Cultural Competence: Glimpsing the World Through Our Patients’ Eyes as We Guide Their Care

The arrival of a family injured in a motor vehicle crash always engenders high emotion among the staff of an emergency department. A memorable incident from my own experience involved a Hispanic family of Jehovah’s Witnesses on their way home from church, hit by a drunk driver at an intersection. I remember the mother unconscious with head and abdominal injuries; the two children bleeding to death from multiple injuries; and a man, presumably the father, who was dead on arrival. My colleagues and I tried to suppress our outrage and shock at the unfairness of the incident.

Our trauma team divided up to care for the family, and in the midst of our efforts a nurse pulled me aside and told me that the dead-on-arrival patient was not the father of the children. The actual father had been in another car and was uninjured. He was now in the waiting room with several members of the church and wanted to speak with me to make sure I understood that his family were Jehovah’s Witnesses and were not to receive any blood. He was Spanish speaking and wanted others from his church to accompany him to help translate. I told the nurse we were too busy to talk with the husband or the church members at the moment; I then mentioned the problem of the blood transfusion to our trauma surgeon. I asked the charge nurse to contact the hospital’s legal team and a Spanish interpreter and tried to assess how important a blood transfusion would be for the mother and children. All of them were hypotensive and would probably need to go to the operating room. These were the days before CT scans and ultrasound were immediately available to define the extent of injury. Much of the diagnostic work would have to occur in the operating room during exploratory surgery. I could not predict how long any of the patients would survive without a transfusion. It could be minutes or hours. How could I let this family die over a religious belief that made no sense to me? How could we quickly discuss these complex issues in two languages? Would I be able to understand the cultural beliefs that might be linked to the eventual decisions?

Our surgeon whisked the mother off to surgery as I pondered the options. He promised to get the children to surgery as soon as his colleague arrived. He made no commitment about the blood transfusion. Over the next hour I alternated between caring for the injured children with our resident team and nurses, and talking to the father, his companions from church, and our hospital attorney. The attorney contacted an on-call judge who could decide whether the family’s wishes about the children could be overruled. The father and his religious community were insistent that no blood be given, regardless of the risk to the family, and explained that even though he and his wife were separated they were still legally married. He explained that if they received blood, they would not be able to go to heaven. The residents and nurses asked me questions about our ethical and legal duties. Wasn’t the welfare of our patients our primary priority, or was the right of patients to make a decision about their care more important? What about when patients were unconscious and you could not verify their wishes? There was no documentation of this family’s wishes in case of an emergency. We had all witnessed patients and families who changed their minds about treatment when faced with the possibility of impending death. And what about the special protections of children? Could parents make decisions that were against medical advice and might lead to their child’s death?

While this situation was extreme in its potential risks and complexity, many of the issues it raised are not so unusual in our current health system as an increasingly diverse population and their religious beliefs encounter health professionals who may have a different understanding of health and disease; may speak a different language; be of a different race, ethnicity, or class; and not share their patients’ religious or cultural beliefs. How do we unravel the various threads of a difficult medical decision, establish respectful communications, and determine the best course of action for the patients? What can we do to prepare our students, residents, and other health professionals to understand the elements of cross-cultural health care decision making and know what resources are available to find the best solutions? What are the deeper questions about developing health professionals’ cultural competence, how to teach and assess it, and, ultimately, to educate caregivers to understand, respect, and fully support diverse populations?

Cultural Competence and Linguistic Competence

Betancourt et al4 define cultural competence in health care as the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.

They suggest that cultural competence has emerged as part of an effort to reduce disparities in health care and describe how cultural competence can be divided into organizational leadership issues, systems issues—such as interpreter and health literacy services—and clinical issues related to values and beliefs.

Goode and Jones5 have defined linguistic competence as the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.
Linguistic competence and cultural competence are intertwined such that the understanding of the meaning of words and phrases is related to the ability to understand concepts and values and to participate in decision making. In this issue of *Academic Medicine*, Ortega comments on the challenges of discordance in language capability between health professionals and patients and provides specific suggestions related to fostering a health system capable of caring for Spanish-speaking patients. It can sometimes be difficult to know whether miscommunication is occurring at the level of the words and phrases, or at the deeper level of concepts and values. For this reason, having the expertise both of cultural experts—who can explain cultural beliefs and customs—and also of professional interpreters—who can explain the meaning of language—can provide the nuanced information needed to understand the thinking of a patient or family from a culture different from that of the health professional.

**Disparities in Health Care**

The issue of disparities in health care related to race and ethnicity was examined by the Institute of Medicine (IOM) in a 2003 report that concluded that evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services. The report presents examples of disparities in cardiovascular care, cancer diagnostics and treatments, use of analgesics, HIV care, diabetes care, kidney transplantation, maternal and child care, mental health, rehabilitation, and many surgical procedures, and further notes that racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life.

**The Concept of “Otherness”**

While the IOM report advocated improved cross-cultural education and better linguistic resources, Wear et al have raised concerns that better training and resources may only be scratching the surface and that a more profound reorientation of the health care system and health care education is needed. They suggest that health professionals be engaged with the stories and lives of patients who differ from them in regard to class, culture, religion, language, or race. They propose the use of stories that illustrate the effects of “otherness” and that highlight advocacy for patients “to do what is right, fair, and good in their care.” “Otherness” is a term that points out the sometimes-subtle ways in which health professionals may classify patients as different from themselves based on looks, language, or habits. Those classified as “other” may then become the source of fear, anger, or bias, all of which can affect communication and decisions about health care.

I think what Wear et al are getting at is that we, as caregivers, must go further than expanding our understanding of the lives and values of those who differ from us and providing better resources to help with communication, such as those presented by Juckett regarding culturally based diseases and related syndromes. Without personal cross-cultural experiences with patients, it is unlikely that a health professional could make use of Juckett’s information with confidence. Other barriers to communication and trust—related to social class and language—would also be likely to affect communication between a health professional and patient about an unusual folk belief. Wear et al are encouraging us to attempt, as much as possible, to see the world through the eyes of the patient using stories, art, or actual experience. While their suggestion broadens the discussion about achieving cultural competence, my own experience of living in another culture and speaking another language suggests that it takes months or years to truly begin to see the world through the eyes of someone from a foreign culture, and to have an inner understanding of the different cultural rules and, in many cases, financial limitations that shape patients’ responses. That is not to say that we should not try for such empathy, but we also need to explore other options to foster cultural competence to improve our care for a diverse population. I will use the case presented at the beginning of this essay to describe some of these options.

**Analysis of the Case, and an Approach**

**Establishing communication**

In the case I presented, the family spoke Spanish. We were able to involve a professional Spanish interpreter, who quickly clarified the complex web of relationships between family members that we had not been aware of. The interpreter was also able to help explain the severity of the injuries in ways that I wasn’t. Even subtle differences in the meaning of words can lead to miscommunication between health professionals and patients or their families. Karliner et al have shown that professional interpreters improve the quality of care provided to those with limited English proficiency more than ad hoc interpreters do. However, Hudelson et al suggest that health professionals have significant knowledge gaps about how best to use professional interpreters. The use of ad hoc interpreters such as friends and family members, while sometimes the only option, can create inaccurate information, breach confidentiality, and limit discussion of certain taboo topics. While the availability of telephone translator capabilities is an option for situations where in-person interpreters are not available, they are cumbersome and can only provide the most basic level of communications.

Ortega in this issue recommends a more formal and standardized approach to issues of the Spanish-language and Spanish-cultural competence of health professionals and the collection of data concerning their linguistic skills. My own experience as someone who speaks decent conversational Spanish is that when there is a trained interpreter available, there are often subtleties that get picked up that I would miss, perhaps partly because I am focused on the medical issues and do not consider the nuances of the language used. In addition to linguistic resources, the availability of a trained community health advocate who understands the culture of the patient can help with establishing rapport and trust. Dean et al have described the importance of rapport building in the acute care environment as part of a socioecological model of communications.

**Cultural concepts and health professions education**

In our case there was a difference of understanding about the role of blood in
addressing a health problem. Members of the Jehovah’s Witnesses religion typically refuse blood or blood products, which presents difficult management decisions when blood loss could be a factor in the outcome. Milligan and Bellamy have described some approaches to address these conflicts. There are many other beliefs about causes of illnesses or treatments related to spiritual, philosophical, environmental, or religious principles. While no one can be aware of all of the various beliefs about health, students should be taught that it is important to know that they exist, find information about them, and be able to distinguish organized belief systems from delusions that may represent mental illness. When time and the acuity of a problem allow, there should be an effort to understand the beliefs.

There may be a tendency to classify the patient with unusual beliefs as a “difficult patient” because of the challenges that exist with developing trust or communications. Steinauer et al in this issue describe the challenge of difficult patients for students. Difficult patients present barriers for students to demonstrate their competence and can create moral dilemmas for students, since these patients can influence how faculty will assess their performance. One student described the challenge of trying to care for a difficult patient:

I felt hopeless because none of the things I was doing was making my rapport with him better. Which was really frustrating because it’s like, you know, I’ve done the [preclinical communication course] stuff…. I’ve basically listened to him, I listened to his concerns … but then it was like a one-way road where I was just doing things for him, but there was … no rapport, I believe, from his side. He wasn’t trying to build a relationship with me.15

Faculty need to be aware of the potential difficulties for students who are caring for difficult patients—including those who are culturally different. However, faculty should also help students realize that there also opportunities for learning and questioning assumptions (such as described by Wear et al) that such patients can provide.

Respecting identity and the “other”

An individual’s identity is both tied to and separate from his or her culture and beliefs. Our patients in the case study could be considered to have multiple identities. They were at the same time Hispanic, separated, immigrants, Jehovah’s Witnesses, children, poor, and of low medical literacy. We had difficulty recognizing these various identities and focused on the one that appeared to create the greatest conflict, the Jehovah’s Witnesses identity. Had we been able to focus on the other identities we might have been able to establish trust and have found a solution together.

There are many identities that patients carry that can affect their needs for health care, such as transgender, disabled, Hispanic, Native American, Muslim, and African American. These identities can also elicit the reaction of “otherness” that makes the establishment of trust difficult. Hinrichs et al describe one such example in this quote from a transgender patient:

I visited a doctor at one point that almost ran out of the room when he got a sense I was different somehow. He could not leave the examination room fast enough. You could just smell the fear on him that I was different.

“Otherness” can create barriers for patients also, since they can be intimidated by their perceptions of the “otherness” of some of their caregivers. A recent episode of the Academic Medicine podcast features a further discussion of “otherness” in health care.16 Baugh in this issue suggests that African American identity is a complex construct that should be understood as separate from the identity of Africans who recently immigrated to the United States. His arguments should increase our awareness of the many ways that we may perceive similarity and difference. Unfortunately, there is a long history of prejudice and stigmatization of those who are perceived to be different. Recognizing the various identities in our country’s diverse population and finding ways to understand, accept, and honor those identities is a part of creating a culturally supportive and welcoming health care environment and addressing health inequities. The selection and training of a diverse health professions workforce can also be an important part of achieving these goals.

Understanding applicable law and ethics

Legal and ethical consultation may help with decision making when cultural conflicts are difficult or impossible to resolve. In our case, the advice from legal counsel helped the health team develop a plan (described in the next paragraph) that they felt was ethically and legally sound. It combined legal and ethical principles and considered the religious views of the family and community. However, the use of the legal system to resolve a cultural or religious conflict may not improve trust between the health providers and patient or family because of the adversarial nature of the legal system. In our case, we defaulted to our legal system and were able to find support for the protection of the children and ultimately the unconscious mother, based on principles of beneficence and justice. While the legal system can help us find a way through the conflicts during an emergency such as we experienced in this case, we should recognize the limitations inherent in using it for decision making. Under nonemergency circumstances, a more collaborative approach is preferable.

Final Words

The case I presented had a relatively happy ending. The judge who was contacted agreed with the health professionals about the risks to the children and decided to provide an order of protection that allowed the children to receive blood, and they both survived. The mother also received blood under the principle that it was not clear what her wishes would have been and that she was estranged from her husband. She survived, and I spoke with her after she regained consciousness several days later and told her we had administered blood to her and her children. She sighed and thought for a moment, and then said in Spanish, “I need to be here for my children. They are my life.” Then she added, “Entiende?” “Do you understand?”

I thought back about how we had all struggled with the decisions about the care of this woman and her children and had tried to respect her rights and the beliefs of her family and community while balancing these with what we thought was the best chance for survival for all of them. I realized that none of us could probably fully understand what this woman must be feeling now and was hesitant to answer her. Finally, I nodded my head in acknowledgment of what she had said. “Yes, yes, I understand,” I responded.
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Editor’s Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.

References


