

Cultural Competence Case Presentation
Culture/Race: Cambodian Refugee Community

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Case Scenario/History

A 65 year-old Cambodian gentleman presents to the Emergency Department following an episode of coughing up blood. The resident approaches the bedside where he finds a thin elderly Cambodian male sitting alone. The patient is Cambodian-speaking only. There are no Cambodian-speaking health care providers or interpreters immediately available and the family has not accompanied the patient into the treatment area. The son speaks some English, while the daughter-in-law speaks only at a very basic level. Once at the bedside, the resident begins to obtain a history. He learns from the son that the patient lives with him and his wife, and that since he is at work most of the week, his wife takes care of his father. The son goes on to explain that he first noticed his father coughing up blood two weeks ago but that today it was much worse. Otherwise, he states that his father had appeared unchanged to him. In an attempt to gain additional history, the resident begins to pose questions for the son to translate to his father.

Physician: 'How are you feeling today, sir?'

Son: 'He says that he is feeling fine. But he never tells us when something's wrong.'

Physician: 'When did you first notice blood in your phlegm?'

Son: 'He says he can't remember but that sometimes it's there and sometimes it's not.'

Physician: 'How much blood has he been coughing up?'

Son: 'He says it's just a little, nothing to worry about. But today there was so much (the son forms a cup with his hands indicating the amount) that I was worried and made him come here.'

Physician: 'Why did he wait so long to come to the hospital? He should have been to see a doctor earlier.'

Son: 'He told us he felt okay, and I couldn't bring him because I work a lot.'

Physician: 'Has this ever happened in the past?'

Son: 'He doesn't think so.'

Physician: 'Has he ever had or been exposed to tuberculosis?'

Son: 'He says no but it's possible since he was in a refugee camp for a while.'

Physician: 'Does anyone in his family, siblings or parents, have any medical problems?'

Son: 'He says he doesn't know.'

a. Review of Symptoms

Per son: Patient has been in normal state of health, except for coughing up blood. Denies fever, SOB, or chest pain. Also denies vomiting, diarrhea or blood in stool.

b. Past Medical History

Question of some form of leprosy, has been present at least 20 years. Possible tuberculosis exposure. Otherwise none, or unknown.

c. Family History

Unknown.

d. Social History

Patient lives with his son and daughter-in-law. He is a refugee from Cambodia. Living in the US for approximately 20 years. He denies tobacco use. Throughout this conversation, the patient does not make eye contact with the physician, but instead focuses down at the blanket covering him.

e. Physical Exam

Temp: T 98.2 P 73 R 18 BP 130/44 PO2 94%

General: Thin, elderly gentleman, no acute distress

ENT: Unremarkable

Neck: Unremarkable

Cardiovascular: RRR, no murmur, no gallop

Lungs: No respiratory distress, bronchi noted bilaterally

Abdomen: Soft, nondistended, nontender, normal bowel sounds

Extremities: As above, hands and feet appear deformed due to skin contracture

Skin: Mottled and tightened over hands and feet, areas of ecchymosis over back

Neuro: Alert, answers questions via son appropriately, motor and sensory grossly intact

The resident, having recognized the areas of ecchymosis on the back as being consistent with a folk medicine practice called 'coining', asks the son about it. The son states his wife had been doing this over the past couple of weeks ever since they noticed the blood. The son speaks briefly with his wife in Cambodian, then goes on to add that they took his father to a healer who recommended to continue the coining and gave them some herbs to make tea for his father with.

The resident leaves the room to order lab work and chest x-ray. When the nurse enters the room to draw blood, the patient refuses the procedure.

The resident returns to the bedside and the son relates to the resident that his father does not want any blood work done. The resident informs the son that blood work is a crucial part of the medical work-up and that a CXR alone will only provide limited information. The patient continues to refuse. The resident leaves the bedside frustrated. Several minutes later, the son finds the resident and asks him if having the blood drawn won't further weaken his father since he is already losing blood. The resident reassures him that they will draw only a small amount which will not impact his father's strength. The son returns to discuss this with his father who then consents to the blood draw.

Questions for discussion

1. What factors contribute to the difficult H&P?

Attitudes/Assumptions: The physician

The patient does not seem to have any awareness of his illness.

Non-English speaking patients are less intelligent/less able to participate in their medical care.

I do not have time to track down an interpreter and the son seems comfortable translating.

Attitudes/Assumptions: The patient

The doctor is busy and does not need to bother with me. I do not want to take up too much of his time.

Western hospitals and medicine are unfamiliar to me. I am only here because my son brought me.

The doctor doesn't understand Cambodian illness and medicine. Although he may be able to make me feel better, he won't be able to 'cure' me.

Provider Knowledge

Knowledge of health beliefs/customs: There are multiple barriers to obtaining an adequate and efficient history in Cambodian patients or any patient from another culture.

Language Barriers: Obtain a professional interpreter whenever possible. Keep in mind that even with an interpreter there may be miscommunication if the patient is not comfortable with the sex, age, or social status of the interpreter. Patients may also feel that they cannot accurately communicate their problems and needs even with an interpreter because of complexity, cultural differences or other factors.

Historical Experiences: Prior experiences can lead to fear and mistrust. Cambodian refugees may have experienced detailed interrogations where their, or someone else's, life was dependent on the content and/or consistency of what they said. This may result in discomfort during the history taking or reluctance to offer extensive detail in their answers.

Stoicism: In general, the Cambodian culture, particularly the older generation, prides stoicism. There is a reluctance to complain, and patients may downplay or deny symptoms. There is also a desire not to be a burden on family or health professionals.

Understanding of Illness: Many Cambodians will differentiate their illnesses into those that can be helped by Western medicine and those that can be cured by traditional methods. Especially for the older, less assimilated population, many patients do not believe that Western doctors can understand or cure 'Cambodian illness'. Patients will be less forthcoming with information if they view it as futile.

Cross-Cultural Tools and Skills

Whenever possible, use a professional interpreter, preferably one who is not only bilingual but bicultural as well. Ask the patient if there is any reason they are uncomfortable providing a history via this interpreter and/or if there is someone else they would prefer to have interpret for them.

With patients who are not forthcoming, general questions will rarely be useful. Keep questions focused and specific. Keep in mind that patients are rarely intentionally keeping information from you. Use family to obtain additional history when you feel the patient may not be fully disclosing the extent of their illness.

Often lack of familiarity with western medicine and the chaos of most emergency departments are very overwhelming and cause patients to withdraw. Take time to put the patient at ease and guide them through the process. Show respect for the patient and acknowledge their stoicism but remind them that you are there to help them and that they are not a burden to you.

Attempt to understand the illness as the patient does. Ask the patient specifically what they think is causing their illness and what they have done to heal themselves thus far. Inquire about visits to Cambodian healers, home remedies and spiritual interventions. By asking about alternative healing methods, you will convey an appreciation and acceptance of other forms of health care that will help build trust between you and your patient.

2. What contributed to the delay in this patient seeking medical care?

Attitudes/Assumptions: The patient

The healer in our community will know best how to help me and I prefer to seek care from someone from my own culture.

I won't be able to communicate with the doctor at the hospital.

I'm not sick enough to go to the hospital and do not want to burden my family.

Attitudes/Assumptions: The provider

The patient wasted time seeing a folk healer before coming to the hospital.

The patient was too stubborn to come in earlier.

The family was a poor judge of how sick the patient was.

Provider Knowledge

Language barriers significantly limit the ability of all non-English-speaking patients to access care. This extends beyond the physician-patient encounter to interacting with lab and radiology techs, making follow-up appointments, obtaining prescriptions and understanding therapeutic regimens. This can be anxiety provoking and may result in the patient delaying care in order to avoid this uncomfortable situation.

A patient's understanding of illness and its causality will dictate how they care for themselves. Many Cambodians conceptualize illness in terms of balances, whether

spiritual, humoral, or natural. They will go to the health care provider who they feel will share their understanding of the illness and best be able to address the cause of their disease within that framework. Western medicine is often perceived by Cambodians and others as being useful for symptomatic treatment but will still seek treatment from their community healers in order to address the cause of the illness.

The Cambodian refugee population may also harbor a distrust of hospitals based on their experiences during the Khmer Rouge and Pol Pot regime. Hospitals were often places where people went to die and less associated with therapy and healing. Accounts of mistreatment of, and unscientific experimentation using, patients have been shared by many Cambodian refugees.

Cross-Cultural Tools and Skills

Given the many reasons for delay in care, physicians must consider the possibility that the patient is sicker and may have been symptomatic for longer than the patient admits (ie a patient with a cough and fever has very often spent the past two weeks attempting traditional or home remedies before venturing into the Emergency Department). This should raise our level of caution as we evaluate these patients.

Avoid being judgmental about the delay in care. Explore that reasons that care was delayed. If the delay involved linguistic barriers, discuss the resources (interpreter in hospital or via telephone) available. If due to a preference for and familiarity with traditional healing, explain to the patient and family that traditional and Western approaches can be complementary. Transportation issues are slightly less easy to resolve; however, remind the family that the Emergency Department is open all the time to accommodate everyone's needs and that EMS is always available in the event of an emergency. Most important, though, is to provide a good experience for the patient and family. This will work to alleviate anxieties, misperceptions about Western medicine, and distrust.

3. *What are the reasons for refusing blood draws or other forms of treatment? Describe the role of negotiating medical care.*

Attitudes/Assumptions: The patient

Why would the doctor want to take more blood when I'm already losing blood?

The healer I go to doesn't need to draw blood to find out what's wrong with me.

Attitudes/Assumptions: The provider

There is an assumption that the patient's explanatory model of their disease is the same as the physician's.

Why would the patient come all the way to the hospital and not let us do any testing?

It's just a blood draw, not surgery.

Provider Knowledge

Patients of all different cultural backgrounds may have a multitude of reasons for refusing procedures, testing or interventions. Some of these reasons may be culturally related and some may be personal.

Although probably not the case with this patient, it is important to remember when dealing with refugees that many of them have survived torture and that some of our procedures may be reminiscent of these events or appear threatening to the patient. Western medicine's studies and the results provided often have very little meaning within the Cambodian model, and understanding, of illness.

As discussed above, the Cambodian explanatory model of illness relies heavily on the concept of balances. This patient may feel that given his current illness and loss of blood that a blood draw will only further weaken him and his spirit.

Cross-Cultural Tools and Skills

An explanatory model is a patient's way of understanding the cause, symptoms, and prognosis of an illness, as well as the anticipated treatment and long-term consequences of it.

In this situation, the patient's explanatory model and the biomedical model are contradictory. The physician wanted to obtain blood to evaluate the source and degree of bleeding while the patient viewed this as counterproductive and unnecessary given his current blood loss. When the physician's and patient's explanatory models do not mesh, refusal of testing, non-compliance with treatment, and resistance to intervention can result.

The most consistently successful way of acquiring consent for a test, procedure or intervention, is to first understand why they are refusing it. Once this is achieved, a process of negotiations can begin. These discussions will involve negotiating the explanatory model as well as the management priorities. Begin by attempting to explain the biomedical understanding of their disease using words and concepts they understand, and, if possible, discuss how their understanding of the illness and yours overlap. Continue by discussing and reconciling each party's management and treatment priorities, focusing on the highest priorities of each person. Whenever possible, attempt to reach a resolution that accounts for both models of disease in your treatment plan.

4. *What sections of the case incorporate the 6 ACGME areas of core competence?*
 - a. **Patient care** – Approaching patient with attitudes that reflect cultural sensitivity, utilizing linguistic and cultural interpreters when necessary and making appropriate medical decisions that account for both the patient's and bio-medical explanatory models of disease all demonstrate competency in patient care
 - b. **Knowledge** – The resident demonstrated their medical knowledge through the use of appropriate diagnostic testing and ultimately correct therapeutic intervention
 - c. **Interpersonal & Communication Skills** – The use of interpreters, and involvement of family and traditional healers, demonstrate the ability to access information and resources that would improve this patient's care. The use of interpreters, family involvement, desire to learn about the patient's understanding of his disease and traditional treatments employed, and appreciation of the

- cultural factors affecting this patient/physician interaction all contribute to competency in communication
- d. **Professionalism** – Professionalism was exemplified in this case by the resident’s commitment to understanding and addressing the cultural factors impacting this patient’s care in order to maintain a quality of excellence in the care of all patients
 - e. **Systems-based Practice** – The utilization of other resources including interpreters and traditional healers demonstrates competency in systems-based practice. Additional resources such as social workers and alliances with community health programs would also be useful in this case.

Case Outcome

Diagnosis: Mycotic thoracic aneurysm

Disposition: Admitted and underwent endovascular repair

The patient’s son was informed of the diagnosis, severity and need for surgical repair. This was initially met with denial and refusal on the part of the patient. Recognizing both the urgency of the medical problem and the difficulty he faced in reconciling the two different understandings of the problem, the resident located a Cambodian medical interpreter. After much discussion and negotiation based on the principles discussed above, the patient agreed to surgery. The local kruu Khmer (folk healer) visited him in the hospital both before and after the procedure.

References

1. Cambodian Health Network www.khmerhealthadvocates.org/healthcrisis.asp
2. Carrillo JE, Green AR and Betancourt, JR. Cross-Cultural Primary Care: A Patient-Based Approach. *Annals of Internal Medicine*, 1999;130(10):829-834
3. Muecke MA. Caring for Southeast Asian Refugee Patients in the United States. *American Journal of Public Health*, 1993;73:431-438
4. Marcucci, John. Sharing the Pain: Critical Values and Behaviors in Khmer Culture. In: Ebihara MM, Mortland CA, Ledgerwood J. *Cambodian Culture since 1975 Homeland and Exile*. Cornell University Press, Ithaca, NY, 1994.