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Health Care Quality Solutions: Cultural Implications in Health Care

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In health care organizations and physician practices, dynamic relationship issues and concerns among family members and their physicians often provide an endless source of cultural challenges.

In my career, one of the situations I experienced was similar to the following example. A risk management staff member was called to the ICU where it was learned a young man who traveled to the United States from abroad suffered an accident resulting in a life-threatening injury. At his bedside were friends who were traveling with him. His family was a full day's flight away.

The patient's mother arrived and asked for cultural rituals to be put in place. In this case, 30 lit candles around the bed. In an oxygen-rich environment, the flames were problematic. Various attempts to explain the reasons why such a request was not possible fell on deaf ears. Wanting her son to have the best chance of healing, the mother stood firm.

To find the best solution for this family, communication needed to go beyond a simple, "No, we can't do that here." Respecting cultural differences and individual needs are but one of the multifaceted aspects of care giving. So are demonstrating a respectful acknowledgement of the patient's culture, leading from a compassionate heart and being open-minded when problem solving. The starting point is using a team approach that identifies the root cause of the issue.

In this case, with the family's permission, a member of the care team contacted a local religious leader in the communitywho was familiar with the traditions and customs of the family. As a result, the care team was better able to understand how they could support the family. The religious leader also provided the much-needed assurances to the mother that battery-operated candles would suffice in satisfying the needed ritual.

Avoiding Allegations of Cultural Discriminatory Practices

Claims of discrimination may come as a result of various factors, such as:

- Religion
- Race
- Gender
- National Origin
- Sexual Orientation
- Disability
- Language
- Medical History

Language and Other Communication Barriers

Ensuring that your organization has acceptable, easily accessible and competent interpreters for patients is vital. Unfortunately, having a written plan for addressing cultural differences is often an oversight. Without a written plan or process, variations in practice by staff will occur and there may be missteps along the way. Intentions may not align with actual outcomes for the patient.

In a study conducted by the National Health Law Program at University of California, Berkeley School of Public Health, 32 of 35 professional liability claims had no documentation that the hospital or physician used a proven and competent interpreter. In some instances, the interpreters were minor children.

According to Quan (2011):
"A competent interpreter is someone who is knowledgeable in issues related to ethics, standards of practice, confidentiality and the role of the interpreter, as well as one who is proficient in English and the non-English language, including specialized medical terminology in both languages."

Creating a written plan and educating your team as to the importance of verifying that staff has followed through on the plan is essential in ensuring

compliance and avoiding patient and family complaints and potential civil rights violations. Ultimately, the responsibility for a safe and credible interpreter falls to the physician as well as the care team.

Gender Bias in Health Care

Women who have heart disease or are suffering from an emergent heart condition display symptom differently than men and may go untreated or care may be delayed. Even women's routine care often will not include a heart risk check like the male patient exam (Powell, 2018).

Also, women are more likely to be judged by their body weight than a male patient. Often, a physician is quick to dismiss health concerns solely based on the patient's size. A woman over the age of 40 may often receive assessments that are incomplete or a plan of care that is not accurate for her condition.

The common quip of "female, fat and 40" comes to mind as it takes its toll on the delivery of women's health care. For example, a female patient presenting with abdominal pain will be quickly diagnosed with gall stones before the exam is complete. However, there are many other conditions that cause abdominal pain or set a patient up for a predisposition to gall stones, not just being "female, fat and 40" (Juan, 2007).

Female patients have been also on the short-end of medical research studies until recently. Since 2018, clinical trials funded by the National Institute of Health require that female subjects now be included (Powell, 2018). However, privately funded studies do not have that requirement.

Medical professionals need to know whether the medication they are about to prescribe was studied in women at the research level or if the test being ordered is as accurate for women as for men.

Sexual Orientation

Patients in need of health care should be able to access a caregiver without any concern for mistreatment or denied care. Several laws have come about through the Affordable Care Act that helped ensure equal care for LGBTQ patients. However, the current administration has sought out ways to make it possible for physicians, businesses and insurance companies to discriminate (Ahmed Mirza, 2018). With such potential for discrimination, the LGBTQ patient may be discouraged from seeking care. Finding another care giver or an alternative source of health care may not always be successful as the patient may have restrictions due to insurance or geographical circumstances.

To Hug or Not to Hug?

One argument supports the hug by physician to patient as a way to communicate compassion and kindness or provide support. The argument against such physical contact could be based on religious issues as well as whether the hug may alter the physician and patient relationship or damage it, if the gesture is misconstrued. Perhaps the best approach is to take the cues from the patient, honor the setting you are in and be cautious in each circumstance of cultural prohibitions for such intimate contact.

Ways to Improve

Clinicians in the United States must be prepared to care for a diverse population and one way to do so is through "cultural competency or cultural humility," (Busko, 2018). Cultural competency includes all factors that make up our unique qualities as individuals. This affords care giving professionals to ensure for their own awareness of the unique needs of others. This approach requires an open mind and an understanding that cultural competence can only come from a lifetime of learning. Many medical schools offer such training as do health systems employers.

The American Medical Association offers training through their module on cultural competency (Murphy, 2017), as do other graduate education programs.

Another option is to put in place the elements of the acronym LEARN, as highlighted by Busko (2018):

- **L**isten, encouraging patients to explain their situation.
- **E**xplain clearly.
- **A**cknowledge the differences between what patients understand and what you know.
- **R**ecommend a treatment plan that is consistent with your conversation with a patient and document this, as well.
- **N**egotiate to get agreement from patients on a course of action.

Other considerations include:

- Clearly document any cultural preferences the patient may have.
- Ensure that the patient is understood – that proper interpretation/translation is provided for language, sight and hearing barriers.
- Make certain that when informed consent conversations are taking place, the patient understands at his/her knowledge level.

- Accommodate cultural differences as much as reasonably possible.
- Verify that any consent documents are written in a language the patient understands.

Physician Discrimination

In the context of this article, we should also address those situations where the medical professional is on the receiving end of discriminatory behavior based on his or her sex, religion, gender, etc. Discrimination is but one more stressor physicians may face (Jain, 2013). Patients may exhibit problematic behavior based on the physician's race or national origin.

Often, residents are trained to best acknowledge a patient's culture and other such factors, but not trained how to react when a patient is biased or attempts to humiliate or discredit the physician in some way.

Solutions

- Learn limit-setting strategies and techniques for defusing aggressive and negative behavior can be helpful to the medical professional
- Make certain as a resident or medical student that disruptive and discriminatory patient behavior is reported to your supervising physician.
- Reassign care or terminate the physician/patient professional relationship.

Resources

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