

Diversity Dilemma



ILLUSTRATION BY SUSAN LEVAN

As the population in the United States becomes more diverse, providing culturally competent care presents challenges for physicians. How to overcome issues of language, trust, and time constraints.

When Alexander Green, MD walks into an exam room at his New York City medical practice, his patient may be an older Hmong woman who doesn't speak English, a man recently immigrated from Somalia, a Chinese American child or a Native American woman. In addition to treating the patient's physical problem, Green may be faced with a language barrier or cultural views about illness and medicine that may or may not be compatible with a standard treatment plan.

Physicians across the country face similar challenges. The population of the United States is growing increasingly diverse. According to Census Bureau statistics, as of March 2000, an estimated 28 million people in the U.S. had been born in foreign countries. Millions more are the American-born children of foreign-born residents. The face of newer residents is changing as well. Until 1970, most immigrants to the United States came from Europe. Since 1970, Asians and Latin Americans make up the largest segments

of the country's foreign-born population. These people bring with them different languages, religious beliefs, dietary practices, and different views of illness and medicine.

"Diversity is a blessing in our country, but it also raises tremendous difficulties in providing a high level of medical care," says Richard Kravitz, MD, the director of the center for health services research in primary care at the University of California Davis School of Medicine and Medical Center. Kravitz has been involved with several research projects related to caring for various cultural groups.

Defining cultural competency

Culturally sensitive, or culturally competent, care isn't limited to immigrants and those from other cultures. Within the native population of the United States, people come from a variety of backgrounds, with different practices and beliefs that may not always coincide with those of the physician treating them. Doctors must find ways to care effectively for these patients.

[Seattle's Cross Cultural Health Care Program](#), a community-based program established in 1992 to address the needs of an increasingly diverse population seeking access to health care, defines cultural competency as "the recognition and respect for differences among patients in terms of their values, expectations, and experiences with



PHOTO/ © 2002 NINA BARNETT

“In my teaching, I try to get doctors to recognize clues that the patient may have different beliefs and opinions...that the patient isn’t buying into the treatment.” —Alexander Green, MD, the associate director of the primary care residency program for Weill Cornell Medical Center of New York-Presbyterian Hospital.

health care, while at the same time recognizing the culture-based practices and dictates of organized medicine, and the values, expectations, and experiences of the providers who practice it.”

As associate director of the primary care residency program for [Weill Cornell Medical Center](#) of New York-

Presbyterian Hospital, Green is well acquainted with the challenges facing physicians who treat an increasingly diverse population. He’s designed a curriculum to address specific issues in cross-cultural care. “In my teaching, I try to get doctors to recognize clues that the patient may have different beliefs and opinions,” Green says. “I try

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to get doctors to think about what clues there might be that the patient isn’t buying into the treatment.”

Crossing language barriers

The most obvious barrier to providing care to people from different cultures is language. Where language barriers exist, they can seriously hamper the physician’s ability to deliver care. Kravitz participated in time and motion studies on a group of Spanish- and Russian-speaking patients at Sacramento-area primary care clinics. The study found that, on average, it took physicians 15 to 20 percent longer to see patients who didn’t speak English as their primary language. “It’s difficult to separate the effects of language and the effects of culture,” Kravitz says. “We think that language accounted for a substantial portion of the additional time.” For instance, it took longer for physicians to explain something as simple as how the patient should sit on the examination table. Time was also spent waiting for interpreters.

In addition, Kravitz’s study found that the non-English speaking patients were less likely to have the recommended follow-up lab work and that they did not comply with recommended treatments as well as English-speaking patients.

Interpreters, preferably trained to work in the medical field, can help overcome language barriers, but physicians may need to repeat instructions, ask more questions to make sure patients understand, and do more follow-up on these patients.

Developing trust

In addition to language barriers, physicians may face patients’ mistrust of physicians or the medical system.

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This mistrust may arise from patients' previous experiences with racism or prejudice or from unpleasant encounters with the medical system.

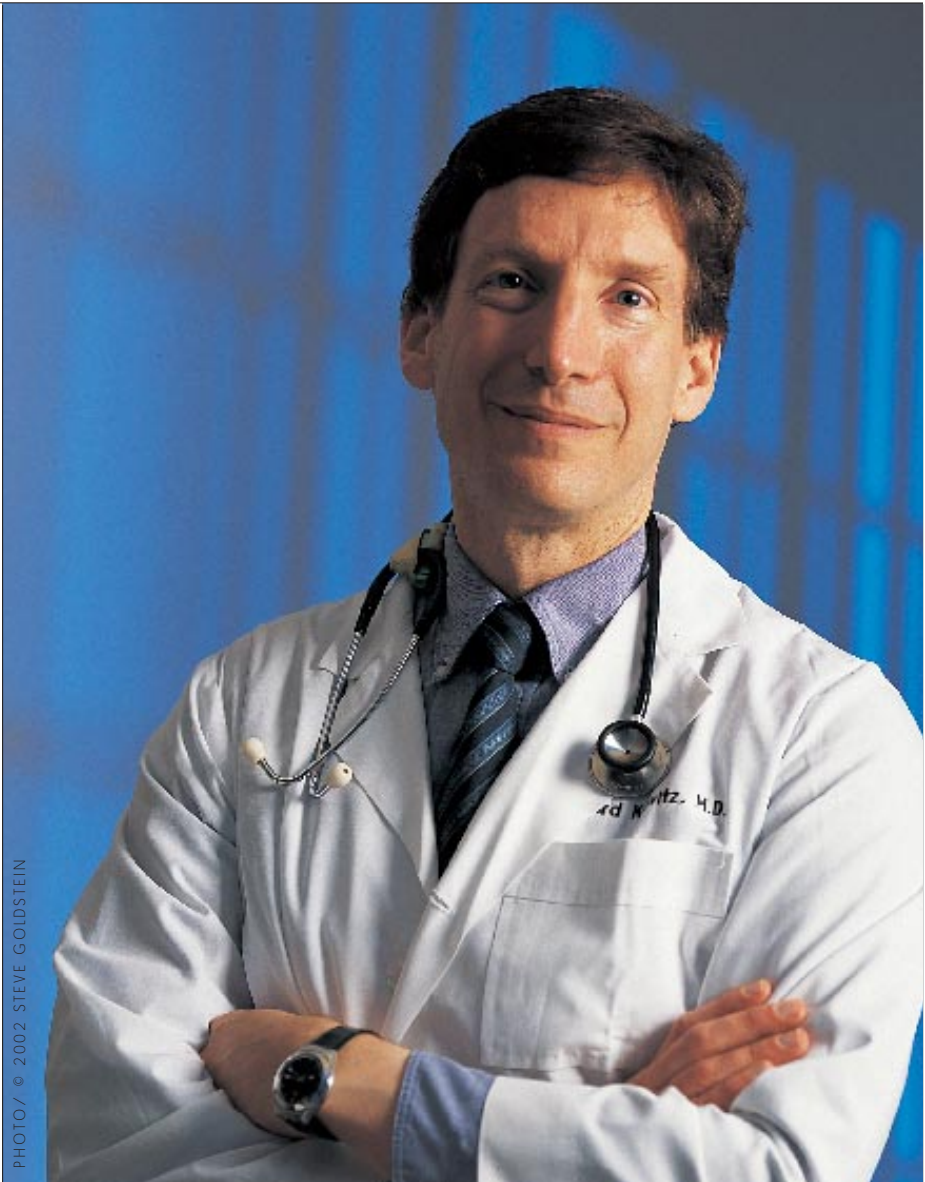
In a 1999 study of 134 African American, Hispanic, and white patients from primary care clinics in northern Florida, psychology professor Carolyn Tucker and graduate student Tyler Pedersen found the African American patients in particular did not trust the mostly-white medical system. "It was surprising how much African Americans still mistrust the white establishment," Pedersen says. "The study suggests that many African American men are very hesitant to even see a physician unless it is a dire emergency."

Asking questions and listening carefully can help win patients' trust. "You need to try to understand where that patient is coming from, and to do that takes the skill of humility," says Jorge A. Garcia, MD, with the division of general medicine at the University of California Davis Medical Center. "The notion of cultural humility is not making any assumptions and realizing there may be gaps in your knowledge and that there are things the individual can teach you."

Green advises doctors who sense mistrust to address the matter directly. "These things are important in the doctor-patient relationship in general," he says. "But when there's a tendency toward mistrust, as there can be in cross-cultural care, it's even more important that they be addressed."

Combating non-compliance

Non-compliance can be one sign that patients do not trust the physician. "Our research and earlier studies indicate that if patients don't feel comfortable with or trust their physicians, then



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they are not going to adhere to their medical regimens, which ultimately results in them being more likely to have medical problems," psychologist Tucker says. "That will cost more health-care dollars, which impacts all Americans."

One challenge of cultural competency training is learning to predict

such non-compliance. In many cultures, it's considered disrespectful to disagree with an authority figure like a doctor, so patients may say nothing, or do nothing, instead of openly disagreeing. "Patients have their own ideas about their illness, what it is and what caused it," Green says. "They sometimes feel that doctors

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throw medications at a problem and don't make an effort to understand the patient's perspective."

The key to overcoming this barrier is to look for clues about the patient's feelings, such as body language, and to ask the right questions. "Doctors can ask patients, 'What do you think this is?' but the patient might answer, 'You're the doctor, you tell me,'" Green says. "So the doctor can take the approach of 'I find my patients know their bodies and their symptoms best and many times they have a good sense of what is wrong. Knowing that can be helpful to me in making my diagnosis.'"

Dealing with ethical dilemmas

Understanding the patient's point of view and agreeing with it are two different things, however. A patient who believes that illness is caused by evil spirits may never accept the doctor's concept of germs and disease. Such culture clashes present tough ethical dilemmas for physicians. "The physician comes from one perspective, the patient comes from another perspective,"

Garcia says. "Whose values should supercede the other? Ideally, neither, but sometimes they're in conflict. How do you resolve the conflict?"

Green believes the answer is compromise, on both sides. "It's always a negotiation in any encounter between doctor and patient," he says. "But it's more striking when it's a cross-cultural

Tips for Fostering Cultural Competency

1 Show respect in interactions with patients.

Greet them when you enter the room and address them by title and surname. "Good morning, Mr. xxx." Make an effort to pronounce difficult names.

2 Introduce yourself. Be friendly, but not overly personal.

3 Welcome family members. In some cultures, family and community are expected to play a role in making important decisions. A patient may bring several family members to the office with her. Be prepared to include them in the discussion of the patient's condition. Elderly members of the group should be listened to and treated with respect.

4 Be alert to body language. If you sense the patient is uncomfortable or doesn't understand something, be prepared to stop and ask more questions. Do this even if the patient says he understands. Such agreement may be his way of showing respect and may not reflect true understanding.

5 Ask questions and pay attention to the answers. What does the patient feel is wrong with her? What does she believe causes this?

6 Address issues that are important to the patient. For example, a patient may present with knee pain, and upon exam, the doctor discovers this patient has uncontrolled diabetes, and has never had a mammogram, though certain factors place her at a higher risk for breast cancer. The physician's main concern may be controlling the diabetes and scheduling a mammogram, but the patient wants relief from the pain in her knee. Don't gloss over the patient's chief concern in favor of one you feel is more important.

7 Be willing to compromise. If a patient wants to try an herbal remedy in lieu of a prescription, agree to the trial if you see no immediate danger for the patient.

8 Offer a welcoming environment. If you see a number of patients from a particular cultural group, consider adding artwork and other decoration to your waiting room that they would find welcoming. If certain patients arrive with a number of family members, furnish one exam room with extra seating for them.

9 Be willing to listen and learn. "Just being open to a patient's way of looking at things and adjusting your attitude may be enough," says Alexander Green, MD, a New York City physician with a culturally diverse practice.

exchange. You can work toward getting the patient to understand your perspective, but you may have to give up something also."

Green gives the example of an Ethiopian man who comes into the clinic with a sprained ankle. The doctor prescribes Motrin for pain, but the patient would prefer to use a root paste

used in his country. Agreeing to the patient using the root paste shows respect for his culture while doing the patient no harm.

Another example might be a Native American patient whose family wanted to perform certain ceremonial rites in the hospital room. Though this might be outside of the hospital's general

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rules and regulations, allowing the ceremony to take place would help foster trust with the patient and family.

“Physicians get caught up in their way of doing things and don’t realize there are other ways of doing things that are important to patients and their families,” Garcia says.

But what about more serious issues—life and death decisions? In those cases, enlisting the aid of the community may help sway the patient toward seeing the doctor’s point of view. A respected member of the cultural community who is familiar with the American medical system may act as an intermediary.

Janet Dahlem, an assistant professor and the director of holistic health studies at the College of St. Catherine in St. Paul, Minnesota, teaches a course on “Culture as a Resource in Health and Healing.” She has found that working with elders in the various cultural communities in the St. Paul area pays big dividends for the medical professionals who treat patients from these cultural groups. Medical professionals in St. Paul hospitals seek out leaders from various cultural groups and ask them for advice on how to better serve members of their community. Medical personnel go into the community to speak at community centers, to meet people, and to learn more about the various cultures. This fosters trust and understanding, as well as forging links with community members.

If possible, physicians shouldn’t wait for an emergency to arise before discussing important ethical and medical issues with a patient. Garcia cited a situation that arose when he was a resident. One night he was confronted in the code room at the ER with an elderly Hmong woman. The only interpreter available was her 13-year-old grandson.

Garcia discovered that do not resuscitate orders had never been discussed with this woman and her family, though it was known she was seriously ill with cancer. “It seemed absurd to me that this had not been discussed before,” he recalled. “In the middle of the night in a life or death situation was not the time to try to explain the concept.”

Discussing such issues as blood transfusion with a patient scheduled for surgery can save misunderstanding and heartache on the part of everyone involved.

The costs of cultural competency Of course all this discussing and listening and negotiating takes time—time that’s at a premium for busy physicians. “Providing high-quality care to these patients goes beyond the cost of an interpreter,” Kravitz says. “It does take more time and resources. We feel the practitioners need sufficient support to compensate for their time and trouble.”

Few payers are willing to pay for even the cost of an interpreter, so physicians must juggle the need to devote adequate time to each patient with the demands of a full schedule and crowded waiting room.

“The provision of medical care even apart from cultural issues has gotten a lot more complex than it was 20 or 30 years ago,” Kravitz says. “The number of new diagnoses and new diagnostic tests has grown, and the expectations of physicians have grown, not only to diagnose and treat conditions, but also to provide preventative care as well as dealing with psycho-social issues such as domestic violence and other issues. This has created a very packed agenda for the physician-patient encounter.”

Is adding cultural sensitivity to the mix too much to ask? Some physicians

think so. “There’s a small subset of people that really don’t want to hear about this [cultural sensitivity],” Green says. “They don’t think doctors should have to deal with all this when they have so much else to deal with.”

Green says a culturally diverse patient population does not always require more time. “I have an extremely culturally diverse set of patients and what I find is that the more familiar you are with these concepts, and the more you integrate them into your general approach, the less burdensome they become,” he says. “They’re just a natural part of your interaction with patients. They can actually be time-saving, clearing up problems in the beginning that would waste time later. Also, you don’t do all things with all patients. You look for clues as to what issues you need to focus on: Is the patient mistrustful? Does the patient prefer alternative treatments? You bite off a little piece at a time.”

Cultural competency in practice If cultural competency is important, how can it be best implemented into medical practice? Some propose the idea of cultural concordance — physicians from various cultural backgrounds primarily treat patients from those backgrounds. For instance, Tucker and Pedersen’s study found that Hispanic patients preferred to see doctors who spoke Spanish, while African American patients felt more comfortable with African American physicians.

With physician shortages in some parts of the country, and few physicians from certain cultural backgrounds, this isn’t always a practical solution. Another approach is to train all physicians to deal with issues involved in

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treating a diverse patient population. Many medical schools and residency programs have added cultural competency courses.

For practicing physicians, help is available from some hospital systems, community programs, and even insurers. Kaiser Permanente has produced a series of handbooks about culturally competent care. The four current handbooks were authored and reviewed by experts representing internal medicine, pediatrics, obstetrics/gynecology, mental health and psychiatry, chemical dependency/addiction medicine, cardiology, gastroenterology, and gerontology. The handbooks provide information about cultural groups and major health concerns of four populations: Latino, African American, Asian and Pacific Island American, and Lesbian, Gay, and Transgendered people.

Various CME courses address cultural competency. For instance, the American Academy of Family Practice offers a clinical practice teaching module: "Quality Care for a Diverse Population" designed to help physicians provide the best care to patients from a variety of backgrounds.

In addition to training physicians to be more culturally competent, many people have suggested training patients as well. "I think we should do what we can to integrate people into our culture, teaching them English and maybe even offering courses on how the American health-care system works," Kravitz says.

Tucker and Pedersen's study of patients suggested that involving people from different cultures in medical research projects and providing more information about health care to minority populations empowered them to take a more active role in their own care.

And as Janet Dahlem's work in Minneapolis-St. Paul shows, involving cultural communities in local health care can help physicians provide more effective care while teaching members of the community how to work with physicians. "Many of the most innovative and effective interventions grow out of the communities themselves," Kravitz says. "I think we should encourage that."

Ultimately, each community's, each patient's, and each doctor's position is different. Danger lies in proposing 'one-size-fits-all solutions' or saying that all Asians should be dealt with a certain way and all Latinos in another way. Groups within these cultures vary widely and individuals within the groups more widely still. The best approach seems to be for physicians to be aware of potential challenges and to arm themselves with skills to deal with these challenges.

"It's a very unscientific process that frustrates some physicians," Garcia says. "This really is art, and clinical art is worth pursuing. But how do you teach something like curiosity about other cultures? You have to want to be culturally competent in the first place." ■

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