



Multicultural Medicine

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Refugees and immigrants enter this country with knowledge, values, and behaviors about health, illness, and treatment that may be drastically different than those that underlie Western biomedicine and the American healthcare delivery system. Healthcare professionals must take on the potentially complicated tasks of diagnosing and treating these newcomers in manners that are appropriate and effective, overcoming barriers of language, concepts, and expectations. Though not all refugees or immigrants experience difficulties with the American medical system, the potential pitfalls for patients and providers are numerous.

Part A of this chapter describes seven general concepts about healing systems that are pertinent for healthcare professionals who strive to provide culturally competent medical care to refugees and immigrants. Part B provides six recommended fundamental principles for applying the information in clinical settings to help professionals provide quality healthcare and promote therapeutic alliances. Though these concepts and frameworks illuminate multicultural care for immigrants, it is important to emphasize that they are relevant to all healthcare encounters.

Part A: General Concepts about Healing Systems

Cultures around the world and through time have created healing systems to respond to sickness and life-cycle changes such as pregnancy, birth, puberty, aging, and death. All healing systems have beliefs about what constitutes health, how the body functions normally, what happens to make it function abnormally, and what people can do to restore health.¹⁻⁴

According to Sharma, there are three minimum requirements for a healing system: it must claim to be curative, have a systematized body of knowledge or theory, and a specified technical intervention that can be applied by an expert practitioner.⁵ These features are applicable to the healing systems in all cultures, irrespective of their origin or content, or whether they are primarily folk, traditional, or professional in nature. They apply to ancient systems, such as the Chinese traditional medicine, or modern, such as biomedicine. And they apply to healing systems with hundreds of millions of adherents, such as the Indian Ayurvedic system, or small healing systems whose devotees are counted in the hundreds, such as those in remote areas of Africa and South America.

It is important for healthcare professionals to have at least a basic understanding of the various cultural healing systems to which their patient populations adhere. Immigrants and refugees bring elements of their healthcare systems with them, often adapting and modifying them to their new homes, adding to the healing cacophony. To help impart some order, we provide information on seven general concepts of healing systems and apply them to a case.

Concepts of bodily functions, health, and disease

All healing systems have beliefs about what constitutes health and disease, and a coherent system of knowledge about how bodies function normally and abnormally.¹⁻⁴ Understanding these may be a first step in gaining insights into health behaviors and forming therapeutic partnerships. For example, the traditional Indian system of Ayurvedic medicine is

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built on the ancient knowledge in the Atharvaveda text about the three humors – *Vita*, *Pitta*, and *Kapha*.⁶ Each person's prescribed lifestyle of diet, exercise, and meditation is designed to maintain his or her specific balance between the three humors. Ayurvedic medicine has influenced other Asian systems, such as the Thais. The traditional Han Chinese system conceives of humans as being part of the universe that is modulated by the opposing *yin* and *yang* forces (male/female, hot/cold, wet/dry, dark/light), which are always changing.^{7,8} Health is maintained by balancing *yin* and *yang* forces and diseases are treated by restoring the balance. The Chinese traditional concepts of health and disease permeated other Asian healing systems, such as Vietnamese traditional healing, including the *am/duong* (or *yin/yang*) forces, and in turn had probably been influenced by them.⁹ Traditional Mexican beliefs of health include the importance of balancing hot/cold and wet/dry, concepts that probably were swayed by traditional concepts of the native peoples, such as the Mayans and Aztecs, and by concepts brought to the New World by Spaniards whose practices had originated with Hippocrates' theory of disease and the four humors.^{10,11} Every healing system has ideas about how natural, social, and supernatural aspects of life are related to health, illness, and healing.² The *natural realm* describes the connections between people and the earth, such as dirt, water, air, plants, animals, etc. The *social realm* describes the connections between people of different ages, genders, lineages, and ethnic groups. And the *supernatural realm* describes the connections between the spiritual world and the human world and includes religious beliefs about birth, death, and the afterlife. Healing systems are indivisible from the cultures in which they are present and are interwoven with other sociocultural elements ranging from familial relations to concepts of the universe.¹⁻⁴ No connections or influences on health systems may be stronger than those of religion and spiritual beliefs.¹² For example, Chinese medicine is interwoven with and influenced by Taoism, Ayurvedic medicine by Hinduism, and Tibetan medicine by Buddhism. Santeria healing rituals comes from Santeria, the syncretic religion formed from Yoruba gods and Catholicism, when Yoruba slaves in the West Indies were forbidden to practice their traditional religion but discovered their gods in Catholic saints. Similarly, people's religious beliefs are intertwined with their interpretations and experiences of health and disease. The Islamic faith, for instance, teaches that all life events come from God or *Allah*, and that illness may be sent as a punishment, or an opportunity to atone

for sins.^{13,14} Some Muslims believe that Allah has predetermined life events, and all statements about the future include the phrase *Insha Allah*, 'If Allah wills,' to acknowledge and accept God's authority. Muslims try to endure their illnesses, and accept their experiences without losing faith or patience with God.

Theories of disease causation

Every healing system has explanations about etiologies. Determining causation has several functions: it guides therapy prospectively, confirms treatments retrospectively, and provides solace and meaning to human suffering. Helman organizes causations into four categories, individual, natural, social, and supernatural causes, with overlap between the categories.² Some healing systems focus more on the individual and natural areas (such as biomedicine), while other systems know that all illnesses are ultimately caused by supernatural forces (such as the Azande). Still other systems examine the intertwined natural and supernatural reasons (such as Aztecs, Haitians, Hmong, Mayans, and Yoruba). In the latter situations, people may identify a single cause for some illnesses, such as change in weather or a germ; for other illnesses, people may recognize an underlying supernatural cause, such as soul fright, which subsequently renders the person more vulnerable to a natural cause, such as a germ; while for other illnesses, particularly chronic life-threatening illnesses, people may suspect and address multiple causations over time. Another method of categorizing disease causation distinguishes between 'internal' and 'external' etiologies.¹⁵ Internal etiologies refer to pathophysiological mechanisms in the body and identify proximate causes, i.e. what specifically caused the internal disorder or disease. Models for understanding proximate causation vary greatly from culture to culture. In Chinese traditional medicine, etiologies invariably involve alterations in the flow of energy or *qi*. In Western biomedical models, disease is usually the result of alterations or disorders of internal physiological homeostatic systems (e.g. electrolyte abnormalities or cancers) or the passage of external pathogens or mechanisms of disease and injury into the physical body (e.g. infectious agents, toxins, or bullets). Note that in the Western system, there is no disease state until such harmful items are 'internalized,' where they can disrupt homeostasis. In contrast, external etiologies refer to mechanisms outside the body and identify the ultimate causes, i.e. what is the external root of

the internal disorder or disease. These tend to focus on spiritual, religious, and philosophical reasons, such as ancestral spirits, divine providence, or fatalism. They may be the primary focus of concern, or may be an adjunct to help consider questions such as ‘why me?’ or ‘why now?’ In contrast, Western biomedicine has tended to ignore such topics. In some cultures, for example among the Azande in Africa, ultimate causation is often the dominant issue. As E. E. Evans-Pritchard discovered in the 1920s, if Azande people were cut while running down a path, the wounds were only part of their concern; they would hope to discover which spirit they had offended or who had bewitched them.¹⁶ Their focus was not on the specific and proximate mechanism of injury, but rather on the spiritual, or ultimate cause.

Classification of diseases

Each medical system classifies illnesses into discrete entities, similar to the manner in which biomedical professionals categorize diseases.² Some systems have been carefully mapped out and written down, such as the Chinese and Ayurvedic systems. Others come from oral traditions, and have only recently been written, such as the Hmong in Laos, and Badaga in India. While all people may recognize abnormal bodily symptoms, such as diarrhea or fever, various healing systems classify them differently. For example, the Maya in Chiapas, Mexico, have eight types of diarrhea while an ethnic group in Mozambique has seven types of diarrhea.¹⁷ The Pakistani folk classification system describes several types of diarrhea, such that Pakistani mothers are more willing to use oral rehydration solution for some types of diarrhea than for others.¹⁸ In another example, Hmong have a disease classification system about childhood fevers with rashes (*ua qoob*) that differs from Western classification, which has caused conflicts between parents and providers about conducting septic evaluations of fever and about obtaining measles vaccinations in a measles outbreak.¹⁹ Different systems ascribe different names and different meanings to a disease, such that there may be no direct translations and no similar interpretations between systems. For Amharic people from Ethiopia, their traditional word for illnesses with jaundice such as hepatitis is *yewof bashiyta*, which means ‘bat disease,’ because jaundice was understood to be transmitted by bat urine when bats flew through the air in Ethiopia. To avoid this connotation, interpreters at Harborview Medical Center

in Seattle, WA, use the word *gubbät* or ‘liver disease’ when discussing hepatitis.²⁰ Unique entities that are recognized by one healing system but not by others, particularly biomedicine, have been called folk-illnesses or culture-bound syndromes.^{2,21} Culture-bound syndromes have a specific cluster of symptoms, signs, or behavioral changes recognized by members of the cultural group, and responded to in a standardized way. They usually have a range of symbolic meanings – moral, social, or psychological – for both the victims and others around them. Culture-bound illnesses often link individual cases of illness with wider concerns, including victims’ relationships with the community, supernatural forces, antisocial emotions, and social conflicts, in a culturally patterned way. Ideally, the response to the illness can lead to the expression and resolution of these wider concerns. The psychiatric Diagnostic and Statistical Manual of Mental Disorders, version IV, includes categories for culture-bound syndromes, including Latino *susto*, Malaysian *amok*, and Laotian *latah*.²² However, folk illnesses can also pertain to physical conditions and not just to psychiatric conditions, including Latino *empacho* (abdominal pain attributed to intestinal blockage by food), *ataques de nervios* (attacks of nerves, caused by social anxieties), and *caida de la mollera* (fallen fontanelle caused by handling a baby roughly or pulling the breast out of an infant’s mouth quickly).²³ Western societies are not immune to the attribution of culture-bound syndromes. Examples from the USA include *high blood*, *colds*, and *chills*, while the French may suffer from a particular type of liver pain (*crise de foie*).² Like the other culture-bound syndromes that may seem more exotic to biomedical providers, each is identified as a unique disorder, mainly recognized and meaningful to individuals from particular cultures. Biomedical physicians may make psychiatric or medical diagnoses, such as psychosis, upper respiratory infection, appendicitis, heart attacks, or dehydration. As folk illnesses are studied, it is apparent that some are not limited to one cultural group, but are shared by many cultures. For example, *koro* or genital shrinking is found among a wide range of Asian cultures; *nervios* is found in various Latino American and Mediterranean cultures; and evil eye has similar features between Latin Americans *mal de ojo* and the Arab’s evil eye.²¹ Similarly, *neck pain* and *headache* are routine among white collar employees and *back pain* among blue collar workers in many cultures around the world. While these may have pathophysiological ramifications, they also provide expression for personal, familial, communal, and social issues and forces. Other illnesses that start as folk illnesses,

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such as chronic fatigue syndrome and premenstrual syndrome, have become part of the biomedical lexicon, which entitles them to be designated as 'true' diseases worthy of medical treatment. For Western medical practitioners treating immigrants and refugees, accurately diagnosing diseases and not overdiagnosing or underdiagnosing is a challenge. Health professionals must avoid providing too many and too few cultural diagnoses when they are not appropriate. For example, diagnosing *ataques de nervios* when a seizure disorder is present is an injustice. Similarly, diagnosing psychosis in immigrants or refugees who speak with their ancestors when they are from cultures where people communicate with spirits and ghosts is a disservice. Difficult dilemmas arise in some situations such as spousal abuse or child brides or female circumcision when cultural norms allow those behaviors. In these cases, the norms and laws of the new land generally prevail, but sensitive interventions are required.

Interpretations of signs and symptoms

The question of how people know they are sick is far from simple. People's interpretations of their bodily signs and symptoms are influenced by their healing system's general concepts of normal and abnormal bodily functions, disease causation, and treatment options.² People must first decide if a sign or symptom is normal or abnormal. For example, refugees and immigrants who are accustomed to seeing pus draining from children's ears may not interpret draining ears as abnormal. Similarly, refugees and immigrants who are usually malnourished do not interpret obesity as a health problem, and those who are asymptomatic with hypertension or diabetes may not recognize they have a disease. If people decide their sign or symptom is abnormal, they must determine the meaning of the abnormality, and decide whether it's trivial enough to ignore or important enough to label as a sickness. People's interpretations are based in individuals' lived experiences and in their group's cultural healing system. Kleinman²⁴⁻²⁶ calls people's ideas about an illness their explanatory model (EM). Explanatory models have five aspects: timing and mode of onset of symptoms, pathophysiological processes, the etiology of the condition, natural history and severity of illness, and appropriate treatments. The sick person, family members, social network, and providers have their own explanatory models about the sickness event, which may be complementary or contradictory. Kleinman conceives that the more agreement

between the patient, family, and provider's EMs, the smoother their interactions are, while the more disagreement between the concepts, the more conflicts there are.

Treatment options – sectors of care

Treatments are closely linked to a healing system's concepts of bodily functions, causation, and classification of diseases.² For example, in Western biomedicine, specialists use medicines and operations to tackle physical diseases caused by proximate natural processes that work internally to disrupt bodily systems. In Chinese traditional medicine, therapies such as acupuncture and herbal medicines aim to rebalance energy flow that was disrupted by external natural or metaphysical forces.^{7,8} In Azande traditional systems, a spiritual healer divines the ultimate supernatural cause and sets about to eliminate that cause, such as by appeasing displeased spirits.¹⁶

Every society has a multiplicity of options for the treatment of diseases and illnesses as part of its healthcare system. This is true whether we speak about a village in the Kalahari Desert or the downtown area of any US city. Every healing system has medicines. Plants, animals, or earth materials are eaten, inhaled, worn, burned, or applied as poultices in order to soothe physical symptoms, restore metaphysical balance, ward away offending spirits, or bring inner peace and strength.²⁷ Most systems also have physical therapies, such as Mexican abdominal massage to relieve *empacho*;²⁸ Southeast Asian cupping, coining, and moxibustion to relieve built-up wind and bad blood;⁹ Chinese *tai chi* movements and acupressure to manipulate *qi*;^{7,8} and allopathic surgical interventions. Spiritual healing approaches are unique to each healing system's connection with the spiritual world. Prayer, incantations, rituals, burning of incense, and sacrifice of animals are performed with different meanings and different interpretations in different religious traditions.²⁷

With the abundance of therapeutic options, both patients and providers need to define and categorize therapies. Kleinman describes three sectors of healers that are overlapping and interconnected: the lay or popular sector, the folk sector, and the professional sector (Table 7.1).²⁵ In the lay sector, treatments are provided by family members or by the sick person, and may include medicines, massage, coining, cupping, burning, incantations, or wound dressings. The folk sector is comprised of healers that emanate from the secular or sacred ethnic or religious traditions (such as priests, shamans, or

Table 7.1 Sectors of care

Sector	Basis of authority	Providers	Payment
Popular/lay	Individual and family based. Culturally integrated and congruent.	Family members and nonspecialist community members.	Often nonmonetary such, as gratitude, appreciation, or exchange.
Folk	Training. Social nexus and community based. Culturally integrated and congruent.	Traditional healers or religious leaders such as bonesetters, herbalists, priests, or shamans.	Gifts, rather than fees. These may be monetary, material items, or involve exchange.
Professional: conventional	Formal education and licensure in allopathic or osteopathic Western biomedicine.	Physicians, nurses, dentists, pharmacists.	Third-party insurance or cash payments.
Professional: complementary alternative medicine	Formal education, apprenticeship, or other pathways.	acupuncturists, homeopaths, Ayurvedic, Chinese medicine specialists, etc.	Third-party insurance or cash payments.

herbalists) and treatments generally require some sort of payment, whether money or gift. Many societies have professional medical personnel, including conventional allopathic and complementary/alternative medicine healers, where formal education and licensing are required and monetary payment is standard. Healers from these three sectors may refer to each other, ignore each other, or compete with each other. In many societies, multiple folk healers exist side by side, providing generalized or specialized services. For example, among Arab Bedouin tribes in the Middle East, wise men or women with knowledge of traditional herbs may deal with simple ailments; amulet-makers tend to illnesses requiring more intensive or spiritual care; and dervishes are the ultimate authorities, reserved for more severe or recalcitrant cases.²⁹

When refugees and immigrants arrive in this country, they bring along their traditional healers and healing methods. There may be barriers to the availability, accessibility, and affordability of these healing methods, from legal laws to financial barriers to structural constraints. But in every American community where immigrants and refugees settle, there are traditional herbalists, acupuncturists, masseuses, injectionists, ministers, midwives, magicians, or spiritual healers who are providing services to their ethnic group and to other populations as well. Mexican-American communities have access to traditional healers, such as *curanderos* who diagnose and treat natural illnesses with massage and herbal medicines that they grow or import from Latin

America; *yerberos* who specialize in herbal medicines to prevent and treat illnesses; *sobadors* who treat bodily pain with massage; and *brujo*s or *bruja*s, sorcerers and witches, who treat supernatural illnesses with incantations and curses. In addition, there are *botanicas*, or shops that sell religious and spiritual products for healing.^{28,30} One might ask whether all these healing systems and options for care in the various sectors actual 'work,' i.e. demonstrate efficacy in terms of health and healing. The simple answer is 'yes,' but the reasons are complex.³¹ All cultural groups have had a vested interest in discovering the healing effects of their actions, and in passing along their knowledge to subsequent generations of healers. Generally, humans have discovered efficacious therapies over time, by objective and subjective evaluation, trial and error, and systematic observation, whether or not the tests were done by scientific principles. Indeed, the efficacy of some traditional therapeutics have been confirmed by modern scientific methods, such as aspirin from willow bark used by people from Assyria, Egypt, Greece, North America, and Sumer; quinine from bark of South American cinchona trees used by Native Americans; and acupuncture, acupressure, and *tai chi* from Chinese traditional medicine. In addition, all cultures have passed along their knowledge to new healers, whether or not their wisdom was written down or passed along orally.

Several other reasons are also relevant. One, most illnesses are self-limited and people either get better or die. Two, the placebo effect means that people's

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desires to be healed and their beliefs in their system promote healing. Three, people tend to remember their successes rather than their failures. Four, failures support the system; patients are blamed for not following the treatment adequately or not seeking help soon enough; practitioners are blamed for not diagnosing the disease correctly or not administering the treatment accurately; and the disease is blamed for being too strong; and spirits or fate or the impermanent nature of life are blamed for deaths.

Medical decision-making

The decision-making process is complex, and includes cultural beliefs and social factors.^{2,25,27} Once the sick individual or the therapeutic management group (such as the extended family) decides the sick person needs healing assistance, they have to decide whom to consult in the lay, folk, and professional sectors. The vast majority of illnesses are treated in the popular sector, as self-therapy and home-therapy are the first approaches to many ailments. When lay therapies are inadequate responses to the sickness, people may seek help from folk healers or professionals. This search for cures is referred to as the hierarchy of resort. Patients may utilize various healers from any of the sectors in a variety of patterns, ranging from sequential use of healers and treatments to simultaneous use of healers and treatments, to a mixture (Table 7.2).

Cultural beliefs such as the explanatory model influence people's decision about which healers to consult and which methods to use, as well as influence people's evaluation of the treatment's effectiveness. A study of Southeast Asians 10 years after their arrival found that ethnic Lao were most likely and Hmong were least likely to seek biomedicine, while Vietnamese started with traditional therapies before seeking biomedical care, and Cambodians didn't seem to have a preference for either system, easily using both.³²

Table 7.2 Hierarchy of resort

Temporal sequence of treatments

1. Sequential:
Popular → Folk → Professional (conventional or CAM)
Popular → Professional → Folk
2. Simultaneous resort
3. Mixed resort: utilization of sequential and simultaneous resort

Social factors influence whether healers or professionals are available, accessible, and affordable, such as location, hours of operation, direct costs, indirect costs, insurance, language, socioeconomic class, and ethnic identity. Also, who decides is influenced by social structure. In many social systems, the family rather than the individual sick person makes medical decisions, such as among Arabs,¹⁴ Hmong,³³ and Latinos.^{28,30} Studies around the world have found that people's cultural beliefs about tuberculosis (TB) play an important role in people's interpreting their symptoms, seeking healthcare, and taking medications for TB.³⁴ But social factors – including access to treatment centers, direct cost of buying medications and indirect costs of losing work, fear of social stigma and rejection by family and community members, language concordance between patients and providers, feeling disrespected and lacking trust with providers – are also important, and may be more important in medication adherence. In a fruitful combination of medical anthropology and public health, Paul Farmer's Partners in Health TB treatment program has illustrated how creating solutions to healthcare that are aimed at community social and economic realities, rather than aimed at community health beliefs, can be successful.³⁵ Healthcare providers and administrators need to integrate community beliefs about disease as well as community social and economic factors into creating successful healthcare system programs.

While immigrant and refugee's ethnic identity is initially strong and plays a considerable role in medical decision-making, acculturation changes ethnic identity over time. Acculturation is not a predictable process that changes people from aligning with their traditional healing system to people who accept the mainstream healing system. Rather, acculturation is an irregular, dynamic, bidirectional process that results in considerable variation for individuals, families, and communities.³⁶ Change is not always away from traditional healing practices. One study found that highly educated Korean-Americans were more likely to see traditional herbalists than noneducated Korean-Americans.³⁷ Other studies document how people move away from traditional practices, such as fewer Hmong seeking shaman as they become Christians and fewer Somali girls having female circumcision operations due to legal sanctions and change in people's assessment of the procedure. However, this movement along the Western acculturation continuum is often individual and nonlinear, and may revert back in times of crises, such as illness events.

Healer–sick person relations

Every healing system has expectations about the relationship between the sick person, family, and healer. The domains of this relationship – communication styles, expected and inappropriate topics, the power dynamics – are culturally and socially influenced. The cultural and social rules of engagement in the United States may seem strange, rude, or unacceptable to immigrants and refugees. For example, refugee and immigrant patients from many backgrounds (i.e. Amharic, Arabs, Chinese, Oromo, Koreans, and others) may not be comfortable talking about sexuality, may not expect to have physical examinations, and may be offended by genital exams.^{8,14,20}

Styles of interacting vary between cultural groups. For example, many Latino patients prefer an interaction based on *personalismo*, which means that trusting relationships are developed through personal, warm, and friendly relationships that include connections with personal and family life beyond the strictly medical context.^{28,30} Muslim patients may prefer that husbands speak for their sick wives, and may expect providers to interact with family members as well as the sick person, including telling family members rather than telling the sick person about serious life-threatening diagnoses.^{13,14} Hmong patients may expect providers to tell bad news in indirect expressions, such as ‘If you don’t have this operation, then you may not get better, and the sky will get blacker and blacker,’ rather than directly, ‘If you don’t have this operation, then you will die,’ as words have power and can cause events to happen.³³

The power differential between patients, families, and providers can be both helpful and harmful to patients.^{2,38,39} Immigrants and refugees are most vulnerable to the adverse effects of the power differential, given differences in language, socioeconomic class, and expectations of the healer–sick person relationship. For example, during interactions between Hmong parents and physicians about septic work-ups for febrile children, parents are more likely to agree with physicians’ evaluations and consent if the parents felt respected, than if they feel disrespected and ‘treated like dogs.’⁴⁹

Part B: Multicultural Care in Clinical Settings

This section provides a framework for applying some of the general concepts of traditional and bio-

medical healing systems presented in Part A. The goal is to assist healthcare professionals in applying cultural information to the clinical encounter with a specific patient and family in order to provide quality healthcare. There are six recommended fundamentals for providing multicultural care: healthcare providers must know themselves as cultural beings; know their patients as cultural beings; have attitudes that express respect and engender trust; develop communication skills that facilitate mutual understanding; apply the LEARN model and similar models in clinical encounters; and develop multicultural negotiation skills that build therapeutic relationships. These six elements are common to many advocated approaches to culturally competent care.^{4,33,40–44} The goal is to provide healthcare interactions that are medically, linguistically, and culturally appropriate, irrespective of the background of the patient and provider, in order to provide excellent healthcare with optimal healthcare outcomes.

Know yourself as a cultural being

‘Culture’ is not just something the patient possesses; it is something that *all* humans possess. Being aware of one’s own cultural beliefs, values, and assumptions is extremely important in providing quality care that addresses cultural components.^{33,40,43,45,46} All healthcare professionals are socialized into cultural systems, as children in homes and in communities, as students in healthcare professions, and as adults in a complex world filled with multiple cultural, ethnic, and religious perspectives. These cultural processes affect healthcare professionals’ interpretations of disease, preferred treatments, healthcare-seeking behaviors, and expectations of patient–provider relationships. Without self-awareness, biases and unchallenged assumptions can adversely affect healthcare delivery, particularly when interacting with people who have different cultural beliefs, values, and ethics. Multicultural care requires self-assessment and identification of one’s awarenesses, ‘sensitivities,’ reactions, biases, and ‘centrism’ (e.g. ethnocentrism). Techniques to become aware of such barriers or facilitators are common in intercultural work, such as the Peace Corps but less common in healthcare.⁴⁷ Knowing oneself and working to recognize and overcome biases is a first step towards cultural competence. The Institute of Medicine report *Unequal Treatment*

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explored research that studied disparities in health-care delivery and found that patients from nonmainstream ethnic and racial groups received worse medical care than mainstream patients because of providers' unacknowledged biases, assumptions, and stereotypes that surface in the face of busy schedules and uncertainties.⁴⁶

Know others as cultural beings

In order to serve refugees and immigrants, health-care professionals should strive to become familiar with the group's cultural background.^{2,4,33,40,43,45} This includes being familiar with traditional lifestyles, religions, social structures, histories (particularly historical events that led to migration or refugee flight), and prior experiences with healthcare, ranging from lay and traditional healing systems to Western biomedicine. This knowledge has utilitarian value in everything from understanding patients' health-related behaviors to forming therapeutic alliances. There are many ways to learn: reading books, articles and websites; listening to patients, interpreters, and community leaders; attending community events and classes; and doing ethnographic fieldwork in the country of origin and in the US. It may be particularly helpful for professionals to identify similarities and differences between the immigrant's traditional system and biomedicine's perspective, which are pertinent to healthcare delivery. What are the similarities and differences in nonverbal communication styles, in concepts of time and personal space, in ideas of disease causation and preferred treatment, and in approaches to decision-making? Finding common ground and identifying points of divergence can be key to creating best practices and delivering excellent healthcare. Similarly, providers can identify potential areas of congruence and incongruence on the culture's general expectations of patient-provider relationships.⁴⁸ How is trust established? What behaviors demonstrate respect? What are patients', providers', and institutions' roles and responsibilities? How is healthcare information shared? How are patient's best interests determined? What constitutes good healthcare decision-making? If the immigrant or refugee group has orientations that are vastly different from biomedical care's orientations to these questions, healthcare professionals will face more challenging situations than when their expectations are similar. In the latter case, providers may need to change their behaviors, their recommendations, and their approaches to families and patients.

Have attitudes that express respect and engender trust

Immigrants and refugees may respond best to professionals who can express respect and engender trust across cultural gaps, and providers need to engage in behaviors that patients, families, and communities interpret as respectful. Indeed, attitudes of respect, interest, patience, and empathy may be even more important in delivering quality care than specific cognitive knowledge about cultural differences.^{2,4,33,40,43,45} One challenge to professionals is that respect is a cross-cultural concept. People from different cultural groups demonstrate and experience respect in different ways. For example, professionals may mean to express friendliness with an open mouth and toothy grin but patients may interpret it as being silly and childish. Similarly, professionals may want their firm handshake to be engaging, but patients may find it aggressive or the contact may be taboo if it is between men and women.

Cultural humility is an exemplary attitude as well as an overall ethical approach to providing multicultural healthcare. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.⁴⁹

Develop nonverbal and verbal communication skills that facilitate mutual understanding

Communication skills are paramount in healthcare for all patients, but perhaps even more important when patients and providers come from dissimilar origins.^{2,4,33,43,45,50} A phrase, a word, or gesture may have vastly different meanings depending on people's cultural milieu. It is highly recommended that healthcare professionals be familiar with differences in nonverbal and verbal communication for the immigrant and refugee groups they serve.

Nonverbal communication is replete with multiple meanings, so that cross-cultural miscommunication can easily occur. Providers should understand the group's general nonverbal communication patterns, such as eye contact (Is direct eye contact experienced as engaging or belligerent?), personal space (Is being close experienced as reassuring or invasive?), gestures (Is using the left hand experienced

as neutral or offensive?), greetings (Is shaking hands experienced as welcoming or odd?), touching (Is a gentle touch on the shoulder experienced as reassuring or seductive?), and body parts (Is touching the head permissible or offensive?). Verbal communication differences must also be addressed. Ideally, healthcare professionals can become fluent in the languages of the people they serve. If this is not possible, it is highly recommended to learn basic greetings and medical words. However, irrespective of one's level of fluency, it is essential for healthcare providers at all levels to become proficient in working with interpreters. There is a vast range of translators and translator services available, from telephone consultations to professional interpreters who are appropriately matched to patients. Guidelines generally encourage working with trained interpreters, rather than adult family members, children, or untrained individuals who happen to know the language. It is important to choose interpreters who are acceptable to patients and family members in terms of their ethnic group and gender, and who can translate directly in first-person singular style, 'word for word,' rather than summarizing. It may also be helpful if they can act as a cultural broker in addition to providing linguistic interpretation. (For more information on interpreters, see Ch. 6.)

Applying patient-centered multicultural communication models in clinical encounters

There are several approaches to applying knowledge, attitudes, and skills to clinical encounters in order to provide excellent healthcare to immigrants. One approach is articulated in patient-centered medicine.⁵¹ The patient-centered medicine model encourage clinicians to explore both the patient's disease perspective and illness experience; understand the whole person in context of individual development, the family life cycle, and the larger socioeconomic and cultural context of people's lives; find common ground in the clinical encounter with good patient communication skills that lead to mutual decisions; incorporate prevention and health promotion; and enhance the patient-clinician relationship, while being realistic about the realities of clinical medicine. Another model is the LEARN model, or Listen-Explore-Acknowledge-Recommend and Negotiate.⁵² This model flows well with the typical clinical encounter, and supports clinician's eliciting, and responding to patients' and families' specific social and cultural needs.

Table 7.3 Kleinman's modified questions

1. What do you (or other people) think is wrong? What do you call it?
2. What do you (or other people) think has caused the problem?
3. How has this problem affected your life (and other people's lives)?
4. What are you (or other people) afraid of?
5. What healing methods have you (or other people) tried?
6. What do you (or other people) think will help?
7. Who usually helps you make decisions (or makes) about your healthcare?
8. What concerns do you (or other people) have about seeking US healthcare services for this problem?

L = LISTEN Healthcare professionals must listen to patients' illness stories, including their beliefs, fears, values, and desires for care in the healthcare system. This information facilitates the diagnostic work for disease identification and treatment planning as well as the development of a therapeutic relationship. Exploring patients' and families' cognitive explanatory models and knowing one's own explanatory models can aid professionals as they meet patients' and families' healthcare needs.²⁴⁻²⁶ The areas of congruence and conflict between patients', families', and providers' explanatory models can influence the interaction between patients, families, and healthcare professionals, both positively and negatively. Also, eliciting and hearing patients' narratives is a rich and easily accessible portal to their culture, experiences, and world view and can be gathered with simple questions about their life and healthcare prior to immigration, their story of passage between lands, and their encounters in their new home. Kleinman has eight questions designed to elicit patients' explanatory models (Table 7.3).²⁵ Seaburn et al. have an expanded list of questions to elicit the patient's story as well as the family's story (Table 7.4).⁵³ In addition, Carrillo et al. have created the 'social context review of systems,' encouraging providers to ask about (1) changes in community context, (2) social stressors and support network, (3) material resources and healthcare access issues, and (4) literacy and language.⁵⁴ And Smith recommends using open-ended interviewing techniques and following patients' leads in interviews to place their illnesses into the broader context of their lives.⁵⁵ Once some information is collected – whether gathered briefly or in-depth, whether gathered in one encounter or over many encounters – that informa-

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Table 7.4 Seaburn et al.'s questions: eliciting the patients and family's story

History of the illness/problem

1. How long have you had this problem?
2. How did you first notice it?
3. How did the family and friends react to changes you were going through?
4. Who first suggested that you seek medical help?
5. How many physicians and other healthcare providers have been involved in your care? How have they been helpful? Not helpful?
6. What tests or procedures were needed to diagnose this problem? Have you been hospitalized? What medications are you taking?
7. What is your understanding of the current status of your health?

Impact of the illness on the individual

1. How has your daily functioning changed?
2. What do you miss most from before you were ill?
3. What have you learned from this illness that has been useful to you?
4. What do you think will happen with the illness in the future?
5. How has your view of the future changed?
6. What do you hope for?

Impact of illness on the family

1. What changes have occurred in the family since the illness began?
2. How are family members coping with this difficulty?
3. Do you talk about the illness as a family?
4. Who has been most affected? Least affected?
5. Who has the greatest responsibility for caring for the ill family member? How does the primary caregiver get support?
6. In general, how do you support one another? How do you express emotions?
7. Does this experience remind you or your family of other difficulties the family has faced?
8. How well do you feel the family is coping? Is there anything the family wishes they could do differently?

Meaning of the illness, and family resources

1. Why do you think this illness has occurred?
2. How long do you think it will last?
3. Are there times when the illness seems stronger than you or the family? Are there times when you or the family seems stronger than the illness?
4. Do you or your family have religious or spiritual beliefs about this illness? If so, what are they?
5. What are the strengths of your family? What keeps you going?

Modified by David Hatem, MD, Workshop, International Conference on Communication in Health Care, Chicago, Illinois, October 2005.

tion can be built upon in the remainder of the clinical interaction, such as in the LEARN model.

E = Explain Healthcare professionals always need to explain their medical perspective, including desired diagnostic tests, recommended treatments, and diagnoses and prognosis, in words and concepts that patients can understand. This may be a challenge with any patient, but more so when treating immigrants or refugees whose medical concepts may be unfamiliar, where translation into other languages may be required, and where levels of health literacy may be difficult to assess. Nonetheless, providers working with multicultural patient popula-

tions should work to tailor their explanations to take into account their patients' language abilities, literacy levels, and cultural concepts.

A = Acknowledge Once healthcare professionals know their patients' models, perspectives, and fears, and have explained their medical perspective in a linguistically and culturally appropriate manner, they can then acknowledge the similarities and differences between the two perspectives. Statements that may be helpful include, 'You said you're worried about cancer, and I hear you. I want you to be reassured that I don't find any evidence of cancer,' or 'We both agree that this could be serious,

but we have different ideas about what disease you may have.'

R = Recommend Healthcare professionals can make recommendations, such as about diagnostic tests, medications, operations, or other therapeutic approaches. Recommending care and then obtaining patients' responses as to whether they agree with this approach is more respectful of patients' cultural orientations than ordering care and expecting patients to comply.

N = Negotiate Ultimately, healthcare professionals must be ready to negotiate about their diagnostic and therapeutic recommendations. If patients do not agree with the recommended medical approach, then it is best for providers to know about patients' and families' reactions, discuss their desires, pursue options, and negotiate alternative approaches. If differences are due to cultural beliefs, values, and ethical formulations, they can be elicited and responded to.

Develop multicultural negotiation skills

Difficulties delivering healthcare in multicultural settings that require negotiation may arise from different patient and provider health beliefs, expectations of life-cycle events, desires for treatment, moral values, or ethical principles. If professionals have objections to patient or family requests for care or refusals of care, they have to decide if they are objecting based on challenges to their personal preferences (i.e. objecting to patients wearing amulets to ward off evil spirits during an operation), personal moral beliefs (i.e. objecting to animal sacrifice in healing rituals), or professional integrity (i.e. families asking to withdraw a ventilator when the patient is not terminally ill).⁴⁸ In the first two situations, providers need to discuss alternatives with the patient, family, and perhaps community members and try to negotiate other actions. If negotiation is unsuccessful, the provider must either accommodate the patient or transfer care to another provider. In the third situation, challenges to professional integrity may also be resolved via negotiating with the patient, but if not, they may need assistance from an ethics committee that has community input. During negotiation, providers have to be aware of the power differentials that exist between themselves, patients, and families.^{38,39} Most often, physicians have more power than patients and family members because they have more biomedical knowledge, institutional

support, and language skills. Inadvertently, this power can operate to put patients at a disadvantage. Studies illustrate how providers' unrecognized biases and prejudices can result in poor healthcare services. To avoid harmful consequences of unintentional biases, physicians must (1) be aware that disparities in health care exist, (2) be aware of their own unchallenged assumptions and preferences, and (3) take actions so that their biases do not impair care.⁴⁶

Conclusion

Immigrants and refugees arrive in this country with traditional healing systems, whether intact or impaired by the deprivations that lead to migration or refugee flight. It is imperative that healthcare professionals learn about the immigrant and ethnic groups that they serve, including their traditional and changing healing system, medical decision-making processes, acculturation influences, social factors that influence availability, accessibility, and affordability of traditional healers, and social factors that influence power dynamics and expectations of biomedical providers. This knowledge is invaluable to provide efficient, effective patient-centered, quality care. Quality multicultural care requires that providers understand themselves and their patients as cultural beings, have attitudes that express respect and engender trust, develop communication skills that facilitate mutual understanding, apply these knowledge, attitudes, and skills in clinical encounters, and develop multicultural negotiation skills.

Websites

Asian and Pacific Islander American Health Forum www.apiahf.org
 Association for Asian Pacific Community Health Organizations www.aapcho.org
 Center for Cross-cultural Health www.crosshealth.com
 Country Studies, Library of Congress <http://lcweb2.loc.gov/frd/cs>
 Cross Cultural Health Care Program www.xculture.org
 Cultural Profiles, Center for Applied Linguistics www.culturalorientation.net/fact.html
 Ethnomed www.ethnomed.org Profiles on immigrants and refugees in Seattle WA, including Amharic, Cambodia, Chinese, Eritrean, Hispanic, Oromo, Somali, Tigrean, Vietnamese, and others, prepared by University of Washington Harborview Medical Center.
 Hablamos Juntos Resource Center www.hablamosjuntos.org/resourcecenter/default.asp
 Hmong Health www.hmonghealth.org
 Islamic Health and Human Services <http://hammoude.com/Ihhs.html>
 National Alliance for Hispanic Health www.hispanichealth.org
 National Center for Cultural Competence www.cultural@georgetown.edu

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National Council on Interpretation in Health Care www.diversityrx.org
National Health Law Program <http://www.healthlaw.org>
National Hispanic Medical Association <http://www.nhmamd.org/>
Provider's Guide to Quality and Culture <http://erc.msh.org>
Profiles on African-Americans, Arab-Americans, Asian-Americans, Central Asians, Hispanics/Latinos, Muslims, Native Americans, Pacific Islanders, and South Asians.
Resources for Cross-cultural Health www.diversityrx.org
Vietnamese Community Health Promotion Project www.suckhoelavang.org/
World Education; Culture, Health and Literacy www.worlded.org/us/health/docs/culture/about.html

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