



Feb 24, 2008

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Cultural Competency in Medicine

Lia Lee was a three-month-old Hmong child with epilepsy. Her doctors prescribed a complex regimen of medication designed to control her seizures. However, her family felt that the epilepsy was a result of Lia "losing her soul" and did not give her the medication as indicated because of the complexity of the drug therapy and its side effects. Instead, they did everything logical in terms of their Hmong beliefs. They took her to a clan leader and shaman, sacrificed animals and bought expensive amulets to guide her soul's return. Lia's doctors felt her parents were endangering her life by not giving her the medication so they called Child Protective Services and Lia was placed in foster care. Lia was a victim of a misunderstanding between these two cultures that were both intent on saving her. The result was disastrous: a close family was separated and Hmong community faith in Western doctors was shaken.¹

How can physicians-in-training prepare for situations like Lia's? Lia was surrounded by people wanting the best for her and her health. Unfortunately, the involved parties disagreed on the best treatment because they understood her epilepsy differently. To ensure good care for diverse patients, physicians-in-training must address cultural issues in medicine.

By the year 2000, almost 50 million people in the U.S. will be ethnically diverse. Immigration contributes to the growing diversity of the U.S. In 1940, 70% of immigrants were from Europe. By 1992, the pool of immigrants had changed: 15% came from Europe, 37% came from Asia and 44% came from Latin America and the Caribbean.³ The U.S. attracts two thirds of the world's immigration and 80% of American immigrants come from Central and South America.⁴ Generalist physicians expect more than 40% of their patients to be from minority cultures.⁵

The health industry is also starting to realize the importance of cultural sensitivity. Michigan Physicians Mutual Liability company underwrites malpractice policies for doctors who receive a 2-5% premium reduction if they take a seminar on cultural competency. In addition, The Pennsylvania Health Law Project has been pushing for stronger linguistic and cultural standards in federally funded health programs. According to Gany, director of the New York Task Force on Immigrant Health, a program of simultaneous telephone interpreting for doctors and non-English speaking patients is being launched in 1998 in New York City.⁶ Recently, a \$400-million initiative to address health differences between minority and white Americans was recently proposed by President Clinton.

- **What does it mean to be culturally competent?**
- **How do physicians-in-training perform a cultural assessment?**
- **Isn't being a good physician enough to treat everyone?**
- **The patient doesn't speak English, now what?**

STUDENT ORGANIZERS' GUIDE

Culture is defined as "the integrated pattern of human behavior that includes communications, actions, customs, beliefs, values and institutions of a racial, religious or social group."⁵ This Project-in-a-Box will discuss how and why differences affect medical care. This Box cannot address the individual needs of all cultures. However, it will be a framework for a culturally competent system. Physicians-in-training will be able to adapt this framework and specify responses to the needs of their community.

This Project-in-a-Box will try to identify some practical ways that individual organizations can start on the road to cultural competency. It will also provide organizations and resources for speakers and further information. This Box is based on Western ideas of integrity and understanding to resolve cross-cultural differences. Western cultures will undoubtedly have different ideas and concepts regarding these issues. This Project-in-a-Box is by no means intended to imply that there are always ways to meet the needs of all cultural groups. Services should be adapted to the needs of the group and the individual based on identity, degree of assimilation, and subcultural grouping.⁵ Physicians-in-training must avoid stereotyping while becoming more culturally aware. Part of cultural competency involves determining the level of acculturation so that the physician can approach that patient appropriately.

Suggested activities

1. Do a self assessment. This allows medical students to explore issues of identity and bias without judgment by others. Consider topics like your family history when, how and why your ancestors arrived; ethnic advantages/disadvantages that you may have;⁷ and stereotypes of other ethnicities that you may encounter when you get a group together and do a cultural self assessment. Discuss your experiences and differences.
2. Go into a community that you would like to learn more about. Community health workers, traditional healers and patients are the best educators. Learn about demographics, traditional health/illness beliefs, maintaining/restoring home remedies, health resources, neighborhood health centers, traditional healers, child-bearing/rearing beliefs and practices, and rituals and beliefs surrounding death and dying.⁴ Then, walk through the community. Visit grocery stores and pharmacies and eat a meal in a neighborhood restaurant.
3. Work with culturally/ethnically organized student groups, medical group community groups and ask about specific health or competency issues in that community. Check out the Asian Pacific American Medical Student Association (APAMSA) at <<http://www.apamsa.org>> and the Student National Medical Association (SNMA) at <<http://research.uokhsc.edu/malc/snr>>. Cultural groups have some medical issues that are particularly important and you might be able to take part in their organized interventions.
4. Discuss the attached case studies to decide how you would have responded if you went wrong? What could have been done better?
5. Arrange a panel of traditional healers or practitioners of complementary medicine to discuss their methods and cultural beliefs.
6. Host a brown bag lunch and invite a cultural competency speaker.

Suggestions for Speakers

- See the Additional Resources section at the end of this PIB for agencies providing cultural competency training and for specific ethnic health care associations.
- Contact community health clinics, universities and hospitals. Physicians, nurses and other health care workers who have regular contact with multicultural communities may speak about the cultural competency demands of their jobs.

- Many cultures do not differentiate between religion and medicine. Reach out to local religious organizations, churches and temples, speaking to the leaders of these institutions. They may be able to provide some insight on what the community believes.
- Traditional healers like curanderos, herbalists, shamans, santiguadores, and medicine men/women are valuable for knowledge and information as complementary medicine. Seek them out through health clinics, religious organizations and patients.
- Patient advocates, legislative/legal advocates and other prominent figures in the community hold influence on your patients. Check the Minority Affairs Office at the university for some specific names and organizations.
- Patients from the community can give valuable insight on the experience of being treated by Western doctors who may not understand their ideas of health and illness. Seek out such patients by asking university physicians if they are willing to ask their patients to come and talk to a group of students.

WHAT DOES IT MEAN TO BE CULTURALLY COMPETENT?

Cultural competency is "a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups. Becoming culturally competent is a developmental process. Terry Cross describes a cultural competence continuum with six stages, each delineated by an attitude and associated action or nonaction.⁵

Culture is a predominant force in shaping behavior, values and institutions. Cultural differences exist, but they also impact health care delivery. Culturally competent providers appreciate family ties and realize that they are defined by their culture for each culture.⁸ Rather than being insulted by another culture's perspective, culturally competent providers welcome collaboration and cooperation. For example, a culturally competent physician who had been taking care of a Native American family for five years noticed that the wife was depressed. The wife slowly revealed that she had been sexually assaulted by her uncle when she was young. The doctor started psychotherapy and antidepressants, which helped but did not resolve the wife's problems. After consulting with a Native American medicine man, who then consulted with the family, the physician and the patient learned that the woman had acquired a spirit from the incest. A traditional purification ceremony was performed that removed the woman of the spirit and her depression.¹⁰

Key Questions to Ask Speakers

- How are traditional healers different from Western-educated physicians?
- How can I work with traditional healers without compromising my beliefs?
- How do I provide "culturally competent" care if that means sometimes patients continue with, in my opinion, less than optimal treatment?
- What are some examples of how a lack of cultural competency can affect the quality of care?
- What are common problem areas in dealing with multicultural populations?
- What are some of the unique problems in servicing your specific community?
- What can the provider do to make treating a minority patient more culturally competent?

GOALS OF CULTURALLY COMPETENT CARE ^{11,12}

1. **CULTURAL AWARENESS:** Appreciating and accepting differences.¹¹
2. **CULTURAL KNOWLEDGE:** Deliberately seeking out various world views and explanatory models of disease.¹¹ Knowledge can help promote understanding.

- between cultures.¹²
3. **CULTURAL SKILL:** Learning how to culturally assess a patient to avoid only on written "facts;"¹¹ explaining an issue from another's perspective; resistance and defensiveness; and acknowledging interactive mistakes that hinder the desire to communicate.¹²
 4. **CULTURAL ENCOUNTERS:** Meeting and working with people of a different culture will help dispel stereotypes and may contradict academic knowledge. Although it is crucial to gather cultural knowledge, it is an equally important, sometimes neglected, culturally competent skill to be humble enough to challenge the security of stereotypes and remain open to the individuality of each person.

DEFINITIONS

Acculturation: The process of adapting to another culture; to acquire the characteristics of another group's culture.⁴

Cultural group: The integrated pattern of human behavior that includes the beliefs, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.⁵

Ethnic: Belonging to a common group; often linked by race, nationality and ancestry with a common cultural heritage and/or derivation.⁸

Minority Group: Globally, non-Caucasians constitute a majority, thus the term is used to refer to a variety of groups who have been disadvantaged in one way or another.⁸

Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.⁸

Stereotype: The notion that all people from a given group are the same.⁴

WHY ARE THERE CULTURAL CLASHES?

Physicians-in-training are part of a cultural group that has its own beliefs, practices, customs and rituals. These include definitions of health and illness; the use of technology; prevention through annual exams; compliance; procedure; and treatment approaches. Medical students engage in customs of professionalism and conduct that have rituals like the physical exam, visiting hours and surgical procedures.⁴ Medical school teaches students scientific rationality and an emphasis on objectivity. Students value numeric measurement and physicochemical data and tend to focus on the mind and body. Medical students reduce patients to individual diseases and body parts without seeing the patient as a part of a family or community.¹⁴ In the past, physicians in training represent an ethnocentric culture--one that values its own culture above others. This inevitably leads to conflicts with the patient's culture.

Medical students must have the capacity to assess themselves, to determine their own inherent culture's biases as well as their medical culture's biases. The realization that their own culture has on medical student's everyday behavior and that they understand the magnitude of cultural influences on their patient's life and behavior.⁵

ASSESSMENT QUESTIONS FOR PATIENTS (Adapted from Kleinman¹⁶)

Because time is often a consideration, these are the barest of cultural assessment questions used to elicit the client's explanatory model of his or her disease and to identify cultural barriers or a low level of acculturation based on history or experience.

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What does your sickness do to you? How does it work?
4. How severe is your sickness? How long do you expect it to last?

5. What problems has your sickness caused you?
6. What do you fear about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to receive from this treatment?

AREAS OF DISSONANCE

Historical Distrust⁵

Past injustices may cause minority patients to distrust their providers. For example, some "illegal aliens" may be hesitant to fill out forms because of deportation. Taking time to establish a rapport and explain why the forms are needed and how the forms may alleviate these fears.⁵

Interpretations of Disability¹⁵

Physicians have many ideas about disability. For example, doctors feel that disability should include intervention and that biological anomalies should be corrected. In some cultures, however, some cultures believe that the "disability" is spiritual rather than physical and that "disability" itself is a blessing or reward for ancestral tribulations.¹⁵

Concepts of Family Structure and Family Identity¹⁵

For patients, family often extends beyond the sphere of the traditional nuclear family. Because patient decision making may include members of the extended family and community, providers should consider familial influence on treatment decisions.

Communication Styles and Views of Professional Roles¹⁵

Westerners tend to separate professional and personal identity. The need for objectivity depersonalizes communication style. However, many cultures value personal relationships that use both roles.¹⁵

Incompatibility of Explanatory Models¹⁴

An explanatory model explains the epidemiology of the illness.¹⁶ If patients' and providers' ideas differ about the structure and function of the body, for example, of diseases being bacteria, virus or the environment versus the "evil eye," "witchcraft," or "curses," it will be difficult to get patients to comply with treatment. Is health a physical or a moral/social balance as well?¹⁴

Disease Without Illness¹⁴

Physicians are well indoctrinated about the dangers of "invisible" diseases like hypertension, high cholesterol and HIV infection, but people in other cultures may not be willing to intervene when there are no symptoms.¹⁴

Illness without Disease¹⁴

The existence of the folk illness may be an area of disagreement between patient and provider. A folk illness is when a patient feels that he or she has an illness not defined by biomedicine.¹⁷ Physicians need to be aware of common folk illnesses that may affect members of a cultural community.^{14,17} "Some may see a medical intervention as relief of symptoms while also going to a folk doctor or traditional healer to find the cause of the illness."¹⁷ In addition, although a few practices may be harmful (and are often misinterpreted as abuse), most folk medical beliefs and practices are not harmful and do not interfere with biomedical therapy.¹⁷ Providers should not try to change benign beliefs but should educate them on the importance of biomedicine as a complementary.¹⁷ A combination of the two forms of therapy may increase compliance because this is within the ethnocultural ideals of the patient.¹⁷ For example, a Puerto Rican mother might believe that her child is suffering from empaque

illness caused by food "sticking" to the inside of the stomach and causing p physician diagnoses viral gastroenteritis and prescribes medication, but also mother to rub her child's stomach. This is not harmful and it fits the cultura the patient, possibly increasing compliance.¹⁷

Misunderstandings of terminology,¹⁴ language or body language⁵

Monolingual providers who encounter patients who do not speak their langu as a barrier to health care. Body language can be misinterpreted between c example, the firm handshake in Anglo-American culture is a symbol of stroi but in some Native American groups, a limp hand is a symbol of humility ar Two people from these cultures would leave this encounter with completely assessments of each other.⁵

Listed below are some common Anglo-American values and some represent differences that other cultures may hold. (Please note that Anglo-American interpreted as those closest to the medical provider culture). Recognizing s values as those of the medical provider and seeing the discrepancy between begin to remedy cultural clashes.

HOW DO PHYSICIANS-IN-TRAINING BECOME CULTURALLY COMPET

The road to cultural competency is long, but here are some suggested ways Berlin and Fowkes suggest the LEARN model guidelines.¹⁹

Listen with sympathy and understanding to the patient's perception of the
Explain your perceptions of the problem and your strategy for treatment.
Acknowledge and discuss the differences and similarities between these pe
Recommend treatment while remembering the patient's cultural parameter
Negotiate agreement. It is important to understand the patient's explanatc that medical treatment fits in their cultural framework.

There are two medical, ethical barriers to culturally competent negotiation.: noted by the American College of Physicians, an ethical conundrum for prov "The physician cannot be required to violate fundamental personal values, s scientific or ethical practice, or the law."²⁰ Second, there must be no misus by providers and the medical treatment used therefore must be within the y cultural framework of the patient.²⁰ Because perspectives change, and "the 'do good' and 'avoid harm' can be interpreted differently,"²⁰ medical studen open their values to criticism and improvement.²⁰ In discussing the ethics c vs. Western ethics, Fadiman describes them not as one viewpoint being eth other non-ethical, but rather differently ethical.¹

In some cases, it may be impossible to resolve an ethical dilemma. For exa circumcision may be regarded as wrong by a western doctor while it is ofte imperative with some African tribes.²⁰ To resolve these cases, both provide must be regarded as having equally important ethical concerns in making d is reasonable to suppose that cultures that have provided the horizon of me large numbers of human beings of diverse characters and temperaments ov period of time. . . are almost certain to have something that deserves our a and respect. . . it would take a supreme arrogance to discount this possibi priori."²¹

SOME GUIDELINES FOR HOW TO USE AN INTERPRETER³³

1. Unless you are thoroughly effective and fluent in the target language, an interpreter.
2. Try to use an interpreter of the same sex as the client but avoid using members as interpreters.³²
3. Learn basic words and sentences in the target language; emphasize tone and speak slowly, not loudly.
4. Be patient. Careful interpretation often requires that long explanatory text be used.
5. Address the patient directly: do not direct commentary to or through an interpreter as if the patient did not exist.
6. Return to an issue if you suspect a problem and get a negative response; the interpreter knows what you want.
7. Provide instructions in LIST format and have patients repeat their understanding of the medical therapy.
8. Use short questions and comments; avoid technical terminology and jargon, like "workup."
9. Use language that the interpreter can handle; avoid abstractions, idiomatic expressions, similes and metaphors.
10. Plan what to say ahead of time. Do not confuse the interpreter by backtracking, rephrasing or hesitating.

10 TIPS FOR IMPROVING THE CAREGIVER/PATIENT RELATIONSHIP IN DIVERSE CULTURES ²²

1. Do not treat the patient in the same manner you would want to be treated. Culture determines the roles for polite, caring behavior and will form the patient's concept of a satisfactory relationship.
2. Begin by being more formal with patients who were born in another country. In most countries, a greater distance between caregiver and patient is maintained through the relationship. Except when treating children or very young patients, best to use the patient's last name when addressing him or her.
3. Do not be insulted if the patient fails to look you in the eye or ask questions for treatment. In many cultures, it is disrespectful to look directly at another person (especially one in authority) or to make someone "lose face" by asking questions.
4. Do not make any assumptions about the patient's ideas about the way to maintain health, the cause of illness or the means to prevent or cure illness. A line of questioning that will help determine some of the patient's concepts about health/illness/illness prevention.
5. Allow the patient to be open and honest. Do not discount beliefs that differ from Western biomedicine. Often, patients are afraid to tell Western caregivers they are visiting a folk healer or are taking an alternative medicine concurrently with Western treatment because in the past they have experienced negative results with Western treatment.
6. Do not discount the possible effects of beliefs in the supernatural on the patient's health. If the patient believes that the illness has been caused by *embrujado* (bewitchment), the evil eye, or punishment, the patient is unlikely to take any responsibility for his or her cure. Belief in the supernatural may lead to his or her failure to either follow medical advice or comply with the treatment plan.
7. Inquire indirectly about the patient's belief in the supernatural or use of nontraditional cures. Say something like, "Many of my patients from _____ do, or visit _____. Do you?"
8. Try to ascertain the value of involving the entire family in the treatment. In many cultures, medical decisions are made by the immediate family or the extended family. If the family can be involved in the decision-making process a

- treatment plan, there is a greater likelihood of gaining the patient's confidence with the course of treatment.
9. Be restrained in relating bad news or explaining in detail complications that result from a particular course of treatment. "The need to know" is an American trait. In many cultures, placing oneself in the doctor's hand is an act of trust and a desire to transfer the responsibility for treatment to the physician. Watch for and respect signs that the patient has learned as much as or she is able to deal with.
 10. Whenever possible, incorporate into the treatment plan the patient's traditional medication and folk beliefs that are not specifically contradicted. This encourages the patient to develop trust in the treatment and will help ensure the treatment plan is followed.

The Cultural Assessment

The cultural assessment is a tool to help providers understand where patients have their ideas about disease and illness. Assessments help to determine beliefs and practices that might have an effect on patient care and health behaviors. Although a completely accurate assessment currently is underdeveloped, there are several factors to consider when doing an assessment. They include²³:

- level of ethnic identity
- use of informal network and supportive institutions in the ethnic/cultural community
- values orientation
- language and communication process
- migration experience
- self concept and self esteem
- influence of religion/spirituality on the belief system and behavior patterns
- views and concerns about discrimination and institutional racism
- views about the role that ethnicity plays
- educational level and employment experiences
- habits, customs, beliefs
- importance and impact associated with physical characteristics
- cultural health beliefs and practices
- current socioeconomic status

LANGUAGE BARRIERS

Language often is cited as a barrier to health care. 12% of the U.S. population (approximately 20 million people) speak a language other than English. Physicians will inevitably encounter people with limited or no English proficiency. Both law (Title VI of the Civil Rights Act of 1964) and good medicine require that physicians make the best attempt at communicating with these patients. Furthermore, the federal government requires a health care provider who receives federal funding from the Department of Health and Human Services to communicate with patients effectively or risk losing that funding.

There are several strategies for working through a language barrier. Becoming bicultural/ bilingual provider should be the main goal, especially if medical professionals plan to work in an environment with a large population of non-English speaking patients, such as in states like California, Florida, New York and Texas.²⁷ Because this goal is not immediately accomplished, consider employee language banks. Language banks are an ad-hoc system that uses the bilingual skills of unofficial volunteer interpreters who happen to work in the hospital or clinic. Although they are sometimes the only option, language banks are fraught with many problems, including time strain on the employee's "real" duties. Unlike official interpreters, hospital and clinic employees are to be untrained and therefore may incorporate bias into their interpretation. Another option is the AT&T language line--a phone interpreter service that has inter-

more than 140 different languages.²⁴ Call (800) 752-0093 or check out <<http://www.att.com/language/line/>> for information. This service is offered subscription (frequent usage-about 20 minutes/month), membership (15 or more) or personal (incidental usage) interpretation and charges set-up and per-minute.

Ideally, a professional medical interpreter is the best choice. Medical interpreters take on a variety of roles, depending on the needs of the provider and the patient. Straight interpretation with no additions, omissions or rephrasing is the basic interpreter role. But in situations where there may be cultural misunderstandings, a knowledgeable interpreter can be a valuable "culture broker," someone who understands about the cultures of both provider and patient and explains when cultural differences that may cause confusion.²⁹ It is up to the provider, patient and interpreter to determine what kind of interpreter is needed. Ultimately, the provider should watch the interaction between the interpreter and the patient. The interpreter should always be completely attentive to the patient.

Though the expense of professional interpreters is often cited as an obstacle, organizations should think of the more expensive monetary and ethical consequences. Poor communication can lead to worse health or liability costs.²⁸ A provider in Washington, D.C., was sued for \$11 million when, due to miscommunication, an abortion was performed on a non-English speaking woman who only wanted contraception.³⁰

A special note on the use of family members, especially children, as interpreters: not only is this role stressful for a child, but adult patients may lie or be reluctant about sexual concerns or life-threatening illnesses when speaking through a family member. Family members, like ad-hoc interpreters, may incorporate bias into their interpretations. Also, there may be a disruption of family dynamics when a child is consulted for their adult family member's medical problems.²⁸

Finally, community members and traditional healers like shamans, curanderos, herbalists may be used to act as cultural brokers/interpreters. They are aware of cultural differences between provider and patient and most believe in Western medicine in adjunct with traditional methods. Also, patients are more likely to stick with a treatment plan that incorporates their beliefs.²⁸

There are, however, some clients who have limited English skills and an interpreter is not readily available. In this case, there are several things that providers can do to improve communication:

- Communicate thoughts in organized way
- Simplify the language
- If using preprinted pamphlets, underline or highlight important passages
- Print in longhand and use both upper and lower case letters (not all caps); do not use abbreviations
- Ask patients to repeat instructions
- Make the instructions relevant to the patient's life; for example, ask the patient when she expects to take her medicine (after breakfast, before feeding the children, after work, etc.)
- Invest in a small cassette recorder and blank tapes; record the diagnostic and advice while interacting with the patient. Let him or her have the tapes for a follow-up referral.³¹

CASE STUDIES

Case 1: Re-evaluating Ethics and Values from a Different Cultural Perspective

An adolescent, unmarried girl in Saudi Arabia was brought to a hospital for a spinal problem when her American doctors discovered that she was pregnant. The doctors, familiar with the gender expectations of young women, knew that pregnancy would bring great dishonor to the family and that punishment could lead to death for the girl. They arranged for her to have an abortion in a neighboring country. They told her parents that treatment for the spinal problem was only available in another country. A third doctor, who had only been in Saudi Arabia a short time, knew he could not be a part of this deception. The other two doctors urgently convinced the third doctor that the girl would be in serious danger if her pregnancy was revealed to her family. The third doctor reluctantly agreed to say nothing. At the last moment, the girl started to board the plane, the doctor uncontrollably felt he could not go along with what he felt was an ethical violation of truth-telling and told the father that the girl was pregnant. The father immediately grabbed the girl and left with her. Several days later, the third doctor ran into the girl's brother and asked about her condition. The brother shook his head and explained that the girl was dead. The family's honor had been restored. The distraught doctor left Saudi Arabia.³⁴

- What were the conflicting values about which the three physicians disagreed?
- Did the third doctor make a mistake by telling the family or was he justified in what he felt was ethically imperative?
- How might re-examining his ethics have helped the doctor make a better decision?
- As the physician, what would you have done? How would you justify your decision?

Case 2: Family Relationships, Truth-telling

Mrs. Lee was a 49-year-old Cantonese-speaking woman who had immigrated from China to the U.S. She lived with her husband and youngest son, Arnold. A medical history revealed that Mrs. Lee suffered from lung cancer that had metastasized to lymph nodes and adrenal glands. Arnold did not want Mrs. Lee's diagnosis to be told to her. Eventually, the cancer spread to her brain. Her physician, knowing her prognosis, suggested a DNR to her son, who refused to even discuss the possibility with his mother. Arnold felt that his role as son and family member meant he must protect his mother from "bad news" and loss of hope. He believed telling her the diagnosis would be cruel and cause unnecessary stress. Though futile, the son insisted that heroic methods be used, including a ventilator, to save his mother's life. He threatened the house staff and physician of racism and threatened litigation.³⁵ As a family member, Arnold considered himself, not the doctors or patient, responsible for his mother's death. He felt an overwhelming family responsibility to save his mother from such a "bad death" as well as from perceived inadequate treatment.³⁵

- Had you been the physician, what would you have done?
- Try and see Arnold's point of view. What might he have been thinking?
- How did cultural differences in the telling of bad news, treatment limitations, and the role of family differ between provider and patient?
- How did Mrs. Lee's age and her son's sense of responsibility to the family affect her care?
- What might have been some culturally competent options for the house staff and physician?
- How do the ethics of "informed consent" and autonomy fit into the case of Mrs. Lee and her family?

Case 3: Conflicts about Disability, Right to Refuse Treatment

A Hmong child was born with a clubfoot. Doctors felt that the foot would cause embarrassment and make ambulation difficult and recommended an operation to reshape the foot. The family believed that the foot was a blessing, a reward

ancestral hardships. Because the family believed "fixing" the foot would bring and punishment to the family and Hmong community, they refused treatment. The family went to the Supreme Court to defend their right to refuse treatment. won.¹⁵

- What do you think should have happened in the court case? Why?
- In this case, the operation did not involve life or death. But what if it

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