Do cultural differences affect the medical care experience?

Do cultural differences, even subtle ones, between health care providers and patients have an impact on how patients view their medical care? In an effort to find out, we talked with clinicians, interpreters and patients, who shared their impressions with us.

Throughout our discussions, three key factors emerged: **communication, concepts of health and healing,** and **personal/past experiences.** Each of these played a key role in how patients experienced their medical care.

Communication, which encompasses nonverbal communication such as tone, gestures, eye contact, posture and touch, as well as spoken and written language, played a very important role in how members felt about their care. When communication fell short, patients tended to react negatively, even when the clinical care was excellent. Patients' concepts about health and healing, which are inextricably linked to the beliefs of their culture, also impacted their health care experiences. Finally, personal and past experiences, shaped by the cultures and worldviews of patients and their families - some of whom come from war-torn countries or have been discriminated against in the past - also had a powerful effect on how they perceived their care.

The following vignettes illustrate how these complex and often interwoven factors can influence the clinical encounter.

Painting by Alexandra Nechita

communication

Let's hear from:

CARLOS

Carlos, a 55-year-old native of Mexico, recently went to the local hospital's emergency unit for a routine medical problem. Although Carlos felt that his condition was not that serious and that he could wait to make an appointment to see his own physician, his family rushed him to the hospital. Later, Carlos' physician told him that, for routine care, he should not go to the emergency unit but call ahead for an appointment in the health center. Carlos didn't disagree with his physician's advice, yet just one week later ended up in the emergency unit again. His physician didn't understand why, especially after he had explicitly explained to Carlos about the appropriate use of emergency services.

What can we learn from this?

Who makes health care decisions differs from culture to culture. In some cultures, including some ethnic groups in the U.S., all health care decisions are made by the family, not the individual. In traditional Hispanic societies, for example, the entire family participates in decision-making.[7] Carlos' family, which is Hispanic, has guarded his health cautiously since he began treatment for a kidney infection. It was later learned that the family defined "emergency" differently than the physician. That's why every time his blood pressure rises or other symptoms become present, his family, who is managing his care, makes the decision to take him to the hospital. Involving the family in the decision-making process and administration of care might remedy this problem.

SERGE

During testing, a physician discovered a genetic anomaly in his patient, Serge, who recently moved to the U.S. from the former Soviet Union. She planned to inform Serge during their next visit. The Russian interpreter was told about the physician's plans prior to the visit and strongly urged her to tell the patient's family first and let them inform Serge, as this is how it would have been handled in their country of origin. The physician was very reluctant, but in this case heeded the interpreter's advice. When the information was passed along to Serge, he reacted as though it were natural that he receive the news from his family.

What can we learn from this?

An American physician's practice of direct disclosure to patients contrasts with the traditions of some other societies. In the U.S., it is considered a breach of confidentiality if a physician withholds information or discusses issues with individuals other than the patient without first getting the patient's permission. In contrast, an Italian physician might withhold a grave diagnosis to sustain hope and protect the patient.[8] In Japan, patients with terminal illnesses may also be protected from bad news even though family members are informed. One way physicians can prevent a problem is to check with the patient early on regarding his or her attitudes toward disclosure to family members.

ELLY

An adolescent girl who is deaf wanted to speak to her clinician through an American Sign Language (ASL) interpreter, rather than through her mother, who had interpreted in the past. Elly was concerned about her recent sexual activity and her hereditary deafness, but did not want her mother to find out about either concern. Once a professional medical interpreter was provided, Elly was able to express her rage about her deafness, how she felt about her hereditary condition, and her fear of passing it on. She told her clinician that she never could have brought up these concerns had her mother continued to interpret.

What can we learn from this?

It is often assumed that patients who speak limited English or are hearing impaired are comfortable with family members serving as interpreters. While this is sometimes the case, there are other instances when the patient does not wish to share certain issues with family members. But he or she may be reluctant to ask for the services of a professional interpreter or be unaware that there is a service available. At these times, a professional medical interpreter may be essential to ensuring confidentiality and facilitating effective communication.

RESEARCH & WRITING | BRIAN NORGAARD

concepts of health and healing

Let's hear from:

ALICIA

"On a scale of one to ten how much pain are you experiencing?" That's the question that Alicia heard repeatedly during a clinical visit regarding her severe abdominal pain. Throughout the 27 years she spent growing up in San Salvador, she had never been asked that type of question. The more she was asked the question, the less she felt she understood it. It seemed to Alicia that her physician could understand her pain only if it were measured on this hypothetical scale. Finally, she answered for the sake of answering. She later told an interpreter that the physician's question made no sense to her.

What can we learn from this?

Language is a reflection of culture. It is not surprising, therefore, that Alicia's physician used a scale of one to ten to measure pain, because Anglo-Americans tend to think and talk in a linear fashion.[9] Alicia understood her physician's words, but could not relate to the concept. It is common to have differing styles of interpreting and analyzing information across cultures. Re-framing the question might well produce a different response.

PHUONG

Phuong, a 65-year-old man originally from Vietnam, was diagnosed with terminal cancer. Phuong's physician wanted to admit him to the hospital, where he could be given care that would alleviate his pain and enable him to be as comfortable as possible. Phuong was advised to go to the hospital immediately, but to his physician's surprise, he spent the next few days at a temple. Considering the pain Phuong was experiencing, his physician could not imagine postponing treatment. Phuong's daughter explained through an interpreter that her father needed to get prepared for what lay beyond his present life - to get his spiritual affairs in order. Only after Phuong spent the time he felt necessary to nurture his soul was he ready to enter the hospital.

What can we learn from this?

People's response to illness and their approach to seeking health care is influenced by their culture. Patients from certain ethnic and cultural groups are likely to consult a healer from their own tradition while simultaneously being cared for by a Western-trained physician - with quite different expectations of each practitioner.[10] Phuong followed his physician's advice, but placed priority on the spiritual element of his life.

BOPHA

Bopha, originally from Cambodia, was instructed by her physician to increase the amount of milk she gave to her six-year-old child, who appeared healthy. She objected, stating that in her culture, milk and other dairy products were not staples, and that she preferred to feed her child traditional Cambodian foods. The pediatrician suggested that she should overcome her insistence on traditional foods, now that she was living in the U.S. Bopha felt that her practices were being unjustly dismissed and continued her traditional menu regardless.

What can we learn from this?

Traditional diets generally have cultural significance rooted in generations of practice, and changing a menu can be a threat to those traditions. Additionally, many Asians are lactose intolerant so their diet does not contain milk or cheese.[11] Bopha saw no need to quit feeding her child a traditional diet, especially since the child was in good health. This does not imply that Western foods cannot be integrated into various diets. But, as with Bopha, people may have difficulty accepting changes if their customary practices are not first acknowledged and validated.

JOSÉ

José accompanied his 12-year-old son, José Jr., to his physician's appointment. His son was suffering from recurring breathing problems, which the physician diagnosed as asthma. José explained that his family had been treating José Jr. with Uña de Gato, an herb that one boils and drinks. His physician was familiar with the herb and asked José how he felt it was helping his son's condition. After a short consultation, he prescribed the use of an inhaler, and approved the continued use of Uña de Gato if needed. José was impressed that the physician knew about the traditional remedy and was able to discuss its merits. José Jr. was eager to try the inhaler.

What can we learn from this?

Uña de Gato is an herb commonly used among Latinos as a cure-all medicine. José Jr.'s physician did not recommend the herb, but knew enough about it to realize that it would not interact negatively with his prescribed treatment. José felt that this physician's medical knowledge was comprehensive, which may have facilitated his easy acceptance of the prescribed treatment for his son.

personal and past experience

Let's hear from:

CHARLOTTE

Charlotte, a middle-aged African-American woman, was referred by her primary care physician to an obstetrician/gynecologist, who happened to be a white man from South Africa. When Charlotte found out about this, she was very upset. "How could my physician know so little about me?" she wondered. Charlotte believed that no white South African physician, however well-respected, was an appropriate person to provide her care. She felt that her primary care physician, by not anticipating that she might have feelings about being treated by a white South African, did not understand the needs of African-American women. She disenrolled from the organization.

What can we learn from this?

The results of an HPHC focus group highlighted the importance African-Americans place on trust in their medical care. African-American participants stated they wanted to be treated with respect by clinical and administrative staff and felt that trust in the medical system was a major concern.[12] It may be that Charlotte already felt a general distrust of the medical system, and the referral then further distressed her. Although making this referral was standard medical practice to Charlotte's physician, it triggered a negative response in his patient. A general awareness of and sensitivity to this issue may have prevented the problem.

MARíA

María, a young mother originally from Guatemala, was very concerned about the health of her one-year-old daughter, Maria Janet. One day Maria Janet developed a fever of 104 degrees. María immediately scheduled an appointment for her child. She was sure to bring one of Maria Janet's diapers so the physician could examine her child's stool, a common practice in Guatemala. The diaper was a clue that contained, in María's mind, the key to her child's malady. At the appointment, the physician threw the diaper away without asking any questions and began his examination. María was devastated and lost trust in the physician. She ended up speaking about it only to the physician assistant and interpreter who were also there to assist her.

What can we learn from this?

Examining stool samples for clues to health is a common practice around the world. How it is done and the importance it has differs across cultures, however. In certain areas of Equador, for example, women depend on their skills at analyzing their children's stool to determine the severity of illness. They have well-defined techniques of classification that tell them, among other things, whether the child should be brought to the physician; if so, it is common practice to bring along the diaper for analysis.[13] In the U.S., however, a physician is more likely to ask questions about the child's stool and request a sample only if needed, to be delivered in a container. In this case, the physician might have explained her actions, however routine they may have seemed, to help María adjust to unfamiliar practices.

LUISA

Luisa came to the U.S. from El Salvador as a refugee. She had to leave her infant son, Jorge, with family members but expected to return for him within a year. Shortly after arriving in the U.S. she developed lupus. Fearing that she would be deported if the government found out she was ill, she avoided getting medical attention until her condition worsened to the point that friends strongly urged her to see a physician. Then it was imperative that she receive a kidney transplant. As she battled her illness over years, she found few opportunities to accomplish some of her goals, including mastering English. Jorge eventually rejoined Luisa when he was seven. One day, he complained of an earache so Luisa took him to her health center. During the visit, at which no interpreter was present, the physician expressed frustration with Luisa's language ability. Luisa was equally frustrated, feeling that her physician was not sensitive to all she had been through. She felt powerless to express her emotions and responded by changing physicians.

What can we learn from this?

Patient's who speak English with limited proficiency face the complexity of learning the language and the judgment of others. The obvious issue between Luisa and her physician was difficulty in communicating. There were, however, other underlying issues. The physician responded only to Luisa's lack of fluency, while Luisa wanted the physician to recognize her life difficulties. A physician from El Salvador might have been sensitive to the fact that, considering Luisa's move to and residence in the U.S., fluency in English was really a secondary matter. Understanding and acknowledging the experiences of immigrants adapting to American culture, therefore, can play an important role in providing quality and compassionate medical care.