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When West Meets East, North, & South

TEACHING NURSES HOW TO BRIDGE THE CULTURAL DIVIDE

When the new students in the Combined BS/MS Nursing Program arrived on campus this past summer, one of their first exercises was to share their beliefs about the common cold, from causes to cures. More than a few of the students must have wondered, “Why are we starting with this? After all, it’s hardly the most pressing problem in health care.” But as the students would soon learn, even the simplest ailment can be weighed down with cultural baggage.

Most scientifically minded people would agree that the common cold stems from infection with rhinoviruses or coronaviruses, and that there’s little in the way of treatment, aside from managing symptoms with over-the-counter medications and perhaps a bowl of chicken soup. But that understanding is hardly universal. The Tiv of Nigeria, for example, believe that colds are linked with the phases of the moon, and that eating raw onions is the ideal remedy. Some Croatians argue that sitting on a frigid surface, such as metal, causes the common cold, which can be cured by imbibing *rakija*, a mild liquor. In India, followers of Aryurvedic medicine insist that a cold can be brought on by weak digestion and alleviated with fresh ginger mixed with honey, taken in water three times a day.

So, what are providers to do, faced with a sniffling, sneezing patient from Nigeria, Croatia, or India? Or, for that matter, with an overweight diabetic from the Dominican Republic who refuses to give up the fried foods of her native cuisine? Or with a Hmong refugee couple who believe that their daughter’s epilepsy is a blessing from the spirits rather than a neurologic disease?

For many nurses, these are not hypothetical exercises, but real, everyday challenges. And they are becoming increasingly common. As any demographer would attest, minority populations are growing in size and diversity, and they are dispersing around the country, to suburbs, exurbs, and rural outposts. In addition, more and more minorities are holding fast onto their beliefs, values, languages, religions, and customs, barely assimilating into the larger culture. The national motto, *E Pluribus Unum* — from many, one — is becoming as anachronistic as Latin itself.

Cultural diversity may well be one of our country’s strengths, but it is also a potential source of trouble between patients and providers, from miscommunications about proper dosages to intractable clashes over what constitutes proper treatment.



by Gary
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To help health professionals bridge the cultural divide, health sciences educators around the nation, including those at Columbia University School of Nursing, are working to infuse cultural competencies and awareness into their curricula.

UNEQUAL TREATMENT

Cultural diversity in health care was largely ignored by both government and academia until a generation ago. In 1986, the Department of Health and Human Services established the Office of Minority Health, the first national platform for addressing health disparities among American Indians, Native Alaskans, Native Hawaiians and other Pacific Islanders, Asian Americans, African Americans, and Hispanics.

But progress was slow. Revealingly, the *Merck Manual of Diagnosis and Therapy*, a leading medical reference, didn't include a chapter on cross-cultural issues until 1992, and then it devoted just three out of almost three thousand pages to the topic.

The issue was brought to the fore once again in 2002, when the Institute of Medicine issued the report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which noted that “racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are white Americans” — even in populations with equal access to care. Among the causes of this “unacceptable” situation, the report stated, was “bias, prejudice, and stereotyping on the part of health-care providers.” Accordingly, the IOM recommended cross-cultural education for current and future health care professionals to raise awareness of health disparities.

Spurred by the report, senior academic officials at the Columbia University Health Sciences campus and the director of graduate medical education at NewYork-Presbyterian Hospital met in 2004 to review the status of cultural competency training for students, faculty, and residents. From this meeting emerged a Curriculum Development Committee for Cultural Competency — since renamed the Curriculum Committee on Cultural Competence — which was charged with helping educators address issues of diversity in health care.

EVOLUTION, NOT REVOLUTION

At the School of Nursing, faculty have introduced cultural competencies into everything from reading assignments and discussion groups to lectures and classroom exercises. Through these different vehicles, students delve into such topics as the IOM report, cultural perspectives on death and dying, the culture of medicine versus the culture of nursing, and the biases and stereotypes that providers themselves bring to clinical care. Each incoming student is required to read Anne Fadiman's *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, a grim and gripping tale of how things can go terribly wrong when patients and providers do not see eye to eye.

All told, these changes are evolutionary rather than revolutionary — at least at the School of Nursing. Cultural content has been woven into the nursing curriculum for years, in such courses as “Nursing Practice in the Community” for undergraduates

“Minority populations are the fastest growing segment of the American population. By 2010, Hispanics, African Americans, Native Americans, and Asian Pacific Americans will make up 32 percent of the population, and by 2050, will make up 48 percent of the population.”

• Columbia University Curriculum Committee on Cultural Competence

and “Health and Social Policy” for graduate students, as well as in clinical experiences that immerse students in ethnically diverse neighborhoods around the city.

Cultural diversity and health disparities also figure prominently in two of the School’s major research initiatives, the Center for Evidence-Based Practice in the Underserved and the World Health Organization Collaborating Center for International Nursing Development in Advanced Practice.

“This isn’t a sea change for this school, and it isn’t a sea change for nursing,” says Mary O. Mundinger, DrPH, Dean of the School of Nursing and Centennial Professor of Health Policy. “Nurses have historically learned how to care before they learned how to cure. When you are a beginning nurse, you don’t have the authority to direct a patient’s care. Your total engagement is listening to patients and working with patients around somebody else’s orders. So, nurses are inculcated to engage with patients, to communicate choices, and inform patients why they have to do certain things to get a good outcome.”

LISTEN, ASK, ACT

By and large, doctors have been nurtured with a different ethic. “We made a mistake by helping young physicians feel a bit too confident in medical science,” says Dr. Mundinger. “In essence, we taught them to believe that they know more than their patients, and that they can make the right decisions for them.

“I remember when I was young, my mother was very sick, and it wasn’t clear if she should be treated medically or surgically. She asked her physician what she should consider in making the choice, and he said, ‘My dear, I’m not going to burden you with that, that’s my job.’ She was totally at ease with that.”

That approach doesn’t go over so well today, of course. “Certainly, younger consumers of care” — a telling phrase that has slipped into the lexicon — “won’t accept it,” says Karen S. Desjardins, MPH, DrNP, Assistant Professor of Clinical Nursing, Director of the Combined BS/MS Nursing Program, and the School’s representative on the Curriculum Committee on Cultural Competence. “They question what the nurse or doctor tells them, and they want their care to fit into their lifestyle as much as possible.”

The lesson for health professionals, says Sarah Cook, DrNP, Vice Dean and the Dorothy M. Rogers Professor of Clinical Nursing, is that “patients may have different expectations as to treatments and outcomes. That’s why we teach students that they must be partners with patients. Sometimes, patients *do* want to be told what to do, but you have to determine that. You can’t assume that.”

“There are a few basic things we try to teach students,” Dr. Cook continues. “One is to listen — not just perfunctorily ask questions. That is very hard to do, especially for today’s generation, which is used to running around plugged into their iPods. Students aren’t used to being quiet and focused. They have to learn how to listen. Another thing we teach is to ask the right kinds of questions, and not only to pay attention to the answers but to act on them.”

Dr. Desjardins also teaches students to be aware of their own cultural influences.





"A lot of us would say we are not biased or prejudiced, but when it comes down to it, the way we were brought up will affect the way we treat a patient," she says.

ADOPTION, NOT COMPLIANCE

Nurses, by virtue of their holistic, patient-centered approach to care, do tend to listen to patients. "Even though you have the scientific evidence that a particular intervention can achieve the best outcome, you don't know if the 'best outcome' is the one that the patient wants," says Dean Munding. "And you don't even know if the patient is willing to make the necessary trade-offs."

This approach is vital in dealing with patients with chronic illnesses, particularly those in the early, asymptomatic stages of disease, according to the Dean. "Patients reason, 'I feel fine. Why should I take medications that make me dizzy and tired and make my legs swell?'" she says. "So, the nurse has to work with the patient to ensure knowledgeable adoption of a regimen. You want the patient to actively take on these new roles, not comply because you say so."

Getting patients to do the right thing gets even more complicated when a different culture is thrown into the mix. "Let's say your patient is a pregnant Hispanic woman," says Dr. Cook. "There are certain things you'll want her to do to assure that both she and baby will be healthy. But it might be a mistake simply to tell her what to do — especially if her 'Spanishness,' if you will, is quite overt. In that case, it might be wise to talk to her husband before making treatment recommendations. In many Hispanic households, the husband is the leader, and if he says it's okay to do this or that, the rest of the family will generally go along."

NURSES AND ANTHROPOLOGISTS

It's not an exaggeration to say that nurses today have to be clinicians as well as anthropologists, as Dr. Desjardins illustrates in an example she often uses with students, that of a middle-aged African-American woman who has never gone for a mammogram (an alarmingly frequent occurrence). The woman's behavior might seem irrational, but it is sensible in her social and historical context, where memories of the notorious Tuskegee experiment and other indignities at the hands of authority figures still loom large. (From 1932 to 1972, in Tuskegee, Alabama, the U.S. Public Health Service conducted an experiment on hundreds of black men in the late stages of syphilis without their knowledge or consent. The "subjects" were not told they had the disease, nor were they given proper treatment.) Without understanding this distrust, says Dr. Desjardins, the provider is unlikely to be able persuade such a patient to seek proper care.

Dr. Desjardins doesn't expect nurses to know every nuance of culture that may be relevant to their patients — certainly an impossibility in America's polychromatic towns and cities. She does, however, expect them to be aware that culture does affect health behaviors. The bottom line, she says, is that "you have to ask enough questions to understand the patient's culture and how it is going to affect his or her approach to health. It's amazing the kind of responses you get if you just ask."

Perhaps the best advice on this whole subject was given by Sir William Osler, the renowned physician of the late 19th and early 20th centuries, who said, "Ask not what disease the person has, but rather what person the disease has."