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From the Editor
Ethics and Multiculturalism in the Patient-Physician Encounter

The changing demographic landscape of the United States has received growing attention among physicians and has added new dimensions to the patient-physician encounter. According to a recent survey of the American College of Physicians (ACP), nearly two-thirds of internists report having active patients with limited English proficiency (LEP); and this group comprises 12 percent of active patients in the practices of ACP member internists [1]. The median age of immigrants in the U.S. is 39.3, [2], so we can expect even more such encounters as older immigrants—who are more likely to hold onto traditional cultural beliefs—enter the U.S. health care system in greater numbers. With the need for immigration reform looming, it is therefore a good time to explore the ways in which cross-cultural interaction can transform many core values of medicine and the medical encounter.

As this issue developed, a few central themes began to emerge. First, ethical principles or values which are well enshrined in Western medicine—patient autonomy or scientific empiricism, for example—are clearly not universal and may not be shared by patients of all cultural backgrounds. Second, language and culture are inexorably linked, so that, even if physicians are bilingual or use professional interpreters, they may still encounter cultural barriers by failing to ask the right questions or consider alternate explanations for a patient's illness. Finally, without prompting, several authors in this issue invoked the relatively recent concept of "cultural humility" as an approach that can help physicians identify and understand alternate belief systems, so it is worth exploring this new paradigm further in this introduction.

Conceived as a response to the discourse on cultural competency, the concept of cultural humility invites physicians to approach individuals and cultures as equals, rather than as groups that present challenges to be overcome in their practice [3]. Thus:

> The starting point for such an approach would not be an examination of the patient's belief system, but careful consideration by healthcare providers of the assumptions and beliefs that are embedded in their own understandings and goals in the clinical encounter [4].

By this concept, an approach rooted in cultural humility would not require memorization of unique beliefs held by certain patients; rather, physicians should be encouraged to develop respectful partnerships through patient-focused interviewing

[4]. In this vein, readers of this issue are encouraged to explore their own values through the cases and discussions that we present.

The clinical cases invite us to examine issues which might emerge in the everyday context of a multicultural medical encounter. Perhaps no ethical principle is as legally enshrined in U.S. medical practice as "patient autonomy," and yet, not all patients may be accustomed to a system where the emphasis is placed on their own individual decision making. A case commentary by Jennifer Blanchard presents a number of approaches to managing situations in which the locus of decision making is in question. The ramifications of relying on family members to interpret is also explored in this case, because some of the problems that give rise to the ethical dilemma might have been avoided if the patient's true beliefs could have been ascertained earlier.

A second case examines what physicians might do when they encounter patients who do not share their beliefs. Of all the medical disciplines, psychiatry may be the one in which patient beliefs exert the greatest importance, and here commentator Andres Sciolla extends the ethical principle of benevolence—providing appropriate care to a patient—to include culturally appropriate care. In a third case, Lindia Willies-Jacobo explores how a physician can skillfully navigate a clinical encounter in which multiple beliefs are expressed, as happens when a physician cares for both a patient and his parents. The point of exploration is "susto," a folkloric illness believed to result from psychological trauma to which the patient's family attribute his illness. The patient's medical illness—Guillain-Barre syndrome—is discussed separately in a clinical pearl segment by Adel Olshansky.

A similar scenario is described in an op-ed article by Matthew Wynia and Megan Johnson, who explore the tensions that can exist between differing belief systems, citing an example where a patient's interpretation of his own illness is "scientifically incorrect." Of course, the extent to which science is its own belief system—after all, we accept studies and evidence without attempting to reproduce the data ourselves—could be the subject of a separate *Virtual Mentor* issue.

For now, as Dr. Wynia argues, even if a physician believes a patient is wrong about the cause of his or her illness, the belief is important and should be acknowledged by the physician. To do so does not require a physician to accept the beliefs as his or her own but rather to understand and address them for the ultimate well-being of the patient.

Dr. Wynia's view that culturally sensitive care and medical science can coexist in the same medical encounter answers the first part of the op-ed by Romana Hasnain-Wynia and Debra Pierce, which poses just that question. They explore whether it is possible to give culturally appropriate care within the confines of evidence-based medicine. The two approaches, they argue, may appear to be fundamentally opposed, but, much like the "art" and "science" of medicine, each approach offers insights, and physicians can and do utilize both approaches in providing effective care.

Yolanda Partida, director of Hablamos Juntos—a national project focused on language barriers in health care—invites us to think more broadly about the topic of multiculturalism, arguing that lessons learned from patients with limited English proficiency can translate into everyday practice for all patients. Viewed in this light, every patient-physician encounter is a multicultural encounter.

Education and research can further sensitize us to issues of cultural difference. Ruby Roy describes a course in which students learned innovative ways of accessing their own cultural assumptions through the use of narrative and includes several examples of student work in the article. Maria Luisa Zuniga explores several themes from a 2001 article by Marianne Sullivan et al.—"Researcher and Researched-Community Perspectives: Toward Bridging the Gap"—citing examples of cultural negotiation that have informed her own community-based research.

As with everything in medicine, there are important legal ramifications to the subject of language and cultural barriers. Mara Youdelman offers a thorough overview of both federal and state legislation which has affected the care of patients with limited English proficiency. Her article concludes with a consensus-driven statement of principles which rests on the premise that quality care can and must be provided to all individuals regardless of their language. Abigail Van Kempen alerts physicians to four areas that they must negotiate when confronted with language barriers if they are to avoid legal liability. She describes several cases where Youdelman's principles might have helped. Unfortunately, as the cases illustrate, the presence of a language barrier can be an enabling condition for the delivery of substandard care—inadequate histories are taken, and assumptions are made that lead to poor outcomes and legal consequences. The physicians in these cases were not sued because they were not bilingual or did not have a professional interpreter on staff, but clearly they could have done a better job had they appreciated the extent to which a language barrier had compromised the care of their patients.

Finally, it is worth nothing that culture is dynamic, shaped by a number of interactive forces and constantly changing. Allison Grady illustrates this notion by showing how American public health messages have evolved from images and cartoons which depicted immigrants as influences to be feared by the mainstream of society to today's use of imagery as a means of communication for a wider audience, including individuals of diverse backgrounds.

As this imagery has changed, we also see that the daily practice and teaching of medicine—so rooted in tradition and itself a kind of culture—has evolved and will continue to adapt to the cultural values held by patients. The articles in this issue demonstrate the ramifications in the fields of medicine, law, education, and most importantly, in the interactions between patients and physicians. I would like to thank all the authors and fellow editors who have contributed to this issue.

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