this patient is her 15-year-old daughter, who is well-developed and clinically overweight. The daughter did not have an appointment, but the mother thought it would be all right if she brought her daughter along to be checked for a "bad cold."

A physical exam reveals a 5'2" female weighing 175 pounds, blood pressure (large cuff) 160/98, resting pulse 90, respiration 28 and labored, pendulous breasts with striae, distant breath sounds, abdomen grossly obese, knees bilateral crepitus, and 1 plus pitting ankle edema.

The patient's lab results were nonfasting blood sugar 210 mg/ml, total cholesterol 320, triglyceride 280, U/A glucose 1 plus, ketones negative.

1. What are the controllable risk factors to identify?
2. Discuss non-pharmacological interventions for this individual. How might the patient's cultural background fit into your recommendations for treatment and prevention?
3. How might you seize this opportunity to apply the principles of health promotion and disease prevention? Would you apply them differently to the mother than to the daughter? Would you attempt a dietary intervention for the 15-year-old daughter? Why or why not?
4. What cultural elements of diet might be important to explore for this case?

## SECTION 5 SUGGESTED ANSWERS

### Case 1

1. *Define or suggest additional environmental situations that may have clinical significance.*

Frequency of cases: Several other patients presented with similar conditions and diagnoses over a short time.

Observable health hazard: In this case, the clinician made a trip to the low-income neighborhood where these patients lived. The clinician detected a strong odor of human feces and saw open sewers that the city had failed to improve.

2. *If the medical history reveals risk factors and exposures of an environmental nature, how might you prevent further transmission of this disease?*

In this case, a long-term solution was sought by putting political pressure on the local government. The provider did so by running for election, winning, and then obtaining government funding for appropriate sewage disposal for this neighborhood.

How far might a clinician be expected to go to address issues of discrimination, economic disadvantage, and public health? The presenter might discuss collaborative efforts that could address these kinds of problems. What kinds of political intervention might be useful? What kinds of community-based interventions? What kinds of family-centered or individual interventions (e.g., minimizing immediate risks through health education until conditions can be changed)? What kinds of institutional change (e.g., systems change)?

3. *Recent health status research indicates there is still a considerable gap between the working and living conditions experienced by many minority individuals and those experienced by the majority of workers in the United States. What are the health provider's responsibilities for creating community-responsive efforts to address this problem?*

In collaboration with the community, a community-responsive health provider can use community-oriented primary care skills to address issues that affect the health of his or her community. This approach involves:

- Defining the target community

- Identifying the community's health problems
- Locating appropriate resources and modifying the health care program to respond to and treat the problems identified
- Monitoring the effectiveness of the health program modifications

## Case 2

1. *What are the controllable risk factors to identify?*

Medically defined obesity may or may not be congruent with cultural definitions of appropriate body size. Discuss the range of variation in these definitions across several cultures and at different times in history.

2. *Discuss non-pharmacological interventions for this individual. How might the patient's cultural background fit into your recommendations for treatment and prevention?*

The patient may carry her weight in beautiful ways. Yet there is evidence that overall quality of life and longevity can be strengthened by factors such as stress reduction, exercise, balanced nutrition, and weight within certain ranges. Such approaches can be used in combination with pharmacological interventions. Support groups or more informal forms of social support also might be beneficial.

The most common intervention would be to suggest a diet. However, food preferences are among the most staunchly defended cultural practices. If the recommended diet contains unusual combinations of food or unfamiliar methods of preparing food, the diet will probably not be followed. In some cases, "Westernized" diets have supplanted indigenous diets that may have been more consistent with optimal health. It may be useful to explore if traditional foods might be reintroduced or used more often to benefit health.

A diet will be more likely to be followed if it includes foods that are central to the patient's culture. Provisions to incorporate and modify amounts of salt, spices, and fat can be particularly important. In this case, meats, cheeses, and desserts might be important to consider.

A useful approach might be to offer Western medical information about a range of choices and consequences, to inquire about the patient's beliefs and preferences, and to involve the individual in selecting an approach to treatment.

3. *How might you seize this opportunity to apply the principles of health promotion and disease prevention? Would you apply them differently to the mother than to the daughter? Would you attempt a dietary intervention for the 15-year-old daughter? Why or why not?*

One option is to take this opportunity to instruct the daughter as well as the mother in order to prevent a recurrence of problems associated with clinically excessive weight and

imbalanced eating habits in the next generation. This approach might not work for all cultures because this type of discussion (with the daughter in front of the mother) might be interpreted negatively. At different stages of the adolescent development process, a mother and daughter may or may not share the kind of mutually supportive relationship that could support optimal outcomes.

4. *What cultural elements of diet might be important to explore for this case?*

All cultures believe certain foods must be present in order for a meal to be complete. These may include meat, some type of vegetable, bread, rice or other grains, or a particular beverage. Diets that incorporate central cultural components are more likely to be effective. In addition, it can be important when recommending a dietary regimen to consider factors such as the customary time for the patient's largest meal of the day.

There also can be biophysical aspects to culture and diet. For example, many people of Asian and African descent lack sufficient enzymes to digest lactose in dairy products and tend to avoid these products in their diets.

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## **SECTION 7 HANDOUTS/OVERHEADS**

## **HANDOUT 1: GLOSSARY**

### **ENVIRONMENTAL CONDITIONS AND CULTURALLY COMPETENT MEDICAL CARE**

**Barriers to Health Care:** Primary barriers to health care are related to economic disadvantage and geographic location. Barriers include distances patients travel to a health care facility, hours of facility operation, cost of health services, patients' loss of income if they miss work to use health services, language and culture, lack of understanding of the Western health care system, and rejection of personal health promotion beliefs.

**Community-Responsive Health Provider:** A provider who uses community-oriented primary care skills to address issues that affect the health of his or her community.

**Economic Disadvantage:** Conditions in which lack of opportunity and poverty affect the capacity of individuals, families, communities, and geographic areas to provide acceptable ways to achieve a satisfactory standard of living.

**Environmental Conditions:** Regional and community conditions that impact day-to-day life, surroundings, environment, and long-term health risk factors. Many people in America and throughout the world live with environmental conditions that the majority of Americans have never directly experienced. Differences in environmental conditions can directly impact personal experiences, beliefs, health options, choices, and outcomes.

**Living Conditions:** A set of immediate conditions that shape day-to-day life and choices. Many people, including people in much of the rest of the world and disproportionate numbers of disadvantaged populations and cultural minorities, cope with living conditions that many people in mainstream America would find unacceptable (e.g., lack of source of adequate heat and food, inadequate and unsafe supply of water, inadequate sanitation and sewage disposal, and lack of washing facilities and blankets).

**Observable Health Hazard:** Can include community-based conditions (e.g., open sewers) that may not be immediately known to a health provider but that can be observed.