

Cultural Diversity in Medical Care: Barriers between patient and caregiver

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The State of New Jersey Board of Medical Examiners (NJBME) has recently added new requirements for cultural competency training for physicians. This training obligation is based on Georgetown University and University of Pennsylvania studies, which were published in the *New England Journal of Medicine*. The studies, along with similar published works, detail disparities in the provision of healthcare. They produce documented proof that referrals for specific types of care, especially cardiac, are not made available to women and blacks as often as they are to Caucasian men.ⁱ

The NJBME stresses the importance of cultural competence and notes that few medical schools currently include it in their curriculum; therefore, special training is now required for physicians' relicensure if they did not receive cultural competency training in medical school.ⁱⁱ

The movement to cultural competence is part of a modification of healthcare practice toward patient-centered care. Instead of focusing primarily on disease or injury, the patient-centered process looks at the patient as a complete entity. That is, the patient is seen as a person who has a disease or injury, rather than concentrating on a disease or an injury which happens to occupy a body.

The complete person is best defined within an understanding of the person's culture. Weston and Brown quote Cassell's description of culture in the following statement:

Culture defines what is meant by masculine or feminine, what clothes are worn, attitudes toward the dying and the sick, mating behavior, the height of chairs and steps, attitudes toward odors and excreta, where typewriters sit and who uses them, bus stops and bedclothes, how the aged and the disabled are treated. These things, mostly invisible to the well, have an enormous impact on the sick and can be a source of untold suffering. They influence the behaviour of others toward the sick person and that of the sick toward themselves. Cultural norms and social rules regulate whether someone can be among others or will be isolated, whether the sick will be considered foul or acceptable, and whether they are to be pitied or censured.ⁱⁱⁱ

O'Connor notes that the health professions often view culture and ethnicity as the same thing, yet all people are culturally defined no matter what background they come from.^{iv} In addition, an ethnic person should not be lumped into a generic group with identical qualities as everyone else in that group; that is simply not an accurate representation.^v She explains, "medical problems have emotional, psychological, aesthetic, religious, interpersonal, and practical dimensions that differ across cultures and belief systems and that impel certain kinds of action and constrain others" and "moral mandates and ethical convictions differ cross-culturally."^{vi}

Understanding how the patient's disease or injury fits into their life, family, social relationships, and work helps a physician communicate more effectively with the patient. It means that fewer clues are missed and that decisions made with the patient on the care plan improve the likelihood the plan will be followed by the patient. Adherence to the care plan is important, as any physician knows; so the physician needs to spend some time finding out what care plan the patient will, or can adhere to, by finding out about their culture and their current circumstances.

A simple example of this might be a physician who is treating a female patient in her mid-twenties for a back injury. The physician advises bed rest during the day along with medication and physical therapy. If the physician does not take into account that she has four children under the age of five and no friends or family to help her, then he may be unhappy with her lack of adherence to his orders. However, if that same woman belongs to a culture which has close bonds with extended family, the physician may find his patient to be more likely to follow his orders.

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continued on page 2

To be more culturally aware, a physician must not only take the training that the NJBME requires, but should look for other opportunities to increase understanding of the differences between cultures.

Immigrants who come from other cultures also are accustomed to other health systems. The American healthcare and reimbursement system is complex and technology-based. We know that this system is often more than a little intimidating to people who have been in the states for generations and are fluent in Americanized English. Imagine the difficulty our system represents to a recent immigrant!

In Montgomery County, Maryland, Wendy Friar, Holy Cross Hospital's Director of Community Health, has used foreign medical school graduates to lecture recent immigrants regarding appropriate use of the American medical system. Every aspect of this interaction must be considered. Immigrants need to understand how to find a primary physician instead of simply using the emergency department. They need to know the importance of preventive care and how to get it. Friar's system helps this new wave of people integrate into the system more effectively.^{vii} Physicians have colleagues from many cultures who can serve as resources to help better understand their patients; they should take advantage of this bounty that is available to them.

Misunderstandings regarding cultural differences can be found in misconstrued words and in nonverbal communications that convey something we never intended to say. It is worth the physician's time to get to know about their patient's culture. As an added benefit, the patient usually warms to the fact that the doctor is interested in them as individuals and as people of a specific background. If the physician knows a little of the patient's language, they may also want to use a few words in conversation, but it is not a good idea to depend on it. Again, this shows respect for the patient as a person and is appreciated, even if the words are not pronounced perfectly!^{viii}

Nonverbal communication is important in every culture, but it is interpreted differently by each. In some cultures, people are comfortable being in close proximity to each other; but other groups require a polite distance. Types of physical bearing, facial expressions, and hand and arm gestures all can be inappropriate or uncomfortable for some cultures. The use of humor or calling a patient by their first name may be offensive to some. Even touching the head of a child is inappropriate in some cultures; and direct eye contact is acceptable in a number of societies, not in others.^{ix} Pages can be devoted to the details of this issue. Since it is important to treat each patient with respect, it will be important for each physician to take the training that is offered, and to learn from both his or her colleagues and their patients.

Verbal misunderstandings can be reduced by several means. If the patient and/or family have some understanding of English, speaking slowly and pausing periodically will allow them to do most of the necessary mental translations. An increased understanding can be obtained by using pictures and diagrams; writing simple instructions in large, easy-to-read print will also help. Periodically asking questions about the patient's understanding of

explanations and instructions, and rephrasing the questions can be helpful. The same thing can be done with the instructions themselves. They should be repeated in different words so that they are more likely to be understood. Ask the patient if their lifestyle and their schedule will allow them to follow the directions they have been given; for instance, will they be allowed to take fifteen minutes every three hours to apply ice to an injury while they are at work?

It is also a good idea to use interpreters and use other experts, like the pharmacist who speaks the patient's language.^x A recent study, published in the 2008 *Journal of the American Board of Family Medicine* stressed that patients prefer physician-patient communications in which they are asked about their understanding, and the physician also acknowledges the challenge of understanding all the information presented. This creates a more comfortable, shame-free environment for the patient.^{xi}

Few people feel comfortable admitting that they don't understand something that has just been explained to them. In a physician's office, when cultural, language, and simple communication differences are often in play, it becomes the physician's responsibility to bridge those gaps so that their patients are given a chance at a better health outcome.

While interpreters can solve many communication problems, cultural barriers can still surface. For instance, when family members are used as interpreters, children may be raised to a position of power over their parents, and that may make both them and their parents uncomfortable. This situation may go beyond mere discomfort in cultures where the patriarch is the only person with authority in the family; the translation simply will not be accurate or will not occur at all.

Matters of sexual or reproductive health are often just too uncomfortable or inappropriate for family members to translate, and in these cases, the discomfort may be compounded by the translator's misunderstanding and mistranslating of anatomical terms.

Finally, some cultures do not want the patient to be told any bad news. In those situations, the translation of the doctor's words may be seriously misrepresented. It is important for the physician to understand what is going on so that they can tailor their care plan to the situation and so that they can work with the family more successfully.^{xii}

Knowledge of other cultures should mean knowledge of culturally related home remedies. We all have them in our own backgrounds; almost everyone can remember a grandmother or great aunt who had a favorite remedy for coughs or colds. It is no different in other cultures, and the well-informed physician can make a more accurate diagnosis if they are aware of what to look for. Since some of these remedies can inadvertently look like physical abuse, or interfere with medications that have been ordered, it is important that gentle, respectful questions be asked of the patient and family. It cannot be stressed enough that the physician's demeanor must be respectful in both verbal and nonverbal communication. Without that respect, the patient will

continued on page 3

likely withhold important information that could impact the quality of the care plan.^{xiii}

The entire reason for this push to increase physician awareness and respect for cultural differences is to improve patient care. If a patient is deeply connected to their heritage, they will likely reject a physician who disrespects it, because that shows disregard for them.^{xiv} There can be no hope for adherence to a care plan in this situation, even if it is a good plan. Per O'Connor, "this is not a problem to solve... but a set of relationships to be negotiated."^{xv}

In an article in *Family Practice Management*, Gottlieb, Sylvester, and Eby describe how South-central Foundation, owned by Alaskan natives, reformed their federally contracted medical services into a patient-centered system that they ran themselves. Over time, they developed four key ideas, which drove their culturally sensitive system: 1. the customer drives everything, 2. all customers deserve to have a healthcare team they know and trust, 3. customers should face no barriers when seeking care, and 4. staff members and supporting infrastructure are vital to success.

They started out with a typical situation in which the caregivers were intent upon giving good care but did not bother to take the patient and culture into consideration. At the end of ten years, they had a patient-caregiver partnership in which most care decisions were made while patients were in the low-acuity phase of their illness and the most impact could be made.

Decisions were made as a team of patients with their caregivers, and the system is successful today.^{xvi}

This is the goal of patient-centered medicine, - patient safety, and - good quality care. The patient is to be well and carefully cared for. In situations of lowered stress where good care is being given, such as this one, it is typical that the caregiver is happier too.

The JCAHO has recently released a series of resources for improving interactions between patients and caregivers, focusing on language and culture. The contents of this list are often focused on the healthcare facility, but a physician who is trying to implement this in their practice can be helped by having a back-up system in the hospitals they affiliate with. If appropriate, the readers of this article may wish to refer some of these resources to their facilities.^{xvii}

Though this new mandate of the NJBME may seem like more work, the value that can be derived from this extra understanding between patients and physicians is evident. ❖

ⁱ 45:9-7.2 "Findings, declarations relative to medical education in providing culturally competent health care." State Board of Medical Examiners Statutes and Regulations. <http://www.state.nj.us/lps/ca/bme/bmelaws.pdf>. Page 38.

ⁱⁱ 45:9-7.3 "Requirements for physician training in cultural competency." State Board of Medical Examiners Statutes and Regulations. <http://www.state.nj.us/lps/ca/bme/bmelaws.pdf>. Pages 38-39.

ⁱⁱⁱ Stewart, Moira, Brown, Judith Belle, Weston, W. Wayne, McWhinney, Ian R., McWilliam, Carol L., and Thomas R. Freeman. "Patient-Centered Medicine: Transforming the Clinical Method." SAGE Publications, Inc., Thousand Oaks, CA. 1995. Page 52.

^{iv} O'Connor, Bonnie Blair. "Healing Traditions: Alternative Medicine and the Health Professions." University of Pennsylvania Press. Philadelphia. 1995. Page 170.

^v Desmond, Joanne and Lanny R. Copeland, M.D. "Communicating with Today's Patient: Essentials to Save Time, Decrease Risk, and Increase Patient Compliance." Jossey-Bass, San Francisco. Page 218.

^{vi} O'Connor, Bonnie Blair. "Healing Traditions: Alternative Medicine and the Health Professions." University of Pennsylvania Press. Philadelphia. 1995. Pages 182-183.

^{vii} Satyanarayana, Megha. "Breaching Barriers of Culture and Understanding: Holy Cross Links Immigrants With Health Professionals Who Speak Their Language." Special to The Washington Post. Tuesday, February 5, 2008. <http://www.washingtonpost.com>. © The Washington Post Company. 2/7/2008.

^{viii} Desmond, Joanne and Lanny R. Copeland, M.D. "Communicating with Today's Patient: Essentials to Save Time, Decrease Risk, and Increase Patient Compliance." Jossey-Bass, San Francisco. Page 205.

^{ix} Ibid, Pages 213-214.

^x Ibid. Pages 207-209.

^{xi} Kemp, Evelyn C., PsyD, RN, Floyd, Michael R., EdD, McCord-Duncan, Elizabeth, MD and Forrest Lang, MD. "Patients Prefer the Method of 'Tell Back-Collaborative Inquiry' to Assess Understanding of Medical Information." Journal of the American Board of Family Medicine. 2008;21(1):24-30. 4/08/2008. ©2008 American Board of Family Medicine. <http://www.medscape.com>. 4/16/08.

^{xii} Desmond, Joanne and Lanny R. Copeland, M.D. "Communicating with Today's Patient: Essentials to Save Time, Decrease Risk, and Increase Patient Compliance." Jossey-Bass, San Francisco. Pages 211-213.

^{xiii} Ibid, Pages 216-219.

^{xiv} O'Connor, Bonnie Blair. "Healing Traditions: Alternative Medicine and the Health Professions." University of Pennsylvania Press. Philadelphia. 1995. Page 171.

^{xv} Ibid, Page 172.

^{xvi} Gottlieb, Katherine, MBA, Sylvester, Ileen, MBA and Douglas Eby, MD, MPH. "Transforming Your Practice: What Matters Most." Fam Pract Manag. 2008;15(1):32-38. 3/21/2008 ©2008 American Academy of Family Physicians. 4/3/2008.

^{xvii} "Hospitals, Language, and culture: A Snapshot of the Nation, Compiled List of Resources." Hospitals, Language, and Culture. The Joint Commission. <http://www.jointcommission.org/PatientSafety> ❖