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References

1. Potter BS. Bibliographic landmarks in the history of dermatology. *J Am Acad Dermatol* 2003;48:919-32.
2. Valentine MC. The beginnings of dermatology: a brief review. *Dermatol Nurs* 1999;11(1):25-6,29-33.

Is cultural sensitivity sometimes insensitive?

Leigh Turner, PHD

Physicians and other health care professionals are often urged to provide "culturally sensitive" care.[1] Numerous guidebooks describe how clinicians should provide care to patients from different cultures.[2,3] Synthesizing survey data, case studies from the medical literature, ethnographic reports, and cultural guides for clinicians offer general standards and practical tips concerning how members of particular ethnic groups should be treated. By now, clinicians will be familiar with many of the assertions made in such guides. Navajos want to hear positive news; they do not want to receive "bad" news about terminal diagnoses. Koreans are highly sociocentric; family members of patients will most likely want to make health-related decisions for these patients when they are seriously ill. Many other standard claims about the values, social practices, family arrangements, and rites of passage of particular cultures could be added to this list.

The concept of culture can play a useful role in medical education, medical research, and clinical practice.[4] Attending to the role of culture in various social settings can serve as a useful reminder that what seems obvious to one person might not be obvious at all to someone else.[5] While some scholars argue that it is time to discard the concept of culture, I do not think it is possible to eliminate all references to culture. We need to be cautious, however, when making claims about a particular patient's "cultural framework."

Culturally sensitive care

There is much to be said for promoting the concept of culturally sensitive care. While ethical and legal limits to accommodating cultural and religious differences need to be recognized, modern health care providers practise in multicultural, multifaith, and multilingual social settings. Just as patients need to understand what their caregivers are saying, clinicians need to comprehend how patients make sense of health, illness, injury, suffering, treatments, and risks. If patients are making important health-related decisions on the basis of explanatory models of health and illness quite distinct from clinicians' biomedical model, it is crucial that health care providers explore how these patients understand matters.

Misunderstandings can be connected to language differences and different understanding of health, illness, and treatment. An awareness of how patients experience the world is particularly important in family medicine where treatment of medical problems commonly requires a detailed

understanding of the family ties, social circumstances, and "life-world" of a patient.

Unfortunately, the concept of culture can get in the way of providing discerning medical care. Cultural guidelines can promote "insensitive" care by encouraging clinicians to slot particular patients into generalized cultural stereotypes. Initiatives to promote cultural sensitivity can undermine efforts to provide medical care attuned to the needs of particular patients. Used inappropriately, the concept of culture can serve as a barrier rather than a bridge to understanding.

Underestimating differences

Countries such as India, Mexico, and China are not monolithic entities.[6] They are not dominated by seamless, integrated, all-encompassing cultures. Determination of a patient's country of birth or ethnic affiliation—taken alone—offers little insight into how a patient thinks about health, illness, medicine, or family relations. Guidebooks with cultural tip sheets can foster the mistaken notion that a single culture dominates a diverse country such as China or Mexico or a diverse group such as the Cree. To know that someone is Chinese-Canadian is to know very little about that person.

More importantly, ethnic background is just one marker of identity. Patients are specific historically, geographically, and socially situated human beings. Many different factors are likely to inform their understanding of health, illness, healing, and medicine. Some patients left their country of origin decades ago. Customs and social practices from their birthplaces might no longer be important to acculturated citizens. Some immigrants are eager to leave behind customs and practices that are widespread in their communities of origin.

Personal history and family history can shape explanatory models of health and illness. Sometimes, particular experiences, such as a history of chronic illness, shape how patients respond to subsequent clinical encounters. Patients from similar ethnic backgrounds but very different socioeconomic levels can have quite different attitudes toward communication and decision making in clinical settings. Sex and sexual orientation can also play an important role in how patients experience illness or relate to health care providers. Personal identity is composed of many different threads.

Language, sex, sexual orientation, ethnic background, socioeconomic status, personal history, education, family history, and many other factors can all contribute to how patients experience illness, engage clinicians, interpret conversations in clinical settings, and make health-related decisions. No single marker of identity has a determining, all-encompassing role in how patients experience medical care.

Avoid making judgments

Patients are not simply Chinese, Korean, or Cree. They are distinctive human beings with individual histories and concrete community ties. As complex beings, they are not likely to be defined by just one marker of identity. Instead of promoting notions of culture, perhaps we should try to place more emphasis on seeking to understand patients and their families in all their particulars. Recognizing the complex identities of patients and their families is particularly important in family medicine.

How, in practice, should clinicians seek to understand how patients interpret health, illness, diagnostic and prognostic information, and treatment alternatives? How can clinicians learn about the world within which their patients live? Rather than making assumptions about salient cultural norms, family physicians and other clinicians need to engage their patients and explore how these patients see the world.

Arthur Kleinman, a psychiatrist and medical anthropologist, encourages clinicians to cultivate an anthropologic imagination and develop "mini-ethnographies."[7] One potentially useful way of proceeding is to avoid making judgments about patients solely on the basis of their skin colour, physical appearance, dress, forms of adornment, or participation in a particular ethnic group. Engagement with the person is required to better understand how a particular patient makes sense of his or her circumstances. Good clinical judgment and

effective patient-physician communication require that patients be treated as individual human beings rather than caricatures or cultural types.

Conclusion

Efforts to promote cultural sensitivity can, however well intentioned, become insensitive and presumptuous. Cultural differences need to be addressed and considered without permitting stereotypes and quick judgments to influence clinical encounters. In many busy clinical practices, lack of time for in-depth conversations with patients is likely to limit opportunities to understand patients in all their complexity. Mutual comprehension takes time and sustained dialogue; this applies to all patient-physician encounters and is not limited to exchanges involving patients and caregivers from different cultural backgrounds.

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References

1. Kristal L, Pennock P, Foote S, Trygstad C. Cross-cultural family medicine residency training. *J Fam Pract* 1983;17(4):683-7.
2. Galanti G. *Caring for patients from different cultures: case studies from American hospitals.* 2nd ed. Philadelphia, Pa: University of Pennsylvania Press; 1997.
3. Huff R, Kline M. *Promoting health in multicultural populations: a handbook for practitioners.* Thousand Oaks, Calif: Sage Publications, Inc; 1999.
4. Berger J. Culture and ethnicity in clinical care. *Arch Intern Med* 1998;158:2085-90.
5. Geertz C. *Local knowledge: further essays in interpretive anthropology.* New York, NY: Basic Books; 1983.
6. Nie J. The plurality of Chinese and American medical moralities: toward an interpretive cross-cultural bioethics. *Kennedy Inst Ethics J* 2000;10(3):239-60.
7. Kleinman A. *Writing at the margin: discourse between anthropology and medicine.* Berkeley, Calif: University of California Press; 1995.

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