

# Cultural diversity in health care: Interpersonal and ethical considerations

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Patient demographics are changing, not only in Wisconsin<sup>1</sup> but throughout the Midwest and the entire United States. In the past, one talked about religious and racial diversity, but now the issues become more complex with cultural diversity. The ethnic or cultural diversity in Wisconsin has grown impressively. Diversity is no longer limited to “white American,” “African American,” or “Native American.” It now includes Asian, Eastern European, Sub-Saharan African, and Middle Eastern countries. Also, many states are experiencing considerable growth in their Latino populations.

This diversity not only leads to societal challenges, but also provides a very complex environment in dealing with the medical problems of people from many cultures and national origins. With all patients, the physician, nurse, or other caregiver has an ethical responsibility to respect the values, priorities, and customs of those entrusted to their care. What may be acceptable or even expected in one culture may be problematic in another.

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The issue is not simply one of an “American” caregiver dealing with a patient from another culture. It may be an American patient interacting with a physician, nurse, or other caregiver from another culture.

How do you deal with a physician from an autocratic, paternalistic culture who now practices in this country where autonomy is of paramount importance? Also, how do you get a recent immigrant to exercise his or her autonomy when they come from a paternalistic society?

Who is “more correct”—the physician from another country who was brought up with limited resources and consequently orders diagnostic testing very sparingly, or the American-trained physician who orders every conceivable high-tech study at the “drop of a hat”?

The situation can become even more problematic if the patient is from an alien culture and the caregiver is from a different alien culture, but both are interacting within American society.

Physicians are expected to know what is best for their patients, and empowering the patient or the patient’s family to exercise their autonomy in the medical decision-making progress may be perceived by the physician as failing his or her “institutional duty.”<sup>2</sup>

There are other transcultural issues that are potentially sensitive. One must consciously be aware of them, even if there are no simple,

easy answers. How do you disclose medical errors or adverse outcomes when dealing with various cultures? How will 2 people from different cultures or religious groups interact in the United States when they may be in conflict back in their native lands?

## **Cultural Diversity**

The medical encounter can be viewed on several different levels: the clinical, the interpersonal, the societal or cultural, and the ethical. One might also examine the religious aspects of a medical encounter. The religious aspect is very often influenced by cultural issues, or the ethical and religious considerations are so intertwined that it is difficult to separate them. (One religious aspect, however, that seems to be totally free of ethical considerations would be the refusal of blood or blood products by a Jehovah’s Witness.) Moreover, the encounter may have interactions on more than one level.

The effect of cultural issues influencing the clinical encounter can take many forms. A Hmong patient may refuse a cholecystectomy or any amputation because he wants to be buried intact with all his body parts. An Asian woman may not complain of menopausal “hot flashes” because of diminished perception, a reluctance to complain, or the undisclosed use of herbal remedies or phytoestrogens from soy products. A Chinese patient may be reluctant to say “no” to a question for fear of being dis-

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respectful to the physician.<sup>3</sup> The Chinese patient may not ask for pain medication. Rather than asking if the patient has pain, a more appropriate response might be, “May I get you something for pain?”<sup>3</sup>

Patients coming from a nation caught in civil strife may be suffering from Post Traumatic Stress Disorder. Also, in dealing with patients who have immigrated from another country, the physician or other caregiver must be sensitive to the fact that there may be, within classes of people, drug intolerances, infection (both usual and unusual), unique metabolic abnormalities, and iatrogenic effects resulting from self-treatment remedies.

Clinical decision-making can often be influenced by cultural values. Segun Gbadegesin writes on the Yoruba concept of *ikuyajesin*.<sup>4</sup> The Yoruba are a tribe in Nigeria. They feel that death is preferable to ridicule or loss of dignity. Gbadegesin uses this concept to explain why a woman might refuse a mastectomy for breast cancer because it would leave her without a breast, or why a paraplegic man would consider suicide.

Serving on a clinical ethics consult service, as well as having discussions with both ethicists and clinicians, has demonstrated to me the tremendous range of interpersonal relationships in the patient-physician encounter. A middle-aged Bosnian woman has cancer, but the son insists that he will determine what is disclosed to his mother. There is a comatose woman from Southeast Asia. The eldest son is not available. The youngest son is present but is uncomfortable asking questions or being assertive as the surrogate decision-maker. Finally, there is the elderly Jewish woman who is uncomfortable with the doctors and nurses dressed in white since they remind her of the concentration camp she was in as a child.

The physician needs to understand

and appreciate patients’ perspectives concerning their illness and what they want and expect in their treatment. Only then can you determine and set up a therapeutic goal that is in keeping with patients’ wishes and values, thus respecting their right of self-determination or autonomy. The patient may opt for conventional treatment, or may opt for conventional treatment combined with some form of alternative therapy, or may opt for no treatment at all.

### **Cultural Competence**

The ancient Greeks questioned whether virtue could be taught, or whether it needed to be inherently present in a person and simply be developed. Renee Fox raises the same issue with cultural competence. “It is commendable that the authors who address these attributes think of them as professional abilities that can be taught and implemented in clinical training, rather than primarily as virtues associated with moral character.”<sup>5</sup>

Trust is essential for a good doctor-patient relationship. Trust, however, is not infrequently lacking. Studies have demonstrated that African Americans were more likely than whites to report low trust in health care professionals.<sup>6</sup> One can only conjecture how much of an issue this might be with patients from other countries or cultures as well.

The concepts of beneficence, non-maleficence, autonomy, and justice are often considered the cornerstone of American bioethics.<sup>7</sup> Beneficence (i.e. to do good, help others, and contribute to their well-being) and non-maleficence (i.e. to not injure, harm, or wrong someone) are not unique to American clinical ethics. It would be hard to argue that there are cultures or societies where the physician routinely disregards the well-being of his patients.

Autonomy, on the other hand, does not have the same critical im-

portance or role in other cultures or nations that it does in the United States.

Autonomy does not simply involve the concept of self-determination, the right to accept or refuse treatment. It is also involves other issues such as disclosure and the degree of disclosure, privacy and confidentiality, and veracity or truthfulness. While veracity and honesty are of tremendous importance in American medicine today, veracity has traditionally been ignored by various codes of medical ethics. It was not until 1980 that the American Medical Association’s *Principles of Medical Ethics* recommended that physicians “deal honestly with patients and colleagues.”<sup>7</sup>

In American society, truthfulness and respect are very intimately connected. It is difficult to show true respect for a person while directly lying to them. Truthfulness is essential for informed consent. A patient has a right to the truth regarding diagnosis, prognosis, procedures, risks, alternative treatments, etc. Without this truthfulness, a patient could not make an informed decision and, thus, exercise his or her autonomy.

While truthfulness, disclosure, and self-determination are crucial in American medicine, other cultures may look upon things differently, and actually consider these elements harmful. The Chinese culture places tremendous importance on family and tradition. There is less emphasis on individual feelings. Family members, rather than the patient, may make the health care decisions, and might even withhold the truth for fear of worsening the patient’s condition.<sup>3</sup>

The family plays a central role in other Asian cultures as well. For example, in the Vietnamese culture, the eldest male is usually the family spokesman. In the United States, however, this role may be assumed by the person with the best command of

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English. Discussion with the patient or the family will usually clarify the identity of the family spokesperson. There may be, however, decisions left to the collective decision-making of the family members, rather than just 1 individual, such as removal of life support. Variability in Vietnamese religious practices may also affect how medical issues are addressed. Most Vietnamese are Buddhist, but others may be Catholic, Evangelical Protestant, or Chinese Confucian.<sup>8</sup>

Just as there may be considerable variability among Asian cultures, there may be considerable diversity among the various Latino cultures. Family involvement is very important, and family decision-making may be more important than individual autonomy. The Latino culture highly values respect. Consequently, older patients often prefer to be addressed formally, rather than by their first name.<sup>9</sup>

Cultural, religious, and ethical issues and values may all converge in the clinical setting. This seems to be especially true in dealing with patients from the Jewish and Islamic faiths. End of life choices and the Jewish law (Halacha) are addressed by Daniel Eisenberg, MD, who writes that “the Jewish person contemplating using a power of attorney may name their Rabbi to be their legal proxy, ensuring that any issues of Jewish law will be dealt with appropriately.”<sup>10</sup> While the tendency is to treat rather than withhold treatment, there is a prohibition about “touching a moribund patient (goses) who is estimated to have less than 3 days to live,” according to the code of Jewish Law.<sup>10</sup> This may therefore pose some difficulty in rendering comfort care to such a patient as he or she approaches death.

Addressing health care issues, especially end-of-life decisions, can be especially problematic in dealing with Islamic patients.<sup>11,12</sup> Apart from the fact that there are several different sects of Islam, many Islamic customs

are directed by national or cultural norms rather than by religious directives. Simple examples of this are the prohibition of women driving cars or the necessity for a woman to cover her face in public. These customs may apply to one Islamic country but not necessarily to others. While discussion with the patient or family is essential, in complex situations involvement of an Imam can prove invaluable. Modesty and touch are often critical issues in dealing with Muslim patients. Some Muslim women will want to remain covered during a physical exam. Other women will want a female physician to examine them. If the physician is a male, then the woman may very likely want her husband present during the exam.<sup>12</sup>

Attitudes about end-of-life decisions are not only necessarily different when comparing American attitudes with Asian or Middle Eastern, but, according to Rubulotta, may be surprisingly different from our Western European counterparts. Surveys have found “major differences in the behavior of clinicians practicing in northern versus southern European countries.”<sup>2</sup>

In dealing with transcultural issues, you must often strive for compromise and attempt to pursue a mutually agreeable treatment plan. Hopefully with this approach we can shift the discussion from paternalistic “compliance” to one of “adherence.”<sup>13</sup>

The bioethical concept of justice as it pertains to cultural diversity is more difficult to address compared to the other 3 principles of bioethics: beneficence, nonmaleficence, and autonomy.

According to Robert Veatch, justice can be looked at in 2 different ways, going all the way back to Aristotle. Justice in the broad sense is synonymous with “the right course of action.” Justice in the narrow sense refers to fairness in distribu-

tion.<sup>14</sup> While it is unlikely that anyone would argue against doing what is right for the patient, the concept of fairness in distribution is more problematic.

The public media and public discourse have focused on immigration, especially “illegal immigration,” and its strain on the health care system and health care resources in this country. The problem goes well beyond whether or not someone is “illegal.” What about the millions of uninsured or underinsured people who also happen to be “legal”? These problems necessitate that our country and government develop a comprehensive, rational, fair, and sustainable health care delivery system.

## Conclusion

How do you therefore deal with multicultural health care? While there is no easy solution, there are several steps that at least provide a starting point.

First of all, you need to be sensitive to the issue. If you are not aware of the issue, you cannot address it or deal with it. Expanding your knowledge base is helpful. This can be done by talking and interacting with people of different cultures. While books and journals are informative, the Internet is proving to be especially valuable in this area.<sup>3,8-12</sup> Educational sessions and lectures are helpful, but only if you attend. Through personal experience, I have found it both amazing and discouraging that even when a hospital or health care system offers a presentation on cultural diversity and health care, attendees consist of people from many different departments and services, but not physicians.

Of tremendous importance is an honest, respectful dialogue or communication with the patient and/or family members to develop a knowledge, sensitivity, and appreciation of their customs, values, hopes, perceptions, and expectations. This can

help establish trust, which in turn can hopefully improve health outcomes as well as patient satisfaction.<sup>6</sup> A meaningful discussion with a cleric, elder, or other respected member of the patient's community can also prove very helpful.

Cultural diversity in health care will continue to grow in the United States. Procrastination or denial will not make it disappear. The longer we wait to address the issue, the more difficult it will become.

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