Maximizing Teachable Moments in Cross-cultural Care for Learners in the Office-based Setting

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In the clinic setting, there is little time to adequately teach medical students and residents. Teaching core medical didactics usually takes precedence over teaching concepts such as cultural competency. But, without some understanding of how cultural beliefs can affect and possibly interfere with medical care, the practice of medicine may often be ineffective. Thus, the importance of teaching learners how to demonstrate cultural competency cannot be ignored.

Learners tend to be extremely thorough, obtaining every possible detail. Their history taking is usually exceptional, with the acquisition of more data than we could ever obtain in a visit. But, occasionally they miss the “big picture.” This is amplified when there are language barriers to overcome, and time with a translator is limited. The classic example is when a Latino patient says, “Mi corazón me duele” and the emotional “heartache” is misinterpreted for chest pain, and an inappropriate workup is performed.

So, what is cultural competency? Cultural competency “enables a physician, in a culturally discordant encounter, to respectfully elicit from the patient and family the information needed to make an accurate diagnosis and negotiate mutually satisfactory goals for treatment.” It is the ability for a health care worker to respect and appreciate a person’s cultural beliefs to give that patient the most effective medical care possible. It implies valuing the patient’s ideas and using them to negotiate health care issues. Now, how do you apply this to actual patient care and teaching situations?

After interviewing a patient, a third-year medical student presented the following history: “The patient is here for her prenatal visit. Her past medical history is negative except for a previous miscarriage. Today, she is refusing her Pap smear because she thinks it will cause her to have another miscarriage. I told her it was very important that she have her Pap smear today, but she refused.”

Together, we went in to talk to the patient. She explained she had received a Pap smear during a previous pregnancy. Soon thereafter, she miscarried, and she was certain that receiving the Pap smear caused her miscarriage. She had heard tales of other women who had prenatal care and miscarried after receiving a Pap smear. She did not want to lose another baby. We explained the importance of an undiagnosed cancer or infection and recommended that she have a Pap smear now. The patient was glad we listened, but she persisted in declining the Pap smear, fearing that it was a risk to her baby’s life. In the end, we negotiated an agree-
ment that I would refer her to an obstetrician-gynecologist later in her pregnancy for a second opinion about a Pap smear. We agreed to refer her when she was 28 weeks pregnant, and the baby would have a greater chance of survival if born prematurely.

The student said to me, “I didn’t get all that from the history.” I replied, “Well, we have to respect her concerns and her wishes. We have explained our concerns to the best of our capability. It is difficult to explain the concept of preventive medicine to persons that have never received it in their life. But in time, hopefully, we will gain her trust.”

This vignette illustrates some key points in regard to cultural competency. One obvious point is that cross-cultural care is not only affected by language barriers but also by misinterpretations of ideologies. It shows the importance of appreciating the patient’s “explanatory model” of her illness. The ideas of the healthcare workers were not consistent with those of the patient. If the student had forced her ideas, this would have resulted in distrust by the patient toward the student.

Cultural competency enables the physician to overcome the obstacles of language, cultural, social, religious, sexual, psychological, or any other possible difference and to incorporate those differences into a carefully tactful, respectful recipe for a patient’s care. An essential component is the willingness to listen. It also encompasses the desire to learn about a person’s culture or views. This is merely basic good bedside manner. We are family physicians because we care. We are teachers because we care. This often-overlooked notion of the past is too important to sweep aside in our busy days of teaching. Therefore, as instructors, we must encourage our learners to not only talk to patients but, more importantly, to listen to what they are saying. Our learners must learn to appreciate body language and nonverbal cues, especially when there are language barriers to overcome.

We must explain the nuances of a culture to students and residents so that they may appreciate what took us years to learn. For example, we may teach a learner that “Yes, I understand you find it impossible to accept that a patient believes the cause of her bleeding problems result from being soaked in a rainstorm while on her menses. However, some patients have not received much education and do not know what a uterus is. Instead of arguing with her or trying to correct her, we must reassure her by saying ‘I am sure it was quite terrible getting caught in a rainstorm. After we examine you, if there is still a concern, we can order an ultrasound to see if there is something else going on.’ We must always respect the patients’ thoughts and especially their fears.”

We must tell our learners to never belittle a patient’s beliefs. Our patients do not understand what they do not understand. And lastly, we must teach ourselves to remember these things as well. We all have heard some of the most outlandish stories from our patients only to later realize that they were only trying their best to explain themselves. And woe for when we completely miss an important diagnosis when we just didn’t listen.

Another important concept is that we cannot stereotype a culture or ethnic group, although some generalizations are often made. There is great variety within ethnic groups depending on socioeconomic background, education, and acculturation to the American culture. We should be extremely careful to understand each patient’s beliefs and not make assumptions based on our past experience with a patient from a similar background or culture.

It does not take hours of didactics to teach some basic concepts of cultural competency. For example, one model summarizes important concepts of cross-cultural care in an easy-to-remember mnemonic, LEARN: listen, explain, acknowledge, recommend, negotiate. Medical students and residents can quickly learn to use a model such as this in their patient encounters.

Allow the learner to concentrate on seeing one patient while you see two or three others. When he/she is ready, take your time and listen to the thorough medical history that the learner will expulse. Psychosocial issues may frequently be left out. Cultural issues may be unacknowledged to them. Take a moment to give a few pearls on cross-cultural care to go along with the medical pearls. These may take learners farther than another macrolide antibiotic for pneumonia lecture.

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REFERENCES