An introduction to cultural differences

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Patients differ in many ways. Some of these differences are due to patient illness, personality, socioeconomic class, or education, but the most profound differences may be cultural. Many health professionals think that if they just treat each patient with respect, they will avert most cultural problems. But that is not always the case. Some knowledge of cultural customs can help avoid misunderstandings and enable practitioners to provide better care. Beginning next month, *wjm* will be running a new series on medicine and culture. Each issue will focus on a different ethnic group and provide essential information about cultural patterns for busy practitioners.

THE DANGER OF STEREOTYPING

The danger in considering cultural differences is that of stereotyping people. All of us are unique. To say, for example, that "Russians do this" and "Vietnamese believe that" is both foolish and possibly dangerous. First, it is important to distinguish between stereotypes and generalizations. They may appear similar, but they function differently. For example, if I meet a Mexican woman named Maria and assume that she has a large family, I am stereotyping her. But if I say to myself, "Mexicans tend to have large families; I wonder if Maria does," then I am generalizing. A stereotype is an ending point, and no effort is then made to ascertain whether it is appropriate to apply it to the person in question. A generalization, on the other hand, serves as a starting point.[1]

Knowledge of cultural customs can help avoid misunderstanding and enable practitioners to provide better care

Consider the following case study. An elderly Irish woman was hospitalized and scheduled to have surgery at the end of the week. A few days before the surgery, she suddenly started complaining of pain to her family but said nothing to her physician. Her physician was also unaware of evidence that the Irish, as a group, tend to minimize expressions of pain.[2] Confronted by the family, the physician expressed little concern because in the physician's country, women having serious pain are much more vocal than this patient was being. The physician ignored their requests that the surgery be done sooner, deeming it unnecessary.

By the time the patient went to surgery, her condition had worsened, and she died during the operation. Her daughter-in-law, a nurse, felt that had the surgeon operated when the patient first complained, she might have lived.[1]

In this case, the surgeon made the mistake of stereotyping the patient—she was a woman, and in the physician's experience, women complained loudly when in pain. Therefore, the physician failed to even reexamine the patient (in itself, bad medical judgment). If the physician had been aware of the generalization about Irish people in pain, the patient's complaints may have been taken more seriously, which may have led to an earlier operation.

THE ROLE OF GENERALIZATIONS

A generalization is a statement about common trends within a group, but with the recognition that further information is needed to ascertain whether the generalization applies to a particular person. Therefore, it is just a beginning. Because differences always exist between individuals, stemming from a variety of factors, such as, in the case of immigrants, the length of time they have spent in the United States and their degree of assimilation, even generalizations may be inaccurate when applied to specific persons.

One of the most widely cited examples of cultural misunderstanding in medical practice involves the Asian practice of "coining." In this procedure, a coin, which may or may not be heated or oiled, is vigorously rubbed on a patient's back. The idea is to "draw the illness out of the body," and the red welts that form are taken as a visible sign that the procedure was successful. American health professionals who are unaware of this traditional practice may mistake it for physical abuse, and in fact, there have been many cases of parents being arrested for employing a folk remedy that is culturally appropriate and designed to help their children.

NOT ALL PATIENTS WANT TO KNOW THEIR PROGNOSIS

American health care puts a great deal of emphasis on patient autonomy and patients' "right to know." This attitude is not shared by all cultures, however, and is contrary to the dominant beliefs of many societies. The custom in many cultures, including Mexican, Filipino, Chinese, and Iranian, is for a patient's family to be the first to

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Muslims kneel in prayer at the start of New York's Muslim World Day parade

hear about a poor prognosis, after which the family decides whether and how much to tell the patient. Members of such cultural groups may believe that it would be insensitive for a patient to be told bad news and that this would only cause the patient great stress and even hasten death by destroying hope.

Some groups share the belief that only God knows when someone will die naturally, so (according to the Hmong, for example) the only way a physician could know when someone will die is if that physician planned to kill the patient.[3] Not all members of a group share these beliefs, so physicians should not automatically assume that every patient who is a member of one of these groups would want to be shielded from information. Nevertheless, a physician who is aware of such cultural differences could arrange to discuss with the patient, in advance, just who should be given information regarding the patient's condition and thus avoid unnecessarily distressing the patient or alienating the family.

Several years ago, I was asked to give a workshop at a hospital located in a predominantly Chinese area of town. The impetus for the workshop was the problem created when one of the members of the hospital's board of directors was hospitalized and put in room number 4. In Chinese (and Japanese), the character for the number 4 is pronounced the same way as the character for the word "death." Just as many American patients would not be comfortable in room 13—a number that is considered bad luck—many Chinese and Japanese patients would prefer not to be in a room called "death." Even the most sensitive health care provider could not be expected to know the significance of the number 4 without some knowledge of these 2 Asian cultures (or their languages).

Lack of eye contact in American culture may indicate many things, most of which are negative. A physician may interpret a patient's refusal to make eye contact as a lack of interest, embarrassment, or even depression. However, a Chinese patient may be showing the physician respect.[4] If the patient is female and from a Muslim country, and the physician is male, she may be trying to avoid sexual impropriety. A Navaho patient may be trying to avoid soul loss or theft. Knowing the meaning of eye contact, or lack thereof, may help avoid misinterpreting a patient's behavior.

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Nurses are generally taught the importance of touch. Yet, if they are caring for a patient of the opposite sex and that patient is an Orthodox Jew, for example, it is important to know that, for that religion, contact outside of hands-on care is prohibited.[5]

Cultural generalizations will not fit every patient whom physicians see, but knowledge of broad patterns of behavior and belief can give physicians and other health professionals a starting point from which to provide the most appropriate care possible. In the coming months, we hope this series will provide insights that can help in the treatment of patients from a variety of ethnic and cultural backgrounds with greater awareness and competence.

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