

Issues in Health Care of Middle Eastern Patients

JULIENE G. LIPSON, RN, PhD, and AFAF I. MELEIS, RN, PhD, San Francisco

Relationships between Middle Eastern patients and Western health care professionals are often troubled by mutual misunderstanding of culturally influenced values and communication styles. Although Middle Easterners vary ethnically, they do share a core of common values and behavior that include the importance of affiliation and family, time and space orientations, interactional style and attitudes toward health and illness. Problems in providing health care involve obtaining adequate information, "demanding behavior" by a patient's family, conflicting beliefs about planning ahead and differing patterns of communicating grave diagnoses or "bad news." There are guidelines that will provide an understanding of the cultural characteristics of Middle Easterners and, therefore, will improve rather than impede their health care. A personal approach and continuity of care by the same health care professional help to bridge the gap between Middle Eastern cultures and Western medical culture. In addition, periodic use of cultural interpreters helps ameliorate the intensity of some cultural issues.

George Engel¹ has challenged Western medicine to broaden its biomedical model of disease to one that includes the psychosocial sphere—that is, to a biopsychosocial model—inasmuch as “the boundaries between health and disease, between well and sick, are far from clear, for they are diffused by cultural, social and psychological considerations.” Such considerations are the focus of this paper, in which we discuss Middle Eastern immigrants and temporary residents who seek health care in the United States.

The number of Middle Easterners in the US has increased during the past decade as a result of continuing political instability in their home countries; consequently, the number who seek health care has also been increasing. Health care professionals, however, are still fairly unfamiliar with the unique cultural characteristics of Middle Easterners when they come for health care and are often apt to view them as “difficult” patients. The misunderstandings tend to be mutual. Although they respect American medicine in general, Middle Easterners, because of unmet expectations, may be confused and angered by health professionals.

Middle Easterners differ in their characteristics from country to country; most American health profession-

als, however, see them as similar. Disregarding for the moment the implications and political ramifications of generalizing about peoples as different as Egyptians, Yemenites and Iranians, there is an advantage in describing their shared values as well as offering suggestions that can guide health professionals in providing more culturally sensitive care. The observations of Middle Eastern patients and suggestions offered here are based on years of clinical work by one author (A.I.M.) and on current research involving Arab and Iranian immigrants by both authors. We will briefly discuss the effects of immigration on health in general and on that of Middle Easterners in particular.

Immigration and Health

In the process of migration, a family or a person loses a social network, the social, human resources on which they depend for both daily and long-term needs. An immigrant experiences a sense of disorganization and disorientation that manifests itself in a syndrome called cultural exhaustion or shock. Others' behavior and symbols no longer mean what they meant before migration and now require considerable energy to interpret. Attending to the basic needs of housing, obtaining

Refer to: Lipson JG, Meleis AI: Issues in health care of Middle Eastern patients, *In* Cross-cultural medicine. West J Med 1983 Dec; 139:854-861. From the Department of Mental Health and Community Nursing, University of California, San Francisco, School of Nursing.

Reprint requests to Juliene Lipson, RN, PhD, Department of Mental Health and Community Nursing, University of California, San Francisco, San Francisco, CA 94143.

food, learning the banking system and mastering English all require much energy. In addition, immigrants experience a degree of loss ranging from mild to most profound.

Published material on the subject suggests that migration causes immediate personal and social disorganization that slowly abates with time. The extent of individual difficulty depends on level of education, occupation, social status, formal social ties with the host country, personality traits, motivation for migration, whether migration is voluntary or involuntary, permanent or temporary and the magnitude of cultural differences between home and host countries—the greater the magnitude, the higher the potential for cultural exhaustion.

The relationship between migration and health is complex. Hull suggests that migration can affect life and health on every level:

Migration affects health directly at the biological level via dietary changes, differences in local pathogens, lack of appropriate immunity, and through the risk of accidents in new situations. The social-psychological effects may affect health indirectly via the postulated physiological effects of stress and change on immunity to endogenous and exogenous infection, and by hastening system failure in chronic disease via a less well understood chain of events.^{2(p34)}

Middle Easterners: Who Are They?

In contemporary usage, the Middle East encompasses a region spanning from Rabat (Morocco) to Tehran (Iran), a distance of roughly 3,400 miles³ (Table 1). However, our observations reported here are based mainly on work with Palestinians, Egyptians, Jordanians, Yemenites, Lebanese, Iraqis and Iranians.

Arab-Americans are Arabic speaking people, usually of Semitic origin, who were born in an Arab country and migrated to the United States, or whose parents

were born in an Arab country and who therefore consider themselves of Arabic origin. Armenians and Assyrians, who maintain their strong ethnic identification even when living in Arab countries and speaking Arabic, are not included in our concept of Arab-American. Arabs began migrating to the United States in 1875 and have continued in waves that have coincided with a number of political upheavals in the Middle East. Except for a small group of Yemenites who are farm workers, Arab-Americans are generally urban dwellers who work in industry and private business, including a sizable group of professionals or semiprofessionals in all fields.⁴

Iranian-Americans are of Indo-European origin and speak Farsi (Persian). Persian culture is very old, the Persian empire having been founded by Cyrus the Great in 559 BC. In the course of history, Iran absorbed numerous invasions, most notably the Arab conquest and subsequent Islamization in the seventh century, but always assimilated its foreign conquerors and maintained its cultural integrity.⁵ Shi'ite Moslems represent about 90% of the population of Iran. In Arab countries, except Iraq, the majority are Sunni Moslems. The few Iranians who migrated to the US in earlier decades came here as students and decided to stay. The political turmoil since the 1979 revolution in Iran has been responsible for a recent large exodus of mainly middle- and upper-class Iranians to the United States.

The exact number of Middle Eastern immigrants and temporary residents currently residing in the United States is not known because of a lack of detailed census data, shifting US immigration quotas and political upheavals in the Middle East that bring many temporary residents, with and without visas, who are unlikely to be counted. Naff⁴ estimates Arab-Americans to number slightly more than 1 million, 90% of whom are

TABLE 1.—The Middle East*

Country	Area Square Miles	Population	Major Language	Major Religion
<i>Arab Countries</i>				
Algeria	919,591	17,422,000	Arabic, Berber	Islam
Bahrain	240	358,857	Arabic	Islam
Egypt	386,659	41,572,000	Arabic	Islam, Coptic Christianity
Iraq	172,476	12,767,000	Arabic, Kurdish	Islam
Jordan	35,000	2,152,273	Arabic	Islam
Kuwait	6,532	1,355,827	Arabic	Islam
Lebanon	4,015	3,161,000	Arabic, French	Christianity, Islam
Libya	679,358	2,856,000	Arabic, Berber	Islam
Morocco	172,414	20,242,000	Arabic, Berber, French	Islam, Judaism, Christianity
Oman	120,000	891,000	Arabic	Islam
People's Republic of Yemen	111,101	1,969,000	Arabic	Islam
Qatar	4,247	220,000	Arabic	Islam
Saudi Arabia	829,995	8,367,000	Arabic	Islam
Syria	71,498	8,979,000	Arabic, French, Kurdish, Armenian	Islam, Christianity
Tunisia	63,378	6,367,000	Arabic, French	Islam
United Arab Emirates	32,278	1,040,275	Arabic	Islam
Yemen Arab Republic	77,220	6,456,189	Arabic	Islam
<i>Non-Arab Countries</i>				
Iran	636,293	37,477,000	Persian, Azerbaijani	Islam
Israel	7,847	3,878,000	Kurdish, Hebrew, Arabic	Judaism, Islam, Christianity

*From Hammond Medallion World Atlas, Maplewood, NJ, Hammond Inc, 1982

Christian and 10% Moslem. Arab consulates estimate the number to be 2 to 3 million. Iranian-Americans numbered between 70,000 and 80,000 toward the end of the 1970s.⁵ An Iranian newspaper article recently stated that there are currently about 200,000 Iranians in California, most of them living in Los Angeles.

Although in this report we describe general cultural themes, the readers should keep in mind the variations that exist between and within national groups of Middle Easterners. Country of origin, urban or rural origin and length of stay in the United States as well as religion are important aspects of these groups. Arab religions, in addition to Islam, include Christian sects like the Eastern-rite churches, Coptics, Maronites, Melkites and Syrian and Chaldean Catholics.⁴ Iranians may be Moslems, Zoroastrians, Chaldeans, Baha'is or Jews.⁵

Ethnic identity is another aspect to be considered. Individuals choose how strongly they identify with their ethnic group, regardless of degree of acculturation. Awareness of both ethnic identity and acculturation in a patient will give a health professional a more complete picture.⁶ During the past decade Arab-Americans have emphasized their ethnicity increasingly since the arrival of new nationalistic immigrants.⁴ Iranian ethnic consciousness has been heightened with the recent dramatic increase of immigrants from Iran.

Middle Easterners represent a wide socioeconomic spectrum in which level of education is the most important aspect. Some differences that observers note between Arab- and Iranian-Americans (such as, Arab-Americans are "more traditional and religious") more likely reflect differences in social class. Whereas Arab immigrants range from illiterate farm workers to well-educated or wealthy people, most Iranian immigrants are well-educated and upper middle or upper class and may be wealthy. They are typically more cosmopolitan than many Arabs. With these variations in mind, we will describe a core of shared Middle Eastern values and behaviors that may affect a person's relationship with health professionals.

Selected Cultural Themes

Affiliation and Family Style

To belong, to be affiliated with other persons, is a universal human need; the intensity of the need varies among individuals and cultural groups. The need for *affiliation* is dominant among Middle Easterners. They thrive on a large repertoire of relationships and family relations fulfill many affiliation needs.⁷ During illness or crisis, Middle Easterners rely heavily on other persons instead of trying to cope by other means.

The extended family is the central, most durable and influential social institution of the Middle East.⁸ Families gather and make spontaneous visits and intergenerational contact almost daily. Children live with their parents until they marry and maintain close contact with parents after marriage. When parents age, the roles are reversed. Children are expected to care for their parents as long as they live. The family structure

is patriarchal; children are expected to submit to the father's authority.

Middle Easterners in the United States are often lonely; the extended family may be scattered or work schedules and pressures may not allow frequent and spontaneous visiting. They may feel isolated and complain about having to make appointments to get together.

The intense caring and involvement with family and close friends is accompanied by mistrust and doubt about the intentions of those outside the intimate circle. But the negative expectations can be rapidly reversed when someone moves from the stranger category to become an insider.⁹ There are striking differences in the behavior toward, and the demands on, intimates versus outsiders.

Context, Time and Space

Context. Given the intensity and frequency of their relationships, Middle Easterners' culture is highly contextual—that is, persons seek understanding of events by examining the entire web of circumstances in which they occur. A Middle Easterner needs to know more about another person than an American does for a relationship to develop. American culture is low in context; the emphasis is on the verbal message and less so on the context in which the message is given.¹⁰

Time. Punctuality is less important in the Middle East than in the United States. A patient might be late for an appointment, or not come at all, because another matter immediately at hand was seen as more important than the previously scheduled appointment. Americans are annoyed by such a nonchalant approach to time, and the Middle Easterners may be offended by the American proclivity to immediately talk about the business at hand instead of taking the time to establish a relationship.

Space. The appropriate conversational distance between Middle Easterners is about .6 m (2 ft), in contrast to about 1.5 m (5 ft) for Americans. This proximity allows a Middle Easterner to finely read the other person's reactions in a conversation.¹⁰ Middle Easterners touch more frequently. The American-born author (J.G.L.) needed months to become comfortable sitting shoulder to shoulder in a room full of Iranians and being embraced on greeting and taking leave.

Interactional Style

Studies of national character are considered to be of limited use; nevertheless, they have an intuitive appeal. Beeman¹¹ suggests that the regularity one feels in national character is due not to uniform character or emotions, but to uniform codes of communication that may hide a vast amount of individual, attitudinal, emotional and personality variation. According to Berger,¹² social history and personal development have combined to produce a society in the Middle East in which insecurity, hostility, suspicion and rivalry are compensated by strong adherence to religious ritual,

patterns of ingratiation and hospitality and a limited form of cooperation.

Westerners are often baffled by Middle Easterners' ritual courtesy toward strangers. Bateson and associates refer to "a constant flow of offers of hospitality, compliments, etc. which to the Westerner sound profoundly insincere, especially when he discovers that he has committed a social gaffe by taking them literally."⁹(p270) The social ritual presumes the restraint of the respondent, and allows a host the pleasure of saying "my house is your house" to a guest who knows when to go home. Ritual courtesy is practiced only between people of unequal status. Between intimates, requests are direct, material goods are common property and one person would "sacrifice himself" for the other.¹¹

Middle Easterners desire to please or to appear good, and weaker persons must at all costs placate stronger.⁸ Personal cleverness, so valued by Iranians, calls for thwarting direct interpretation of one's own actions, but for successfully interpreting the actions of others,¹¹ which is particularly apparent in "bargaining." In the "top man culture" of the Middle East,¹⁰ the person at the top makes the decisions, and in Islamic society there are no intermediaries. The one with the most authority in any situation is usually the oldest and most educated person. Middle Easterners will attempt to obtain the services of the top person in a field, such as wanting to be seen by the head of a department in a well-known university medical center. Middle Easterners value social status more highly than do Americans; they are always interested in learning "Who is your family?" and "Who do you know of importance?"

Health and Illness Behavior

Middle Easterners generally have respect for Western medicine. However, in working with any immigrant population, health care professionals should keep in mind that folk beliefs and practices are often retained. Middle Easterners would not refute germ theory, but would place it side by side with other disease etiologies, such as the Evil Eye (*Ein el Hassoud* in Arabic, *Cheshmé Bad* in Farsi). They believe that a positive event, such as a promotion or giving birth to a beautiful baby, provokes jealousy and envy in others, giving the eyes of the envious party the power to inflict an accident, illness or other negative event on the fortunate person or family.^{13,14} Some Arabs wear amulets with verses from the Koran or blue beads to encourage God's protection. Few Iranians would admit to a belief in the Evil Eye, but more than a few burn "esfand" (a kind of seed) because, as one Iranian commented, "The smoke is healthy, and it keeps the Evil Eye away. I don't know if there is one, but it won't hurt."

Food and other substances are believed to play a role in health and illness. Some Iranians use teas, such as *Gole gov zabon* (an herb) for nervous upsets or *Nabat* (a concentrated sugar) for stomach upsets. Iranians mention eating only fresh foods and avoiding

canned or frozen foods to prevent illness. Humoral theory is evident among Middle Easterners in the use of "hot" and "cold" foods—honey and walnuts are "hot," cucumbers and yogurt are "cold"—and they avoid eating incompatible foods at the same meal. Inappropriate or inadequate diet is seen to cause weakness or illness.

Other causes of illness according to folk beliefs include exposure to cold and dampness, sudden fear, emotional upset and carelessness.¹³⁻¹⁷ Illness is often associated with bad luck and poverty, health with good luck and wealth. A physically robust person is considered healthier than one who is thin. It is commonly believed that illness is sent from God as punishment for sins because God is seen to be afflicter as well as healer.¹⁸ Health professionals have frequently observed among Middle Easterners a fatalistic acceptance of disease or death. Moslems are sustained in adversity by the belief that whatever happens to them is in accordance with God's master plan.¹⁹ The Koran states that each person's fate is sealed from the moment their soul is created. Even though fate is predetermined, a person cannot know their fate, so it is wise to strive for God's favor through obedience.

Middle Easterners' pattern of somatization of anxiety or depression and their negative stance toward psychiatry is similar to that of Hispanics and Asians.^{20,21} Ulcers and headaches are common among recently immigrated Iranians and are related to relocation stress and worry over the political situation in Iran. But Middle Easterners resist seeking help from psychiatrists because of the stigma associated with mental illness. Insanity is often attributed to evil spirits, head trauma, emotional trauma or sudden fright, but may also be attributed to heredity; families tend to conceal the fact that a member is a psychiatric patient for fear that their daughters' prospects for marriage will be jeopardized.⁸ By the time psychiatric help is finally sought, a person may be very sick indeed. Middle Easterners are not adverse to seeking help for "nerves" and sometimes inappropriately consult neurologists.

Their expectations of encounters with physicians are culturally influenced. Preventive care is not practiced in the Middle East and medication is heavily used. Middle Eastern patients may complain that "The doctor didn't do anything," if they have not received a prescription. Injections are preferred over medicines in liquid or tablet form, colored pills are preferred over uncolored and larger over smaller ones.⁸ But these preferences are more common among rural and less so among educated people.

Middle Easterners often fear hospital admission because hospitals are considered places of misfortune where people go to die. Moslems are concerned that a family cannot be sure that the body of one of its members will be treated correctly according to religious customs, should a patient die in hospital. These customs include bathing and clothing a body in prescribed ways and burying it in the earth, without embalming or

casket. Middle Eastern families often emphatically refuse an autopsy.¹⁵

Family Roles During Illness and Death

Discussion of illness and death of Middle Easterners of necessity focuses on the family. The affiliation needs of Middle Easterners are intensified during illness. A person seeking medical care may be accompanied by one or more persons who expect to be present during the examination or interview, who listen carefully and often answer for the patient. Usually it is an elderly person who will feel offended if not invited into the physician's office, or intimates of the patient who consider themselves duty bound to be there, lest their failure to be there is considered a lack of attention.²²

The role of the family is to insist that a patient receive the best care possible from health personnel. Demanding behavior is prescribed by the culture and shows that the family cares about the patient. Family and friends are expected to show exorbitant concern, never to leave a patient alone and to constantly shower care and attention.

The family gathers when a family member is dying. According to Racy, "To die without issue or kin is the greatest defeat. To die surrounded by one's children and relatives is a great solace."^{19(p874)} However, family members do not plan for death and never give up hope until a patient has actually died; grief is not permitted to be shown in the presence of a dying person. Once death has occurred, mourning is loud and obvious and expected to be so. Some women pound at their face and chest, others tear at hair and clothes; men sob openly. A person who is not overcome with emotion is not admired.⁹ Condolences are the most binding social obligation; visits are expected not only from relatives and close friends, but from all acquaintances. Memorial services are held at the time of the funeral and several times afterwards, depending on the rituals followed by the family, such as first Thursday after death, on the 40th day and at the one year anniversary.

Health Care Issues

Several problems related to the cultural norms and values mentioned above were elicited through consultation requests we received from health professionals who work with Middle Eastern patients. The problems included difficulty in obtaining adequate information from patients, demanding behavior of patients' families, patients' disinclination to plan ahead and other communication obstacles.

Defining the Problem

Relevant information with which to understand a patient's presenting complaint is indeed difficult to get from Middle Easterners. Obvious problems with the English language are shown by a recent immigrant's statement that "A few hours before I go to doctor, I was thinking what I should say. I open dictionary to write the words, but the dictionary didn't have." Often Middle Easterners express vague symptoms, giving

generalized and global descriptions of their health status. Vague physical symptoms substitute for anxiety or depression because Middle Easterners lack concepts that distinguish mental states from physical states, and their experience does not permit them to carefully describe signs and symptoms as they are associated with different parts of the body.

Passivity in the presence of a physician (an authority figure) also interferes with eliciting information. Because the authority of a physician is never questioned, a Middle Easterner is not likely to ask questions or give information that would contradict or "show disrespect." This very respect for a health professional's expertise prevents a Middle Easterner from understanding why a physician cannot diagnose and prescribe without resorting to tests and "irrelevant" questions.

A third obstacle to communication is the Middle Easterners' resistance to disclosing detailed personal information to strangers. Arabs value privacy and guard it vehemently, even though privacy within a family is virtually nonexistent. They view the comprehensive health assessment on admission with suspicion and as an intrusion until the relationship between medical problem and personal questions is made clear to them. A formal interview in a non-Arabic language tends to yield answers designed to please the interviewer, to save face and to absolve the family from responsibility for the illness.²³ Once trust with a caregiver is established, personal information is given more freely.

We remind readers that political refugees, such as Iranians, Palestinians and other Middle Easterners who are here illegally, are likely to be highly suspicious of the questions of any "official." They may assume that a health professional has direct and regular contact with the immigration office or other government officials.

Persistent and Demanding Behavior

Frequently a health care professional is confronted by an overbearing family and a seemingly docile patient. The family's indulgence of the relative and demands on the staff are intended to show their caring for the relative, but such behavior more often than not interferes with professional care. In the following example, the nursing staff of a neurology-neurosurgery unit requested expert consultation on a patient because "the nurses were burned out by the end of the day and asked not to be reassigned."

Mr Ali (as we will call him), a 69-year-old man who immigrated from Iran 12 years ago, was admitted for craniotomy and possible tumor. Even though he lived in another city, he was accompanied by his wife, three of his four adult children and the wife's sister. Mrs Ali remained at his bedside at all times, sleeping on a cot in the hospital room. Family members insisted that nursing staff take care of all activities of daily living and requested that no medical or nursing students be assigned to Mr Ali. Mrs Ali instructed the nursing staff on tasks whenever they entered the room. The nurses'

verbatim notes give a flavor of Mrs Ali's requests: "Quick, I need linen, where is linen? . . . I changed him. . . . He needs more pillows. . . . He needs to be washed. . . . I brushed his teeth, but after that orange juice, he needs them brushed and flossed again. . . . I have to go to dinner now; who will be with him when I am gone?"

A clinical nurse specialist, realizing that the wife, normally submissive to her husband, was behaving in a culturally appropriate manner during his illness, looked for additional cultural clues. A major issue was noted to be trust. The nurse specialist then visited the Alis daily and suggested that a nurse be assigned to Mr Ali for more than a day at a time. With this change, Mrs Ali's demands decreased considerably and Mr Ali became more cooperative.

Health professionals are likely to interpret a characteristic pattern of repetition in Middle Easterners' speech as condescending iterations. Repetition, however, is a style of communicating, not necessarily indicating that a health care provider has not heard. Repetition is used for emphasis and as an indication of the significance of the matter at hand. On the one hand, repetition is a characteristic of Moslem prayers, which may be repeated 110 times; on the other hand, Hall and Whyte²⁴ point out that the only way one Arab gets another to do anything is to "needle him."

The Perils of Planning

Planning ahead is a Western value, not a Middle Eastern one. There, planning may be seen as defying God's will and capable of bringing on the Evil Eye or some other misfortune. Medical or any preparation for birth or death is diametrically opposed to Middle Eastern values. These events should be left in God's hands until the moment when they occur. To "interfere" is to outguess God, an act that could bring disaster to a family.²⁵ For example, it is rare for an Arab mother to prepare clothing and a room for her infant before delivery. Similarly, resistance to birth control is related to a preference for spontaneity, trust in God's guidance and a suspicion that family planning potentially challenges God's will.⁷

Related to planning is the issue of compliance. Middle Easterners appear to comply with health regimens and professional advice, but in fact may ignore advice. This point is illustrated in the following example:

Another patient (we will call her Mrs Wahby) came to the outpatient department reporting vague complaints of fatigue and dizziness. A complete medical work-up revealed no organic causes for her dizzy spells. Her overweight prompted a careful taking of her nutritional history. Because her heaviest meal was the midday meal and because she shared this meal with her husband and sons who came home for it daily, she was advised to remove herself physically from the house while her husband and sons were eating. In addition, it was suggested that perhaps she should not prepare lunch at all and have members of the family who came

home for the meal take it elsewhere or prepare it themselves.

Mrs Wahby seemed agreeable to the suggestion but also had profound misgivings. The midday meal is the main meal in Arab families and continues to be so in the United States. Furthermore, one of the most significant aspects of the motherly and wifely role is the preparation of elaborate meals. To advise Mrs Wahby not to prepare such meals and, even worse, to disappear from the house altogether, is inappropriate and incongruent with Arab culture, and impossible to implement. Mrs Wahby seemed to accept the advice given her because most Arabs believe that disagreeing with authoritative advice shows disrespect or at least a questioning attitude toward an expert. To discuss a prescription or question advice is not usual practice. Moreover, agreeing to heed personally unacceptable advice can be a face-saving mechanism that hides a sense of powerlessness in making the suggested changes.

Communicating Grave Diagnoses

Middle Easterners, although valuing open communication and truth in general, do not communicate openly in crises, disaster, grave illness and impending death. Middle Easterners' "denial" in such matters clashes with Western medical need for full disclosure of fateful information and causes ethical dilemmas for a health professional. Middle Easterners believe that because only God knows how poor a prognosis is, hope should never wane and to give up hope would mean to forfeit God's help. Hope helps a patient cope with illness, even if such hope is futile by Western standards. Confronting a patient with a grave diagnosis "is not only a tactless act, but an unforgivable one."²⁵

A patient's family acts as clearinghouse for information and often intervenes forcibly to block communication about a grave illness. The family feels that nothing but harm could come from upsetting the patient, as, indeed, patients who are told about their malignancy often give up. Some form of nonverbal communication regarding the prognosis likely takes place, but verbal utterances denoting a fatal outcome are strenuously avoided. To speak of death is "to bring it about."⁹

Guidelines for Health Care Professionals

Our suggestions are based on the premise that quality health care includes respect for the cultural values of patients and that it is a health professional's responsibility to maintain a flexible approach to accommodate patients from varying backgrounds. We hope that health professionals will recognize the cultural characteristics of Middle Easterners to improve rather than to impede their care.

Information Disclosure

In reference to important medical information, health professionals should include a family spokesperson rather than communicate solely with a patient. The spokesperson is usually the oldest man present, because older men are considered to be wiser and more

able to cope with bad news with fatalistic reasoning. In some instances, the spokesperson may be a grandmother, though even she should be protected because women are believed to be more deleteriously affected by bad news. In the case of Mr Ali, the patient himself did not ask about his prognosis; Mrs Ali was consulted about hospital care and discharge planning and the oldest son was given the results of the pathology report.

A health professional must be particularly careful about how negative information is presented. A common communication practice in the Middle East is to reveal the news of a tragedy or a poor prognosis in stages. For example, a colleague learned that her mother in Egypt was ill. The colleague prepared to visit but was unable to get concrete information from her family. At each of several stops on her journey home, she was given slightly more information over the telephone: "She will recover. . . . She is in the hospital. . . . She has cancer." Not until the family was bringing her home from the airport was she told that her mother had died. Potentially upsetting information should be given gradually, within the context of other information and events, and carefully modulated with hope. Hall and Whyte²⁴ suggest that we should learn to control our so-called frankness in dealing with people of a culture that puts a high value on maintaining pleasant surface relations.

Once a grave diagnosis or poor prognosis is communicated, it should not be discussed again. A health professional should be sensitive to the customary ways of handling such information, namely, by using the family's choice of euphemisms. If death is anticipated, it is important not to suggest nor request a visit from a religious official until a spokesperson of the family clearly requests such a visit. To suggest or request a visit on behalf of the family violates the value of hope, "interferes in God's plans" and conveys an image of a health care system that "gave up." All that predisposes a mistrustful relationship between a patient and health professionals.

The Personal Approach

Many difficulties with Middle Eastern patients dissolve when a health professional is accepted into the family system. An approach that combines expertise and authority with personal warmth more likely encourages trust than would a stiff professional facade. Gaining initial trust may not be totally under a health professional's control. A young female physician may not be accorded the same respect automatically accorded an older male physician until she has proved her competence and patient and family get to know her well.

In the contextual culture of Middle Easterners, individuals are seen as members of families, groups and even universities; they will naturally be more comfortable with a health professional about whom they know something beyond the specialty. It is useful to offer some personal information in the interest of gain-

ing trust and, if asked personal questions, one should not refuse to answer them. Withholding information may prompt patient and family to withhold important health state information. Volunteering personal information helps enhance a trusting relationship.

Because immigrants value courtesy and hospitality, a health care professional is well advised to take a few minutes to "warm up" before delving into the business of the appointment or visit. Similarly, food is heavily laden with meaning in the Middle East. Offering or receiving food is a powerful symbolic gesture of acceptance of a person. The Arabic saying "We ate bread and salt together" signifies social obligation to an insider. *Namek geer* in Farsi means "I have tasted your food, now I am your slave." One would not hurt someone with whom one eats. A nurse was not completely accepted by an Arab family until she accepted an invitation to a meal at their house. Accepting a piece of baklava or a chocolate helps provide the warm-up period before a health professional takes a history. However, if one is offered food, it is considered polite to initially refuse (so as not to appear too eager) but to accept when pressed. A firm and final refusal could be interpreted as a rebuff. Whenever possible, offering a Middle Eastern patient tea does much to give an initial visit a positive beginning.

Continuity of Care

Because health professionals give of themselves not only technically but personally, it will be helpful to sustain continuity of contact. Trust grows with cumulative experience; Middle Eastern patients and their families will become increasingly cooperative with increased contact and trust. As we have seen, Mrs Ali reduced her demands on nursing staff soon after the clinical specialist spent time with her and her family each day. In another case, Hisham was a child with leukemia who was seen by a number of attending physicians in a university hospital. Having the same pediatrician during the long hospital stay was the single most important factor in reducing the mistrust, bargaining, demanding behavior and frustration experienced by Hisham's family.

The increased effectiveness of just one person who is the main source of health care for a Middle Eastern family, however, engenders disadvantages. Intense contact can be emotionally draining and exhausting. Middle Eastern patients are likely to telephone their primary physician or nurse at any hour, day or night. They tend to involve a health professional in an ever-widening sphere of life events: One might be invited to a wedding, pressed for legal advice or consulted about any concern they consider appropriate for someone who has been taken into the family system. Health professionals sometimes hesitate to treat Middle Easterners because of the intense involvement. One should be aware that consultation time required by one Middle Eastern family is longer than for patients of other nationalities, and that scheduling should be arranged accordingly. It is useful to collaborate with the other

health workers involved with a particular family by conducting patient care conferences.

Mobilizing a Social Network

Middle Eastern patients who have few family members or friends in the area are unable to mobilize their own social network. Being alone when ill can be most traumatizing and so distressing as to interfere with healing. A health professional might contact a patient's acquaintances in the area, Arab social clubs or the consulate, if necessary. It is useful to recruit Arabic- or Farsi-speaking health personnel to visit a patient periodically; the difference in a patient's morale can be dramatic.

Use of Cultural Interpreters

Health professionals are well advised to use consultants as cultural negotiators to help resolve difficulties in caring for immigrant patients. Such consultants need not be health workers, but should either be bicultural or have in-depth experience with the population. Weidman's²⁶ term "culture broker" acknowledges the role of establishing links between separate cultures or subcultures. A culture broker interprets differences in language or communication style, value preferences and life-style to patients and health care professionals.

Cultural negotiators are provided by the Mideast SIHA (Study of Immigrant Health and Adjustment) project of the University of California, San Francisco. SIHA was developed in response to the problems confronting Western health care professionals and Middle Easterners who must negotiate their way through the American health care system. The SIHA project staff also conducts research on illness behavior, health risks and needs and adjustment patterns of Middle Easterners. Health professionals and institutions that serve multiethnic and immigrant populations may benefit from developing similar resources. Cultural interpreters can significantly improve health care for immigrant and ethnic patients.

Conclusion

The issues and problems in health care for Middle Eastern immigrants and temporary residents we have described are derived primarily from clinical and consultation experience. Preliminary research, however, supports these themes. Despite the difficulties in working with Middle Eastern patients, there are definite rewards. Once their trust has been gained, Middle Easterners show a strong faith in their practitioners and are very cooperative. Because they are emotionally

expressive, the health professional gets immediate feedback, including the gratification of being intensely appreciated and of knowing where one stands. Once accepted into an extended family, the love, care and involvement one experiences can have a significant impact. A pediatrician who worked closely with an Arab family whose child eventually died of leukemia was so profoundly affected by the experience that, according to his statement, he felt he would never be the same. Working with Middle Easterners gives health professionals the enriching opportunity to experience another culture and the significance of close extended family and relationships. For most, the rewards more than balance the difficulties.

REFERENCES

1. Engel GL: The need for a new medical model: A challenge for biomedicine. *Science* 1977 Apr 8; 196:129-136
2. Hull D: Migration, adaptation, and illness: A review. *Soc Sci Med* 1979 Jan; 13A:25-36
3. Eickelman DF: *The Middle East—An Anthropological Approach*. Englewood Cliffs, NJ, Prentice-Hall, 1981
4. Naff A: Arabs. In Thernstrom S (Ed): *Harvard Encyclopedia of American Ethnic Groups*. Cambridge, Mass, Belknap Press of Harvard University Press, 1980, pp 128-136
5. Lorentz JH, Wertime JT: Iranians. In Thernstrom S (Ed): *Harvard Encyclopedia of American Ethnic Groups*. Cambridge, Mass, Belknap Press of Harvard University Press, 1980, pp 521-524
6. Clark M, Kaufman S, Pierce RC: Explorations of acculturation: Toward a model of ethnic identity. *Hum Organization* 1976 Fall; 35: 231-237
7. Meleis AI: Arab American women and their birth experiences. *Am J Maternal Child Nurs* 1981 May/June; 6:171-176
8. Racy J: Psychiatry in the Arab East, chap 10, In Brown LC, Itzkowitz N (Eds): *Psychological Dimensions of Near Eastern Studies*. Princeton, NJ, Darwin Press, 1977, pp 279-329
9. Bateson MC, Clinton JW, Kassarian JBM, et al: Sāfā-yi Bātin: A study of the interrelations of a set of Iranian ideal character types, chap 9, In Brown LC, Itzkowitz N (Eds): *Psychological Dimensions of Near Eastern Studies*. Princeton, NJ, Darwin Press, 1977, pp 257-273
10. Hall ET: Learning the Arabs' silent language. Interview conducted by Kenneth Friedman. *Psychol Today*, 1979 Aug, pp 45-54
11. Beeman WO: What is (Iranian) national character? A sociolinguistic approach. *Iranian Studies* 1976 Winter; 9:22-48
12. Berger M: *The Arab World Today*. Garden City, NJ, Doubleday, 1962
13. Shiloh A: The interaction between the Middle Eastern and Western systems of medicine. *Soc Sci Med* 1968 Sep; 2:235-248
14. Maloof PS: *Medical Beliefs and Practices of Palestinian-Americans*, unpublished thesis. Catholic University of America, Washington, DC, 1979
15. Meleis AI: The Arab American in the health care system. *Am J Nurs* 1981 Jun; 81:1180-1183
16. Good BJ: The heart of what's the matter: The semantics of illness in Iran. *Cult Med Psychiatry* 1977 Apr; 1:25-58
17. Alemi AA, Mohseni M: A causal concept of disease in an Iranian community. *J Biosoc Sci* 1978 Oct; 10:347-351
18. Pillsbury BL: *Traditional Health Care in the Near East*. US Agency for International Development, 1978
19. Racy J: Death in an Arab culture. *Ann NY Acad Sci* 1969 Dec; 164:8717-880
20. Kleinman AM: Depression, somatization and the 'new cross-cultural psychiatry.' *Soc Sci Med* 1977 Jan; 11:3-10
21. Cohen L: *Culture, Disease and Stress Among Latino Immigrants*. Research Institute on Immigration and Ethnic Studies (RIIES) Special Study. Washington, DC, Smithsonian Institution, 1979
22. Davidian H: The application of some basic psychological theories in the Iranian culture context. *Int Soc Sci J* 1973; 25:532-541
23. Meleis AI, Warshaw C: *The Arab American and psychiatric care*. *Pers Psychiatr Care*, in press
24. Hall ET, Whyte WF: Intercultural communication: A guide to men of action. *Hum Organization* 1960 Winter; 19:5-12
25. Meleis AI, Jonsen AR: Ethical crises and cultural differences (Medicine in Perspective). *West J Med* 1983 Jun; 138:889-893
26. Weidman HH: Concepts as strategies for change. *Psychiatr Ann* 1975 Aug; 5:17-19