

Negotiating Clinically Workable Solutions Across Cultures: Lessons Learned

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For roughly 20 years, clinicians have recognized cultural competence as important to medicine. A case from early on illuminates what may have changed – and what has not – in the ensuing two decades. More importantly, it shows that cultural competence is a crucial clinical skill set, not simply an abbreviated form of anthropological knowledge.

CASE ANALYSIS

TBL, a 26 year-old Hmong man, was admitted via the Emergency Department to an urban, East Coast teaching hospital for upper GI bleed from previously undiagnosed esophageal varices. He had no history of hematemesis, and had complained of no discomfort prior to this sudden-onset event. On workup he was noted to have abdominal ascites and considerable edema of the extremities. He was diagnosed with chronic hepatitis and portal hypertension. Recommended treatments included sclerotherapy of the varices, and liver transplant.

Seen through biomedical eyes, a transplant offered Mr. L the hope of many years of good quality of life. No transplant portended rapid deterioration and high risk of re-bleeding (at 20-30% risk of fatality per episode). Other therapies included sclerotherapy of the varices, medical management of his portal hypertension, and a diet of clear liquids with supplemental intravenous nutrition. Meticulous informed consent procedures would be followed. The treatment plan would be demanding, but a team of skilled physicians and nurses would see the patient and family through it; the transplant center was top-notch. The patient was young and otherwise healthy, an excellent candidate for transplant. The informed consent process included careful explanations, with illustrations and simple sketches; the clinicians encouraged questions, and repeatedly and willingly answered them. The hepatologist was optimistic, willing to spend “extra” time with the family.

From the Hmong perspective, things looked very different. There were con-

siderable misgivings about the health care team and treatment plan—starting with the diagnosis. How could anyone be sick for years without knowing it, without even feeling bad? Who were all these people involved in Mr. L's care? Why were they all there? Where was the one you trusted? Some of these people were young and unskilled and clearly “practicing” on Mr. L. Alarming, many caregivers displayed poor knowledge and attention by asking questions that had been answered several times already. A great many declined to answer the family's questions, suggesting they “talk to the doctor about that” – but which one? and *when*? What were these people concealing, ducking their questions? Even the most senior doctor would not directly answer basic and straight-forward questions (“when will he get better?”). Obviously, family members would need to be ever-present and vigilant, actively protecting Mr. L.

In addition, there were three influential “disconnects” between the cultures and expectations of hospital medicine and the Hmong patient, family, and community: the special needs and appropriate treatment of sick people; the issue of consent and where, precisely, it was located; and the functions, meanings, and nature of the Liver.¹

TREATMENT OF THE SICK

The presence of family members at every juncture in illness and recovery, and the importance of proper nutrition in times of debility, were crucial for Mr. L, his family and community supporters. Hospital personnel would have preferred to limit visitors to two or three, during prescribed visiting hours, which family members declined to follow. The Hmong custom called for a family advocate to accompany Mr. L at all times, since the ultimate safety of patients—not to mention the gauge of practitioners' competence—is a family responsibility. The hospital's rejection of accompaniment during the first sclerotherapy in-

tensified distress, raising a “very big suspect that some of the doctor[s] might try to do something to my people” (TBL, author interview). Accommodating the request during the second treatment engendered even more distress: not having been given an explanation, Mr. L's accompanying ‘brother’ (in clan lineage terms, different from US definitions of sibling-brothers) feared he was being choked. His reports dovetailed with an existing oral tradition of potential bizarre American medical abuses: that after patients die, American doctors open up their heads to take out their brains; that American doctors take large amounts of blood out of patients; and that American doctors might try to eat the kidneys, liver, and brain of deceased patients.²

Mr. L's clear-liquid diet created deep distress for him, and concern within his support system. Several days into his hospitalization, when Mr. L was asked how he was doing he replied with quiet sorrow, “I want to eat rice.” For traditional Hmong, rice is the dietary centerpiece, their “staff of life.” It is the fundamental ingredient of every meal and, lacking other ingredients, can convey both the physical and emotional satisfaction of nourishment. How could a sick man be denied this quintessentially life-sustaining food? (Those too ill to eat are nourished with a rice-water broth.) Repeated entreaties for rice were met with sympathetic explanations of why this was impossible – but the conversations went no further. This was to remain one of Mr. L's most traumatic memories of the hospital experience (TBL, author interview).

LOCUS OF CONSENT

Hmong families traditionally seek and select the treatments for their sick members.³ The individualism so central to American culture—and underpinning the concepts of patient Autonomy and Informed Consent—is indifferent in traditional Hmong culture. Individuals are not expected to make important decisions for themselves; the more consequential

the decision, the more critical family and community consultation become. As a war orphan, Mr. L had no birth family to advise him. He was therefore exceptionally grateful to clan and lineage members: at one point 17 people in his room debated in minute detail the implications of suggested treatments.

Though his own opinions and preferences were sought in these discussions, Mr. L demurred. He worried that his family members' better judgment might be swayed by emotion if he expressed preferences. He also felt that since the problem was his own, he could not trust the clarity of his own thoughts: he was confused by its proximity and immediacy (TBL, author interview). Hospital staff were anxious about coercion or 'undue influence' of the patient by these numerous and 'unrelated' (by US kinship norms) advisors, and they continued to proffer the consent form, and address their questions, only to the patient. They would likely have found troubling the notion that the actual *consent* resided in a collective process: the patient could provide only the signature—and he wanted it that way.

CONSIDERATIONS SPECIFIC TO THE LIVER

To traditional Hmong, the liver carries the special symbolic significance with which American macro-culture invests the heart.⁴ It is the locus of feeling and personality, character and motivations. What kind of person might one become through liver transplant? Who would want to emerge from surgery a stranger to himself and others?

There were also ominous religious and spiritual implications. Alongside the Christianity they had practiced for many years, Mr. L and other community members retained several profoundly affecting traditional Hmong religious beliefs, including the existence of multiple souls per person, and anatomical location of one of the major souls in the liver. What if Mr. L should die during surgery, after removal of his liver? The ghastly prospect was a mutilated, soulless body, incapable of reanimation, and a rootless soul unable to pursue its proper spiritual destiny. Risks to reincarnation, and to Mr. L's surviving family members from an unquiet, earth-bound spirit, were numerous and frightful. Incredulity at the notion that

someone's "dead liver" could be installed and made functional in a new body paled by comparison. All things considered, the metaphysical risks of liver transplant considerably outweighed the physical risks, and their consequences were more severe, longer-lasting, and affected more people.

CONSTRUCTING COLLABORATIVE SOLUTIONS

The immense disjunction of expectations, treatment goals, and worldviews in this case seems to defy resolution. Yet solutions might have been found, had the resources and concerns of *both* belief systems been brought together. The hospital kitchen might have offered rice-water as part of Mr. L's clear liquid diet; or family members might have brought him clear rice broth from home. Worries about rumored American abuses might have been explored with empathy and reassurance, not dismissed with scorn. Questions might have been invited and answered as to why Mr. L seemed to choke during sclerotherapy, and why no one stopped the endoscopies when he did. Even the radically different 'moral anatomies' and concerns about the liver might have found a jointly crafted solution. Indeed, several friends and family members did generate a possible scenario for transplant. It went like this:

Could a Hmong shaman, skilled in the soul-calling that is often required in instances of soul loss, accompany Mr. L to the operating room? Could s/he call forth the soul from Mr. L's liver, maybe even tend it during surgery, and/or call it back to its new home after the transplant procedure was completed? Well, yes, that might be possible. If the liver donor could be assured to have received the proper last rites of his/her religion, so that the soul inhabiting that liver would have gone on its spiritual way and the organ could be received as an empty vessel, would that make a difference? Possibly; worth considering. Would the transplant surgeon permit the shaman into the OR? Mr. L's hepatologist was willing to propose it.

In the end, transplant was refused: it was just a step too far. Of the hepatologist's concern for his life expectancy without transplant, Mr. L observed philosophically, "If I am going to die, then I want to die with my liver."

RELEVANCE TODAY

What makes this 20-year old case relevant to the practice of medicine in Rhode Island today? Now that at least two generations of Hmong have been born and are growing up in the US, gaining acculturative distance from the old ways of the initial refugee generation? Now that the Hmong community of Rhode Island, relatively small to begin with, has largely migrated to larger US Hmong population centers? Now that the likelihood that many of you will treat Hmong patients is fairly slight, especially away from the greater Providence area?

One answer is that many of the challenging features of Mr. L's case might hold for *any person*, of any ethnicity, nationality, language fluency, or educational background—involving as they do the meeting of lay people and medical professionals, neither of whom has much understanding of the lives, goals, experiences, knowledge, values, and mandates of the others. Sadly, these features are as likely to be found in clinical settings now as they were then.

The central lessons of cultural competence, of culturally-responsive care, are not "content" lessons about specific identity groups. Rather they are about the nature of diplomatic relations between any two groups: lessons about the importance of understanding and accommodation, and the consequences of their absence; about the difficulty of explaining ourselves to others when so much of what propels us literally 'goes without saying'; and lessons about the potential for crafting workable solutions by drawing on the cherished beliefs, values, and goals of *all* parties, no matter how incongruent they may seem.

CULTURAL COMPETENCE RULES OF THUMB

The study of cross-cultural cases allows us to derive broadly applicable conceptual guidelines for culturally competent care.

Among them are the following:

"Culture is the entire non-biological inheritance of human beings. Everything that is socially constructed and learned is a part of culture."⁵

Anything that humans have acquired from other humans that has not come through biology, has been acquired through culture. This applies as much to medical knowledge and practice as to

shamanic knowledge and practice, to science as to religion, to systems of authority relations and recognition, to dietary rules, to kinship systems, and modes of communication. We *all* operate on the basis of cultural assumptions, expectations, and norms. This *self-awareness* is clinically relevant knowledge that wards off the false presumption that culture is a curiosity, or that it comes through the door only with patients.

“Difference” requires a reference point.

Different from *what?* from *whom?* Answering this question helps keep us honest and accurate. The answer (e.g., “different from me” or “from most of my other patients, with whom I seem to have a good working relationship”) provides a foundation for building solutions. Continue the inquiry: different in what respects? Which is important to the situation (“the difference that *makes* a difference”)?⁶ How do the differences affect providing care that is acceptable to both patient and physician? (Table 1) We must remind ourselves that “Difference does not equal Deficit.”

Cultural Barriers are always between the groups in question.

It is tempting to assign the barrier to the group that is “not-me.” We often (usually unconsciously) assign the barrier to the “other” group because our own cultural templates are largely invisible to us. Thus we commonly say that “the patient doesn’t speak English” to identify a “language barrier.” The *real* barrier is the fact that *we and the patient* do not share a language. It is easy—and incorrect—to leave ourselves out of the equation.

Culture is not identical to race, ethnicity, nationality, religious affiliation, or minority group status.⁷

Diversity *within* identity groups is as great as diversity among them. Phrases like “our culturally diverse patients” refer accurately to an entire patient population, but *not* to particular subsets. “Culturally diverse” is not a proper euphemism for ethnic minority membership – although its usage in the health professions gives that impression. A scan of journal articles quickly reveals this implicit equation, by

the juxtaposition of “cultural diversity” in titles and “ethnic minorities” in the opening sentences or paragraphs. The high value placed in medical culture on linguistic and conceptual precision should motivate us to reject these careless usages.

Cultural competence is not “snapshot anthropology.”

It is useless to memorize facts about “what *x people* believe” to facilitate cross-cultural interactions. The enormous range of variability within cultural groups, coupled with the tremendous dynamism of cultures, makes this a futile exercise. A little knowledge in this respect is dangerous, because it facilitates stereotyping and its resulting damage. Although physicians should have some basic understanding of the cultural repertoires of groups in their patient rosters, that understanding should be used like epidemiologic data: to outline a broad phenomenon that might be taken into account, but that gives no information about a particular patient.

If one of your patient groups were Hmong, the case of Mr. L would be informative about traditional beliefs and practices operating in the early resettlement years. Some of these will still be represented in the US Hmong population today; one might want to inquire about them. It would also be essential to know that today’s Hmong communities are extremely conversant with electronic technologies (used in part to preserve cultural traditions), use the Internet, include at least one state legislator and scores in local government positions, and are increasingly represented across the professions. The growing ranks of American Hmong holding doctoral degrees include 59 physicians – among them Xoua Thao, Brown Med 1989.⁸ Hmong culture has undergone rapid, extensive change in a short period of time. A static picture of “what Hmong people believe” would hinder good medical care.

CONCLUSION

In the end, culturally responsive care is *individually* responsive care, informed by understanding of the patient before you, in the context of family, community, and culture. Patients themselves are often the best sources for this information.

Table 1. Questions for Health Care Encounters⁹

Seek answers to the following questions with respect to **all the participants** (physicians, nurses, chaplains, patients, families, etc.)

- What do you/they feel is the most pressing problem?
- What does the particular diagnosis or treatment/prevention recommendation mean to you/them (cognitively, emotionally)?
- What special requirements or avoidances do you/they understand to accompany this condition?
- What are your/their goals for treatment/prevention? What do you/they want to gain from them? To avoid?
- What range of healing/health maintenance resources are you/they familiar with, and which do you/they feel are applicable to the patient’s situation?
- What level of priority do you/they assign to the medically indicated course of action, when weighed against other life goals and constraints?
- What is important to your/their sense of self or identity?
- What are your/their expectations of sick people and their care-givers?
- Who do you/they feel should be in charge of decisions and actions that affect the patient?
- Who is considered family, and how is their kinship defined (by you/them)?
- What do you/they feel is the proper or essential role of family members and significant others with respect to the patient? The role of health professionals?
- What do you/they define as an appropriate decision making process? Who needs to be involved? Why?
- What sources of authority do you/they recognize? Where does the authority of health professionals fit into your/their hierarchy?
- What concessions can you/they bear to make?
- What are the consequences of having your/their important values and goals disregarded or thwarted?
- What common ground can you discover?

Cultural competence is a key clinical competency, and like other clinical competencies it entails an interplay of knowledge, skills, and attitudes. It requires continual practice and updating through deliberate rehearsal and new learning. Perhaps more than others, it requires reflective and mindful practice. Cultural competence begins with self-assessment and self-awareness.

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