

Curbside Consultation

Improving Sensitivity to Patients from Other Cultures

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Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous.

Please send scenarios to Caroline Wellbery, MD, Department of Family and Community Medicine, Georgetown University Medical Center, 212 Kober Cogan Hall, 3800 Reservoir Rd. NW, Washington, DC 20007. Materials are edited to retain confidentiality.

Case Scenario

A 41-year-old Indian woman recently presented to me, a male physician. She reported feeling weak during the past two months. She said she wakes up tired and becomes more tired as the day passes. She sleeps lightly and sometimes wakes up early. Occasionally, she has dull, aching pain in her lower back. During the review of systems, she denied any nausea, vomiting, diarrhea, change in appetite, cough, abdominal pain, or headache. However, when I asked about any genitourinary problems, she looked down and replied softly that she had been having a white vaginal discharge for the past three months. She seemed embarrassed, and asked to see a female physician. I was surprised that I had made her feel uncomfortable. How should I have handled this situation?

Commentary

In this scenario, the physician is facing several challenges: making a patient from another culture feel at ease; managing a female patient's discomfort with a male physician; and recognizing the patient's chief concern. Physicians often treat patients from cultures different from their own. Establishing a rapport with these patients is important and requires awareness and sensitivity. It is helpful for physicians to familiarize themselves with patients' values, beliefs, and biases.¹

First, to help them feel more comfortable, physicians should learn appropriate ways to greet patients from other cultures. Many conservative South-Asian women (i.e., from India, Pakistan, Bangladesh, Sri Lanka, and Nepal) will not shake hands with a man, particularly someone who is perceived to be in a position of authority, such as a physician. This is especially true of Muslim women or women from Pakistan, Bangladesh, or rural areas of India.

Although making appropriate eye contact with patients can build a relationship and convey empathy,² conservative South-Asian women generally do not establish direct eye contact with men and feel uncomfortable with men who do so. It is also considered immodest to talk about urinary and genital symptoms with men, even if they are physicians. These women usually prefer to see a female physician not only because of modesty, but also because of subtle fears and prejudices against men, especially those from other races and ethnicities.

Physicians should be perceptive of patients' nonverbal cues. In this scenario, if the physician sensed that the patient felt uneasy, he could have asked whether she would prefer to see another physician. If the female physicians in the office were busy, he could ask the office staff to schedule her to see a female physician on another day. In offices without a female physician, staff could offer to help the patient find one.

Second, physicians need to identify the patient's agenda, which may be more challenging with patients from other cultures. Many studies have reported that physicians often fail to elicit patients' complete agenda and instead focus on a concern that is less important.^{3,4} This patient may be interpreting the psychological distress of depression as weakness and is using the leukorrhea to explain her fatigue. Ill-defined, mild, or medically unexplained symptoms, as well as psychological distress, are often subject to cultural interpretations.⁵⁻⁸ Many poorly educated, conservative Hindu women believe that leukorrhea drains the body of vital energy, thus causing physical and mental weakness. This condition is known as *dhat* in ayurvedic medicine, and is considered the female counterpart of the loss of semen in men.⁷

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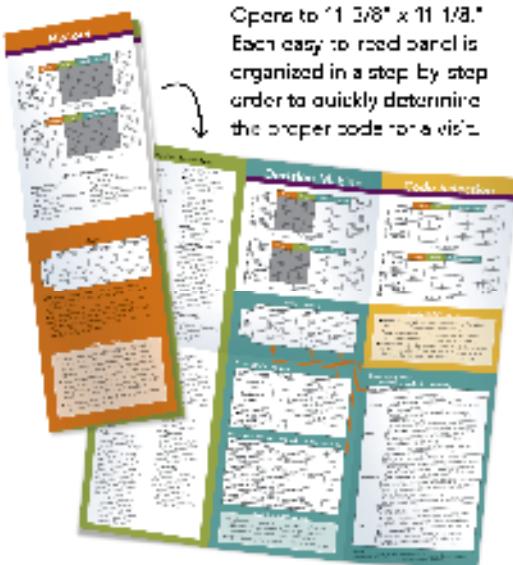
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Like other Asians, Indians may experience somatization.⁹⁻¹¹ Psychological symptoms and problems are less salient than physical symptoms in Indian culture. They suggest weak character and personal deficits, and evoke self-blame, shame, or dishonor to the family (*izzat*).^{12,13} Patients may use somatic imagery and creative narratives to describe their distress. Instead of admitting they feel sad or depressed, Indian women may say they have weakness (*kamzori*). Somatic preoccupation may lead to unnecessary biomedical investigations and treatments when depression is the actual cause of the patient's concerns.⁷

By familiarizing themselves with these somatic metaphors and narratives, physicians can create a better relationship with patients from other cultures and identify the underlying reason for the visit. Also, learning how to greet and approach patients can make them feel more at ease. If a patient still seems uncomfortable, it is appropriate to offer him or her the option of seeing another physician.

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