How cultural differences impact on my consultations

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I was born in Germany. My father is a Dalmatian and my mother is a Slovenian. We immigrated to New Zealand in 1960. I consider myself to be a New Zealander. I am married to Marian and we have raised two teenage children Tomaz and Moja in the Wellington region.

I did my schooling in the Wellington region and obtained most of my education in New Zealand. Over the last 20 years, I have started two general practices from scratch as well as developing my academic interests in general practice and primary health care. I enjoy teaching general practice, Informatics, and EBM to undergraduate and postgraduate students at the Wellington School of Medicine & Health Sciences. I have contributed to a wide range of topics in the field of general practice research.

The future of academic general practice requires research and teaching that is relevant in a changing environment. My goal is to use my skills in teaching and research to do this. I would like to see more research into EBM in general practice and the development of a philosophy of medical science within the university with a particular focus on conceptual analysis of scientific and ethical issues in general practice.

I belong to an ethnic minority in New Zealand. I am always reminded of this in my day-to-day work as a general practitioner. My cultural identity matters as it influences the quality of my consultations with patients, and can cause clinical errors on my part. It also influences my income.

Having a foreign name influences consultations

My surname (Kljakovic) is difficult for European New Zealanders to pronounce. They find it hard to get their tongue around saying the consonant cluster of 'klj – such clusters are common in Slavic languages but not so in English. An introduction to new patients usually starts with my saying my name and sometimes having to write it out phonetically. The fun aspect of this little ritual is that it allows me to address the difficulties I have with many other cultural names – such as the weird Irish, Scottish names that people spell one way and say another. Recently patients from Vietnam were relieved that I did this little ritual because it allowed them to tell me how to say their name after I had told them about mine.

My surname keeps some patients away from me. For example, when I first started in general practice my surname Kljakovic was known as a Yugoslav name. Then the war broke out in former Yugoslavia in the early 1990s and a number of my Yugoslav patients decided to transfer elsewhere. They knew that my name actually was Dalmatian (part of Croatia) and they were Serbian. Despite consulting with me for over five years, they felt uncomfortable with the animosity that was occurring at the other end of the planet. It is interesting that it took about 10 years before a new Serbian patient consulted me again. My first name is also confusing and contributes to keeping some patients away. I have had the amusing experience of female patients walk into my surgery only to exclaim, *'You are a man!'* They were confused that 'Marjan' is not a feminine name (the feminine version is Marianna).

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Paradoxically my foreign name also attracts other patients to consult. I have found new Croatian patients search the phone book for a doctor's name similar to their culture. They have chosen to consult with me for my matching culture rather than for any particular medical expertise. Other new immigrant patients consult with me because they discovered English was not my first language. One Asian patient said *'You speak another language and this means that you understand the difficulties foreigners have in expressing themselves to English speaking New Zealand doctors'*. Such people

must have made an effort to find out about my linguistic abilities because, actually, I speak with a broad New Zealand accent.

Cultural differences make consultations complex

Every consultation in general practice is a complex relationship between the doctor, the patient, and the illness the patient brings to the consultation. Psychologists,[1] medical anthropologists,[2] and academic GPs[3] have argued that cultural beliefs contribute to this complexity. The following examples show how cultural differences between patients and myself have added to the complexity of consultations.

Once I asked an Iraqi patient to consult with me so that I could tell him about the new illness I had diagnosed. I was busy being as clear as I could to tell him about type 2 diabetes when, in the middle of a sentence, he told me to stop talking. As he was leaving, he told me that there was nothing personal about his leaving, but that my jersey was totally offensive to him. It was a very expensive, striped, Australian jersey with many colours in it. It seems that the Iraqi police had been wearing similar jerseys while they tortured his family. I had no idea that my jersey could have such significance in this patient's culture. In the next consultation I wore my usual jacket and continued with the conversation on diabetes.

At another consultation, a Maori elder thought I was a 'good fella' because I had told him that the eczema in his legs was hard to treat with simple creams and that perhaps it would be better to fix the varicose veins with surgery. Following this consultation he referred his mokopuna, their parents, and finally his wife to consult with me. I treated this whanau for 10 years where I was involved with all kinds of clinical issues and social misfortunes. I was honoured to be an attendant to the Maori elder's terminal illness with prostate cancer. I had a consultation with the Maori elder's wife near the end of my time with that particular general practice. We talked about my experiences with the whanau. It turned out that one of the reasons they consulted with me was that they thought I was a Tarara. This is a person who is of Croatian and Maori ancestry. We had a good laugh when we realised that I act like a Tarara even though I am not one! Since then I have met other Maori patients who were sure I was a Tarara and that this is why they felt comfortable consulting with me. (I have never met a Tarara. I can only surmise they must be relaxed, loud, gregarious, olive skinned people who like talking to Maori.)

I find it a virtue that my cultural identity is seen to be foreign by many New Zealanders. It has forced me to understand the nature of cultural difference and untangle some of the complexities of consultations and their clinical conduct

These examples illustrate that my patients' cultural perception of what I wear and my ancestry can influence the very fact that they consult with me.

Cultural differences influence clinical presentation

The next examples illustrate how cultural differences influenced clinical activity in my general practice. A 50-year-old Englishman consulted me because he had a slight pain in his left side that came on after he had been cycling for 20 minutes. He cycled to work daily and this pain had been 'a bit of a problem' over the previous month. It took another month for me to realise that his 'slight pain in the chest' was actually an example of an English understatement. Furthermore he did not want to bother me too much. It turned out he had severe triple vessel coronary heart disease, but I found this out only after I decided to ignore his understatement and referred him for investigation of chest pain. The delay of a month was due to my cultural blindness. The sentence *'I have a slight pain'* is taken to mean in my culture that it is not a serious pain. I have since learnt that the mere fact an Englishman consults for an apparent 'slight pain' speaks volumes. I should listen as much to his actions as to his words.

Another example is of a Kurdish family who consulted as new patients to me because they wanted a prescription of 'Septrin'. In their experience all kinds of health problems had been cured with this antibiotic. I felt I had to bow to their pressure to prescribe Septrin because they would not take the usual asthma medication for their child unless I prescribed (and it was not just any version of co-trimoxazole. It had to be Septrin because that was what was done in their village). Eventually they stopped demanding Septrin, but only after many consultations of my explaining why I thought Septrin was not a good routine treatment for asthma. The clinical work I had to do in this example was to overcome the difference between the patient's cultural perception that Septrin signified good western treatment and my medical culture that it does not.

The final example is unusual because I would like to describe the kind of situation where cultural differences cause patients to avoid consulting with me. The example I choose is that I cannot remember ever treating a Pacific Island teenager with an acute sore throat. This lack of clinical presentation may not be very surprising given that a small proportion of my practice population includes Pacific Island people. However, the example illustrates a cultural difference between what patients and doctors signify as 'serious illness'.[4] It is one instance of the

variation in the presentation rates of sore throat between different ethnic groups in New Zealand.[5,6] Rheumatic fever is an important sequel of throat infections and those most at risk of rheumatic fever are children aged 5–14 years.[5] A 1991 morbidity survey of GP visits in the Waikato found that no Pacific Island teenager presented with an acute sore throat.[5] This finding may be a peculiarity of the sampling procedure used in the study. Nevertheless, it was a startling result and suggests cultural differences between patients and their doctors influence the significance of sore throat as an important symptom.

Cultural difference matters

Original research carried out in Wellington in the 1980s found that GPs were likely to encounter patients who identified themselves from a wide range of ethnic groups.[7] Therefore, it is likely that most New Zealand GPs will encounter cultural differences among patients in their practice population. I find it a virtue that my cultural identity is seen to be foreign by many New Zealanders. It has forced me to understand the nature of cultural difference and untangle some of the complexities of consultations and their clinical conduct. My recognition of the seriousness of an English patient's condition, my success in instituting correct therapy in Kurdish patients, and the lack of presentation of clinical symptoms among Pacific People are examples of cultural differences having an impact on clinical activity. Such differences matter not only for the individual doctor-patient consultation, but also for future patient encounters.

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References

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Cross-cultural empathy

'Imagine the anxiety our monstrous [North American] system might trigger for a person whose healthcare was always provided by a trusted community healer in a rural village. Imagine being told by a professional, white-coated American doctor that you need an invasive procedure when such a thing, unheard of in your homeland, is a severe affront to your cultural and religious beliefs. Imagine meeting with a doctor who expects you to quickly agree to a treatment program when, in your culture, an elder makes such decisions or the family as a whole decides jointly after extensive consideration and discussion. Imagine trying to understand the directions for barium enema cleansing when you don't read English and have never heard of such a thing. Imagine having a physician suddenly palpate your sinuses when your religious beliefs hold that the head is the most sacred part of the body. Think about the woman who is asked about her sexual history by a stranger – a cultural taboo unthinkable in many communities. Suppose you are told to eat many small meals a day for metabolic problems when you are Muslim and it is Ramadan, the holy month when you must fast from sunrise to sunset. These are no longer extraordinary situations, and we need to be prepared to meet them sensitively and competently.'

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