Commentary

Cross-cultural Communication in the Physician's Office

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Physicians are increasingly called on to provide care for patients whose cultures differ from their own. I describe strategies, attitudes, and investigative methods that will enhance the experience of cross-cultural medicine for both patients and physicians.

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Society in the western United States is increasingly multicultural and multiethnic. Virtually all of us who practice or teach medicine here regularly see patients whose language we do not speak and whose medical beliefs, practices, and expectations differ from our own. While this has always been so for physicians affiliated with university hospital teaching programs, the need for cross-cultural care has now penetrated every corner of the medical community. Even health maintenance organizations serving affluent coastal areas frequently need interpreters and culture brokers. In greater Los Angeles, for example, patients may speak any of 103 different languages.

Busy practitioners have limited time to research the literature or to consult with professional anthropologists. Drawing on my own clinical experience over the years, I outline basic issues in cross-cultural health care and present case histories that illustrate the importance of those issues.

Caring for Patients—It Works Best for Those Who Seem to Care

Patients have an uncanny ability to tell who is really interested in helping them—who really cares about them as people. They can tell by the concern shown in physicians' eyes when they listen, and they can tell by the respect accorded them by office staff. Whereas most of us know this to be true of patients from our own culture and language group, it is no less true for people whose language we do not speak. Even when physicians may be working through interpreters, patients can tell if they are really interested, and taking the time to let one's genuine interest and feelings show pays off.

When physicians are friendly and helpful, patients are more likely to reveal their concerns, which enhances a physician's ability to build rapport and to develop a repertoire of knowledge—both of which are essential for improving the quality of medical care. Learning about a given cultural group's major holidays, the general principles of their traditional medicine, and a few key phrases from their language that can be used in greetings and during examinations goes far to prevent any aura of alienation that might otherwise block cross-cultural communication.

What People Do Before They Come to the Doctor

Everyone does something before seeing their physician. Self-medication is practiced in more than 90% of illnesses.[1] In the process, advice is almost always sought from someone else about the nature of the problem and what to do about it.[2] That someone may be a neighbor, an influential member of an ill person's extended family, or even a community leader—as in the case of the Lao Hmong, who tend to go to their leaders for advice just as they did in the old country. In fact, there have been boycotts of hospitals by the entire Lao Hmong community when this tradition was not respected and emergency surgical procedures were done without the usual process of consultation and consent.

Often home remedies or other traditional treatments are advised by both lay health consultants and traditional or alternative healers. Such healers are consulted much more frequently than physicians may realize.[3] Physicians should always ask patients what they have done before coming in, both to learn about possible sources of delay in treatment and to understand parallel systems of medical care that may be used concurrently with biomedicine. Although alternative systems are sometimes harmless and

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comforting havens of culturally familiar support, they can also be siren songs luring patients away from more effective therapy.

Finding Out What Patients Think and Do

Learning about people's beliefs and behaviors is the core of applied medical anthropology, and it is centrally important for physicians practicing across cultural boundaries. Clinicians should routinely ask patients what they think is the cause of their illness. The trick is how and when to ask.

One of my medical students whose field project took her to a barrio clinic reported back to me that she was learning nothing. People responded to her queries by asking, "How should I know why I'm sick? I've come to the doctor because *he's* the expert!" It turned out, however, that the student was jumping right into the subject a few moments after meeting the patients. I advised her to first establish a relationship by talking with them about their lives and families. She returned to the same clinic using this new approach, and the patients' stories began to flow.

Suddenly the folk beliefs of Mexico were being revealed. My student learned, for example, that many pregnant women wore a bright new safety pin on their underwear to deflect dangerous rays from an eclipse, which could cause a child to be born with a cleft lip. Some women confided that eclipses could occur suddenly, without notice, and without scientists knowing about them. They also said that fright sickness *(susto)* could cause a fallen fontanel, even in adults, and that it could usually be diagnosed only by a traditional healer. Such a healer would know how to treat it by putting her index finger in the victim's mouth and pushing up on the palate so that the fontanel could pop back in place.

Family as a Source of Insight and Locus of Persuasion

Even a physician who is familiar with a particular cultural group will think from time to time that patients are doing something that does not make sense. In such cases, meeting with the family along with the patient often provides important insights.

In an instance of "therapeutic failure" involving an Italian-born woman, I learned that the patient was convinced that she had been hexed by someone's evil eye. She believed that until the hex was removed, she was never going to be entirely well. This emerged from a discussion with the family about her "total body pain"—which never seemed to get better with anything that I did.

By meeting with families of Vietnamese patients whose blood pressure levels would not come down, I learned that Vietnamese people commonly believe that Western medicines are too strong for them because they are smaller than we are. Thus, they often take only half of whatever dose of medicine physicians recommend. I now take pains to explain to such patients that the proper adjustments for their size and weight have already been made and that the medicine will not work unless they use the proper "Vietnamese" dose of medication that I am prescribing.

Families are often more cohesive and powerful in other cultures than they are in our own. Physicians who recognize this can use the family both to better understand a patient's behavior and complaints and to bring group influence to bear on the patient. Conversely, a physician who goes against the advice of a grandmother or a mother-in-law in such a cultural group may have virtually no chance of prevailing. Often, for example, older women are the critical persons who must be convinced about the need to treat a young bride or a young pregnant wife. Even in the context of a busy American medical office practice, such shadowy figures—who frequently do not speak English and seem "old-fashioned"—can wield massive influence. They should be sought out and included in decision making so they are part of the solution, not part of the problem.

Physicians must understand that in many societies, patients do not make decisions on their own. Elders in the family decide whether or not someone is sick, what are the likely causes, and who, if anyone, is the appropriate person to visit for therapy. But a strong sense of family can also be used to persuade patients to seek out and follow medical advice. One must sometimes go first to the young women to help the old. The tradition of self-sacrifice is so strong among older Mexican-born women, for instance, that they may not go to their physicians for Pap smears, even with alarming symptoms such as postmenopausal vaginal bleeding, unless their adult daughters plead with them to look after their health for the sake of their families. The same type of reasoning succeeded with Hispanic men in northern California in a campaign against high blood pressure and heart disease. During the Stanford Heart Disease Study, television spots appealed to men as heads of families to get their blood pressure checked and to stop smoking for the sake of their families who loved and depended on them (C. Gibson, oral communication, September 1984).

Going Beyond the History and Physical Examination

The conventional history and physical examination does not facilitate learning about patients' family lives or their traditional health beliefs and practices. Instead, it is like an algorithm designed to lead physicians to the single Oslerian diagnosis that explains all the symptoms. It will not work when the cause is something outside the realm of physical disease or when the patient presents with a set of symptoms that are "impossible" according to the biomedical model of illness.

For example, patients from other cultures frequently describe feelings and sensations that seem to make no scientific sense, such as Vietnamese patients who complain of feeling "tired" deep in the chest. Translated into Western models, this complaint corresponds best to depression, hopelessness, mental exhaustion, or exasperation. But it *must* be translated; it should not simply be written off. Similarly, Hispanic patients often say that they "hurt

all over," and I have found that this, too, is commonly associated with depression.

Other Themes in Cross-cultural Medicine

There is now an abundant literature on beliefs and practices of many groups that have come to the United States from other parts of the world.[4-10] Although some patients may not adhere to these specific beliefs and behaviors because of their education or their length of stay in the United States, physicians should be familiar with concepts that are frequently encountered because they represent general attitudes that have clinical importance.

Fear of Blood Loss

People from many developing countries fear that blood that is drawn for laboratory tests will not be replaced and that the blood loss will weaken the body. Some may even withdraw from treatment to avoid the procedure. This problem should be anticipated and the procedure approached as a negotiation. For example, the physician could ask, "How would you feel about having some blood taken?" If abject panic comes over a patient's face, the test should be deferred until the blood replacement process can be explained to the patient.

Fear of Cold

A fear of cold, especially for women in the first 40 days after giving birth and for newborn children, is so strong in many cultures that even a severe illness will not be enough to prompt people to go outside to seek help from a physician during the winter months. Thus, it is important for physicians to explain that with proper bundling up with blankets, new mothers and their infants can safely come to health facilities.

Traditions of Male Dominance

Another useful generalization is that in most developing countries, men have an important role in the family as leaders and decision makers. Physicians must involve them—especially husbands—in discussions of the medical problems of family members. This should be the case even if the men intentionally absent themselves from the physician's office, an environment in which they may sense a loss of power. My experience has been that husbands and fathers very much appreciate it when I show respect by discussing the diagnosis and treatment with them.

Conservatism in Sexual Matters

In many cultures, paternal protectionism reaches its zenith in the protection of teenaged girls. This does not mean that the girls do not quickly become Americanized, but their parents are much less likely to embrace American sexual liberty, and one has to negotiate delicately about such matters as pelvic examinations or birth control. At times I have resorted to distracting the parents while a woman staff member talked with the girl about birth control or venereal disease problems or made arrangements for her to return alone for a pelvic examination. Although this is a disquieting way for a physician to relate to families, it is necessary at times when girls cannot let their foreign-born parents know that they are sexually active.

Lack of a Preventive Health Orientation

The concept of preventive health is often unfamiliar to people from developing countries. Most do understand the importance of immunizing their children because immunization campaigns have been carried out in the developing world since the era of smallpox eradication. But the rationale for obtaining regular Pap smears, mammograms, prostate examinations, and blood pressure checks is less obvious and usually has to be taught by the physician.

Intolerance of Side Effects and Expectations of Expeditious Wellness

Many, if not most, educated middle-class Americans can understand relatively benign side effects of treatment. The same cannot be said of many immigrants to the United States, however. Patients from Southeast Asia in particular are likely to sense an ominous incompatibility between themselves and their medication at the first hint of a side effect. I have rarely been able to talk them into not worrying about such things, and rather than try to overcome deep misgivings that may be rooted in a sense that balance is all or that one should not go against signs, I usually change the medication.

Possibly reflecting previous experience with treatments that were not efficacious, many patients from developing countries do not brook protracted therapy without results. As a rule of thumb, I assume I have just a couple of days to make foreign-born patients better, or I had better do some explaining or plan on losing the patient to another health care provider. This is not surprising if one considers that in some developing countries it is the custom to prescribe medications for only a day or two. Sometimes this practice is combined with a shotgun approach—spectacular polypharmacy with multiple antibiotics being common practice in many developing countries. In any case, conditions that require treatment for a sustained period—such as viral diarrhea or viral pneumonia—may warrant extra effort at patient education to ensure mutual understanding and compliance.

Somatization of Depression

Depressed patients who seek medical care for fatigue or other vague somatic complaints are familiar to all primary care physicians. Usually with a few diplomatically phrased questions, physicians can uncover the covert "blues" and confront them, sometimes with antidepressants. Few physicians are prepared by their own cultural backgrounds in the United States to handle the degree of resistance to discussing feelings that is seen in certain foreign-born patients. Many Islamic persons, for example, have been acculturated to believe that prayer is the appro-

priate strategy for dealing with sadness and that to do otherwise might be reprehensible. More pervasive than this, however, is the resistance of Vietnamese persons to discussing emotional feelings with non-family members. This can rarely be overcome, in my experience, but with effort, once depression is suspected—as it should be in most older and monolingual Vietnamese immigrants—patients can be persuaded to take antidepressants provided they do not experience side effects.

Health Belief Model and Beyond

About a decade ago, two new concepts were popularized in medical anthropology by the Harvard physician-anthropologist Arthur Kleinman. The first of these was the notion of "illness without disease."[11] The phrase refers to the somatization of unhappiness and depression by people who need, for whatever reason, to deny that they have emotional problems. It came to be recognized as a common phenomenon as physicians recalled how often in ambulatory primary care medicine they encountered illness without a diagnosable disease—some say 40% to 50% of the time.

The other perspective advocated by Kleinman was that patients' own conceptual models of disease had an important effect on their illness behavior.[12] This led to the insight that when patients seem to be behaving in a noncompliant manner, they are actually proceeding logically according to their own belief system.[13] A physician who understands their conceptual model will have a better chance of negotiating new and more healthful behaviors. Theoretically, also, the more physicians explain the biomedical model of the health problem, the more patients will understand why they should do what the physician suggests.

Anthropologic Methods for Physicians' Offices

In communicating with patients, knowing the precise details of specific medical beliefs and practices is less important than showing warmth, interest, and concern. Moreover, published taxonomies, lists, and tables of health beliefs, while useful,[14] are always going to have limitations and almost always must be qualified for individual patients. Thus, each physician can and should practice his or her own form of "anthropological research" to begin to understand a patient's conceptual world. Some possible ways to do this follow.

The Focus Group in the Waiting Room

Focus groups have made the transition from advertising to international public health, and they are also useful here in the multicultural United States. In the standard focus group, a number of people of the same age, sex, and status are brought together and the characteristics of a certain illness are explored—how it is recognized and by whom, how it is treated at home, and the like. This way of eliciting information enables the interviewer to get information from different people in a relatively short period of time. Physicians can gather appropriate persons together in their waiting rooms during the lunch hour or at the end of a day to form an informal group to learn about any aspect of patient behavior. For example, my students and I have used it effectively to learn about Mexican-born patients' attitudes toward their diabetes.

Projective Research Methods

Some of the medical anthropology methods most useful in field research are equally effective in an office setting. For example, I developed a technique that I call the clinical vignette.[15] These vignettes describe the symptoms of a person with a symptom complex well known to bioscience, such as chest pain radiating down the left arm in a middle-aged man. After relating the vignette to the interview subject, that person is asked what could be the cause of such a problem and how it should be treated. This approach helps physicians to learn about systems of belief and therapy that may be unfamiliar to them.

Another useful technique is displaying photographs to elicit patients' attitudes.[16] For example, if a physician wants to know what patients think about breast-feeding, smoking, or some other behavior, the physician can show them pictures of people from different socioeconomic strata in the patients' own culture and then ask which person is a smoker, which one is a breast-feeder, and so on. The kind of person identified and the patients' attitudes toward such a person help in understanding a patient's own behavior.

Participant-Observer Technique in the Office

What most people think of as anthropology—the bearded anthropologist living interminably amid a tribe, enduring privation, learning the language, and ultimately emerging from the jungle to publish an erudite ethnography—has come to be known as the "participant-observer" method. Being as unobtrusive as possible, the practitioner of this skill is expected to participate so fully in the culture (not only in ceremonies but in daily life) that people are no longer on their good behavior around him or her. In that way, an anthropologist can observe the most intimate truths of a society. Although time-consuming and laborious, this method has a persuasive power that transcends that of any mere interview or questionnaire.

Like a field anthropologist, a physician can, and should, become a participant-observer in the patient's world. Of course, no one would argue that people are at their most relaxed in a medical office or a hospital bed. But the goal is to be alert to glimpses of meaning, to try to understand the meaning of the illness to the patient, and above all to be sensitive to the little problems created by our medical system so that physicians can try to make it better. House calls and social activities in the communities of patients enable physicians to see the patients in their own milieus, and often our understanding and our appreciation of them are enhanced.[17]

Over and over again, one sees that understanding the social matrix of patients is crucial and that presenting ideas in a culturally sensitive way can make every difference in terms of clinical success or failure.[18] This is one

of the reasons that I prefer to think of medicine as quintessentially a social science. To paraphrase what used to be said about anatomy, all physicians make mistakes, but those who know their anthropology make fewer of them.

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AMERICAN ROULETTE

Forty-two and once again I am on my sick bed.
Third time in six and a half years: sarcoidosis, cancer,
now double intestinal obstruction:
a complication from the cancer surgery:
scar tissue sealed off the intestine
at two spots.
Another day or so and maybe
peritonitis, gangrene,
death.
A little emergency surgery and my guts are working again.

For the third time I have been caught
with insurance.

Lucky me:
For eighteen months I have hold-over insurance
from a City of Austin job:
no pre-existing condition clause.

One of these days I will have insurance
and all of those premiums will make no difference:
"It all stemmed from the cancer," they will say,

unless, of course, I am lucky.

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