

Smith Seminars
AARC-Approved for 2 CRCE

Caring for Patients of Different Cultures

Objectives

1. Define culture, stereotype, and generalization of groups.
2. Identify the factors of prejudice and discrimination.
3. Define values, world view, and emic and etic.
4. Identify the concepts of ethnocentrism and cultural relativism, and time orientation.
5. List the beliefs of cultures about food, disease, and pain.
6. Define the cultural factors about staff relations, death and dying, mental health, folk medicine.

The health care system in the United States has been in a state of crisis for some time. An obvious problem is the cost and apportionment of medical care. A more subtle problem that is beginning to receive attention involves the cultural gap between the medical system and the huge number of ethnic minorities it serves.

The goal of the medical system is to provide optimal care for all patients. In a multiethnic society, this can be accomplished only if the health care providers understand such things as why Asian patients rarely ask for pain medication whereas patients from Mediterranean countries seem to need it for the slightest discomfort, why Middle Easterners will not allow a male physician to examine their women, and that coin rubbing is an Asian form of medical treatment, not a method of child abuse.

Cultural differences can create conflicts and misunderstandings and may result in inferior medical care. Some basic understanding of anthropological principles is required.

Culture

A basic working definition of culture is that it encompasses beliefs and behaviors that are learned and shared by members of a group.

A man I know removes his shoes when he enters the house. He has indoor shoes and outdoor shoes and will not wear one for the other. Is this a cultural trait or a personal idiosyncrasy? From the information given, it is impossible to tell. One must know his ethnic background. If he were Japanese, it would be a cultural trait. He is not. He is a white Anglo-Saxon Protestant from New York. Thus this trait is a personal idiosyncrasy. For behavior to be cultural, it must be learned and shared by members of a group.

Stereotype Versus Generalization

A stereotype and a generalization may appear similar, but they function very differently. An example is the assumption that Mexicans have large families. If I meet Rosa, a Mexican woman, and I say to myself, "Rosa is Mexican; she must have a large family," I am stereotyping her. But if I think Mexicans often have large families and wonder whether Rosa does, I am making a generalization.

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.

Lily was a forty-eight-year-old woman from the Middle East. She was in the county hospital to have surgery for gallstones. Sandy, a Mexican American nurse, was caring for her prior to surgery. Sandy cared for Lily for three nights and describes them as a nightmare. Lily did nothing but moan and groan and demand pain medication. She was on the call light continually. Sandy did her job but resented Lily's behavior. She chalked it up to Lily's ethnic background – Middle Easterners are often demanding and express their pain freely and loudly. She looked forward to Lily's surgery; at last, her gallstones would be removed and she could go home.

When Sandy returned to work a week later, she learned that Lily had not had gallstones after all. When the surgeons opened her up, they discovered that cancer had invaded her entire gastrointestinal system. She died on the operating table. Sandy's heart sank. She had stereotyped Lily as just another loud, complaining

Middle Easterner. It turned out that she had been moaning and groaning and requesting pain medication, not because she was Middle Eastern, but because she was riddled with cancer and in excruciating pain. It was an important lesson for Sandy about the dangers of stereotyping.

A generalization, on the other hand, is a beginning point. It indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual. Generalizations may be inaccurate when applied to specific individuals, but anthropologists do apply generalizations broadly, looking for common patterns, for beliefs and behaviors that are shared by the group. It is important to remember, however, that there are always differences between individuals.

Factors other than innate personality can cause individuals to deviate from the norm for their culture. These factors include the length of time they have spent in the United States, the age at which they came here, their desire to assimilate, whether they live in an ethnic community or an "American" one, whether they came from a rural or urban area, and their level of education. Social and economic class can be even more important than ethnic background. Middle-class Blacks, for example, often have more in common with middle-class Caucasians than with lower-class Blacks.

Individuals who have not assimilated to a great degree and whose beliefs and behaviors deviate from those expressed in the American health care system. It should not be inferred that all or even most members of these groups will act in the manner described. The ones who are Westernized do not generally present problems. It is those who adhere to traditional ways that are most likely to present problems. It should be remembered, however, that assimilation occurs in unpredictable stages. Individuals may be quite Westernized in some areas but traditional in others.

The term "Hispanic" or "Latino" includes people from such diverse cultures as Mexican, Puerto Rican, Argentinian, and Peruvian. "Asian" refers to people from a variety of countries, including China, Japan, Korea, Vietnam, Cambodia, and the Philippines. It is dangerous and inaccurate to think they are all alike. When I do make such generalizations, it is because there are some traits that are fairly consistent across cultures within the designated group. But never forget individual differences.

Also remember, when you come into contact with people from different cultures, it is often highly offensive to them to be labeled by the wrong country. Many are historical enemies. There is also a tremendous amount of prejudice and stereotyping within each larger culture area. A Chinese student shared that many Chinese think that Vietnamese have prominent cheekbones, Koreans have small eyes, and Japanese are short. These are all seen as characteristics that are inferior to those of the more "beautiful" Chinese. A Chinese person would likely be insulted if mistaken for a Korean, and vice versa. Ethnocentrism is universal, and stereotyping occurs even within ethnic groups.

Carla, a half-Mexican nurse, observed that in Mexico those with more European blood often feel superior to those with more Indian heritage. In addition, city people look down somewhat on rural people. It is an insult to call someone "provincial." Those from D.F. (Distrito Federal, Mexico City) feel superior to everyone. She, however, prided herself on being immune to all the hierarchical structuring; she firmly believed in the equality of all people.

One day Carla had a patient who was from Mexico. Carla assumed from Mrs. Arroyo's dark skin, black hair, and facial features that she was a Mexican Indian, probably with little education. Carla realized she would have to speak to her rather simply, to make sure that she understood. This was probably her first time in a hospital. She then asked the patient which part of Mexico she was from. Mrs. Arroyo looked Carla directly in the eyes and said, "I'm from D.F. And you?"

Carla, who had never realized her own inherent prejudices, was speechless for a moment. She replied, "My father is from Guanajuato." To which Mrs. Arroyo responded, "Yes, I thought as much. I can always spot you provincial people; you are very different."

There are some lessons to be learned from this incident. One is that most of us, even though we may consider ourselves free of prejudice, probably are not. Another is that even within the same culture, people

judge and stereotype each other. Finally, it is always a mistake to stereotype people on the basis of appearance.

Generalizations about large cultural groups such as Asians or Hispanics may be seen as a way of distinguishing broad geographical groupings from each other while recognizing that there are differences within them. Also, on occasion, the only ethnic identity given for a patient is Asian or Hispanic because more detailed information is not known.

Prejudice and Discrimination

An important related issue in today's world, given strained inter-ethnic relations, is that of prejudice and discrimination. The long history of slavery in this country, followed by Reconstruction and its aftermath, along with less institutionalized racism, has led many African Americans to distrust the health care system.

Mr. Harris, a sixty-eight-year-old Black male, was scheduled to have his cancerous prostate removed at a government hospital. Two days after scheduling the procedure, he called Karen, his nurse, in panic. He had spoken to several friends about his upcoming surgery, and now wanted to know about various forms of alternative treatments. Karen spent about an hour on the phone with him and gave him a great deal of information as well as phone numbers he could call to learn about other options. She realized that he was probably overwhelmed and frightened about his diagnosis.

Right before hanging up, Mr. Harris said, "You know I trust you, Karen; I just don't know if I trust the hospital to take care of me. I have older friends who were subjected to government studies without knowing it back in the '40s and '50s." Karen suddenly realized it wasn't just the cancer he feared, but what a white institution might do to him, a Black man. The experiments done with syphilitic Black men who were left untreated in order to study the course of the disease are infamous.

It is no wonder that many African Americans are distrustful of hospitals – and white institutions in general. Prejudice and discrimination are real. Not surprisingly, if you have been a frequent victim of discrimination, you are likely to come to expect it, even, when it is not there. Prejudice and discrimination do exist. Unless one has had the experience of being stopped by the police simply for driving a nice car in a good neighborhood, or been asked by a white salesperson, "Are you sure you can afford it?" when buying a high ticket item, it is difficult to understand what it is like to be the recipient of racial prejudice. We are all individuals and want to be treated as such, but, unfortunately, minorities are often judged simply on the color of their skin.

At the same time, however, years of discrimination may have led some individuals to be acutely sensitive and to perceive prejudice when it does not exist. Health care providers should be aware of this and do what they can to ensure that their words and actions do not unintentionally hurt their patients.

Values

Values are the things we hold as important. Just as each individual holds certain values, each culture promotes different ones. American culture (although there are literally hundreds of subcultures within the United States) currently values such things as money, freedom, independence, privacy, health and fitness, and physical appearance.

In the United States, independence is manifested by the desire to move away from home as soon as one is financially able. In many cultures that value family, more than independence, adult children rarely move out before marriage and often not thereafter. The health care culture also supports the values of independence and autonomy in its efforts to teach self-care and in often giving information only to the patient, excluding other family members.

Privacy is also very important to most Americans, who build fences to separate their houses from each other. The U.S. health care culture tries to provide privacy for patients by limiting visiting hours and offering no sleeping accommodations for visitors. Many non-Anglo patients, however, prefer just the opposite.

Health and fitness are popular movements, particularly on the West Coast. There are hundreds of food products labeled "low fat" and "low cholesterol." People can be seen jogging on most city streets, and attendance at gyms is high. This obsession with health leads the medical profession to expect patients to comply with suggestions regarding changes in diet and exercise, assuming that health and fitness is a value shared by all. It is not. Furthermore, what is considered "healthy" varies cross-culturally.

Concern for physical appearance is manifested at every magazine stand. There are few women's magazines that do not have articles on the latest diet, makeup, hairdo, and clothing. The incidence of cosmetic surgery for both men and women is at a record high. Surgical techniques are developed to minimize scarring and maintain beauty. What is considered "beautiful," however, is not the same for every culture.

Understanding people's values is the key to understanding their behavior, for our behavior generally reflects our values. A dramatic example occurred in the early 1980s, when a Japanese ship captain was bringing a boatload of cars to the United States. There was a disaster at sea, and the cargo was ruined. The captain had done nothing to cause the disaster, and he could not have prevented it. If an American ship captain had had a similar experience, the first thing he probably would have done when he reached land was call his insurance agent to see who would pay for the damages. The Japanese captain killed himself.

There is obviously a big difference between calling one's insurance agent and killing oneself. The different reactions are dictated by different values. The hypothetical American captain would probably value money, his concern would be for the financial loss. The Japanese captain was concerned with his honor. As the captain of the ship, he considered himself responsible for the accident. The loss of the cargo meant the loss of his honor. Without honor, he felt he could not live. Committing ritual suicide was the only way for him to regain his honor.

Values influence our everyday behavior as well. Nearly everything we do reflects our values on some level.

Values and the American Health Care Culture

One reason for so many conflicts and misunderstandings in hospitals is the great disjunction between the values of the health care culture and that of the patient population.

The health care culture values autonomy and independence. Patients often value the family over the individual, and prefer to make decisions as a group and to assist the patient in "self-care" functions the staff thinks the patient should do on his or her own. Many prefer to have family members with them at all times, leading to chaos and loss of control from the perspective of the health care provider.

The health care culture's value of efficiency often conflicts with patients' value of modesty. Many health care providers find concern about keeping patients covered difficult when their primary focus is performing an appropriate procedure. The health care culture also values self-control. Many patients, however, come from cultures in which emotional expressiveness is the norm. This can lead to resentment toward such patients on the part of the staff.

Problems also result from a disparity between the world view of the health care culture and that of the patient population.

World View

The second most important concept for understanding people's behavior is to understand their world view. People's world view consists of their basic assumptions about the nature of reality. These become the foundation for all actions and interpretations. Religion largely defines the world view of people who are devoutly religious. Belief in the existence of God, for example, might be part of their world view. If people believe God confers both health and illness, it may be very difficult to get them to take certain medications or change their health behavior. They might not share the health care culture's belief that germs cause disease and that diet and exercise contribute to one's health. They would see no point worrying about high blood pressure or bacteria when moral behavior is the key to good health.

Since people's world view consists of their assumptions about the nature of reality, they rarely question the veracity of their beliefs. For example, would a devout Christian conclude that God does not exist on the basis of the accidental slaughter of innocent children? Probably not, rather, the Christian might see it as further proof that "God works in mysterious ways." No matter how much "evidence" is presented to the contrary, people rarely change or even question their world view. Instead, they reinterpret events in a manner consistent with their beliefs.

Emic and Etic

The terms "emic" and "etic," derived from linguistics and rarely used in ordinary life, are extremely important in anthropology. They refer to perspectives. Emic perspectives are the insiders' perspectives, natives' views of their own behavior. Etic perspectives are those of outsiders. These two simply represent different vantage points, and knowing both helps provide a more complete picture, a fact which caregivers would do well to remember when treating patients from different cultures. Try to understand their perspective on their condition, as well as your own.

People's Relationship to Nature

Another aspect of world view involves people's relationship to nature. American culture, for example, believes people can control nature. If the land is dry, they irrigate. If the disease is caused by bacteria, they destroy the bacteria. If the heart does not work, they replace it. This also relates to the health care culture's view of the body as a machine; if it becomes broken, one should quietly turn it over to the mechanics, health care providers, to be fixed. To the consternation of many health care professionals, not all cultures share that belief.

Other cultures, such as Asian and Native American, see people as a part of nature. They strive to maintain harmony with the earth, and look to the land to provide treatment for disease. Herbal remedies are important in their cultures. Still other cultures, such as Hispanic, believe people have little or no control over natural forces. *Que será, será*, Preventive health care measures are likely to be ignored. They would do no good anyway. What will be, will be. Thus world view can have important implications for health-related behavior.

Ethnocentrism and Cultural Relativism

Two key anthropological concepts are ethnocentrism and cultural relativism. They refer to attitudes. Ethnocentrism is the view that one's culture's way of doing things is the right and natural way. All other ways are inferior, unnatural, perhaps, even barbaric. Cultural relativism is the attitude that other ways of doing things are different but equally valid. It tries to understand the behavior in its cultural context. Most humans are ethnocentric. It is natural to think one's own culture's way is best. Anthropologists, however, strive to be culturally relativistic.

If I were to tell most Americans about a group of people in Africa who sometimes kill healthy newborn infants, they would probably take the ethnocentric attitude that these people were barbarians. If I were to explain that they were hunters and gatherers living on the edge of starvation and that if a second child is born too close to the first, chances are about 100 percent that both will die because the mother does not have enough milk to support both, their attitude might change. They still might not condone infanticide, but they might understand it as the only viable choice in a desperate situation. Rather than seeing the Africans as barbarians, they might realize that the people were forced to extreme measures by hopeless circumstances. Their attitude would thus change from being ethnocentric to culturally relativistic.

The Western health care system tends to be ethnocentric because practitioners believe that their approaches to healing are superior to all others. There is a lot we can learn, however, from other cultures. Many modern drugs, including quinine, were derived from plants used by native peoples. Westerners are beginning to acknowledge the effectiveness of acupuncture for certain conditions. The goal of all systems of healing is the same – to help people get well. If all cultures could study each other's techniques with a culturally relativistic perspective, the cause of modern medicine would be greatly advanced.

Time Orientation

Time orientation, one's focus regarding time, varies in different cultures. No individual or culture will look exclusively to the past, present, or future, but most will tend to emphasize one over the others. Chinese, British, and Austrian cultures have a past orientation. They are traditional and believe in doing things the way they have always been done. Interestingly, in many cases, countries that emphasize the past are ones

that were once more powerful than they are now. This may be their way of recognizing and valuing that time in their history. These cultures usually prefer traditional approaches to healing rather than accepting each new procedure or medication that comes out.

People with a predominantly present time orientation may also be less likely to utilize preventive health measures. They reason that there is no point taking a pill for hypertension when they feel fine, especially if the pill is expensive and inconveniently causes unpleasant side effects. They do not look ahead in hope of preventing a stroke or heart attack, or they may feel they will deal with it when it happens. Poverty often forces people into a present time orientation. They are not likely to make plans for the future when they are concerned with surviving today.

Middle-class white American culture tends to be future oriented. That is reflected in the medical system's stress on preventive medicine and enthusiasm for each new medical technique or drug. In contrast to past-oriented cultures, progress and change are highly valued. China is also shifting to a future orientation, as evidenced by the long-term plan to reduce the country's population by limiting family size.

Hispanics and African Americans tend to have a present time orientation. This does not mean that they do not recognize the past or the future, but living in the present is more important to them. Their concept of the future may also be different from the Anglo concept. For example, African Americans are more likely to say "I'll see you" than "I'll see you tomorrow." The former implies the future but is not specific. The future arrives in its own time. From this point of view, one cannot be late. Conflict may occur, however, in interactions with white middle-class people, for whom time is very specific.

Time orientation appears to be related to subsistence economy. In countries with economies based on agriculture, people tend to be more relaxed about time; "The crops don't care what time they get picked." Many people in traditional agricultural villages do not own clocks; the pace is slower and more attuned to nature's rhythms. In contrast, industrialized nations must pay attention to clock time. There are large numbers of people to organize, and each must complete his or her task according to schedule in order for the next person to begin. Without clocks, chaos would reign.

Hierarchical Versus Egalitarian Cultures

Just as cultures differ in time orientation, they also vary in social structure. American culture is organized according to an egalitarian model. Theoretically, everyone is equal. Status and power are dependent on an individual's personal qualities rather than age, sex, family, occupation, or any other characteristic. In reality, things may operate differently, but we hold equality as our ideal. Some cultures such as Asian are based on a hierarchical model. Everyone is not equal. Status is based on such characteristics as age, sex, and occupation. Status differences are seen as important and people of higher status command respect. Social structure, then, can have an important influence on the way people interact.

Family of Orientation Versus Family of Procreation

During the course of their lives, many people are members of two different family groups – the family they are born into and the one they create through marriage and children. Anthropologists distinguish the two as "family of orientation" and "family of procreation." The family of orientation is the one a person is born into, the one to which one first orients oneself. It includes the individual, parents, brothers and sisters, and any other household members. The family of procreation is the one formed through marrying and procreating. It includes the individual, spouse, and children. Some cultures, particularly those in which the married couple continues to reside with the parents of the bride or groom, emphasize the family of orientation. Other cultures emphasize the family of procreation. Americans tend to set up their own nuclear family households, and that family takes precedence over all others.

Disease Etiology

Most Americans believe that germs cause disease. Not all cultures share that belief, however. Other causes of disease include upset in body balance; soul loss, soul theft, and spirit possession; breach of taboo; and object intrusion. Treatment for diseases resulting from such etiologies must vary to be appropriate to the cause.

Upset in body balance is a notion that appears to have originated in China and spread from there to influence beliefs in Asia, India, Spain, and Latin America. It refers to the belief that a healthy body is in a state of balance. When it gets out of balance illness is the results. In Asia, the balance is between yin and yang. All things in the universe are primarily either yin or yang, including diseases, which may result from excess yin, excess yang, deficient yin, or deficient yang. Yin and yang are generally translated as hot (yang) and cold (yin), although these refer to qualities, not temperatures. For example, we perceive chili peppers as hot, even if they have been refrigerated.

The balance between hot and cold can be upset by a number of factors, including an improper balance of foods and strong emotional states. The goal of treatment is to restore balance to the system. This is generally accomplished through the use of foods (for example, cold foods should be eaten to cure a hot illness), herbs, or other treatments. To prevent disease, one should avoid extremes, such as ice water. Diet is exceedingly important. Dietary staples such as rice are generally thought to be neutral, a fortunate and practical designation.

Foods that are hot in one culture may be cold in another, so it is difficult to make up a comprehensive list. Patients' beliefs in hot and cold qualities can generally be ascertained only by observing their behavior. If they refuse certain foods or medications, it may be that an illness they perceive as hot is being treated with a hot food or medication. Offering other foods or liquids to take with the pill to "neutralize" it may solve the problem. If they will not take the pill with ice water, they might take it with hot tea, orange juice, or hot chocolate.

Although the importance of maintaining a balance between hot and cold is not recognized in Western medicine, there is a growing recognition that stress plays an important role in affecting the immune system's ability to fight disease. Stress represents a kind of imbalance. Recent studies indicate that a person's emotional state may also have a significant influence on the immune system. Thus, though the words we use are different, body balance is a notion to which we should be able to relate.

Paradoxically, China is moving away from traditional medicine in favor of Western medicine, while there is increasing interest in the United States in traditional Chinese healing practices. In the concept of yin and yang with germ theory, it is explained that when yin and yang are out of balance, germs can cause disease. This is nearly identical to the Western notion of the relationship between stress and disease.

Soul loss, along with related soul theft, is another category of disease etiology. The concept is self-explanatory. The soul has either left the body on its own or been stolen, leaving the body in a weakened and ill state. The goal of treatment is to return the soul to the body. It usually requires a specialist, such as a shaman, who can "leave" his or her own body to search for and return the missing soul. Although Western medicine lacks a similar etiological category, catatonic schizophrenics can be described metaphorically as bodies with "no one home."

Spirit possession involves the taking over of the victim's body by a spirit being. The victim usually acts in ways that are inappropriate for him or her. In some cultures, this may give the victim a form of power. It is generally the poor, the oppressed, and minorities who become "possessed." For example, in Ethiopia, women may become possessed by powerful "Zar" spirits. When this occurs, their husbands must treat them with unaccustomed kindness and respect, for they are no longer dealing with their wives but with powerful Zars. The negative side of possession by a Zar is that the woman is thought to be crazy and must seek help through a Zar cult. Exorcism is the treatment for spirit possession.

The next etiological category is breach of taboo, which means doing something forbidden, whether it is eating food cooked by a menstruating woman, speaking directly to one's mother-in-law, or, among some Christian sects, having extramarital or homosexual relations. Disease is the punishment meted out by a supernatural force such as God. Treatment involves penance and atonement.

The final major category is of object intrusion. It refers to the condition in which a magical foreign object enters the body and causes the individual to become ill. Treatment involves removing the object. In most cases, a shaman will suck it out from the afflicted part of the patient's body. The shaman then produces the

offending object. Upon analysis, the object often turns out to be bits of hair, animal parts, teeth, or plant material, mixed with blood from the shaman's mouth. One shaman, accused by an anthropologist of practicing legerdemain, freely admitted to secreting the object in his mouth prior to sucking it out of the patient's body. He explained that the real object he removed was invisible, but that it was important for the patient to see something tangible, so he practiced a bit of sleight of hand (or mouth) for the patient's psychological benefit.

Two important points should be made regarding disease etiology. First, the treatment must be appropriate to the cause. If germs cause disease, kill the germs. If the body is out of balance, restore balance. If the soul is gone, retrieve it. If a spirit has taken over the body, exorcise it. If a rule has been violated, do penance. If an object has entered the body, remove it. All these remedies are perfectly logical. Whether these etiologies are the true causes of the disease is irrelevant. A patient who believes he or she is ill because of soul loss will not be cured by any amount of antibiotics. The mind is very powerful, as the placebo effect demonstrates. The patient's beliefs, as well as body, must be treated. Many Americans feel they have not been treated properly if they do not receive an antibiotic for a virus, even though antibiotics are effective only against bacteria. Psychologically, they need the pill to get well.

Second, we must not let our ethnocentrism blind us to the merits in the beliefs of other cultures. They may be right. It is easy to look down on other systems, citing science to support Western medical beliefs. But all medical systems are based on observed cause-and-effect relationships. The major difference with the scientific approach is that science is falsifiable. A scientific hypothesis can be proven wrong. The beliefs of other systems cannot.

At the level of the individual, however, Americans demand no more proof than do people of any other culture. Most believe germs cause disease because their mothers told them so. Few have ever actually seen a germ, and fewer demand to see proof of viruses or bacteria at work. The experts have done that, and their word, along with our mothers', is enough. The same is true in other cultures. People believe disease is caused by spirit possession or object intrusion because their mothers and cultural experts told them so. They have seen people become ill when that happens and get well when treated. What further proof is necessary?

Theoretical Perspective

The underlying theoretical perspective is based upon adaptation theory. In most cases, people have developed traditions designed to achieve success in the broader environment in which they live. This includes adaptations to both the physical and social environment. Obviously, there are exceptions, and there are other theoretical approaches which are equally fruitful in explaining people's behavior. When cultural conflicts occur, it is often because what is successful under one set of environmental circumstances may be less so under others.

Cultural Customs

Utilizing adaptation theory, it can be argued that most cultural practices originate for very practical reasons. People, however, do not always act in a practical manner if the benefit to them is not obvious and immediate. They may need a "higher" purpose. Ideological injunctions are much more likely to be followed.

For example, the Hindu prohibition against killing cows may seem bizarre in a country where most people are starving, but it has a practical basis. Most cows are malnourished and if slaughtered would provide very little food. Living, however, cows are good substitutes for tractors. Their milk provides food. Their dung provides fertilizer, fuel for cooking, and, mixed with water, an excellent household flooring material. Far more use is made of living cows than could ever be gained from dead ones. Hungry individuals, however, might look at a cow and see dinner. Forgetting the animal's other practical uses they might kill and eat it. But if the animal is made sacred, religious ideology will prevent such killing.

Circumstances sometimes change, obliterating the practical need for a custom. Ideology, however, is enduring and soon becomes tradition. Although many cultural and religious traditions no longer have any practical value, they have an important psychological one, they provide a sense of identity and belonging. They serve as a strong reminder that the individual is not like everyone else; he or she belongs to a special group. Abstaining from meat when everyone else is having hamburgers reminds the Hindu that he is

Hindu. Walking to temple instead of driving on the Sabbath reminds the Jew that she is Jewish. The more difficult or impractical the custom is, the stronger the reminder of ethnic or religious identity. Thus the benefits of adhering to seemingly outmoded customs can be enormous in a country like the United States, where feelings of isolation and anomie may be strong.

One of the issues that often arise is that of ethics. Why should the Western health care system adapt to the needs of other cultural groups? We hear complaints such as, "Why don't they adapt to our ways?" "Why don't they learn to speak English? My grandparents did." Certainly, hospitals in most other countries are not nearly so accommodating to patients of other cultures.

One response is to say, yes, they should adapt to our culture and learn our language. That is not, however, the most compassionate or practical response. It is the goal of the medical profession to provide optimal health care for all patients. Unless cultural differences are taken into account, this goal cannot be accomplished. Misunderstandings can sometimes lead to misdiagnoses, as in the case of coin rubbing. Danger signals may be overlooked with a stoic Irish or Japanese patient.

The most important underlying message is that cultural behavior is generally a result of adaptation to both the physical and the social environment. Different countries have different conditions, different weather, population size, vegetation, political circumstances, economic bases, and so forth. Cultures develop norms, values, and behaviors that are suited to these conditions. Over time, they take on the strength of tradition. Even when circumstances change, traditions often do not.

We are socialized by our culture at an early age. Early conditioning is very hard to overcome. Even when we move to a new country, where the customs and values are different, it is hard to change, even under the best of circumstances. Illness, particularly illness that requires hospitalization, is far from the best of circumstances. On the contrary, it is the very time when we are most likely to regress and behave in ways that were reinforced in childhood.

Certainly it is best for people to speak the language of the country in which they are living. Unfortunately, many immigrants to this country work long hours every day at physical labor. They are often too tired at night to attend English classes. Furthermore, they tend to live in ethnic communities where everyone speaks their native language, and thus they have no pressing need to learn English. Finally, not everyone has an equal facility with language. English is difficult to learn. The rules are far more irregular than in the Romance languages such as Spanish. It is much easier for children to learn new languages, perhaps because they are not so inhibited or afraid to make mistakes as adults are. For many people, the idea of learning a difficult new language may be overwhelming. So though ideally everyone in the United States should speak English, many do not. Does that mean they should receive inferior care?

Whether patients should speak English and adapt to our ways is irrelevant. The fact is that they do not and may not. The options are to provide inferior medical care (and experience high levels of stress resulting from frustration) or to make accommodations so as to provide optimal care (while at the same time reducing stress and frustration).

Some of the most common or difficult problems that occur in hospitals are a result of cultural differences. In some instances, knowledge can prevent problems from occurring, as in the case of dietary taboos or preferences. In other cases, merely understanding why patients act the way they do may help hospital personnel be more compassionate and experience less frustration. Although at times it may appear that a patient's sole goal is to make things difficult for health care providers, this is rarely the case. The patients are merely behaving in ways they were taught were appropriate or that were successful at other times in their lives.

Racism, discrimination, and prejudice are a sad reality of modern life. They usually result from stereotyping, from seeing people as members of a group, rather than as individuals. Don't perpetuate this mistake. Be sensitive to feelings of perceived racism among minority group members. As a result of years of slavery and discrimination, Blacks, for example, may be sensitive even to unintentional threats to their self-esteem.

Communication and Time Orientation

Idioms should be avoided whenever possible. Also remember that all English is not the same. The same words may have different meanings in different English-speaking countries, for example "fanny" and "fag" (the latter is a cigarette in England). The identity of the speaker is also important. A Black person may refer to a Black man as a "boy," but it would be very inappropriate for a Caucasian to do so.

A patient should be referred to as Mr., Mrs., Miss, or Ms. unless told by the patient to do otherwise. People suffer tremendous loss of dignity when they become patients; it is important not to add unnecessarily to this loss.

Remember that "yes" may not always mean the affirmative; for an Asian, it may be a way of avoiding the embarrassment of saying "no." Or, it may be the grammatically correct but misleading answer to a negative question, as in, "Haven't you taken your medication yet today?" It is best to ask open-ended questions and to avoid negatives whenever possible. Also be aware that masculine and feminine pronouns do not exist in many Asian languages, and interpret statements accordingly.

When choosing an interpreter, it is not enough for the person to speak the same language as the patient. It is important to choose someone of the appropriate sex and relationship. Same-sex interpreters are usually best. Children and other family members are often inappropriate.

Americans do not feel as comfortable with conversational silences as do some ethnic groups. When talking to Navaho patients, be sure to give them plenty of time to respond to your questions.

People from many cultures may be reluctant to discuss anything about their personal life or problems. Hispanic patients may feel it is the business only of other family members, not strangers. Asian patients may be trying to avoid the stigma of mental illness or fearful of government reprisals. Gypsy patients may simply not trust outsiders.

Eye contact may have different meaning in different cultures. Lack of eye contact may reflect respect or concern rather than disinterest.

Realize that not everyone will be comfortable being touched. Asians usually refrain from public gestures of affection. Opposite-sex touching should be avoided with Orthodox Jews and devout Muslims.

Time orientation varies among different ethnic groups (as well as among individuals). Present-oriented individuals may be late for appointments. Tardiness may be compounded by poverty; reliance on public transportation and difficulties in getting time off from work may also contribute to this problem. In addition, people with a present time orientation may not practice preventive health care, and those with a past orientation may be reluctant to try new techniques.

Pain

Some cultures encourage emotional expressiveness while others encourage emotional control. Speak with the family to ascertain whether the individual is a typical representative of his or her culture and, if so, adjust the attention given accordingly. It is important not to ignore the stoic Asian or Irish patient and not become overly concerned with the moans of a Mediterranean or Middle Eastern patient. Since many Asians may practice traditional stoicism, they might not request pain medication. The safest approach is to anticipate their needs and simply administer the medication without waiting for a request.

Recognize that many people, particularly Filipinos and East Indians, may hold a culturally enhanced fear of addiction. In that case, it is important to discuss with them the need for pain medication, as well as the risks of addiction. Remember that not everyone will want the least invasive forms of medication. If there are alternatives available, present them to the patient, and let the patient choose.

Religion, Beliefs, and Customs

Religion is often an integral part of people's lives, becoming even more important during times of illness. Patients' religious beliefs should be respected and incorporated into their care whenever possible. Time should be set aside for the patient to pray undisturbed, if so desired.

Try to respect religious prohibitions, such as contact with the opposite sex. In such cases, make every effort to assign same-sex caregivers.

Some religions have beliefs that conflict with Western medicine, for example, Jehovah's Witnesses' beliefs about blood transfusions. When confronted with such conflicts, consider the patients' perspective and the possibility that their beliefs may be correct. Also remember that they live within a social network. The social cost of violating religious taboos may be too high for them to be willing to do so. If patients are resistant to Western medicine because they believe only God can heal, try to incorporate their faith into your treatment.

It is also important to be aware of holy days and restrictions associated with them, such as the Orthodox Jewish prohibition against any form of work on the Sabbath (Saturday).

Recognize that sacred symbols can take many forms, from Catholic rosary beads to Cambodian wrist strings. These should not be removed without discussion, and it is best to try to keep them in contact with the patient's body whenever possible. This can be psychologically important to the patient.

People may hold magical beliefs, such as in evil eye or soul loss. Ignoring such beliefs can cause emotional stress for the patient. You need share their beliefs to respect them.

Dietary Practices

Many religions and cultures have dietary taboos or prescriptions which should be ascertained at the intake interview. Muslims and Orthodox Jews are forbidden pork, Hindus beef, and Asians and Hispanics may be concerned about hot/cold body balance.

Different cultures have different food preferences. It should not be assumed that a patient who refuses to eat lacks an appetite; it may just be that inappropriate foods were served, or that appropriate foods were served in an inappropriate form. Japanese, for example, usually eat meat cut into small slices and mixed with vegetables rather than in the form of a steak. Suggest alternative foods to the patient or the family. Be aware that some ethnic groups cannot tolerate certain foods, such as dairy products, and adjust the menus accordingly. If there are restrictions to be placed upon the patient's diet after discharge, be sure to discuss them with the family members who do the cooking. Some ethnic diets are extremely high in fats and salt; alternative cooking methods will need to be learned.

Family

Most non-Anglo cultures value family highly. Many patients come from large families – a necessity in agricultural communities. When a family member is ill, the rest feel they must be there with the patient. For the well-being of the patient and the family, it is best to be as flexible as possible regarding visitors and visiting hours, setting limits when necessary. If possible, place patients with frequent large groups of visitors (such as gypsies) in a room at the end of the hall, or where there will be minimum disturbance to other patients.

Self-care, a medical goal for patients, is often ignored. The family will often take over feeding and grooming the patient. This may be an important way for family members to demonstrate their love and respect for the patient. It may also be a way for a male patient from a hierarchical culture to demonstrate continued control over his family, despite physical weakness. If self-care is necessary for recovery – as in the case of burn patients – give the family tasks that will not impede the patient's progress. If the staff's emphasis on self-care is primarily a reflection of the American value of independence, do not insist but allow the family to continue caring for the patient.

Some families may be particularly demanding of hospital staff and services. Often, the best way to handle them is to spend a few minutes talking with them when the patient first checks in, and then a few minutes in conversation each day. Ask questions about the patient as a person, such as, what kinds of things does the patient enjoy doing or how many children are in the family? Let them know that you care about their loved one. Also, offer the family small, helpful tasks they can do, such as rubbing lotion onto the patient's hands, so they feel they are doing something useful. It is often the feeling of helplessness that causes them to be demanding.

Recognize that although it may be against hospital policy, many patients will try to give gifts to health care providers, either to remove the debt of obligation or to ensure good service. It is best to accept such gifts but to encourage only those that can be shared by the entire staff.

Realize that kinship systems may differ from that found among Anglo Americans and that other relatives may be closer to a child than the biological parents. Hospital rules regarding who may sign informed consent will still have to be followed, but consult with appropriate relatives, such as grandparents or uncles, for example, in the case of a Navaho or African patient.

Men and Women

Few cultures share an egalitarian ideal for men and women. In most cultures, men are thought to be the heads of the house and the primary decision makers. This situation is gradually changing as a result of the spread of Western influence, but change is slow and sporadic. Males may therefore serve as spokespersons for their wives. Female caregivers should remember that these wives may be perfectly content with the arrangement.

In hierarchical cultures, age generally carries authority. Elders may make decisions for their grown children. Often it may be the best policy for hospital personnel to address their first remarks to the eldest family member present, rather than to the patient.

Some cultures, such as Asian or Middle Eastern, may prefer male children over females because males traditionally take care of parents when they are old, and they carry on the family name. The latter is especially important in cultures like Chinese that practice ancestor worship. Although hospital staff may be disturbed at seeing parents show preference for male children, they should not expect people to change.

Female purity is especially important in the Middle East and in Muslim countries in general. Intimate contact between the sexes is forbidden outside of marriage. The use of same-sex health care providers will get the best results. Modesty is also a major concern in Hispanic, Asian, and Gypsy cultures; in fact, it is important in most cultures and should be respected. Although it is often not expedient to take the time to ensure a patient's personal privacy, it is a goal to strive for with all patients.

Staff Relations

A major source of conflict between staff members derives from the fact that in many other cultures, the power gap between health care providers is much greater than in the United States. This gap is exacerbated by the fact that many health care providers come from hierarchically based countries, such as those in Asia, India, and the Middle East, where men are perceived as more important than women. Thus, many foreign-born male doctors are exceedingly domineering and often find themselves in confrontations with American-born health care personnel.

There are two ways to approach this problem. One is for hospitals to offer in-service training to foreign-born doctors on what to expect from American personnel. The fact that an important function of health care provider is to act as patient advocate prevents them from blindly obeying any order the physician gives if they feel it may be detrimental to the patient. Physicians often interpret that as disobeying and disrespecting the doctor, rather than standing up for the patient. Another approach is to suggest that health care providers, realizing that the physician may be unaware of the American health care system, act in a less confrontational manner.

The power gap between doctors and nurses in other countries also creates a problem for foreign-born nurses, particularly those from countries in which women are socialized to be submissive. Many, when they first come to the United States, act in a very subservient manner toward physicians and others above them in the hospital hierarchy. This can cause stress between foreign born and American-born nurses as well as impede the former's move up the nursing hierarchy, since they may lack the assertiveness skills necessary for supervisory positions. In such cases, assertiveness training classes may help, although those whose basic nature is assertive may quickly overcome their early socialization without the aid of instruction. Those who are passive both by nature and training may have to be content with positions more suited to their temperament.

The lack of sexual equality in some countries encourages male employees to refuse to take orders from a female supervisor. While this behavior may have to be tolerated in patients, termination is an option if change does not follow open discussion of the problem with staff.

Several other problems can arise between foreign-born and American born health care providers. The role of the American health care providers is often much broader than that of the foreign-born caregiver. Not only must they take care of the patient's health needs but also provide personal and psychosocial care – functions usually handled by the family in other countries. A foreign-born caregiver's reluctance do such things may be interpreted as laziness or bad care provider. Similarly, some foreign-born health care providers may feel that asking for or accepting help from another nurse is a sign that he or she cannot do the job, creating conflict between co-workers, who perceive instead that the individual is not a "team player." Many of these misunderstandings could be resolved by an in-service workshop on the specific jobs expected of American caregivers as well as the nature of health care provider culture.

Since the role of the doctor vis -à-vis the patient is so different in the United States, where patients often want to be listened to and actively participate in their treatment, it can be problematical for foreign-born physicians who believe the authority of the doctor precludes the need to explain anything to the patient. At the same time, patients who come from some Asian and Native American cultures may expect physicians to act more authoritatively, neither asking questions nor revealing serious diagnoses. This can prove tricky for doctors, on legal as well as social grounds. One suggestion, again, is in-service training on doctor/patient roles in different cultures. Sometimes, it might be best for the caregiver to ask questions of the patient. Generally, some sensitivity on the part of physicians, and discussion with family members, will be effective.

Other problems which frequently arise between staff members involve language and communication. Speaking native languages in the workplace is a very sore point at many hospitals. The best approach to handling this problem is twofold. First, there should be open discussion among both sides, each sharing their feelings and reasons for their behavior or attitude. Second, there should be clear rules: no speaking in a foreign language around patients, switch to English when non-native speakers enter the room, but allow it on break time when no non-speakers are around.

Other language problems, which frequently arise with speakers of Asian languages, can be avoided with knowledge of different language customs and social rules. People need to let each other know, in a friendly way, when something someone said has hurt them in some way. Such misunderstandings are often culturally based and can be cleared up immediately.

Finally, hospital staff may have religious beliefs that interfere with some medical practices, as in the case of a Catholic nurse who refused to assist in an abortion. Staff members should make such restrictions known to their supervisors, who in turn should try to respect them.

Death and Dying

American culture values autonomy; a great deal of emphasis is placed on the patient's "right to know." This is not the case in many other cultures, where both the family and the patient may try to shield each other from knowledge of the seriousness of the patient's condition. When a patient enters the hospital, it would be wise to talk with a family member to discuss who should be given information about the patient's condition. If it is not the patient, the patient can then sign a waiver to that effect. At the same time, nurses

should be sensitive to the needs of the patients, who may not have anyone else with whom openly to discuss their feelings about dying.

Whether or not to remove life support is a traumatic personal issue for anyone. Cultural and religious factors contribute to the decision-making process. Many of these factors, such as faith in God to perform a miracle and the desire to show faith and courage in the face of suffering, are almost predictable. Sometimes, however, they can be surprising, as in the case of the Vietnamese family who used astrology to determine the most auspicious date for their son's death.

Individuals express grief in a variety of different ways. Culture can influence whether the mourners stoically suppress their feelings or give open expression to them. The latter can create a disturbance on the floor, which can be distressing to other patients. In such cases, it would be best to move the deceased and the family to a private area, such as the chapel, so they can be allowed to grieve without disturbing other patients.

If you have Gypsy patients, realize that it is customary for them to light candles around the bed of a dying patient. Take precautions with regard to oxygen equipment.

Numbers may have lucky or unlucky associations, which should be taken into account when assigning rooms. Try to avoid use of the number 4 with Chinese and Japanese patients, since it signifies "death." Use it instead with Navaho patients since for them, it has positive connotations.

Finally, be familiar with religious and ethnic customs regarding organ donation and autopsies, and be sensitive to the patients' desires.

Mental Health

Behavior which is seen as normal in one culture may be interpreted as deviant in another; not all "deviant" behavior may be a result of mental illness, but rather an expression of cultural traits. For example, in many cultures, visions of the recently deceased are common and normal; they should not be interpreted as signs of mental illness in the absence of other symptoms.

Many people believe in the reality of what most Americans would term the "supernatural." Regardless of your own beliefs, remember that it is generally more effective to treat problems from within the context of the individual's world view. For example, use exorcism to treat possession. Incorporate traditional healers when possible.

Realize that it may be extremely difficult to get members of some ethnic groups to talk about personal problems due to the highly stigmatized nature of mental illness or the belief that personal problems should remain within the family. Utilize the aid of trusted traditional healers or more acculturated family members when necessary.

Finally, be especially alert for stress caused by inter-cultural conflict among the children of immigrants. They may require the help of culturally aware social workers, though any mention of "counseling" or "mental illness" should generally be avoided.

Folk Medicine

All cultures have developed their own methods for treating illness based on observed cause-and-effect relationships. Some techniques, such as coin rubbing and cupping, produce marks that may appear to be signs of child abuse or unrelated symptoms. It is important to recognize these before jumping to unwarranted conclusions.

Conventional wisdom generally treats fever by trying to sweat it out; Western medicine tries to cool it down. Patients may be very resistant to cooling measures. When such measures are used, the rationale for them should be carefully explained. First, however, consider the possibility that allowing the patient to have additional blankets may have an important psychological effect.

Patients may occasionally experience pica – a craving for nonfood substances. A common pica among pregnant Black women is Argo laundry starch. The quantity consumed should be monitored for health reasons, but the psychological benefits of allowing a small amount may be substantial.

When doctors are unable to cure a patient or to obtain consent to certain procedures, it may be beneficial to agree to a patient's request to bring in a traditional healer. Such healers are occasionally successful, whether from the efficaciousness of their treatments or a placebo effect.

Noncompliance regarding medications may result from such things as unfamiliarity with the prescription system or a conflict in time orientation. Taking the time carefully to explain procedures and reasons for the medication will usually avoid the problem. Body image varies cross-culturally. "Beauty is in the eye of the beholder" is an old cliché but an accurate one nonetheless. Members of some cultures may value features Americans dislike, for example, scars or body fat. Do not assume that everyone shares our ideals. Fat may be seen as a sign of health and fertility in a culture where starvation and malnutrition are common.

Finally, remember that all toilets are not alike and that bathroom habits may vary. People from Third World and even some European countries may be used to squatting over a hole and may have difficulty using a toilet seat or bedpan.

Summary

Transcultural health care requires a holistic and culturally relativistic approach. Treat the patient as a whole person with psychological and spiritual needs as well as physical ones. See patients as members of a family unit, not as just individuals. Do not assume that patients or coworkers will view the world the same way that you do; they may have different values and different ways of looking at things. Do not make assumptions and do respect differences. Recognize that other people's views are just as valid as yours. If this advice were applied to all patients, no matter what their ethnic or cultural background, we would go a long way toward providing better care for patients from all cultures.

Finally, one of the most effective things a culturally diverse hospital can do is encourage the staff to talk openly to each other about their cultures. The cultures of the patient population are usually well represented by the staff population. Ask questions about behaviors that disturb you; the answers may be surprising. A trained facilitator may be necessary to start such discussions, but once people see that it is "safe" to ask questions, an open dialogue should continue. Individuals must be willing to let others know when someone has done something which offends them, and, at the same time, "lighten up" a bit and realize that most people are offensive out of ignorance and not because they intentionally want to hurt others. Imagine what would happen if everyone followed this advice everywhere, on the streets as well as in the hospital.

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