The Challenge of Serving and Working with Diverse Populations in American Hospitals

by Geri-Ann Galanti, Ph.D.

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Dr. Galanti is a faculty member of the Doctoring Curriculum, UCLA School of Medicine; California State University's Division of Nursing and its Department of Anthropology.

Americans can take some pride in the fact that attaining what the medical profession calls "cultural competency" is a goal of most health care institutions. However, achieving this goal in today's health care environment, filled with diverse patient and provider populations, is no easy task. In addition to the complications imposed by the proliferation of managed health care, American hospitals are increasingly being staffed by and serving diverse populations. This creates the ideal breeding ground for conflict and misunderstanding, which can result in tension among the staff and inferior patient care.

Hospitals can be a source of stress and frustration for patients and their families, since they are most vulnerable when they are there and are placed at the mercy of values and beliefs not their own. It is common for people from other countries to travel here for health care since the United States offers the finest in medical technology and expertise worldwide. Since our hospitals were built by European-Americans for European-Americans, their values, such as autonomy, independence and privacy, prevail in our institutions. Patients who have immigrated or are visiting from other countries often value the family over the individual or view the male head of household as the decision maker for the patient. Families may be more apt to assist the patient in "self-care" functions while the medical staff thinks the patient should value gaining independence as a critical goal of recovery. The U.S. health care system tries to provide privacy for patients by limiting visiting hours and rarely offers sleeping accommodations for visitors. Many non-Anglo patients prefer just the opposite.

In this article I will address some of the problems that can result from a lack of attention to cultural differences, as well some ways they can be remedied. I have chosen examples of individuals who have not assimilated to a great degree and whose beliefs and behaviors deviate from those expressed in the American health care system. It should not be inferred that all or even most members of these groups would act in the manner described. We must also recognize that assimilation occurs in unpredictable stages and that many people work hard to rightfully maintain their cultural traditions despite prevailing American values and traditions.

Stereotypes versus Generalizations

Anthropologists commonly make statements about groups of people; it's what we do–we look for broad patterns of similarity among groups. However, in the health care arena we cannot make the mistake of assuming that all members of a group fit the same pattern. This is particularly important when a health care provider's logic can mean the difference between life and death. By distinguishing the difference between stereotypes and generalizations as they apply in a health care environment, we can identify the point at which our health care system breaks down and suboptimal patient care results.

While these two thought patterns appear to be the same, they are very different. A generalization is a beginning point; we recognize a cultural pattern and then look to see if the individual fits that pattern. Making the appropriate generalization in health care situations can be a useful tool that narrows the field of thinking and can sometimes help save a life or prevent medical complications.

A Chinese nurse told me about a Mexican woman who suddenly developed a severe condition requiring immediate surgery. The nurse, knowing that older Mexican women commonly view their husbands as the family decision-maker, told the physician she would call the patient's husband. The doctor told her it was unnecessary, saying that once he explained the situation to the patient, she would undoubtedly sign the consent form. The nurse ignored the physician and called the patient's husband anyway. When the physician finished talking to the patient and asked for her consent, the patient refused, saying she would wait for her husband. Since time was of the essence, the physician could not wait much longer before sending her to surgery. Fortunately, her husband arrived at that moment and convinced his wife to give consent for what turned out to be a successful surgery. Had the nurse not acted upon her generalization of gender role patterns in traditional Mexican households, the patient's outcome might not have been as positive.

A stereotype, on the other hand, is an end point and can be dangerous. In this form of thinking we develop conventional, formulaic and oversimplified conceptions and opinions. It then becomes easy to categorize a patient as being a certain way and make no further effort to learn whether the individual in question fits the conception. Take the statement, "Mexican women often express their pain loudly." If I have a female Mexican patient who is moaning about her pain and I ignore her, thinking, "Don't worry; Mexican women express their pain loudly," then I am guilty of stereotyping. If, on the other hand, knowing that female Mexican patients often express their pain loudly, I check with the family to see if this particular woman is vocal when in pain, and follow up by checking her complaint, then I am generalizing.

For example, a 62-year-old female Mexican patient who had a bypass graft on her leg could have suffered serious complications had the nurse not acted, despite his stereotypes. When she awoke in the recovery room she began screaming in pain. Her nurse immediately administered the dosage of morphine the doctor had prescribed, but to no avail. He then checked her vital signs and pulse and found that all were stable. Her dressing had minimal drainage. To all appearances, the patient was in good condition. The nurse soon became annoyed over her outbursts, stereotyped her as a "whining Mexican female who, as usual, was exaggerating her pain," and took no further action.

After an hour of cries, the nurse called the physician. The surgical team opened her wound dressing to find a large amount of blood, which was pressing on the nerves and tissues in the area and causing her excruciating pain. She was immediately sent back to surgery. Had the nurse held on to his stereotype and the physician not discovered the problem, the patient could have suffered severe complications.

In a less fortunate situation, a physician was guilty of both stereotyping and lacking knowledge about the patient's culture, when he treated my student's Irish mother-in-law who was in the hospital for surgery. Her family became very concerned when she suddenly started complaining of pain. They knew she was typically Irish in her stoicism, so they spoke to her doctor, who was from India. The physician, however, was not concerned. In his country, women were usually vocal when in pain, so he mistakenly assumed his female Irish patient would be as well. He refused the family's requests that the surgery be done sooner, thinking it unnecessary.

When he finally did operate, he discovered that the patient's condition had progressed to the point where she could not be saved. My student, an RN, felt that had the physician recognized her culturally atypical expressions of pain as a sign that something was very wrong and had operated sooner, she might have lived. This is a case where the physician made the mistake of stereotyping the patient based upon what he knew about women, without any knowledge of cultural differences between groups. Even if he knew nothing about the common Irish response to pain, he could have listened to the reports of the family who knew the patient's complaints were atypical.

Cultural Practices Can Impede Correct Diagnosis and Treatment

Knowledge of cultural practices can also be important in determining a correct diagnosis and treatment. A Korean man was brought into the emergency room, unconscious, his chest covered with red welts. The family spoke no English and no interpreter was available. The staff assumed that the patient's lack of consciousness was related to the red welts, that both were symptoms of the same condition. They spent many crucial minutes exploring incorrect diagnoses that could link the welts and unconsciousness. By the time they discovered what the patient was suffering from, it was too late to save him. Had they known to ignore the welts, they might have saved his life.

The welts had been caused by a traditional Asian practice known as "coining." There are several variations, including heating the coin or oiling it, but they all involve vigorously rubbing the body with a coin. This form of healing is believed to draw the illness out of the body, a result that is confirmed by the presence of raised welts. This practice, which is used widely throughout China, Korea and Southeast Asia, has received a lot of press because it often has been mistaken for child abuse. It is important that health care practitioners recognize this practice and not let it distract them from the real problem.

In another case, a Japanese man in his 60s was a patient in a rehabilitation unit following a stroke that rendered his left side extremely weak. He had to relearn to feed himself, dress, shave, use the bathroom and perform other daily living activities. His nurse spent a great deal of time carefully explaining to him how to do these tasks, but he listened only passively. Despite detailed instructions on self-care, the patient refused to do anything for himself and continually barked commands at the nurse. When his wife was there, he demanded she do everything for him. He was discharged after four weeks almost as dependent as when he first arrived.

His dependency greatly frustrated the nurses, who took his "failure" personally. This is one of those instances when health care providers must recognize that they are trying to impose their own value system ("independence" as a primary value) on someone who comes from a culture that does not share that value. In Japanese culture, for example, family interdependence is far more significant. It is important to distinguish when self-care is necessary for physical recovery (as in the case of burned skin, when the self-care activities provide the exercise needed to stretch the skin) or because there will be no one to care for the patient at home, and when it is merely an imposition of the American value system and family structure.

The health care culture's value of efficiency also often conflicts with patients' value of modesty. Many doctors and nurses find concern about keeping patients covered difficult when their primary focus is performing an appropriate procedure. For example, an Arab man refused to let a male lab technician enter his wife's room to draw blood following the birth of their child. When the nurse finally convinced him of the need, he reluctantly allowed the technician in the room, but not until he made sure that his wife was completely covered. Only her arm stuck out from beneath the blankets, and he watched the

technician intently throughout the procedure. The next day, the toilet in his wife's room overflowed. He flew into a rage when three men from engineering and housekeeping were about to enter the room after knocking. He refused to allow them in. The toilet went without repair until the couple left the next day.

Both incidents stem from the fact that among Arabs, family honor is one of the highest values. Since family honor is tied to female purity, extreme modesty and sexual segregation must be maintained at all times. Hospitals that do not have female physicians on staff should have a referral system so one can be found when needed. Female housekeepers should clean the rooms of Arab women and they should be tended only by female nurses whenever possible.

Disease Etiology, Worldview and Religion

Problems can also result from a disparity between the worldview of the health care culture and that of the patient population. If people believe it is God who confers both health and illness, it may be very difficult to get them to take their medications or change their health behavior. They might not share the health care culture's belief that germs cause disease and that diet and exercise contribute to one's health. They would see no point worrying about high blood pressure or bacteria when moral behavior is the key to good health.

For example, a 75-year-old African American woman was in the hospital recovering from a heart attack. She was very religious and spent most of her time praying. Her brethren from the church visited daily, and she appeared closer to them than to members of her family. During her hospital stay, the patient consented only to the procedures and medications she believed were ordered by God, because according to her world view, only God could make her well.

Other beliefs dramatically influence a patient's decision making and care needs. The notion of upset in body balance, which originated in China and spread from there to influence beliefs in other parts of Asia, India, Spain and Latin America, refers to the belief that a healthy body is in a state of balance. When it gets out of balance, illness results. In Asia, the balance is between yin and yang; in Latin America, it is between "hot" and "cold." In other cultures soul loss, along with soul theft, leaves the body in a weakened and ill state. In this case, the goal of treatment is to return the soul to the body, which usually requires a specialist, such as a shaman, who can "leave" his or her own body to search for and return the missing soul. Similarly, spirit possession involves the taking over of the victim's body by a spirit being.

From a religious perspective, many health care professionals have strong moral difficulty in respecting the Jehovah's Witness position. The conflict lies in two areas: values and worldview. The Jehovah's Witnesses believe that when Armageddon comes 144,000 of those who have followed God's laws will rise from the dead to spend eternity in heaven. Those who have followed God's laws but do not go to heaven will spend eternity in a paradise on earth. All those who have violated God's laws (e.g., had a blood transfusion, placed themselves above God by celebrating their own birthdays or worshipped idols by saluting the American flag) are doomed to spend an eternity in nothingness.

A 37-year-old woman with two children was admitted to the hospital following a horseback-riding accident. Her medical alert card identified her as a Jehovah's Witness and stated that under no circumstances was she to receive blood. Her physician knew this, but felt compelled by his Hippocratic oath to save lives and gave her a blood transfusion. His actions saved the patient's life; however, she was not grateful and sued him for assault and battery, winning a $20,000 settlement. In a study done of

Jehovah's Witnesses in the 1980s, two-thirds of those polled said they would sue if transfused against their will.

Suppose for a moment that Jehovah Witnesses are correct. Choosing to have a blood transfusion can be interpreted as giving up the chance to spend eternity in heaven or paradise in exchange for a few more years on earth. The worldview of Jehovah's Witness patients comes into direct conflict with that of most health care professionals since they value the life of the physical body. In refusing blood, the Jehovah's Witness is valuing the life of the soul over that of the physical body. The question is, does any group have the right to impose its values and beliefs on others? Can we be so arrogant and ethnocentric as to be sure we are right and they are wrong?

With regard to disease etiology, two important points should be made. First, the treatment must be appropriate to the cause. If germs cause disease, kill the germs. If the body is out of balance, restore balance. If the soul is gone, retrieve it. If an object has entered the body, remove it. All these remedies are perfectly logical. Whether these etiologies are the true causes of the disease is irrelevant. A patient who believes he or she is ill because of soul loss will not be completely cured by any amount of antibiotics. The mind is very powerful; as the placebo effect demonstrates. The patient's beliefs, as well as body, must be treated. Many Americans, for example, feel they have not been treated properly if they do not receive an antibiotic for a virus, even though antibiotics are effective only against bacteria. Psychologically, they need the pill to get well.

Second, we must not let our ethnocentrism blind us to the merits in the beliefs of other cultures. They may be right. It is easy to look down on other systems, citing science to support Western medical beliefs. But all medical systems are based on observed cause-and-effect relationships. The major difference with the scientific approach is that science is falsifiable. A scientific hypothesis can be proven wrong. The beliefs of other systems cannot.

Education is the Key to Change

If health care professionals are serious about their desire to provide the best possible care for all patients, regardless of race, gender or ethnic origin, it is essential that they educate themselves and become culturally competent. Obviously it is not possible to know everything about every culture, but the first important step is an awareness of the fact that different cultures have different rules of appropriate behavior.

Many educational institutions are recognizing the importance of teaching health care professionals about culture. UCLA School of Medicine's three-year mandatory Doctoring Curriculum focuses on teaching medical students about the psychosocial and cultural aspects of being a doctor. Students practice their interviewing skills with "standardized patients" – actors playing the role of patients. Cultural elements are a factor in a number of cases. The Division of Nursing at CSU Dominguez Hills has a four-unit required course on Human Diversity as part of its Bachelor of Science in Nursing program. At the hospital level, the Kaiser Permanente National Diversity Council has created a series of handbooks on Culturally Competent Care for a variety of diverse populations comprising its membership. Many other hospitals provide workshops on cultural diversity for staff, although a single workshop can only be a start in the journey toward cultural competency. There are many books and Web sites health care professionals can read to educate themselves. Finally, health care providers can take advantage of the diversity in their workplace by respectfully asking each other about their culture's beliefs and traditions.

Hospital Staff Relations and Diversity

Cultural differences can also create conflicts and misunderstanding among hospital staff. A Japanese physician, for example, ordered a nurse to give a patient a specific dosage of a medication. However, since everything the nurse knew about the medication led her to believe it would be harmful in that dosage, she refused. The doctor insisted, but she was adamant. When the doctor reported the nurse to her supervisor, he suggested that the appropriate response would have been to agree to give the medication, but then not to have done it. Such action, however, is not legal in American hospitals. This example highlights a difference in values between Asians and Americans. Asians generally believe it is important both to avoid conflict and to show respect for authority. Rather than refusing directly, it is more appropriate to agree to a supervisor's face and then not follow through. Americans, in contrast, feel it is important to be direct and honest. Disagreement is not avoided. In the U.S., assertiveness is valued as an egalitarian ideal. The doctor's major complaint was not that the nurse disobeyed him, but that she disagreed to his face, thereby denying him proper respect.

Sex-role differences in other countries also create friction among hospital staff. For example, a Nigerian male nurse assistant would often have "a temper tantrum" whenever a female nurse asked him to do something. Other times he would sulk and simply leave the room. What he would not do is take instructions from a woman. In Nigeria, men tell women what to do, as they are considered superior. This, of course, creates a problem in American hospitals. Nursing is a hierarchical profession in which orders are followed according to rank, not sex. The RNs thus expect nurse assistants to do what they are told. As a Nigerian male, the nurse assistant felt that he should not have to take directions from women, despite his lower professional rank. Unless someone with this cultural disposition can be placed under the supervision of another man, it will be difficult to maintain a viable working relationship on the floor.

In another example, a Filipino nurse who did not get along well with her coworkers felt they were taking advantage of her by constantly asking for her assistance. She was upset about what she perceived as obvious discrimination. Her only consolation was the belief that she was a better nurse, since she could do her work without help. In addition, she took pride in the fact that she was not lazy like they were. She took care of her patients; the other nurses insisted that patients take care of themselves. The Filipino nurse was eventually befriended by an Anglo nurse on the unit. After they got to know each other the Anglo nurse explained that it was common procedure for nurses to help each other. She confided that the other nurses thought the Filipino nurse was snobbish and proud because she never asked for help. What the Filipino nurse had interpreted as laziness was actually teamwork. The Anglo nurse also explained that American health care providers believe that independence is important and encourage self-care among their patients. The Filipino nurse was stunned, and after some help from the Anglo nurse, the cross-cultural misunderstandings were resolved. The Anglo nurse bridged the communication gap between coworkers by explaining to the others that the Filipino nurse was trying to save face by never asking for help; she didn't want them to think she couldn't do her job.

It would be helpful if hospitals offered training to their foreign-born staff on the expectations of American hospitals and the more egalitarian relationship between the sexes and among the staff. At the same time, American staff would be well advised to remember the special importance that other cultures place on certain characteristics, such as self-esteem and dignity. Although these qualities are important to all humans, they are even more strongly stressed in other cultures.

Dr. Galanti is also the author of "Caring for Patients from Different Cultures". She has been collecting examples of cultural competency for more than 20 years and regularly updates the medical profession on her findings as author of the Medicine and Culture section of the Western Journal of Medicine.

Recommended Web Sites:
www.ggalanti.com (Cultural Diversity in Health Care)
www.healthlinks.washington.edu/clinical/ethnomed/ (EthnoMed Homepage)
www.amsa.org/programs/gpit/cultural.htm (Cultural Competency in Medicine)
www.megalink.net/~vic/index.html (Transcultural Nursing)