Editorial

Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

Cross-cultural health care

Most of my life as a New Zealand GP has involved working in a predominantly monocultural system with a variable amount of biculturalism interspersed. New Zealand is, however, becoming increasingly cosmopolitan, some regions much more so than others. Most of us will inevitably be consulted by patients from various ethnic backgrounds.

I have been fortunate to have had the opportunity to live and work in two countries other than New Zealand, one with increasingly similar beliefs, attitudes and language to ours, and one vastly different.

In 1978 I spent a short time in the United States. I clearly recall being in the Emergency Department soon after I arrived. A middle-aged woman was brought in by ambulance. She was pale and sweating with chest pain radiating to her neck. On arrival the ED staff went straight for her handbag. I thought to look for anginine or aspirin, but no, it was to look for her insurance cover card to see if they would treat her at this hospital or send her off to another. Back then I was aghast but I suspect that nowadays I would scarcely blink.

In 1994 I went to work in the United Arab Emirates (UAE) and spent some time in relatively isolated clinics in a rapidly evolving, Muslim, predominantly Arabic speaking, multi-cultural society. Most weeks for almost seven years I spent time in different primary health care clinics observing, teaching and seeing patients. I learned a few things about cross-cultural communication and health care. Most importantly this experience confirmed my belief in the importance of patient-centred care. I discovered that body language has more in common across cultures than spoken language. I learned that what we take for granted with respect to touching and physical examination is culturally determined. I also found that illness, apart from relatively uncommon, culture-specific syndromes, is much the same, irrespective of ethnicity, but that symptom presentation may vary quite widely. Not long after arriving in the UAE I came across some interesting data, published by the Ministry of Health, listing the prevalence of diseases seen in primary care clinics. Near the top of the list was polymyalgia rheumatica (PMR). This seemed unusual until we discovered that the official who compiled the list had coded all non-traumatic, generalised body pain as PMR. Non-traumatic musculo-skeletal pain is a very common presenting symptom mong Gulf Arabs. A recent study of Kuwaiti nationals over the age of 14 years found a prevalence of 35.7% in females and 20.2% in males.[1] After spending some time in the UAE clinics it seemed that there was a strong association, particularly among older women, between the presentation of generalised body pain and a diagnosis of depression. This whole body pain did not appear to be related to arthritis or to muscle tenderness or to abnormal laboratory results. Our assumption was that it was most likely a symptom of depression.

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Being sensitive to the patient as a person is essential when communicating cross-culturally and asking the patient about what they think may have caused their distress is often very rewarding. It may also be helpful to be aware of common customs and beliefs about sickness and dying and about illnesses that are culturally determined. It has been suggested that cultural competency in health care holds four major challenges for providers.[2] The first is to recognise differences in the prevalence of certain diseases in different ethnic groups (e.g. diabetes, thalassaemia). The second challenge is communication. The third involves ethics and respect for the belief systems of others and the fourth challenge involves trust.

I briefly mentioned culture-specific illness and it may be important to consider a culture-bound syndrome when a diagnosis is elusive. We should be aware of makutu among Maori (I have had two patients, that I know of, die from this illness) and if we have Asian patients it might be helpful to know about Shenku (Chinese), shinkeishitsu (Japanese) or amok (Malaysian). However, these will be relatively uncommon presentations as are the western culture-bound syndromes of bulimia and anorexia nervosa. What is important is that if we have no idea that such illnesses exist we will never find them.

Although, for many of us, cross-cultural considerations will only be important when our patients are from a different ethnic background to our own, it is becoming increasingly common for GPs in New Zealand to have a different ethnic background from the majority of their patients. We recently had two Malaysian TIs in our practice and they told me that 33 of their classmates had joined the fourth year medical school class in Auckland. Contact with recent registrar groups and new members of the College leaves no doubt that we are becoming a multi-cultural profession. When I was working with doctors from many different countries I became aware that the sub-culture of medicine allowed us to communicate with each other much more easily than with laypeople from the same countries. We all understand history-taking, differential diagnoses, scientific explanations and pharmacotherapy even if we have different cultural beliefs, eat different food and work in different political regimes.

So, what to do when seeking contributions for an issue of the *NZFP* on cross-cultural health care? Contact a few old friends. I had such a positive response from those that I approached that I had no need to look elsewhere. The contributions from an Eastern European, a Taiwanese, a Sri-Lankan and a Yemeni are neither inclusive nor representative of New Zealand's multi-cultural population. They are published much as I received them and, I believe, provide some useful insights into some aspects of multi-cultural health care in New Zealand.

Figure 1. Clinical skills

Figure 2. Waiting for the GP

Figure 3. A group of multi-national GPs

References

1. Al-Awadhi AM, Olusi SO, Moussa M et al. Musculoskeletal pain, disability and health-seeking behaviour in adult Kuwaitis using a validated Arabic version of the WHO-ILAR COPCORD Core Questionnaire. Clin Exp Rheumatol 2004; 22(2):177–183.
2. Setness PA. Culturally competent healthcare. Postgraduate Med online 1998; 103(2).

Culture-bound syndromes

'Study of the culture-bound syndromes can teach an important lesson. In considering the situation of a suffering human being, especially if the goal is to ameliorate that suffering, it is necessary to consider not only the physiology, but also culturally significant beliefs and practices and the patient's social situation in puzzling out whether to intervene and, if so, how. In my experience, sometimes the best therapy is a shamanistic healing ceremony, sometimes it is an antidepressant or antipsychotic, and sometimes it is an antibiotic. Since people presenting with an indigenous diagnosis of a culture-bound syndrome may in fact be suffering from tuberculosis, schizophrenia, intrafamilial oppression and so on, the best therapy is that which deals with the problematic factor in the specific case. Often, just as in Western psychiatry, a combination of several approaches makes the most sense.'

Simons RC. Introduction to culture-bound syndromes. Psychiatric Times 2001;18(11).