Risk Management Program "Needs Assessment Survey" on Medical Mutual Web site

Let us know how we can better meet your educational needs! Medical Mutual's Risk Management Department is offering a needs assessment survey on our web site. This survey asks you to name the "top risk management concerns that you would like to see addressed through an educational activity" along with related questions in a brief, five-question format. Please take a few moments to give us your feedback so that we can design even better educational programs for you and your medical office staff.

Publication of Medical Mutual/Professionals Advocate®

DOCTORS Rx

Volume 13, No. 2 Spring 2005

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DOCTORS Rx

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A Letter from the Chair of the Board

Dear Colleague:

We are using this issue of the Doctor's Rx newsletter to focus on the increasing problems of conflict and misunderstanding that are often the result of behavioral differences from culture to culture that our patients represent. The goal is to assist you in understanding why people of different cultures believe and act the way they do, and how your understanding of these differences can assist you in getting your medical message across with an emphasis on providing quality patient care.

Sincerely,

D. Ted Lewers, M.D.
Chair of the Board
Medical Mutual Liability Insurance Society of Maryland

Culture and Medicine

Geri-Ann Galanti, Ph.D.[1]

Practicing medicine was difficult enough before the advent of HMOs, HIPAA regulations, and explosion of new techniques and pharmaceuticals. Add to that the challenge of treating patients from all over the world, and you have a recipe for stress overload. The aim of this article is to aid physicians in improving the quality of their care while reducing the frustration created by treating patients from a variety of cultural backgrounds.

Before discussing culture, it is essential to distinguish between *stereotypes* and *generalizations*. While generalizations can be extremely useful, stereotyping can have the opposite effect.

Stereotype vs. Generalization

The different between a stereotype and a generalization is not the information, but how the information is used. An example is the assumption that Mexicans have large families. If a patient, Mrs. Gonzalez is Mexican, and the physician thinks, "Mrs. Gonzalez is Mexican; she must have a large family," s/he is stereotyping her. But if one thinks, "Mexicans often have large families" and then *asks* Mrs. Gonzalez how many children she has, s/he is making a generalization.

Continued on next page

[1] Dr. Geri-Ann Galanti has over 20 years of experience lecturing to groups of doctors, nurses and managers on issues of cultural diversity and competency. She received her Ph.D. from UCLA with an emphasis in medical anthropology. She is currently on the faculty of the Division of Nursing at Cal State University, Dominguez Hills, the Doctoring Program at the UCLA School of Medicine, and the Anthropology Departmental CSU Los Angeles.

[2] Kleinman, A., L. Eisenberg, and B. Good (1978) Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. Annals of Internal Medicine 88: 258-58.

[3] Developed by Stuart Slavin, Alice Kuo and Geri-Ann Galanti for the UCLA Doctoring Program.

A stereotype is an ending point. No attempt is made to learn whether the individual in question fits the statement. Stereotyping patients can have negative results; while generalizations can help the physician avoid potential problems, as can be seen in the following case.

An Irish woman in her early sixties was hospitalized and scheduled for surgery at the end of the week. A generalization about the Irish is that they are typically stoic with regard to pain. Unfortunately, the patient's physician knew nothing about Irish culture, and stereotyped women as being very vocal with regard to pain. As a result, he did not take her complaints of pain as seriously as he should have. When he finally did operate, he discovered that the patient's condition had worsened to the point that she could not be saved and she died on the table.

The case was reported to me by the patient's daughter-in-law, a nurse, who firmly believed that had the physician not stereotyped her as a "loud woman," but rather verified with the family that the loud cries of pain were indeed unusual for this typical Irish woman, and urgently operated, he might have saved her. While ultimately it may not have made a difference in the outcome, physicians should always take complaints of pain seriously, and this is a case where an inaccurate stereotype may have contributed to a woman's death, while an accurate generalization might have saved her life.

How much does a physician need to know about various cultures in order to treat patients with cultural competence? The good news is not a lot. What is needed is an appreciation for the variation within and between cultures, and an attitude of *cultural relativism* (see below). While it is helpful to know some of the common patterns found among various ethnic groups, there's no need to memorize a list. There are several useful books and websites to consult when necessary. Concise references are available that include cultural profiles on multiple ethnic groups, including African Americans, Anglo Americans, Asians, East Indians, Hispanics, Middle Easterners, Native Americans, Russians, and Southeast Asians. Before treating a patient from a particular ethnic group, a physician can spend several minutes reviewing major cultural patterns that might be expected.

A realistic goal for physicians is to have an understanding of some of the dimensions along which cultures vary, and the insight and skill to ascertain which cultural beliefs, values, and practices are held by their patients. The most crucial thing to remember is not to stereotype. There's no guarantee your patients will behave according to the traditional rules of their culture, but knowledge of the rules is a good place to start.

Ethnocentrism and Cultural Relativism

An attitude of *cultural relativism* is crucial to providing culturally competent care. Cultural relativism is the notion that different peoples' ways of doing things may be different from your own, but equally valid. This is in contrast to *ethnocentrism* – the attitude that your culture's way of doing things is the right and natural way, and that all other ways are inferior. Ethnocentrism is the natural human response, but it leads to prejudice and discrimination. Cultural relativism will help the physician to accept the possibility that a patient may want to consult with family members before making a decision regarding their healthcare, or may value maintaining their modesty above treating their health, or may prefer not to know about a negative prognosis. Maintaining an attitude of cultural relativism may be more challenging when it comes to treatments, given that physicians are highly invested in biomedicine. However, if patients sense that the clinician has an ethnocentric attitude, they may be reluctant to discuss any complimentary or alternative treatments they may have been using. It is important for patients to trust their physician, in the very least because such trust will lead to greater compliance. This trust can be crucial in some cases, since patients may be using traditional remedies that can be harmful either alone or in conjunction with western medications. Azarcon, for example, a traditional Mexican remedy used for treating abdominal pains, has been reported to cause lead poisoning.

Doctors RX

Elizabeth A. Svoysky, J.D., *Editor*
Director of Risk Management Services

D. Ted Lewers, M.D., *Chair of the Board*
MEDICAL MUTUAL Liability Insurance Society of Maryland

Numbers you should know!

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Risk Management Seminar Info	ext. 223 or 225
Risk Management Questions	ext. 224
Main Fax	410-785-2631
Claims Department Fax	410-785-1670
Web Site	www.weinsuredocs.com

CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent twice each year to the insured physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) gain information on topics of particular importance to them as physicians,
2) assess the newsletter's value to them as practicing physicians, and
3) assess how this information may influence their own practices.

CME Objectives for Culture and Medicine

Educational Objectives: Participants should be able to:
1. Distinguish between a stereotype and a generalization.
2. Recognize cultural variations in family structure as it applies to decision-making.
3. Identify cultural variations in birth attendants.
4. Know how to deal with cultural variations in attitudes toward giving a patient a fatal diagnosis.
5. List three health beliefs and practices that can be misinterpreted by western healthcare practitioners.

	Strongly Agree				Strongly Disagree
Part I. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

_____

_____

_____

Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: _____ Date: _____

Part 4. Identifying Information: Please PRINT legibly or type the following:

Name: _____ Telephone Number: _____

Address: _____

_____

_____

_____

CME Test Questions

Instructions for CME Participation

CME Accreditation Statement — MEDICAL MUTUAL Liability Insurance Society, which is affiliated with Professionals Advocate, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. MEDICAL MUTUAL designates this educational activity for a maximum of one hour in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Instructions—to receive credit, please follow these instructions:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading:

   Med•Lantic Management Services, Inc. Fax: 410-785-2631
   225 International Circle
   P.O. Box 8016
   Hunt Valley, Maryland 21030
   Attention: Risk Management Services Dept.

3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the Doctors RX. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: ***????*** 7, 2005
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you. Please allow three weeks to receive your certificate.

1. Stereotyping patients can help the physician avoid potential problems in treatment.

   A. True B. False

2. Cultural Relativism is the notion that your culture's way of doing things is right and all other ways are wrong.

   A. True B. False

3. Ethnocentrism can lead to prejudice and discrimination and make patients reluctant to discuss alternative therapies.

   A. True B. False

4. In many cultures, the individual is not the primary "unit"; the family is; and, it is inappropriate to tell a patient bad news about their condition.

   A. True B. False

5. One way to provide culturally competent care is to focus on the patient's understanding of their disease.

   A. True B. False

6. Physicians should steer clear of incorporating traditional remedies into more culturally appropriate treatments.

   A. True B. False

7. Understanding the patient's point of view can help the physician deal with potential barriers to compliance.

   A. True B. False

8. Perhaps the most important thing a physician can do is to not treat patients from other cultures.

   A. True B. False

9. Anthropologist and psychiatrist Arthur Kleinman has developed a series of questions that can be useful for **all** patient encounters.

   A. True B. False

10. You can be guaranteed that most patients will behave according to the traditional rules of their culture.

    A. True B. False

Asking the Right Questions

Perhaps the most important thing a physician can do to provide culturally competent care is learn to ask the right questions. Arthur Kleinman, an anthropologist and psychiatrist, developed a list of eight questions which are useful in this regard.[2]

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you? How does it work?
4. How severe is your sickness? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

Another way to remember what to ask is to think of the 4 C's of Culture.[3]

1. What do you **call** your problem? This focuses on the patient's understanding of the disease. 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. For an excellent example of what can happen when caring, competent physicians do not understand the patient's perspective, see Anne Fadiman's 1997 book, *The Spirit Catches You and You Fall Down*. Understanding the patient's point of view can help the physician deal with potential barriers to compliance.

2. What do you think **causes** your problem? Not everyone believes that germs can cause disease. In some cultures, what is recognized in Western medicine as a bacterial or viral disease is thought to be caused by upset in body balance, breach of taboo (similar to what is seen in the U.S. as diseases due to "sin" and punished by God), or spirit possession. Treatment must be appropriate to the cause, or people will not perceive themselves as cured. Doctors thus need to find out what the patient believes caused the problem, and treat that as well. For example, it may sometimes be appropriate to bring in clergy to pray with them if they believe God is punishing them for some transgression.

3. How do you cope with your condition? This provides the physician 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 physicians learn to ask – in a non-judgmental way. Culturally competent physicians can also use this information to increase both trust and compliance, as illustrated in the following case:

> *When a clinician asked a diabetic Mexican patient what she had been taking to cope with her diabetes, she told him that she had been eating nopales to lower her blood sugar. The clinician observed that her blood sugar had indeed gone down, and asked her for more details. He learned that when she eats nopales with eggs at breakfast, she eats few tortillas. Substituting fiber for starch is good for her diabetic condition, so he congratulated her on increasing the fiber in her diet and for eating more vegetables. Rather than challenge her interpretation, he encouraged her to eat nopales and other non-starchy vegetables. In this way, he was able to incorporate traditional remedy into a culturally appropriate dietary plan for diabetes.*

4. What are your **concerns** regarding this problem? The treatment? This can lead you to any beliefs that may be interfering with compliance with prescribed treatment. 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 physician asks, however, s/he may not elicit such beliefs from the patient, who will simply not take their insulin. By asking, the physician can correct any misconceptions that can interfere with treatment.

Cross-cultural misunderstandings and conflicts can arise in many different areas and interfere with the provision of good health care.

Many examples of these are documented in the book, *Caring for Patients From Different Cultures*, 3rd *edition* and include the following:

Family/Gender Issues

The typical American family is small. Men and women are considered – at least theoretically – equal. The individual is the primary unit. This is in sharp contrast to most other cultures in which family size may be large, men are dominant over women, and the family is the primary unit. These variations become important in health care settings when it comes to decision-making. We expect individuals to make decisions for their own healthcare, or, if a child is the patient, that either parent will feel empowered to sign informed consent. Failure to realize that in many cultures men are dominant can lead to delay in obtaining consent for medical procedures. A traditional Mexican or Arab woman, for example, may want to wait until her husband arrives before signing consent for herself or her child. Culturally sensitive healthcare providers will offer the opportunity to involve the husband from the outset, and discuss the situation with the couple together. It would be advisable for physicians to make a regular practice of consulting with their patients in advance to find out whether they will want to make their own decisions regarding their care, or whether they prefer to have decisions made by the family (as in many Hispanic and Asian cultures), the husband (as in many Middle Eastern families), or the elder males of the family (as in Gypsy culture).

Gender issues can also affect health care. Modesty is important to most women, but may be particularly crucial in some cultures.

A forty-nine-year-old Mexican woman on hemodialysis with access in her upper thigh had bled from the access point on two separate occasions. Although it can be life threatening if not discovered immediately, she made no effort to stop the bleeding or call for help; she was more concerned about exposing herself. Once the nurses understood the importance of modesty to this patient, they learned to use more tape to hold the needed insertion, assess clotting times more carefully, and monitor her more closely to insure less blood loss. Had they known the importance of modesty in Mexican culture, and discussed possible contingencies with her, they might have avoided the problem in the first place.

Birth and Death

Most cultures have numerous rituals, customs and beliefs surrounding important stages of the life cycle. This is particularly true when it comes to birth and death. One example regards the appropriateness of potential labor partners during childbirth. In the United States, the husband is generally the preferred birth partner, but in most traditional cultures, that role is usually held by a female such as the woman's mother-in-law (Korean culture) or mother.

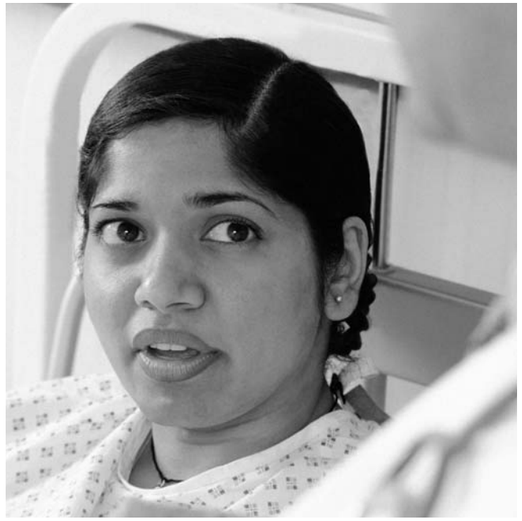
A woman who had recently moved to California from Mexico was five months pregnant when she began to bleed vaginally. Her mother and husband brought her to the emergency room, and it became clear that a premature delivery was inevitable. Labor lasted one and a half hours. During this time, she continuously cried out for her mother. The nursing staff brought her husband into the room to provide moral support, but she ignored him. He, in turn, sat in a chair a few feet from her bed with his back to her and stared out the door. She continued to cry for her mother.

While the outcome was not affected, the entire process – an already stressful one – was made even more difficult for both the patient and her husband. This could have been easily avoided if someone, knowing that Mexican women generally prefer their mother over their husband as a labor partner, had asked her whom she wanted in the labor room with her, rather than assume it would be her husband.

An area of increasing conflict is delivering the news of a fatal diagnosis. The usual practice in the U.S. is to inform the patient. This, however, is based on the American cultural belief (supported, if not demanded by HIPAA regulations), that the individual is the primary "unit" and has both the right and desire to know the details about their health. This is not a belief shared by many other cultures. In most traditional Asian, Hispanic, and Middle Eastern cultures, it is considered inappropriate to burden the patient with such depressing news. Many believe it will cause the patient to give up hope and die even sooner. Others believe that only God knows when someone will die, and always has the power to save that individual. Some Hmong would become very distressed by such a prognosis, believing that the only way someone would know you are going to die is that he is planning to kill you.

In most of these cultures, the individual is not the primary unit; the family is. Therefore, in these countries, it is usually the family who is informed of the diagnosis, and they make the decision whether or not to tell the patient. This may be consistent with the wishes of some patients, but not with others. The most important thing a physician can do is ask the patient – well in advance of need, if possible – to whom s/he would like information about his/her health be given, the patient or a designated family member. Washington State has passed legislation regarding the patient's right *not* to know. Physicians in other states should check with hospital legal advisors to be sure that they operate within the laws of their state.

The concept of not communicating key information to the patient is difficult for some Western-trained physicians. Keep in mind that the patient's well being is inextricably linked to their psychological well-being. Ignoring their cultural beliefs, such as their desire not to be informed about a dire, perhaps lethal diagnosis is not in line with a patient-centered focus and is, frankly, not a compassionate practice.



Health Beliefs and Practices

Many cultures have health beliefs and practices that can be misinterpreted by western healthcare practitioners. These can include such things as:

- Coining (practiced in some Asian cultures) and cupping (some Asian, Russian, Armenian, and Latin American cultures) which leave bruises and welts that can be misinterpreted as child or elder abuse;
- Avoidance of the number 4, which has the connotation of "death" in some Asian cultures;
- The belief that complimenting a child, without taking the appropriate measures, can cause a child to become ill (some Middle Eastern, Mediterranean, and Latin American cultures);
- The fear that souls reside in different parts of the body, and that removing them surgically can cause illness or death, and may doom them to be incomplete in the next incarnation (some Southeast Asian).

It is important that physicians are aware of such beliefs and practices in order to best serve their patients. They can learn about common cultural health beliefs and practices by reading or via websites devoted to culture and health care (see Resources below), or by simply asking patients the right questions.

Learning about culture and incorporating it into your practice can be challenging, but also fascinating. And the rewards can be tremendous.

Resources

Books

Fadiman, A. (1997) The Spirit Catches You and You Fall Down. New York: Farrar, Straus and Giroux. (Hmong)
Galanti, G. (2004) Cultural Sensitivity: A Guidebook for Physicians & Healthcare Professionals. Oak Park, IL: Doctors in Touch.
Galanti, Geri-Ann (2004) Caring for Patients From Different Cultures, 3rd edition. Philadelphia, University of Pennsylvania Press.
Gardenswartz, L. and A. Rowe (1998) Managing Diversity in Health Care. San Francisco: Jossey-Bass Publishers.
Gropper, R.C. (1996) Culture and the Clinical Encounter. Yarmouth, ME: Intercultural Press, Inc.

Websites

Cultural Diversity in Healthcare
http://ggalanti.com
Contains basic concepts, cultural profiles, case studies, links to other websites, recommended books, articles, and other information relevant to cultural diversity in health care. Information on workshops on cultural diversity is also included.
Note: all the websites listed below can be accessed directly from the "Related Links" page of this website.

The Provider's Guide to Quality & Culture
http://erc.msh.org/mainpage.cfm?file=1.0htm&module=provider&language=English
This comprehensive website is designed for clinicians to help them provide culturally competent healthcare. It contains an interesting "Quality & Culture Quiz," as well as information on several ethnic groups, along with links and other resources.

Cultural Competency in Medicine
http://www.amsa.org/programs/gpit/cultural.cfm
A teaching module produced by the American Medical Student Association, designed to help medical students become culturally competent. Suggests activities, provides brief case studies for individual or group learning experiences, definitions, criteria for culturally competent care, questions for physicians and patients, suggestions for using interpreters, and list of references.

EthnoMed Home Page
http://ethnomed.org/
Contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle, many of whom are refugees fleeing war-torn parts of the world.

Providing Culturally-Sensitive Health Care
http://offices.colgate.edu/alana-culturalcenter/communityservice/utica/default.htm
St. Elizabeth's Family Medicine Residency Program provides short bits of information on a variety of topics and ethnic groups to help physicians provide more culturally sensitive care.