

Can You Take Care of My Mother? Reflections on Cultural Competency and Clinical Accommodation

Cultural competency is a term that has become ubiquitous within medical education. It has been placed within the core competency of professionalism, and cross-cultural communication skills have been identified as one of the ways to address healthcare disparities among cultural and ethnic groups. This case highlights the need for cultural competency and places the argument within an ethical paradigm. When are we obliged to accommodate patient requests, and how do we negotiate between the values systems of medicine and that of our patient?

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I and another male resident were working when the emergency medical services (EMS) brought in a middle-aged South Asian female. She appeared to be anxious, in moderate respiratory distress, and having choreic movements of her upper torso. As I paused to gain triage information, the patient's son approached and said, "My mother saw that you are working, can you take care of her?" I am a Muslim of South Asian descent and understood the implication of his words to mean that perhaps our shared background would allow me to better relate to his mother culturally. Replying in the affirmative, I proceeded to her room.

Mrs. Khan (pseudonym used to protect patient confidentiality) told me that she had been unable to urinate or defecate since she fell onto her back 24 hours prior. She also described shooting pains from her lumbar region into her right foot as well as difficulty ambulating. The call to EMS had been precipitated by sudden onset of substernal chest pressure with dyspnea, an hour ago. She also had Parkinson's disease that was generally well controlled but could be exacerbated by stress.

I informed her that I needed to perform a physical exam, and she softly stated, "please don't." After I explained the examination's importance, she only acquiesced to auscultation of her heart and lungs. As I insisted on examining her back, I initially was politely refused, but after some coaxing, I was allowed to examine her spinal column with gloves on (thereby avoiding direct skin-to-skin contact), and I noted spinal tenderness. I realized the possibility of spinal cord injury and knew that a rectal tone examination was indicated. However, my patient had a strong sense of modesty, and I had just broached multiple physical boundaries during the examination. I decided to address that issue later.

My attending physician and I agreed to a diagnostic workup of new-onset chest pain and potential spinal cord injury, with radiographs of the chest and lumbosacral spine, and we considered a magnetic resonance image (MRI) of the lumbosacral spine and admission for observation. I related to him her reticence about physical examination and offered that her discomfort was enhanced by he and I both being male. After the initial treatment and diagnostics, I approached our patient to conduct a rectal examination. She adamantly refused and asked to see her nurse.

Some time later, I found Mrs. Khan in better spirits, yet frustrated that she was not being allowed to walk to the bathroom (she declined the bed pan). Her nurse had been denying this request because protocol required a patient who had been placed on cardiac monitor to remain in bed. I told her that I would speak with her nurse and conveyed to Mrs. Khan the results of our diagnostics, while suggesting that she spend the night in our observation unit to obtain a ventilation-perfusion scan and an MRI of the lumbosacral spine. She agreed but was concerned about her environment in the observation unit; she wanted a private area and desired to be able to walk to the bathroom or allowed a commode, otherwise she would leave. I spoke with the observation unit personnel and was able to procure a curtained area and bedside commode for her.

During my sign out to the observation unit team, I was criticized by the attending for not performing a rectal examination. In my defense, I offered the concept of patient autonomy and proposed that a female practitioner would likely be able to make the patient feel more comfortable. At the end of my shift, I was forced to smile as the next nurse for our patient ran up to me and said, "Mrs. Khan just had a huge bowel movement, I don't care if she's not supposed to get up from her bed, I walked her to the bathroom myself...I mean my God, look at the poor woman."

Mrs. Khan stayed in the observation unit overnight, and our workup was negative for acute disease or injury. The following morning she was able to urinate and defecate and requested discharge; thus, an appointment with her neurologist and an outpatient MRI were arranged.

REFLECTIONS

Mrs. Khan's emergency department visit presented the sort of challenges to my abilities in cultural competence

and negotiation that can serve to enhance one's professional development in cross-cultural care. As medical practice becomes increasingly multicultural, clinicians often must negotiate multiple, different barriers and value systems to provide care. It is known that culture greatly influences health care values and behavior and that religious beliefs are manifested in culture through the setting of mores and ethical values.¹ Thus, both cultural and ethical competence are essential to providing culturally sensitive care and are emphasized within medical training. Yet a significant percentage of residents feels inadequately prepared to provide components of cross-cultural care relating to caring for persons who have health beliefs that are at odds with Western norms and to caring for those whose religious beliefs impact treatment. More striking is that a large proportion of residents feel that they lack the skills necessary to identify cultural customs that impact medical care.² Hence, there is room for improvement.

In the case of Mrs. Khan, there are three areas in which cross-cultural communication played a role and ethical dilemmas ensued. The encounter began with a request for me and not another physician to provide care. Perhaps this stemmed from the patient's hope that a health-care provider from a similar cultural background would better understand her viewpoint. Alternatively, the request may have stemmed from a religious and cultural value system within which there exists a hierarchy for physician selection. Illustratively, Islamic medical ethics outlines a system by which a Muslim should choose a physician. Preference is given to a Muslim physician of the same gender; followed by a non-Muslim of the same gender; then a Muslim physician of the opposite gender; and last, a non-Muslim of the opposite gender.³⁻⁵ Should we as healthcare providers accommodate requests for specific providers, be it for religious or cultural reasons? It is common on the labor and delivery floor that accommodation is made for patients who request female providers. Could a patient at triage make such a request, and are we obliged to accommodate such? This concern was particularly striking for our emergency department, because only weeks before this case, a man had driven up to the ED asking whether there were any female or Muslim practitioners to care for his wife. When he received a reply in the negative, he sped off to search for another ED. What standard should we use to accommodate such requests? What if an African American male requested only African American practitioners? Alternatively, what if a white supremacist demanded that a person of color not take care of him? At what point should we not respect another's cultural beliefs, and is that a morally sound position?

Another ethical conflict that arose was Mrs. Khan's refusal of the rectal exam. By using Beauchamp and Childress's model of biomedical ethics, one could argue that respect for patient autonomy conflicted with the physician obligation of beneficence.⁶ Should I have continued persuasion, or was I providing culturally sensitive care in complying with her wishes? In a study of the bioethical conflicts between Muslim patients and German physicians, Ilkilic quotes patients who felt violated during hospital stays. For example, a Turkish male stated about his stay in the hospital, "the most awful thing for me about

it was not my illness, but being cared for and washed by a woman."⁷ Similarly, a German Muslim woman stated, "I was so embarrassed, I wished the ground would open up and swallow me" when her sense of modesty was not respected.⁷ Hence, does physician beneficence extend to preventing emotional distress? Should I have asked a female colleague to perform the rectal examination on Mrs. Khan? Precedence for such action does exist, as in cases of sexual assault; we usually accommodate requests for a same gendered provider to perform that evidence collection. What are the criteria for such action?

The third dilemma occurred when Mrs. Khan refused to use the bed pan and demanded to use the bathroom. This request may have stemmed from Islamic concepts of cleanliness. Protocols are replete in emergency medicine and are aids in streamlining and in providing a standard of expected care. How far can I go as a provider in deviating from established care pathways to make accommodations? The nurse's insistence on protocol caused our patient discomfort and distress, so much so that she almost refused to stay in the hospital. As health-care providers, we need to be attuned to needs of our patients in such a way as to elicit and respond to their concerns so that we are providing culturally sensitive care. This small but significant issue highlights the necessity of developing and learning cross-cultural communication skills within healthcare education.

The ethnic and cultural diversity within the medical arena raises challenges within healthcare access and delivery. These challenges go beyond language and encompass worldviews, concepts of health and illness, as well as values attached to medical interventions and physical examination. In emergency medicine, we are on the frontlines, where constraints on time and resources also weigh in heavily on patient care. How far should we go to accommodate patient requests, and what are the criteria upon which such a decision should be made? Cultural and ethical competency, as well as cross-cultural communication skills, are integral to providing proper medical care, and their application within the emergency medical context needs to be further investigated and emphasized.

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Commentary: The Muslim Ethical Tradition and Emergent Medical Care: An Uneasy Fit

Islamic medicine was perhaps the most highly developed health care system in the world from the 10th through the 15th centuries. Medieval Islamic legal and medical scholars addressed many ethical questions in the clinical setting and established specific recommendations regarding gender-related issues. In addition to these *religious* injunctions, *cultural* beliefs play an equally important role in shaping the medicoethical preferences of individual Muslims today.

The separation of genders in Islam is the norm for both general society and medicine. The Islamic doctrinal concept of modesty holds that men and women who are not married or closely related by blood should not view the *awrah* (area of the body that should not be publicly exposed) of others.¹ Considerable debate exists among Islamic scholars as to what the *awrah* actually comprises, but all descriptions include the genital area. Most Islamic scholars believe that a patient seeking nonemergent treatment should choose a physician according to the following order of decreasing preference: Muslim of the same gender, non-Muslim of the same gender, Muslim of the opposite gender, non-Muslim of the opposite gender.¹ Whenever possible and without compromising proper care, the patient and physician should attempt to maximize modesty by minimizing physical examination of the *awrah*.

However, all scholars, including those in the conservative Hanbali school of jurisprudence, maintain that necessity allows things that are ordinarily forbidden to be permissible. Ibn Qudama, an eighth-century Hanbali scholar, writes: "It is permissible for the male doctor to inspect whatever parts of the woman's body that the medical examination warrants."² According to Ibn Muflih, also of the Hanbali school: "If a woman is sick and no female doctor is available, a male doctor may treat her. In such a case, the doctor is permitted to examine her, including her genitals."³ Scholars are also clear that female doctors may fully examine male patients in cases of necessity. In all cases, a third party of the same gender as the patient is required to be present for the examination.

Prophetic historical precedence also supports these legal opinions. We know that the army medical corps during the time of Muhammad was an all-female unit known as the *asiyaat*, or women healers.^{2,3} They were responsible for entering the field of battle and carrying wounded soldiers back to camp. They examined the male soldiers, dressed their wounds, and acted as physician-nurses. No Islamic prohibition to the necessary physical examination of male soldiers by female caregivers existed on grounds of preserving modesty.

The emergency department (ED) is the prototypical example of a setting in which the priority of necessary evaluation outweighs that of maintaining the Islamic concept of modesty. In the case of emergent care, no religious opposition exists to complete physical examination of the patient by a physician of the opposite gender.¹⁻⁴ However, many Muslims may be unaware of these juridical rulings and possess strong cultural opposition to the concept. These cultural values may be as strongly held as religious beliefs and are equally valid for the purposes of determining individual ethical preferences. It is, therefore, not a prudent strategy for the male emergency physician (EP) to discuss the intricacies of Islamic law with the female Muslim patient in an effort to expedite rectal examination to assess for signs of potentially devastating cord compression.

What is required in such cases of cultural differences is to strive for a balance of two ethical principles, as outlined by Beauchamp and Childress: beneficence and patient autonomy.⁵ In this particular example, beneficence dictates that the EP optimize the patient's medical care by performing the rectal examination to assess for cord compression. The degree of neurologic deficit, treatment strategies, and prognosis cannot be accurately assessed without this.

However, patient autonomy mandates both cultural sensitivity from the EP and informed consent from the patient. Physicians should be sensitive to the concept that Muslim patients may be unwilling, for cultural reasons, to be examined by physicians of the opposite gender. If the patient requests a same-gendered physician and it is reasonable, in the opinion of the EP, to accommodate this, then efforts should be made to do so. If this is not reasonable, then the EP should discuss it in a manner that indicates an open, nonjudgmental acknowledgment and understanding of the patient's cultural beliefs while informing the patient of the logistical realities of the ED.

Additionally, physicians must give patients proper informed consent and right of informed refusal. In this specific case, the resident could have indicated to "Mrs. Khan" that he understands that she is culturally opposed to the rectal examination but that not performing it exposes her to certain risks, namely missing an injury that could cause permanent paralysis. The physician also could have enlisted the aid of family members to help the patient make an informed decision.⁶ The patient must be aware of, understand, and accept the risks of leaving out a key part of the medical evaluation. Beneficence argues that the physician strongly encourages the patient to comply with the rectal exam, but patient autonomy, given appropriate cultural sensitivity and informed consent, should balance this.