

Culturally Competent Care - a book of case-studies for medical students –

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Introduction

The presence of migrants and refugees in the Netherlands has changed physician's medical practice. Physicians increasingly deal with a diversity of patients. Medical teachers and students are interested to learn about diversity and ethnicity, yet appropriate educational material is scarce. In order to deal with this lacuna, a project has started in 2003 to develop a book of case-studies about immigrant patients.

Development of cases

We used national and international literature to identify the most significant problems in care for immigrant patients. Subsequently we approached physicians and asked them about cases concerning these specific problems. In a semi-structured interview with the physician further information about a specific patient was obtained. This information was completed with information from a semi-structured interview with this particular patient. Physicians were selected from different disciplines (general practitioners, company doctors, gynaecologist, internist and cardiologist), patients differed in ethnic and cultural background (Moroccan, Turkish, Surinamese, Afghan, Ghanaian, Bosnian).

Case framework

Each case-study discusses the physician's perspective as well as the patient's perspective. A case is divided in several sections, each section is followed by knowledge questions (for example: how can compliance of immigrant patients be improved?) and reflection questions (for example: what would you do if an illegal patient asks you for a place to stay?). Knowledge questions will be answered in separate textboxes. Topics like prevalence of diseases in different ethnic groups, cultural and religious habits and communication skills are discussed in these boxes. The case-study concludes with a reflective analysis where the reflection questions are discussed and related to intercultural competences. On average, a case covers six pages.

The cases confront students with a versatility of real life problems. Students are taught intercultural competences like: recognizing own ideas and prejudices, being open to patient's illness experiences, knowledge about prevalence of different diseases, knowledge about the effects of migration on health, and they are encouraged to develop (intercultural) communication skills.

In total 20 case-studies will be written. The cases will be published in 2005.

Examples

Diabetes patient suddenly pregnant

- epidemiology diabetes mellitus type II
- consanguinity
- values about pregnancy, motherhood, family influence

A non-insured patient

- specific problems of illegal patients
- migration history (torture and trauma)
- regulations concerning asylum seekers and illegal patients

Misunderstanding in the consultation

- communication- and language problems
- virginity and Islam

Suspecting female circumcision

- medical and cultural aspects
- values concerning physical integrity
- regulation

A patient with heart problems

- illness experience and presentation of complaints
- Diet and Ramadan

EMEL

A concised case-study as illustration

Emel, a 26-years old woman of Turkish origin, has got diabetes mellitus type 2 (DM2) for four years. Despite education and medication with insulin, she is not able to regulate her diabetes well. Her HbA1c is often between 15 and 20%. In addition to this, she suffers from several complications such as hypertension, obesitas (BMI>30), liverenzyme-disturbance and kidney problems.



Knowledge question: How can you educate your patients as good as possible about diabetes?

Diabetes education to migrant patients

It is difficult to give good education to diabetes patients because of the complexity of the disease. Advice about diet, physical activity and medication does not always relate to the patients' way of life. It can be a problem for migrant patients when their usual or favourite food is not included in their prescribed diet. For some patients it can be difficult to maintain their diet at other places than at home, for example at work or during family visits. If you give dietary advice to your patients try to let their food preferences return in the prescribed diet. Try to work out, together with the patient, which moments make it difficult to maintain the diet, e.g. at work (is the patient able to eat regularly in the work situation?), and whether there is a social network (e.g. does the family support the patient? Is the patient sensitive to what the family thinks or says?).

Physical activity can create another problem. For patients who consider sports as a form of leisure an advice to have more physical activity may easily be imbedded in their daily life. For patients who do not consider physical activity as part of their lifestyle (elderly, migrants) it can be quite difficult to adhere to this kind of advice. Apart from that, there are large differences in what persons regard as physical activity. It is easily understood as sport or doing physical exercises in the gym, but less often as walking stairs, working in the garden or walking to the bus stop. As a physician you can take into account these daily activities of patients when giving advice, underlining that these activities are also forms of physical exercise. When advising migrant patients it is of extra importance to check if you talk about the same concept.

Cultural sensitive interventions show that health improvement can be achieved when the cultural background of the patient is taken into account. In practice this usually means that education is given by someone who shares the same ethnic background with the patient.

Epidemiological differences between ethnical groups

Different studies show that the prevalence of diabetes mellitus is higher in certain migrant populations. The prevalence is highest amongst people from Hindustani-Surinamese origin (above fifty years of age 30% and above sixty it is 40%). The prevalence in the Turkish, Creole-Surinamese and Moroccan populations is three to six times higher than within the native Dutch population. Research shows that the blood sugar levels of Turkish and Moroccan diabetes patients are often worse than in the native population. On the one hand this can be related to lifestyle factors (obesitas, physical inactivity), on the other hand this can be an indication that diabetes care is not cultural sensitive and less to the benefit of migrant patients.

Emel just told her internist over the telephone that she is five weeks pregnant. This came as a surprise to the internist. The internist knew that Emel wished for children but in the eyes of the internist it is better to regulate Emel's diabetes first. Then Emel can consider a pregnancy.

The internist had explained the risks of a pregnancy in this situation to Emel, like premature birth, congenital defects or a stillborn child. According to the internist Emel agreed with her to postpone a pregnancy. After all Emel is young enough.



Reflection question: Why do you think Emel did not follow the advice of the internist?

Emel is married for almost five years now and her family keeps asking why she does not have any children yet. Over and over again she had to explain that the internist has advised her to wait with a pregnancy because of the diabetes related risks, but her family does not think of this as a good reason. They assume Emel does not want to have children. The past years Emel opposed to this until she had enough. She does want to have children *very much*. Although rationally she knew she better had to wait with a pregnancy, she decided to follow her feelings and become pregnant.



Reflection question: What do you, as a physician, think of Emel's choice?



Knowledge question: Which (cultural) aspects could have played a role in Emel's choice? How would you deal with them?

(Cultural) influences on choices

Emel is well aware of the risks she is taking. Research shows that patients need to have certain knowledge about their diabetes but that, despite this knowledge, they interpret the advices of their physicians in their own way or simply ignore them. So non-compliance does not only result from ignorance. Patients are not passive receivers of medical advice but interpret actively what an advice means for them and feel they have their own reasons to deviate from it. Furthermore, a physician should take into account that patients will not always tell everything and that sometimes you are in for a surprise. This is the case for native as well as for migrant patients. With migrant patients, however, you may feel a larger 'cultural distance', a feeling that you do not understand each other. Try to find out whether this is caused by a difference in culture or that other factors like a difference in personality, a difficult communication or bias play a role.

Decisions about a pregnancy are also based on customs and values about parentage. These differ between cultures. Commonly, Turkish women become mother at an early age. At the age of 21 about half of the Turkish women in the Netherlands have one or more children. The mean age in the Netherlands of women to have their first child is 29. Almost every Turkish woman becomes a mother (95%). Of Dutch women around 15% stays childless. Motherhood at a young age is also related to a low Socio-Economic Status.

Apart from the fact that Emel is quite old compared to the age of Turkish women when they have their first child, she also weighs her family's opinion in her decision. One of the dimensions on which cultures can be compared is the dimension collectivism versus individualism. Worldwide, collectivism is the rule and individualism a (western) exception. In collectivistic cultures group awareness plays an important part. Peoples' behaviour is for the largest part based on norms which are strongly related to social roles.

Turkey is more collectivistic oriented than the Netherlands. That is why the opinion of her family and the sense to fulfil a social norm will probably be more important to Emel than for young western women. For four years she complied with the internist's individualistic oriented advice and defended this to her family. The idea of the internist that Emel is young enough to wait with a pregnancy may medically be right. But also here the physician's own background (culture, education) influences the physician's ideas.

Reflection

At first it appears as if a misunderstanding has occurred caused for example by miscommunication: the physician thinks that Emel did not understand the risks of a pregnancy in her situation. Emel, however, did understand the risk, that was why she first postponed a pregnancy. Other factors are important for her as well, like the wish to be a mother and the influences she experiences from her family. The physician has a medical perspective about this decision and weighs the medical risks. The patient, however, often has, apart from the medical perspective another perspective. Patients always have their own reasons to follow or to disregard an advice. Maybe these reasons seem irrational to you as a doctor, for patients these are definitely meaningful. In this case the misunderstanding is not because the patient did not understand the risks. There is a misunderstanding because the physician is under the impression that there is an agreement with the patient. This agreement is suddenly broken by the patient. As a physician you should be open to the patients' perspective and accept that patients make their own choices. With migrant patients do not assume too quickly that the problem is about communication. This may block the possibility to find the real reason.

The physician's perspective is based on norms learned during the medical education, like the importance of autonomy, of rational decision making and the importance of biomedical information. Also own norms and values play a role. It is important to know what norms are important to you and what they are based on. Often you are confronted with your own (implicit) norms and values when the behaviour or choices of a patient causes irritation, incomprehension or anger, as may be the case with the risky pregnancy of Emel. The clashing of norms can negatively influence the doctor-patient relationship. If you as a physician know your own norms and values and support these, this makes your own behaviour more clear, for yourself as well as your patients. Could the risky pregnancy (from a medical point of view) have been prevented by the internist? In this point in Emel's life probably not, as it is Emel's hard-felt wish to have a child. But maybe earlier efforts to regulate Emel's diabetes could have been made, for example in being more sensitive to her (cultural) background. In this case Emel's pregnancy becomes a motivation for her to be more compliant; it gives her a feeling of self-management of her disease. Sometimes, as a physician, you should empathize with the patients' perspective and respect their wishes even though they do not fit your own normative framework. Supporting and helping the patient can enlarge the self-management of a patient.

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