Working with Families in a Culturally Diverse Society: Cross-cultural Care for Family Physicians

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The Working With Families Institute, Department of Family & Community Medicine, University of Toronto
In today's world, families are under increasing stress, from financial and time constraints, to family breakdown, substance abuse, and threats of violence. Family physicians are seeing an increase in psychosocial issues such as anxiety and stress-related disorders, often co-existing with and complicating medical problems such as diabetes or pneumonia. The psychosocial issues are often more difficult to diagnose and manage than are the medical problems—and all take place in the family context. Very often, the family is the key to dealing effectively with the whole spectrum of complaints, requiring a psychosocial assessment. In the crowded family medicine curriculum, this vital area of knowledge and skill is often ignored in favour of more clear-cut procedural skills.

To educate family physicians about dealing with families, a group of family medicine educators, practitioners and mental health professionals affiliated with the Department of Family and Community Medicine at the University Of Toronto founded the Working with Families Institute (WWFI) in 1985. The WWFI has developed various training experiences for trainees and practising physicians.

**Goals**

The goal of these modules is to provide a learning resource for physicians dealing with common medical and psychosocial issues that have an impact on families. The modules seek to bridge the gap between current and best practice, and provide opportunities for physicians to enhance or change their approach to a particular clinical problem.

The modules have been written by a multidisciplinary team from the Faculty of Medicine, University of Toronto. Each module has been peer-reviewed by external reviewers from academic family medicine centres across Canada. The approach is systemic, emphasizing the interconnectedness of family and personal issues and how these factors may help or hinder the medical problems. The topics range from postpartum adjustment to the dying patient, using a problem-based style and real case scenarios that pose questions to the reader. The cases are followed by an information section based on the latest evidence, case commentaries, references and resources.

**How to Use the Modules**

The modules are designed for either individual learning or small group discussion. We recommend that readers attempt to answer the questions in the case scenarios before reviewing the case commentaries or reading the information section.

The editors welcome feedback on these modules and suggestions for other modules. Feedback can be directed to Dr. Watson at dfcm.wwfi@utoronto.ca.

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*Bill Watson*  
*Margaret McCaffery*  
*Toronto, 2014*
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SUMMARY

Canada is acknowledged to be the home of one of the world's most racially and culturally diverse populations. To accommodate the diversity, Canada adopted a multicultural policy in 1971, which set a framework for a pluralistic society. Within the Canadian context, physicians need to be cognizant of the ethnic, racial, and cultural dimensions of health and medical care. For example, what cultural considerations might affect the doctor’s approach to illnesses and how do family doctors deal with disclosure of health information to other family members in a different cultural context? This module provides an overview of some of the issues that must be considered and the ways in which family physicians can best provide cross-cultural care in a setting of racial and cultural diversity. The case examples illustrate some of the more important principles of cross-cultural care.

OBJECTIVES

By completing this module, you will have the opportunity to develop:
1. an increased awareness of the influence of culture on health and medical care;
2. an appreciation of how common such issues may be;
3. an understanding of the influences and ramifications that beliefs and values of health and illness have on the delivery of medical care, and
4. approaches for providing care for patients and families from diverse cultures.

Key Features

1. Physicians need to have an understanding of the cultural and ethnic dimensions of health care.
2. Using a family-centred approach will help physicians and their patients with decision-making on clinical problems such as chronic disease and terminal illness.

Core Competencies

1. Display effective, professional and non-judgmental communication skills
2. Demonstrate sensitivity to cultural, gender and socioeconomic differences
3. Engage and mobilize other resources appropriately in the health care system on behalf of the patient
CASE STUDY

Case 1: Mr. Timinio, aged 68

Mr. Timinio is from Italy and speaks only a little English. His 35-year-old daughter accompanies him and acts as interpreter. The daughter first brought her father to see you 10 days ago. She is concerned because he is suffering from gradual weight loss, general fatigue, and a cough of three months’ duration. At times he coughs up a little blood. You ordered some basic investigations, including a chest X-ray examination and sputum cytology testing. The results indicate that he has mild anemia and the X-ray film shows a 6-cm mass in the middle lobe of the right lung, which strongly suggests carcinoma. Sputum cytology testing is positive for cancer cells.

• How would you disclose this information to the patient?
• How would you try to involve the family?

Mr. Timinio’s daughter pleads with you not to tell her father the truth about his illness; she says that he would be unable to accept such catastrophic news and would lose the will to live.

• How would you respond to this request?
• How do you feel personally about responding to the daughter’s wishes?
• Does this patient’s cultural background make any difference to your approach?
• What issues might arise if an interpreter were not available?

Mr. Timinio’s condition deteriorates. Despite all discussions about the terminal nature of his condition, the family members refuses to sign a “Do not resuscitate” order. Immediately after his death, the family gathers around their dead father in a very quiet and calm manner.

• What are some of the cultural considerations when seeking ‘do not resuscitate’ orders from a family?
• What are some of the cultural and religious beliefs that need to be considered in providing support for the family immediately after death?

Case 2: Tamiko, age 15

This Japanese-Canadian girl comes to see you because of vague abdominal complaints. Your examination reveals no physical findings and all the investigations are negative. You have noticed that she seems to be dejected. After probing, you discovered that her school marks in English are poor. You have just read in the newspaper that in Japan, there has been a surge of teenage suicides when they encounter academic failures.

• What do you do now?
• How would you relate the physical complaints to psychological distress?
• How would you manage her care?
• Will you tell her parents?
Case 3: Mr. Grantel, age 33
Mr. Grantel was admitted to hospital with severe anemia after a several-month history of bruising and weight loss. On admission, his hemoglobin was 5 and he was found to have acute myelocytic leukemia. After extensive investigations, the hematologists suggested that he receive an immediate transfusion and that bone marrow transplantation should subsequently be considered. He has come to tell you that he does not wish to proceed, because his culture and religious beliefs do not allow such treatments.

- How would you respond to him?
- What are your legal and ethical obligations?
- How would your management differ if the patient were a five-year-old child?

Case 4: Mrs. Gurpreet, aged 36
An Asian couple in your practice is pregnant for the third time. They have two daughters and are desperate to have a son. They request amniocentesis to determine the sex of the baby. They advise you that if the fetus is female, they will be requesting a therapeutic abortion.

- What are some of the cross-cultural ethical issues involved?
- How would you work towards a resolution?

Case 5: Mr. Ngo
Mr. Ngo is a political refugee to Canada from Vietnam. He comes to your office with his five-year-old child, who has a fever and bluish marks over his body.

- What do you think may have caused the marks?
- What are some of the issues that need to be considered in the care of this child and his family?
INFORMATION POINTS

1. Global migration has increased population diversity in all countries around the world. Canada has become home to people who have emigrated here from many places. Canada has had a fairly constant immigration rate over the years: in 2011, foreign-born individuals represented 20.6% of the total population, versus 19.8% in 2006. Immigration has had a significant impact on our society and on the system of medical care. Over 33% of the Canadian population now identify their ethnic background as being other than English or French, while in cities such as Toronto, Winnipeg, and Vancouver, a majority of the population so identify themselves. Most of the provinces report that a significant percentage of their population is neither English nor French in origin. Cultural pluralism is thus a reality in Canada.¹

2. During the early 1950s, some 90% of the immigrants that settled in Canada originated in Europe, but in the past five years fewer than 10% have come from there. Most of Canada’s immigrant population now originates in such globally diverse areas as South Asia, South East Asia, South and Central America, and Africa. In the 2011 census, over 19% of 32.8 million Canadians had an ethnic origin other than European. First Nations comprise 4.16% of the population.¹

3. Canada is not alone in coping with such demographic changes. Many countries have undertaken specific initiatives to examine and understand the relationship between cultures and health.² England, for example, has been a leader in looking at what the British call "ethnic minority and majority issues," and the data they have produced provides one good source in the area of multicultural health.³ Australia has also been examining multicultural health issues,⁴ while in the United States, the Office of Minority Health was created as a result of the Task Force Report on Minority Health.⁵

4. Family physicians must be sensitive to the differences in how various cultural groups view health, illness, and life stages, including birth and death. Family medicine has changed. It is now widely recognized that patient-centred medical care is important.⁶,⁷ Physicians must be sensitive to the cultural dimensions of care if they are to be responsive to patients’ needs. Cross-cultural care incorporates not only common cultural and racial characteristics, but also the variations that exist within individual groups.⁸⁹ Similar care issues frequently occur as a result of gender, age, religious, or socioeconomic differences.¹⁰ Properly applied, therefore, the principles of cross-cultural care will be applicable to intra- as well as intercultural communication. Recognizing and applying the principles of cross-cultural care will help physicians to practice and provide care in a pluralistic society. The net result will be improved patient compliance and a more effective and rewarding medical practice.
Definitions and Cautions

5. Multicultural health refers to an approach to health care that features a systemic approach sensitive to racial and cultural diversity. Within this context, cross-cultural care is an approach to care for patients of various cultural backgrounds.

6. To begin, we need to recognize the following cautions:
   • The use of terminology that refers to a person's ethnicity, such as "Chinese" or "Italian" should be seen as exclusively referring to ethnic background, not to citizenship.
   • Generalizations that refer to commonalities must be carefully used. Generalizations are dependent on the point of commonality identified by the generalization. For example, “Hispanic” would refer to mother tongue, not geographic origin, as many who speak Spanish come from diverse points of the globe. On the other hand, “Italian” refers both to people with that mother tongue and country of origin. “Jewish” refers to people of that religion; South Asian denotes people originally from that geographic part of the world. The use of any generalization with reference to an individual results in stereotyping if the generalization is an overgeneralization or inappropriate. However, generalizations can form background information to help formulate questions, but they should not be used as absolute characteristics of an individual's life.
   • Socioeconomic considerations may well outweigh other cultural factors. Education and literacy levels, financial resources, and access to needed services are all significant considerations in the care of individuals and their families, and may well supersede ethnocultural issues.
   • Each individual's life circumstances must be recognized and carefully considered. While information on cultural characteristics (generalizations) can help in better understanding the cultural context of the individual's life and help frame exploratory questions, life circumstances such as time of immigration, gender, age, immigration by choice or by force, as in the case of refugees, are all considerations that will impact significantly on the cultural context of any individual or family.

Medical Considerations

7. Significant possible genetic and biological associations must be considered in the care of individuals from various ethnic groups. For example, thalassemia is more prevalent amongst those from Mediterranean or Chinese communities, Tay-Sachs disease is prevalent among people of Jewish origin, and lactose intolerance varies considerably between different ethnic groups, ranging from approximately 40% among those from northern European countries to as high as 80-90% among people in the black or Chinese communities.

8. Similarly, mortality and morbidity may differ considerably between communities. For example, those from the black community are more likely to suffer from hypertension, and may also be less likely to respond to some therapeutic agents such as beta blockers, because of biological factors.
People from the Chinese community have a greater risk of cancers of the nasopharynx: prevalence is 35% higher than in the Caucasian community in the first generation, and decreases but persists in subsequent generations. Individuals of Chinese descent who present with recurrent sinus problems should therefore be investigated appropriately.

**Cross-cultural Interactions and Communication**

9. It is difficult for any of us to realize our own particular biases in our daily interactions and communications. These biases are part of our personality. We need to recognize that the way we interact with others is built on years of interaction, personal cultural norms, values, beliefs and patterns that have been developed over the course of each person's life.

10. These patterns or biases assume increasing importance when the interactions and communication occurs in settings in which there may be significant cultural differences. These interactions require greater understanding of the underlying cultural norms, values, and patterns of communication. For example, some cultures place greater emphasis on the concepts of autonomy or independence, whereas others may place greater emphasis on interdependence with the family or community. In the former instance, interactions between an individual and the family or community are generally seen as distinct from each other.

11. However, in other cultures, a different pattern of interaction is more likely, in which the individual is central to the family and not apart from it. Isolating an individual in this model of interaction is likely to become very disruptive to the community and family; reintegration is often very difficult and sometimes may be impossible.

12. Similarly, communication styles differ considerably between cultures. Misinterpretation of verbal and non-verbal cues can lead to unnecessary difficulties in health care interventions. Respect, as shown by silence, may be interpreted as agreement or apathy by another cultural group that places a greater emphasis on asserting oneself, while in a more expressive culture it may be interpreted as anger or hostility. In all instances, the expression of the sentiment is cultural. Misinterpretation of the cues can easily lead to misunderstandings.

**Beliefs of Health and Illness**

13. Beliefs about health and illness causation differ among cultures. While some attribute illness to specific biological causes that can be proven scientifically, others look at illness as a result of disharmony between such concepts as mind, body, spirit and the environment. In general, such beliefs may be divided into three broad categories of causation:
   i. beliefs in nature or natural causation of health and illness;
   ii. beliefs relating to the self which affect health, and
   iii. beliefs in the effects of supernatural forces on the health of individuals.
14. Natural beliefs most commonly maintain that health is a balance or harmony of opposing elements or forces, disruption of which results in illness. The belief in hot and cold elements is common to many cultures. In traditional Chinese medicine, *yin* energy represents cold, preservative forces while *yang* energy represents hot, active forces. A mild imbalance of these two implies a diseased state and a total disruption of the harmony may lead to death. Health may be restored by either removing the excess (purging, sweating) or strengthening the deficit (dietary). Thus, many foods and food groups are included in such belief systems, as part of a method of maintaining or restoring the hot/cold balance of the natural or healthy state of the body (Table 1). An illness believed to be caused by too much *yin* can be treated with foods that are *yang* and vice versa (Table 2). Included in the natural causation is the ubiquitous belief of an external energy flow which, when disturbed from its natural flow, can result in illness. Concepts of energy flow have their origins in diverse global beliefs, such as *vitalism* in North America, *Ch'i* in traditional Chinese medicine, *prana* in yoga, and *pneuma* from the ancient Greeks. The use of herbal medicine, acupuncture, Shiatsu, and homeopathic medications can all be related to re-establishing the balance of such energy.

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<tr>
<th>Table 1</th>
<th>Hot/Cold Classifications (based on common Hispanic beliefs)</th>
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<td><strong>Foods</strong></td>
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<tr>
<td>HOT</td>
<td>NEUTRAL</td>
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<tr>
<td>Foods</td>
<td>Alcohol</td>
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<tr>
<td></td>
<td>Coffee</td>
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<tr>
<td></td>
<td>Peas</td>
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<td></td>
<td>Peppers</td>
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<tr>
<td></td>
<td>Eggs</td>
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<tr>
<td><strong>States</strong></td>
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<tr>
<td></td>
<td>Pregnancy</td>
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<tr>
<td>Medicines</td>
<td>Penicillin</td>
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<td></td>
<td>ASA</td>
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<td></td>
<td>Diuretics</td>
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<tr>
<td></td>
<td>Most western medicines</td>
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<tr>
<td><strong>Illness</strong></td>
<td></td>
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<tr>
<td></td>
<td>Constipation</td>
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<tr>
<td></td>
<td>Diarrhea</td>
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<tr>
<td></td>
<td>Ulcers</td>
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<td>Rashes</td>
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### Table 2

#### Yin/Yang Classifications

<table>
<thead>
<tr>
<th></th>
<th>Yang (Hot)</th>
<th>NEUTRAL</th>
<th>Yin (Cold)</th>
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<tbody>
<tr>
<td><strong>Organs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder</td>
<td></td>
<td></td>
<td>Liver</td>
</tr>
<tr>
<td>Stomach</td>
<td></td>
<td></td>
<td>Spleen</td>
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<tr>
<td>Large &amp; small intestine</td>
<td></td>
<td></td>
<td>Heart</td>
</tr>
<tr>
<td>Bladder</td>
<td></td>
<td></td>
<td>Lungs</td>
</tr>
<tr>
<td><strong>Foods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td>Beer</td>
</tr>
<tr>
<td>Coffee</td>
<td></td>
<td></td>
<td>Chrysanthemum &amp; many herbal teas</td>
</tr>
<tr>
<td>Peppers</td>
<td></td>
<td></td>
<td>Water chestnuts</td>
</tr>
<tr>
<td>Ginger (and many spices)</td>
<td></td>
<td></td>
<td>Watercress</td>
</tr>
<tr>
<td>Peanuts</td>
<td></td>
<td>Rice</td>
<td>Melons</td>
</tr>
<tr>
<td>Most western medicines</td>
<td></td>
<td></td>
<td>Herbal medicines</td>
</tr>
<tr>
<td><strong>States</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
<td>Postpartum</td>
</tr>
<tr>
<td>Youth</td>
<td></td>
<td></td>
<td>Old age</td>
</tr>
<tr>
<td><strong>Illness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td>Colds</td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td>Anemia</td>
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<tr>
<td>Ear ache</td>
<td></td>
<td></td>
<td>Leukemia</td>
</tr>
<tr>
<td>Fevers</td>
<td></td>
<td></td>
<td>Shortness of breath</td>
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</tbody>
</table>

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i. These classifications are based on some common Chinese beliefs.
ii. Foods that have been heated by methods other than boiling increase yang.
iii. Foods that have been refrigerated or frozen increase yin.

15. The *self*-relating category of beliefs refers to those that associate the individual’s psyche or nature with the maintenance of health and the cause of illness. No balance or harmony is postulated and believers feel that the psyche can cause illness. Two categories are identified: psychosomatic and constitutional. Under the psychosomatic category, people believe that an individual’s psyche can cause illnesses. For example, in China, neurasthenia—a condition that includes neurotic depression, anxiety, hypochondriasis, hysteria, and physical symptoms—is a common
Another example of self-belief is the Italian concept of nervosa, referring to a mental state that may adversely affect an individual’s health. A person considered nervosa is believed to suffer from a real illness that consists of mind and body dysfunction. When they believe that their illness is simply a part of their nature, it is difficult for a physician to treat them medically. Constitutional beliefs hold that some individuals are constitutionally more susceptible to illness than others, e.g., in some south-east Asian communities, mental illness or emotional disturbances may be considered a result of familial inheritance. In order to avoid the stigma of having mental illness, these people prefer to manifest physical symptoms instead. Physicians need to recognize the potential shame or harm that may be created by attempts to force new cultural beliefs on these patients.

The third category of health/illness-related beliefs is the association with supernatural causes. These forces or influences are beyond the scope of nature and require special knowledge or intercession beyond most individuals’ abilities. These disorders are believed to result from some force or entity that supersedes the normal world. Healers provide both natural treatments and intercede with supernatural forces on behalf of the patient. For example, in some Asian cultures, sickness is believed to be a result of bad karma, or a form of punishment from a previous life.

Religious or supernatural considerations may also significantly affect diet. Some foods may be prohibited by different religions or belief systems, for example pork by Islam and Judaism, beef by Hinduism, and shellfish by Rastafarianism. Many religions/belief systems require much stricter recognition of dietary observations, for example kosher in the Jewish community, halal among Muslims, and vegetarian cooking that has not come into contact with utensils that have been used for cooking meats, as adhered to by some Buddhists. Many religions/belief systems prohibit the use of alcohol, for example the Baha’i faith, Christian Science, Mormonism, Islam, and Sikhism. For these patients, medications prescribed in syrup form are not acceptable, since these syrups frequently contain alcohol.

Often, people adhere to multiple beliefs that may coexist, such as the belief in prayer or ceremony while receiving in-hospital care, and seeking herbal or alternative medicines at the same time. People often see no conflict in recognizing and working within multiple parameters; for example, a patient may utilize the chaplaincy system within the hospital, which frequently co-exists comfortably with self-help programs or relaxation therapies.

**Dying and Death**

All cultures maintain certain rituals and beliefs at the time of death. Such processes are important to help ease the suffering of the living and to permit the family and friends to accept the loss of a loved one and get on with their lives. There are a variety of rituals that should be recognized at this sensitive time, for example:

- Some religious beliefs such as Christian Science, Islam, Jewish and Rastafarians do not permit a post-mortem unless required by law.
• In some faiths, such as Islam and Hinduism, people who are not of that faith should not touch the deceased. In these instances, health professionals should wear disposable gloves when touching the body.
• Some faiths, such as Islam and Judaism, require a prompt funeral.
• The deceased person’s body must be attended until cremation occurs. Many of the Hindu faith prefer to have the body laid on the ground.

Cross-cultural Care
20. Cross-cultural care is based upon a patient-centred approach that encompasses the family as well as the community identified by the individual (Table 3). The approach involves the family physician working with other health care providers, the patient, the patient’s family, and the extended cultural support group. 38, 39, 40, 41, 42, 43, 44

<table>
<thead>
<tr>
<th>Table 3. Cross-cultural model for physicians and other health care providers dealing with patients’ health and illness</th>
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<tbody>
<tr>
<td>• Explore one’s own issues in dealing with health and illness.</td>
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<tr>
<td>• Work with other health care providers, the patient, the patient’s family, and support group.</td>
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<tr>
<td>• Attempt to understand the patient’s and the family’s ways of dealing with illness.</td>
</tr>
<tr>
<td>• Work with patients and their families who are coping with serious chronic illnesses (e.g. Parkinson’s disease, Alzheimer’s disease, schizophrenia) and cancer.</td>
</tr>
<tr>
<td>• Try to find resolution by balancing one’s professional responsibility with the wishes or perspectives of patients and their families.</td>
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</table>

21. Physicians must recognize their own personal cultural biases or perspectives. As previously discussed, such biases are strongly affected by the physician’s own personal family and life experiences, generally known as an individual’s world-view. The degree to which physicians are able to recognize their biases will be a significant factor in how well they will be able to understand and respond to the cultural components of the care intervention. 45, 46, 47

22. Physicians and other health care providers must understand and appreciate the world-view of patients and their families. This will involve recognizing factors such as beliefs of health and illness, lifestyle or life circumstances, as well as the individual’s family and community relationships. The family physician will also need to explore the impact of the illness on the patient’s cultural context, such as family members’ roles, decision-making, family function, and interaction patterns. Physicians must be sensitive to the fact that patients may not understand or even agree with what physicians consider to be the objective of the medical intervention. An understanding
of cultural health beliefs will facilitate communication. However, this understanding does not replace sensitive communication where the patient's wishes are respected and thoroughly considered.

23. Discussion with the patient is important, to better understand the patient's particular point of view. This process will give the physician the opportunity to assess the relative importance of some issues that are affected by the patient’s background. For example, did the patient resettle or relocate and if so, when? To what extent has the patient been acculturated to the dominant culture? Has the patient been subjected to bias or racial discrimination, either intentional or unintentional, in the process of seeking assistance? Are there social, religious, or cultural norms to be respected? Will the patient be able to afford treatment and have the resources to attend for treatment? These and similar considerations are important issues that the physician must understand before proceeding.

24. In many situations, treatment will be simple and straightforward. In others, resolution may be more difficult. Extended family and community members whom the patient identifies as important should be encouraged to participate. In cases where there is disagreement between the physician and the patient, it is important for the physician to keep the door open to follow-up. Physicians must be prepared to accept that the patient may not agree with the physician's treatment plan. In those instances where the physician feels very strongly that treatment is required in order to maintain the person's health, or if the condition is potentially life-threatening, it is important that physicians recognize the limitation of their influence. The patient may not accept the physician’s recommendations; this is the patient's right. The most a physician can offer in those instances is an open door.

25. In a cross-cultural setting, it may be necessary to include family members to a greater degree than the physician may be used to. Spouses, parents, and extended family may need to be involved, to resolve the issue appropriately in the patient’s cultural context. Solutions found within the individual’s cultural context are much more likely to be successful.

26. Achieving a satisfactory conclusion to the patient/physician intervention will be much easier if the physician understands cross-cultural issues. A cross-cultural approach does not necessarily mean that the health care provider accepts the cultural practices or beliefs; it means that the physician or health care provider understands the role of the patient’s context or culture.

CONCLUSION

27. To summarize some of the basics about cross-cultural care, the family physician needs to:

- find the most appropriate, culturally sensitive way to communicate to the patient and the family about the presenting condition.
- explain the various treatment modalities to the patient and family. This explanation should include the nature, adverse effects, complications, prognosis, and outcome of the condition.
• listen to the patient and family to learn how they would like to receive treatment, then work collaboratively with them, respecting their wishes and values.
• be aware that family members and their cultural perceptions play a part in illness management.
• remember to focus not only on the patient, but also on the well-being of other family members as they strive to cope with the illness.
• be aware of spirituality in patients and their families.
• welcome support from the patient’s cultural or spiritual groups.
• reach a resolution in the patient/family-doctor interaction.
Case 1: Mr. Timinio

Several issues arise in this particular case. The most immediate is communication and how ethical issues are involved in providing or withholding information from patients. Some cultures, such as in North America, place a high value on being informed, because they place a high priority on independence and autonomy. Other cultures do not place such a high value on autonomy.

Working with patients suffering from cancer is a daily part of family practice. One out of four people can expect a diagnosis of cancer in a lifetime, and three out of four families will have a member with cancer at some point. Coping mechanisms to deal with dying and death are part of any cultural group; how these are carried out in different cultural groups differs considerably. In Mr. Timinio’s case, the best way is to assist him and the family to accept the reality of the impending loss and the seriousness of the illness. The dominant North American norm is to focus on the autonomy of the individual and place a priority on patients' right to know everything that affects them and their destiny. In some cultures, such as Japanese, patients prefer not to ask, even when the doctor knows and the patient knows that the doctor knows. In other words, the involved patient does not want to know all the details of the illness, but would not mind if the family members knew. This is consistent with the extended family concept.

A related issue in this case is the patient’s health/illness beliefs. It is not uncommon for many seniors of Italian background who immigrated to Canada in the 1950s to have a limited understanding of cancer. Many are not knowledgeable about recent advances in medicine and most of their experience has been with individuals that they have seen in considerable pain or distress from terminal cancer; hence the reluctance of the family to discuss the issue with the father.

The family physician has to weigh the sharing of medical information with the patient involved while respecting cultural considerations raised by the family members. Approaches to such sharing of information vary culturally. Many Asians view confrontation as disrespectful and lacking in moderation, so an indirect way to resolve problems is advisable. One possible solution for the physician is to indicate honestly to Mr. Timinio in the presence of his daughter that he has a serious illness. Mr. Timinio can then choose the extent to which he and his family members would like to be involved with the details and the possible treatment plan. Once there is a mutual understanding and an openness to input from the family, the physician can then proceed with the patient’s care. An article on whether or not to tell patients about the diagnosis of Alzheimer’s disease concludes that the literature supports honest communication with patients and families about the diagnosis, but the timing and method of revealing can vary depending on the existing relationship with the patient and the family members.
In this instance, it would have been necessary to ask a family member to provide interpretation. Even with a professional interpreter, the family may have been alienated if a reasonable compromise was not achieved between the physician, patient and family. A compromise might have been that limited information would be given, with an agreement that no one would lie to the patient. Such an approach must be considered on a case-by-case basis and negotiated with the patient and family.

Some people believe that signing a "do not resuscitate" order is equivalent to participating in the death of the individual. There may be the concern in this instance that the person’s spirit or soul may be troubled because the loved ones have in some measure contributed to the death. The result may be a delayed or impaired grief resolution, with remaining anxieties or doubts over the person's death.

Cultures express grief in many ways. There is a belief in some cultures that expressions of grief or distress at the time of death will inhibit the soul from leaving the body or prevent the soul from making a transition to the after life. Hence it is important to show restraint at these times. In other cultures, it is most appropriate to express grief openly. To do otherwise suggests that the departed individual is not being mourned.

Case 2: Tamiko

In this case, the physician might not be aware of the correlation between academic failure and teenage suicide. Tanaka-Matsumi 57 and Mock 58 have shown that Japanese-Americans are more likely to express depression through somatic and/or metaphoric language than are North Americans. The physician should try to explore with the patient how her low English grades affect her life and family. If the physician is sensitive to the high value that parents from other cultures put on the importance of academic advancement, she/he can then appreciate the pressure and stress that Tamiko is going through, and can help her to cope with the problem better.

Lee 59 offers certain treatment strategies in working with Chinese immigrant families that may well apply to other Asian immigrant families. The strategies include:

• forming a social and cultural alliance with the family;
• involving the whole family in the initial sessions;
• defining the problem and setting treatment goals;
• employing a benevolent but authoritative attitude;
• building an alliance with members who have power;
• using a directive approach;
• assuming multiple helping roles;
• taking a psychoeducational approach;
• reinforcing culturally sanctioned coping mechanisms and cultural strength, and
• overcoming language and cultural barriers.

In this case, the physician can honestly explain that the investigations have revealed nothing abnormal and can openly ask Tamiko whether perhaps she is...
going through some difficulties in life that result in her physical complaints. The physician can then find out whether school, family, and relationships could contribute to the distress. Once a possibility is identified, e.g. poor schoolwork, the physician can inquire if Tamiko feels willing to talk to some family members who would help. If she agrees, the family can then be involved. At all times, the doctor should show Tamiko that he/she is interested in her well-being and would like to help her resolve her problem.

**Case 3: Mr. Grantel**

This case presents an ethical dilemma for the family physician. On the one hand, the specialists have made it very clear that the bone marrow transplantation can save the patient's life. On the other hand, the patient does not wish to go against his beliefs. The family physician is often placed in the middle. The four basic principles of biomedical ethics are *justice, beneficence, nonmaleficence, and autonomy*.

- **Justice** means that the physician ensures that the patient is treated fairly and all the available resources to manage the patient’s condition are provided. This is not the issue in this case.
- **Beneficence** means that the physician advocates for the well being of the patient.
- **Nonmaleficence** means “do no harm” to the patient. In this case, not doing the transplant may result in death.

The family physician may face a personal dilemma. If the physician maintains that the priority must be to preserve life regardless of religious or cultural beliefs, he/she might insist on treatment. However, **autonomy** means that patients have the right to direct their own care. The best route for the doctor is to share openly his/her dilemma or even frustration in weighing the two sides. The doctor may indicate a preference, but must respect the patient's choice and should remain available for consultation.

If the patient is a child, the parents must be given all the information about the child’s condition, possible treatment or non-treatment, and the benefits, risks and consequences of each option. Having heard all these, if the parents decide to choose non-action and the child's life is placed in jeopardy, the Children's Aid Society must be contacted and become involved.

**Case 4: Mrs. Gurpreet**

In several Asian countries, people believe that only the male child continues the family genealogy. In a country like China, where the official government policy allows one child per family in order to limit the population explosion and poverty, the parents often want that child to be male. This family already has two daughters. The parents really want to have a son. The family physician will certainly understand their frustration, concern and hope. It may also be appropriate to find out if the couple would like to involve other individuals in the decision-making process.

- The patient’s age fulfills the criteria for amniocentesis. But determining the sex of the fetus is not included in the criteria, particularly when there is no concern for hereditary disease. Theoretically one could refer her for amniocentesis, but not for the reason it was requested. However, if the
results of the amniocentesis showed a normal female fetus, then the family doctor would have to deal with these issues:

- Differing beliefs about therapeutic abortion
- Differing beliefs about 'selecting' the gender of a fetus
- The rights of the parents versus the right of the fetus

**Case 5: Mr Ngo**

It is a common belief among people in many cultures that illness results from an imbalance of cold and hot elements within the body. Some people believe that the imbalance must be removed to help the individual get better, for example the common practice of sweating out a cold. This case represents such an example: the practice of cupping is used to remove the offending causes of disease. Cupping consists of gently heating a glass or similar object and applying it over the body, creating a partial vacuum where the glass is applied. The result is an ecchymosis that appears as a bruise. In another related technique, people scratch a coin on the body, creating marks. This practice is known as "scratching the wind" and is harmless. But if physicians are not sensitive, they might have mistaken these to be possible physical abuse and report them to Children’s Aid, causing unnecessary turmoil and trouble for the immigrant families.

Other issues must be considered in the care of this individual and family. They may be political refugees. The introduction of the police and Children's Aid may be extremely frightening and even threatening. Moreover, without translation services, the situation may well go unrecognized. In the medical treatment of children, we also need to consider such factors as immunization and nutrition, issues that are frequently associated with recent refugees who have been caught in situations of political distress or unrest and whose health status may have suffered as a result. Illnesses such as anemia and parasitic diseases should also be considered. Moreover, in south-east Asia, hepatitis B is endemic and consideration should be given to determining the hepatitis status of the family and the child.
REFERENCES


