15 Stern HS, Gregoire RC, Kashtan H, Stadler J, Bruce WR. Long-term effects of dietary calcium on risk markers for colon cancer in patients with familial polyposis. *Surgery* 1990;**108**:528-33
16 Waddell WR, Ganser GF, Cerise EJ, Loughry RW. Sulindac for polyposis of the colon. *Am J Surg* 1989; **157**:175-9
17 Herrera L, Kataki S, Gibas L, Pietrzak E, Sandberg AA. Gardner syndrome in a man with an interstitial deletion of 5q. *Am J Med Genet* 1986;**25**:473-6
18 Bodmer WF, Bailey CJ, Bodmer J, *et al.* Localisation of the gene for familial polyposis coli on chromosome 5. *Nature* 1987;**328**:614-16
19 Dunlop MG, Wyllie AH, Steel CM, Piris J, Evans HJ. Linked DNA markers for presymptomatic diagnosis of familial adenomatous polyposis. *Lancet* 1991;**337**: 313-16
20 Sasazuki T, Sasaki M, Sugio K, *et al.* Molecular and genetic analysis in familial adenomatous polyposis (FAP). *Int J Colorectal* 1990;**5**:57
21 Okamoto M, Sato C, Iwama T, Miyaki M. Loss of alleles in patients with familial adenomatous polyposis and colon cancers. In: Herrera L, ed. *Familial adenomatous polyposis*. New York: Alan Liss, 1990: 383-91

How to avoid pitfalls in ethnic medical history, examination and diagnosis

Transcultural Medicine means the science and art of dealing with patients from different cultures. It is defined as follows:

'Transcultural Medicine is the knowledge of medical and communication encounters between a doctor or health worker of one ethnic group and a patient of another. It embraces the physical, psychological, and social aspects of care as well as the scientific aspects of culture, religion and ethnicity without getting involved in the politics of segregation or integration.'[1]

This approach may be useful in a cross-cultural contact during a medical consultation as short as 10 minutes or a detailed medical examination lasting an hour. I recognize four realities - patriotism, neo-colonialism, racism, and fundamentalism - as political issues of our times, but leave them to other experts who specialize in these fields.

A British general practice list or a hospital ward may have patients from two cultures (Western or Eastern), four races (European or Caucasian, African or Negroid, Asian or Asiatic, and Chinese or Mongoloid) and six major religions (Hinduism, Buddhism, Sikhism, Judaism, Christianity, and Islam). In addition, many patients will be: westernized Easterners; children of mixed marriages; and custodians of secular views. It is within a doctor's intellectual grasp to appreciate these categories (without stereotyping) and provide appropriate care. This Editorial deals with a doctor's role in the management of patients from cultures other than his or her own, and it highlights only a few out of many transcultural issues.

Every doctor must ask each patient about his or her history of: presenting complaints; story of present illness; summary of past illnesses; menstrual, obstetric, and sexual difficulties; treatment used for present and past illnesses; family patterns of disease; social habits; and occupational hazards. If a doctor and the patient come from the same culture, race and religion, then standard pathological, psychological, and socio-economical terms will probably be sufficient in making a diagnosis and routine questions should be asked. Where this is not the case, transcultural factors must be considered. In taking history, three cultural aspects are now described relating to language, the meaning of pain, and the privacy of age and religion.

It is important to make sure that the doctor and the patient are talking about the same thing. It is traumatic for the doctor and impending disaster for the patient if an English patient were to be interviewed by a French doctor who could not speak a word of English. Where a language barrier exists, an interpreter or link-person (language and culture translater) should be used.

Pain of some sort is the commonest complaint which brings a patient to the doctor. It is naive to think that the social education of patients from all ethnic groups is the same as that of the doctor. Pain means different things to different people[2]. An Oxbridge patient may describe pain as an ache, cramp, hurt, irritation, pang, soreness, spasm, tenderness, throb, trouble, twinge, agony, anguish, bitterness, disquiet, distress, grief, heartache, misery, suffering, torment, torture, and woe. A Navajo (North American Indians who live in Arizona) tourist may be at a loss when seeing an English doctor because the Navajo are the only people in the world who have no word for pain in their language[3]. The vocabulary about various degrees of pain varies with the age, social class, education and culture of a patient. It is not uncommon for an ethnic minority patient: to be unable to describe the type and severity of pain; to translate wrongly from the mother tongue into English; to repeat the same word due to lack of vocabulary; and to exaggerate the symptom by using a word that a doctor from another culture can understand, so as to attract his attention. The knowledge of medicine is science but its practice is an art. A doctor should remember 'cum Scientia Caritas' and spend more time when taking history from patients from other cultures. An accurate history is a prerequisite of correct diagnosis and appropriate management.

English patients are shy of revealing their age and reluctant to discuss their religion or political persuasion because they consider this a part of their personal privacy. An ethnic minority doctor should be very tactful when asking about their ages or religion. However, the reverse is the case among the ethnic minorities. An English doctor should be bold in asking the age or religion when taking the history from an Asian, African, Chinese, or other such patients because they feel proud to give this information. In general, they live by their religion. Age is an advantage in the East and with advancing years an

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Eastern person achieves more authority in the family hierarchy and more respect in Eastern society.

In a multi-ethnic practice the 'all or none' law should be replaced by 'a thin slice of a cut loaf for everyone' rule. It is a fairer deal.

A physician or surgeon is expected to carry out a physical examination with speed and thoroughness, without tiring or exposing the patient more than necessary, by clinical methods - inspection, palpation, percussion and auscultation: so as to assess the general state and condition of different systems as indicated by the history. A doctor who examines a woman's breasts, when she complains only of a sore throat, can become a victim of disciplinary tribunals! This applies to the examination of patients from all ethnic groups who attend a GP surgery or hospital clinic. However, some cultural variations should not be ignored. Three factors are mentioned here: attitudes, taboo zones and free expression.

In respect of attitudes English patients will be happy to have a physical examination - screening or diagnostic - if a doctor asks for this and will be equally contented if a doctor does not consider an examination necessary. They like to discuss their problems with a doctor and consider physical examination to be of secondary importance. West Indian and African patients expect a doctor to examine them because for them, 'touch' and explanation of the illness by the doctor is more important than mere verbal consultation. However, non-westernized Asians are very shy of undressing for examination, particularly if the doctor is of the opposite sex. They should be given more time. I remember, for example, a West Indian patient who complained against a Bangladeshi doctor to the Family Practitioner Committee because he did not examine his throat, but prescribed treatment for his sore throat merely on the history; and a Muslim man who forgot to mention his history of diabetes due to embarrassment when a woman English doctor examined his genitalia because he complained of frequency of micturition and soreness of the glans as a result.

Absolute taboo zones in Eastern culture are the genitalia and anal region. These are not seen even by spouses or the patients themselves. Doctors in the East are hardly ever permitted to examine these sensitive areas and an English doctor should counsel an Asian, African, Arabian or Chinese patient before a rectal, for example, or vaginal examination, because it may be the first time in a patient's life to have such an experience. It is no joke!

Even if a vaginal examination is carried out by a woman doctor, it is not uncommon for an Asian or Italian woman to shout out loud 'Aai Aai!' or 'Mama mia!'. Labour ward midwives are very familiar with this 'cultural phenomenon' of free expression of feelings of fear. A Western doctor, who may be accustomed to English stoicism, should not feel intimidated or guilty, but should get on with the examination.

In making a diagnosis one has to evaluate the information obtained by history-taking, physical examination, and laboratory investigations in patients from every ethnic group. All this could, however, be influenced by a patient's race - genetic and biochemical variations - and his or her religion and culture which are strong environmental influences. The differences in staple foods, dietary habits, expression of symptoms, expectations from a doctor, and other ethnic variables should also be considered in reaching a diagnosis. Finally, it should be remembered that a doctor of the opposite sex is not likely to obtain the same information from ethnic minority patients as a doctor of the same sex. It is due to the fact that sex segregation is a respectable entity in all religions except Christianity.

Here are only a few aspects of transcultural encounters that take place in a 10-minute medical consultation or even an hour-long medical examination. Only those problems can be solved which can be identified and quantified objectively. I would like to leave the reader with one thought - that the awareness of the depth of the complex ethnic (majority and minority) problems in Britain has just begun.

Bashir Qureshi
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References

1 Qureshi B. *Transcultural medicine: dealing with patients from different cultures.* Lancaster: Kluwer Academic, 1989
2 Feinmann C. Psychogenic regional pain. *Br J Hosp Med* 1990;**43**:123-7
3 Hull R. Pain. *Horizons* 1990;**4**:94

The portrayal of the physician in non-medical literature - the one-track mind

'The doctor stood frowning and shaking his head
And he took up his shiny silk hat as he said
"What the patient requires is a change" and he went
To see some chrysanthemum people in Kent.'[1]

Sophocles[2] criticizes the 'leech who mumbles charms over ills that need the knife'. Chaucer[3] wrote sarcastically about the physician who 'knew the cause of every maladie'. Sinclair Lewis[4] described an ear, nose and throat surgeon (Roscoe Geake) whose 'earnest feeling regarding the nasal septum was that it never hurt any patient to have part of it removed'. Geake was a dishonest salesman but there are also many apparently sincere fictional physicians who are lampooned for their obsession with theories or treatments which subsequently turn out to be incorrect but which, in the meantime, are used indiscriminately on all patients.

Moliere[5] in 'Le Malade Imaginaire' has a chorus of learned physicians singing in dog-Latin while they examine a student who is about to graduate. One of the examiners mentions a hypothetical case:

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