

The Influence of Culture on Patient Care

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Introduction:

The objective of this paper was to study culture and the effect that culture has on the delivery of healthcare in the United States. The paper is broken up into three sections. Part one examines what culture is, and how people of different cultures might access and utilize healthcare differently. Part two looks at the research that is currently available which would offer an insight on the effect of culture on healthcare. And part three gives ten examples of how a particular culture is affected by the system of healthcare in the US.

The author hopes that this paper will be a resource to student and graduate healthcare providers who want to learn how to become more culturally competent in the practice of medicine.

Part One: Culture and Cultural Assessment

Culture is defined as a system of symbols, which are shared, learned and passed on through generations of a social group. It influences how people perceive the world around them, and helps them make decisions. It guides people's interactions with each other. Culture is not a "thing" as much as it is a "process" which can be slightly different in each individual and can change over time.

In the United States, maybe more than anywhere else in the world, we are a melting pot of different cultures. Aside from the American Indians, our ancestors all came from somewhere else and brought with them their culture. It is estimated that by the year 2000, one in every three Americans will be part of an ethnically diverse cultural group (Campinha-Bacote, 1996). In this country's major cities, the culture may change drastically from neighborhood to neighborhood,

while in sparsely populated areas, the cultural differences might be less noticeable. Everyone has a culture, though, and it influences how they see, think and feel; and it influences how they interact with their healthcare provider.

Competency in Healthcare

Although we are one of the richest, most developed countries in the world, and we spend more money on healthcare than anyone else does, our system is far from perfect. We are currently in a state of dramatic changes, with managed care taking over the corporate 'drivers seat' and taking us in new directions. Many of the changes of the last few years have not been welcomed, by either providers or consumers, but one thing that has come out of the managed care environment has been the notion of clinical competency. To be clinically competent, a provider must be able to demonstrate that he or she has the proper training to provide the care, and that the outcomes of that care have been measured and are favorable (Kleinman, 1978).

As one component of competency, providers are more commonly being asked to show that they are 'culturally competent.' This term can be interpreted in several ways, and some say that it cannot be achieved because one individual cannot be aware of every different culture and treat people with just the right kind of care based on that cultural knowledge. A more reasonable definition of cultural competence might be that the provider understands how to do a proper cultural assessment, and then has the skills to take that information and use it to provide care that fits within the boundaries of that persons cultural system (Lipson, 1996; Klessig, 1992).

This paper will attempt to outline a method of cultural assessment that can be used by a healthcare provider to understand their patient better, and thus provide better care. It will also detail several of the cultures which are present in the United States, showing how the information gained can affect the delivery of healthcare. The author cautions the reader, however, not to use this information to stereotype people from a certain ethnic group or certain country. To stereotype is to take information and make assumptions about an individual. Understanding that each individual is different, these assumptions are frequently wrong. To generalize, rather, is to use information about a group to make a hypothesis about an individual. Asking the individual questions can then test this hypothesis.

Having the background information to generalize, and having the skill to make appropriate questions and test them with appropriate questioning, is the essence of being culturally competent (Geissler, 1994).

Culture and Healthcare

The allopathic system of healthcare in the United States is a culture of its own, and those of us who were born and raised in this country and have accessed this system all of our lives still sometimes do not understand it. For immigrants to this country, or for those who have a culture that is very diverse, the healthcare system here can be as frightening and confusing as anything they have ever encountered. The following list begins to illustrate some of the many ways in which culture and healthcare can collide.

- **Conversational Style** - Allopathic healthcare providers (especially physicians) in this country are often bold, confident, and outgoing, and these qualities may be demonstrated by their style of speech. While this style may be desirable in some cultures, it may be offensive in others. Many cultures consider it insulting to talk loudly, quickly, or emphatically, and a patient may consider this a sign of anger on the part of the provider. Conversely, silence or softspokenness on the part of the patient may be misinterpreted by the provider as a sign of inattention or disinterest, rather than respect. These simple qualities of conversational style can lead to many problems across cultures (Qureshi, 1994).
- **Eye Contact** - Cultural traditions may cause people to avoid direct eye contact or to look at others with only a fleeting gaze. This may be done out of respect, as an effort to avoid another's personal space, or because of gender, as an effort to avoid inappropriate contact with the opposite sex. This can be misinterpreted by the provider as a negative personality characteristic, or by the patient as inappropriate behavior or aggression.
- **Personal Space** - Each culture has its own guidelines for personal space. In those cultures where the circle of personal space is large, a provider may easily invade that space and offend the patient. In cultures where that space is very small, the patient may invade that of the provider.

- Touch - Each culture has norms about who can appropriately touch whom, and which areas of the body can be touched at which times. In many cultures that stress modesty, touching the chest, abdomen or pelvis of a stranger or of someone of the opposite gender is very uncomfortable. In some cultures, touching the head is seen as disrespectful, and the feet and genitals are seen as unclean, and should not be touched before other parts of the body. In many cultures, related persons of the same gender openly hug, kiss and hold hands, but the same is not done with strangers. In the United States, this behavior may lead providers to incorrect assumptions about the patient.
- Time - In some cultures, time is measured by the clock, and appointments and schedules are important tools of interaction. In other cultures, time is measured by events and interactions, and interruption of those events because of the “clock time” is unheard of. This can lead to problems with expectations about when things will start and when they will end.
- Language - Until one is in a foreign country where the native language is not understood, it is hard to imagine how strange and frightening our system of healthcare can be without communication. Interpreters can help, but accurate translation is a difficult task, and many of the local colloquialisms and medical jargon do not translate well at all.
- Dominance Patterns - Interactions between the genders, between the old and young, or between the leader of a family and the other members is highly influenced by culture. Expecting a young female patient, for example, to make a decision about her own healthcare may be appropriate in some cultures, but may be very inappropriate in others.
- Dietary Customs - Culture will dictate what types of foods are acceptable and which are not. Providing patients with inappropriate foods can be very insulting to them, while expecting them to follow certain diets may be completely unrealistic.
- Religious Customs - Patients from certain cultures may need time for prayer and may wish to use oils or fragrances to aid in this prayer. These practices can interfere with the routine of allopathic medicine, and can cause great conflict with the patient and the family. Religious

culture may directly impact medical care, by forbidding certain medications, blood products, surgical procedures, or post-mortem examinations.

- Beliefs About Healing - While some cultures rely solely on allopathic medicine to heal the sick, most cultures incorporate other means as well, including prayer, touch, folk medicine, or even magic. Nearly everyone recognizes the strong influence that the mind has on the body, so beliefs about healing are a very important consideration.
- Culturally Specific Disease Patterns - People of different cultures may have different diets, may work and live in different environments, and may be subject to different endemic diseases. Knowledge of where they are from, what diseases are endemic to that area, and what other health practices may affect them will help a provider avoid overlooking an important disease process or making a misdiagnosis.

Cultural Assessment

With these factors in mind, a plan for a cultural assessment can be developed (Garcia, 1994).

When first encountering a patient, a series of observations can be made. These observations can be the basis for questions. The answers to those questions, in addition to further observations during the question and answer period, can complete the assessment.

The following observations can be made at the onset:

- The patient's physical appearance - age, gender, skin color, facial features, clothing.
- The patient's physical condition - cleanliness, body habitus, size and shape.
- The patient's emotional condition - expression, vocal tone, gestures.
- The patient's escorts - family, spouse, children or friends who may accompany the patient.

The following questions can then be asked:

- Where was the patient born, and if outside the US, how long have they been in this country?
- What ethnic group does the patient identify with, and how strong is this affiliation?
- What are the primary and secondary languages of the patient?
- Who are the patient's support people?
- What is this patient's religion, and are there any beliefs that have to do with medical care?
- Are there any food preferences, restrictions, or customs surrounding food?

- What is the patient's economic situation?
- What customs do they have surrounding life transitions such as birth, major illness, and death?

During this questioning, further observation can reveal other types of information.

- The patient's conversational style. Their mastery/understanding of the language.
- Their need for personal space. Does the patient draw back when you approach?
- The amount of eye contact the patient makes during conversation.
- Reaction to touch, by you or by others.
- Interaction with their escorts. Do they influence answers or behavior?

Consideration of all of this information will make up an excellent cultural assessment, and allow the provider to formulate and test hypotheses about the patient's culture, and then consider how this culture might effect the patient's medical care. The provider may need to modify their own style, offer alternative treatment options, work with family members or religious representatives, or change their plan in some other way to be able to provide care in a manner that will suit the patient (Giger, 1995).

Part Two: Research on Culture

A Medline search was performed of all English and Foreign-language publications on the database for articles that dealt with culture and healthcare. The articles that were found can be divided into several categories. The first group is the largest and consists of epidemiological studies which document the differences in incidence and prevalence of specific diseases among different ethnic groups. There are thousands of articles in this category, because nearly every disease will affect some ethnic group differently. Some of these findings are commonly known, such as the higher incidence of hypertension among African Americans in the US. Other findings, however, are not well known and not at all understood.

For instance, Singh (1996) found that in Maryland, there was a different incidence in adverse pregnancy outcomes among women who were born in the US and women who were foreign born. Suarez (1996) found that there are cultural differences that predict when a patient will

return to work after a hip replacement surgery. Keenan (1998) found that certain cultural populations living in the US have a higher incidence of domestic violence. Lannin (1998) found that women are more likely to present with end-stage breast cancer if they are from certain ethnic groups. And finally, Bronner (1996) found that the nutritional status of children is different among different ethnic groups in the US. These studies demonstrate that there are epidemiological characteristics of each racial/cultural group that should be known by those who are providing healthcare to individuals in that group. Part of being a culturally competent provider is anticipating which diseases an individual is likely to acquire, based on their culture or race.

The second category of research contains studies that look at how healthcare is received differently by different cultural groups. A few of these actually compare how healthcare is received more effectively when it is presented in a culturally competent way, but most just show that there is a potential for this effect. For instance, Atri (1997) studied over 2000 women who failed to attend an appointment for breast cancer screening, to see whether they could be convinced to attend these appointments by the clinic staff. They found that the calls to patients by the clinic staff were most successful when the staff member and the patient were from the same cultural background. This would indicate that being culturally sensitive can improve healthcare delivery.

Baldwin (1996) developed a substance abuse/AIDS prevention program specifically for American Indian youths that was much more successful than previous programs. The study concluded that culturally sensitive approaches work better. A similar approach was taken by Parker (1996) in developing a smoking prevention program for black and Latino youth. It was found that the most successful programs were ones delivered by people of the same cultural background who were sensitive to issues within that culture.

A population of women in London was studied (Naish, 1994) and it was shown that a population of Bengali, Kurdish, Turkish, Urdu, Punjabi, and Chinese women did not take advantage of available cervical cancer screening services. After a culturally sensitive education program was instituted that targeted these groups, the use of these services improved dramatically. In Orange County, California, it was found (Chavez, 1995) that the breast cancer awareness program that was effective in white women was not effective in Mexican and South American women. This

was because the Latino women did not believe that risk factors such as age and family history were as important as “bad behavior” or “breast trauma”. It was concluded that a program that addressed those beliefs within that culture would be more effective.

A group in Melbourne, Australia (Yelland, 1998) interviewed foreign-born women to see whether they were satisfied with their hospital care during delivery. They found specifically that Filipino, Turkish and Vietnamese women were not satisfied with the care they received, and concluded that there was a cultural factor to this satisfaction. The study recommended that the hospital investigate ways to be more culturally sensitive to these groups.

Formenti (1995) studied women who did not complete treatment for cervical cancer, because the success rate when the treatment protocol is followed is very high. They could not understand why anyone would fail to complete such a treatment program, and risk having their cancer return. The study found that the only thing that predicted whether patients would complete treatment was their race. Latino women were the ones who were not following through with treatment, and the study recommended that a culturally sensitive educational program be immediately instituted with this patient population to ensure that they received the treatment they needed.

Organ transplant coordinators in Minnesota (Danielson, 1998) developed a program to increase organ donation among American Indian populations. They found that if a potential donor’s family was approached by a healthcare worker from their same culture, that 81% were willing to agree to organ donation (a much higher percentage than found even in white populations). They suggested that same-culture healthcare providers be used to discuss this option with family members whenever possible. In a similar study, Morrison (1998) found that certain cultural groups did not complete advanced directives when hospitalized. Once again, it was suggested that if same-culture providers were to discuss advanced directives with the patient, that the results may improve.

Several researchers used case studies to illustrate the effectiveness of cultural sensitivity. Cooley (1998) profiled two African American men undergoing treatment for prostate cancer to illustrate how cultural differences could be assessed and integrated into the patient’s care to generate positive outcomes. Amirali (1998) studies a case of psychiatric illness in an 11-year-old immigrant boy whose care had to be significantly altered to account for the cultural differences

of his family. The treating physician was able to provide successful treatment, but felt that his standard approach to this problem would not have worked.

Obstetricians from Oslo, Norway (Vangen, 1996) looked at the use of anesthesia during delivery, and found that Pakistani women were given significantly less anesthetic than women from other ethnic groups. In fact, they found that when adjusted for the mother's age, parity and duration of labor, Pakistani origin was the only predictor for receiving no analgesia at all. This led the researchers to conclude that there must be some cultural factor that is allowing for the under-medication of these patients. A focused cultural assessment was recommended.

Finally, an Albuquerque, New Mexico study (Abbott, 1998) compared a standard alcohol treatment program with one that incorporated both standard and traditional American Indian healing practices. It was found that American Indian patients did much better in the combined program than they did in the standard program alone. They concluded that culturally competent programs are more effective.

The last category of research contains articles that discuss the impact of culturally-sensitive healthcare on the healthcare system itself. Astin (1998) found that each year an increasing proportion of Americans use some form of alternative or complementary medicine. Between 30 and 50% of patients want to include these treatment options, which are often culturally-based, as part of their healthcare. The study also found that large numbers of physicians are becoming more open to recommending alternative care to augment that which they provide.

Jones (1998) suggests that cultural competency will be a pre-requisite of future healthcare providers, and outlines methods by which future providers can be trained in this skill. Yutrzenka (1995) makes the same argument (three years earlier) and reviews the psychological literature which supports the idea that cultural differences must be taken into account to provide good psychological care.

R J Lavizzo-Mourey and E. MacKenzie (1995) sum up much of what this paper has tried to convey in the following passage from their work:

“Establishing guidelines for culturally competent medical care will help all physicians to fulfill their mandate to meet the healthcare needs of the

individual patient as well as of patient populations, and to lower costs by encouraging a healing partnership with the patient, thus increasing patient responsibility for his or her own health. Being culturally competent is not enough. Nor is simply classifying patients according to race adequate. Many researchers in social science and health services increasingly agree that race in our heterogeneous US population has limited biological meaning and more often than not is just a poor proxy for culture or socioeconomic status. Guidelines and quality indicators that seek to measure and improve cultural competence must take into account, in an integrated fashion, these three necessary components in the delivery of high-quality services to populations: 1) the health-related factors; 2) the incidence and prevalence of diseases in the population; and, 3) treatment outcomes peculiar to that population.”

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