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How to Provide Culturally Competent Haelthcare

A patient's children believe it is their right to see their father's general practitioner to discuss the results of his recent investigations for weight loss; they are adamant that, if found to have cancer, their father should not be informed.

A woman calmly tells her doctor that she cannot sign consent form for the emergency laparoscopy being hurriedly organised to investigate her abdominal pain; she must wait for her husband to arrive before making that decision.

A man with diabetes refuses to take insulin, even though his doctor tells him it is necessary.

What do these three scenarios have in common? They represent typical examples of the kinds of situations that frequently arise in general practices and hospitals in many western countries reflecting the challenges inherent in the care of culturally diverse populations. Although such situations can be challenging, cultural knowledge and sensitivity can improve the quality of medical care by increasing patient trust, a key factor in adherence. At the same time, it can reduce stress on the part of the healthcare providers.

Stereotype vs. Generalisation

It is important to distinguish between a stereotype and a generalisation. Both are broad general statements about a group. The difference is that a stereotype is used as an ending point. The statement about the group is assumed to apply to all members of that group, without further investigation of the individual. A generalisation, however, is used as a starting point, recognising that individuals within a group will very often be heterogeneous. Effort is made to see whether or not the generalisation fits the individual in question. Any statements made about specific ethnic groups in this article should therefore be seen as starting points or generalisations that may or may not apply to any particular individual. For example, a widely held generalisation is that individuals from certain cultures tend to be more expressive than those from other traditions. Some of the former include Hispanic, Middle Eastern, and southern European cultures, while the latter include British, northern European, Asian, and Native American cultures. When patients and healthcare providers come from different cultures, this can create tensions, but it is also important to note that this is not inevitable. A British healthcare provider may be overly concerned (or annoyed) by the 'moaning and groaning' of an Iranian patient, while an Italian healthcare provider might not even be aware that her Japanese patient is in extreme pain, a condition manifested only by a tensing of the jaw. Knowledge of the generalisation could aid a healthcare provider in asking appropriate questions and better applying their knowledge of the typical levels of pain associated with particular conditions and procedures and offer analgesia appropriately. At the same time, it would be a grave mistake to stereotypically assume that because an Italian patient is complaining loudly, s/he can be ignored. Something serious could be wrong. Families are often a useful source of information.

Values

One of the keys to understanding people's behaviour is to understand their values. While each individual develops their own set of values, there are also values that are promoted by one's culture. For people belonging to minority traditions these values may come into conflict with biomedicine. For example, the North American culture values the individual, whereas in Asian and Hispanic cultures the primary unit is the group. This may for example manifest as clinicians expecting to talk to the patient about his/her diagnosis and prognosis. Many Chinese families, however, will be upset if the physician reveals a negative diagnosis such as cancer directly to the patient. They may expect the physician to present such a diagnosis to the family, who will then decide whether or not to tell the patient. How can such issues, which potentially involve breaching confidentiality, be overcome? One strategy that many healthcare professionals now successfully use is to explicitly discuss with the patient beforehand whom he would like information about his condition to be given. If the patient prefers that it be given to a designated family member, make sure that all legal requirements are met.

Time Orientation

Cultures may have a past, present, or future time orientation. People from those with a past orientation (such as China or India) tend to prefer traditional remedies and treatments; those with a future time orientation (such as the United States) generally believe that newer is better, and want the latest treatments and drugs. Other cultures, particularly those of the developing world are, by and large, present-oriented. Members may be less likely to utilise preventive health measures reasoning, for example, that there is no point taking a pill for hypertension when they feel fine, especially if the pill is expensive and inconveniently causes unpleasant side effects. They do not look ahead in the hope of preventing a stroke or heart attack, or they may feel they will deal with it when it happens. In such cases, additional effort may be needed to explain the importance of prevention to increase the chances of patient cooperation. Similarly, it is also essential that physicians explain why an antibiotic must continue to be taken, even when symptoms have disappeared; present-oriented patients are most likely to discontinue medication with the cessation of symptoms.

Gender Roles

A failure to realise that males are thought to be dominant in many cultures can lead to delay in obtaining consent for medical procedures. A Mexican or Arab woman, for example, may want to wait until her husband arrives before signing consent for herself or her child. Seasoned healthcare providers will offer the opportunity to involve the husband from the outset, and discuss the situation with the couple together. It is, we believe, advisable for clinicians to consider consulting in advance with patients in order to ascertain whether they prefer family members to play an active-role in decisions regarding their care. This may be particularly relevant when caring for people of Hispanic, Asian or Middle-Eastern origin since the husband is typically involved in important decisions; in Gypsy culture it is usual practice to involve the elder males of the family.

Asking the Right Questions

The key to providing more culturally competent healthcare is understanding the patient's point of view. Ultimately, culturally sensitive care is patient-centred care and should be practiced with all patients. A way to understand the patient's perspective is to ask the right questions. There are many excellent examples, but one with an easy mnemonic is "The 4 C's of Culture":

Call

Cause

Cope

Concerns

1.What do you call your problem? (Remember to ask "What do you think is wrong?" It's getting at the patient's perception of the problem. You should not literally ask "What do you call your problem?") The same symptoms may have very different meanings in different cultures and may result in barriers to compliance. For example, among the Hmong, epilepsy is referred to as "the spirit catches you, and you fall down." Seeing epilepsy as spirit possession (which has some positive connotations for the possessed) is very different from seeing it as a disruption of the electrical signals in the brain. This should lead to a very different doctor-patient conversation and might help explain why such a patient may be less anxious than the physician to stop the seizures.

2.What do you think caused your problem? (This gets at the patient's beliefs regarding the source of the problem.) Not everyone shares the same beliefs with regard to the cause of disease, and thus they may not adhere to treatment recommendations that do not make sense to them. For example, an African American patient who believes their disease was caused by sin may feel the need for penance, not prescription medication. Bringing in clergy might greatly improve cooperation with medical recommendations. A Muslim Arab who believes that only medication derived from 'lawful' sources will facilitate cure may be reluctant to take capsules encased in gelatine derived from animals that have not been ritually slaughtered. A Chinese patient who believes that her illness is due to an upset in the balance between yin and yang may be resistant to specific medications which might be seen as exacerbating the imbalance. Healthcare professionals conversant with such beliefs may, in the case of the latter example, suggest an alternative medication, or that it be taken with a liquid other than water in order to 'neutralise' it.

3. How do you cope with your condition? (This is to remind the practitioner to ask, "What have you done to try to make it better? Who else have you been to for treatment?"). This will provide the healthcare provider with important information on the use of alternative healers and treatments. Most people will try home remedies before coming in to the physician; however, few will share such information due to fear of ridicule or chastisement. It's important that healthcare providers learn to ask – in a nonjudgmental way – since the occasional traditional remedy may be dangerous, or could lead to a drug interaction with prescribed medications. This question can also help you discover if they've been unable to cope with whatever it is that's going on.

4.What are your concerns regarding the condition? (This should address questions such as "How serious do you think this is?" "What potential complications do you fear?" "How does it interfere with your life, or your ability to function?" and "What are your concerns regarding the recommended treatment?"). You want to understand their perception of the course of the illness and the fears they may have about it so you can address their concerns and correct any misconceptions. You also want to know what aspects of the condition pose a particular problem for the patient; this may help you uncover something very different from what you might have expected. It is also important to know their concerns about any treatment you may prescribe. This can help avoid problems of non-adherence, since some patients may have misplaced concerns based upon past experience. For example, some patients may not be taking insulin because they believe insulin causes blindness. They've seen friends and family members go blind after going on insulin, and they incorrectly perceive that as the cause; it's a logical assumption based on observed cause and effect. Unless a healthcare provider asks, however, s/he may not elicit such beliefs from the patient, who will simply not take their insulin. By asking, the healthcare provider can correct any misconceptions that can interfere with treatment.

Conclusions

The practice of medicine in today's increasingly multicultural world requires more than just clinical expertise; it requires cultural competency as well. Understanding of and sensitivity to the cultures of the patient population can help healthcare providers provide more effective care while avoiding the frustration that stems from a lack of understanding.

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