

## Cross-Cultural Perspective in Treating Patients with a Brain Injury

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Each year in the United States 300,000 people suffer serious head injuries requiring treatment in critical care settings (1). Within this patient population a certain percentage of these patients and their families/significant others will be non-English speaking persons who have limited or no experience with American English and culture. Although medical and nursing curriculums are becoming increasingly sensitive to teaching the importance of providing culturally relevant care, students remain fairly homogeneous. Nurses, in particular, remain largely non-Hispanic European-American women from working and/or middle class backgrounds. Homogeneity of medical and nursing professionals can lead to an ethnocentrism that can adversely affect and delay desirable patient outcomes.

Therefore it is important for such professionals to recognize that there is an important relationship between medical treatment and a patient's cultural and linguistic background. By using my experience as a case study, I will discuss some obstacles to cross-cultural communication like peculiarities of spoken regional American English and suggest some ways to prevent and overcome them.

The problem of cross-cultural communication in medical settings has been discussed in a number of articles (2,3). I would like to cover the problems of cross-cultural communication in a rehabilitation setting and the way of measuring health status in foreign patients.

Fairly recently I had an opportunity to closely observe a relative of mine who was unfortunate to be involved in a motor vehicle accident. He is a native Russian speaker, but knows English having been trained to be an English teacher in Moscow, Russia.

His injuries included a right clavicular fracture, bilateral pneumothoraces, left humeral fracture, type III odontoid fracture, right parietal/occipital subdural hematoma, and a temporal lobe contusion. He required a halo, tracheotomy, and J and G tubes. For an excruciatingly long time the patient was on the brink of life and death, deeply unconscious, but luckily recovered, having spent much time in a rehabilitation department of a major university hospital. There he faced different kinds of cultural misunderstanding, a problem I would like to tackle in detail and in different aspects.

Quite often a patient expresses anxiety, depression (connected with the present illness) in certain peculiarities of behavior and body movement. By studying how anxiety and depression are expressed by a patient (especially a foreign patient), we are able to investigate core cultural clinical problems. By assessing culturally legitimated final common behavioral pathways along which particular societies channel particular kinds of normal and deviant behavior, we can derive a clearer sense of the psychocultural processes constituting the culture-bound discomfort.

Practitioner-patient transaction can be carried out taking into account different factors; for instance, institutional setting (i.e., specific location in a given health-care system's sectors—popular, folk, professional—and subsectors). Another factor is interaction between persons: number of people in the interaction, the amount of time the treatment takes, whether the interaction is episodic or continuous. Quality of the relationships, attitudes of the interacting persons, and manner of communication are other factors. Then we can turn to explanatory models (e.g., shared, openly expressed, tacit, or conflicting, etc.) and clinical reality (i.e., the type of social climate made in clinical relationships) (4).

These aspects were not neglected at the hospital where he was treated. In particular, there was a special treatment session where specialists pointed at possible consequences of head injury in professional and personal lives. However, some culture-based aspects were neglected, which was explainable since hospital staff is mostly concerned about the patient's health. And he was the only patient from outside the culture. For instance, such aspects as cross-cultural communication (especially after a head injury), the ways and means a former foreign patient can adjust to everyday life in another country, etc. were not considered.

The treatments during the sessions should be done by culturally-aware therapists in case there are foreign patients in the group. Therapists must give a certain amount of culture-loaded information: long-term memory of head-injured patients may suffer and they do not possess enough cultural background for their own cultural community to say nothing of a foreign one. In fact, a similar point was made by Gilson et al. (5) who argue that studies of access to health services have stressed the need for consumers to receive health care within the context of their cultural and linguistic backgrounds.

These cultural difficulties in receiving health care might influence the patient's impression about the stay in the hospital. Greeneich and Long (6) devote an article to a discussion of the patient's satisfaction. The patient's level of satisfaction can be defined as the degree of match between the health-care consumer's expectation of nursing care and the care actually received (7). The patient and the family frequently form a dyad of satisfaction because the patient is often psychologically unstable and urges the family to act as spokesperson for the perceived nursing care needs of the patient. The perception of family satisfaction is actually an outcome of nursing care and that is why family satisfaction depends on the nursing behavior toward the satisfaction dyad. Greeneich, Long, and Miller (7) present a model for evaluating the primary factors that affect family satisfaction with critical care nursing.

Here anew service can be offered to foreign patients: a "cultural coordinator," a person who can help foreign patients adjust to a new, hospital community. This coordinator could find an interpreter if the patient does not understand English, or provide some literature in the native tongue, or verify that mental status tests for head injured patients (i.e., tests that check the effect of a head injury on mental capacities) contain culturally neutral information. With the advance of computer technology the cultural coordinator can get in contact with head injury professionals in the countries where foreign patients come from via the Internet to check mental capacity tests for their cultural validity and reliability. Taking into account common financial difficulties, we could think of a nurse-interpreter-cultural specialist who received special training in this area and is able to serve a region of hospitals with foreign patients.

Concern about equality of health care to various cultural and linguistic groups centers on the inability to evaluate services completely unless a measuring instrument is addressed to consumers in their own language and reflects their own value structure. Gibson et al. (5) state that the solution of the cross-cultural problem can be found under the following conditions: (1) a consensus exists on the importance of the linguistic/cultural barrier in health care; (2) an outcome measure of demonstrated validity and reliability exists in the source (dominant) language; (3) the measuring instrument has been translated accurately into the target (minority) language; (4) a subject who is bilingual in both the source and the target languages is similarly assessed by the instrument when it is administered twice, once in each language; (5) if the instrument is scaled, varying cultural groups have acted as judges and the resulting value differences or similarities in the scaled items are reliable and are clearly documented; and (6) the final translated and scaled instrument was utilized in the evaluation of minority health issues and found to be discriminative and sensitive. I will

clarify the problems of measuring instruments with foreign patients further on, speaking about mental capacity tests.

The interdependency of language and culture first gained wide attention in the 1950s as the Sapir-Worf Hypothesis (8). The theory states that human beings do not live solely in the objective world nor alone in the world of social activity as ordinarily understood. They are very much at the mercy of the particular language which is the medium of expression for their society. The real world is to a large extent unconsciously built upon the language habits of the group.

The situation of my relative is a typical illustration of this statement. First of all, head injured people have many complications. One of them, which is often found in head injured patients and which results from brain injury, is speech disorder, the difficulty of articulating sounds. The patient struggled with this complication. Although he was speaking badly in Russian and in all foreign languages that he had learned, the personnel understood the effect of his Russian accent on his English. They did not treat this drawback although he told them that he had used to speak English with an almost imperceptive accent. Sometimes his speech was so disordered that the medical personnel did not understand him at all and he had to express his thoughts on paper.

And this leads to a very important issue in nursing: communication skills. The view that communication is a necessary component of nursing is widely supported (9, 10, 11, 12, 13). The importance of this area is also emphasized in Statutory Instrument No. 1456 (14) where the use of appropriate communication skills to facilitate the development of caring and therapeutic relationships with patients and families is stressed. Further, Roper et al. (15) have emphasized that adequacy of communication enables the nurse to comply with the professional duty to be accountable. The importance of this category is heightened with the implementation of the nursing process. Unless nurses can communicate skillfully, they can neither assess patients' needs for care, plan care effectively, implement it, nor evaluate it (16, 17).

Interpersonal skills that are likely to promote competent nursing action have been identified by Kasch (18). He claimed that skill is required in eliciting information for nursing diagnosis and decision-making and to promote patient understanding. Dunn (19), while acknowledging the value of skills to facilitate nurse-patient interaction, asserted that the ability to utilize these in a therapeutic manner is also required. Thus, nurses need to be skilled in recognizing indirect and subtle cues from patients, families, and significant others.

While central to the quality of patient care, communication is frequently avoided or performed badly (20). Several studies highlighted the limited and ineffective communication which often occurs between nurses and patients. Indeed, some researchers suggested that poor communication may be linked to the inadequacy of teaching communication skills in nurse education programs (20, 21, 22, 23, 24). Other possible explanations for effective communication may include nurses' inability to cope with stress, insufficient time, fear of patient involvement (25), the inhibiting effect of senior staff, and nurses' awareness of the limitations of their knowledge (13).

In the case study reviewed in this article, there was a circumstance where human interaction and language difficulty converged in critical care. In the intensive care unit, friends and family of patients were invited to bring photographs of their loved one to the hospital. The purpose was to make the visitors aware that the rather inert body with a swollen, contorted face, and innumerable tubes prominent is indeed the person they know. When asked to bring the picture of him, his Russian spouse understood the request as a picture for him and complied by presenting a photo of his favorite landscape. This underscores the potential for miscommunication great and small when crossing the divide of language.

Another language difficulty occurred when he regained consciousness and started to speak. The Russian he spoke was misunderstood as meaningless sounds. These sounds were attributed to

the injury and only acquired meaning when an English-speaking Russian visitor translated his words.

Because of cultural difference he also experienced problems with the tests routinely given to all head-injured patients to ascertain mental capacity. He was asked to name all the American holidays he knows. Having spent only a year in the U.S. he was acquainted with a handful of holidays, but did not have all the knowledge that a life long resident would have. If he had been asked about Russian holidays he could have listed them without difficulty.

Further mental tests revealed additional cultural bias that could greatly skew results rendering them worthless. Asked how many ounces in a gallon, most foreign patients, citizens of nations that use the metric system exclusively, would be completely puzzled for reasons that are cultural, not medical.

Let me illustrate with a concrete example. For instance, he was asked to add 13 inches and 5 inches and to give the result in feet. The doctor checks the time it would take him to add and to convert. But he does not account for cultural difficulties: the patient should not only add two numbers, but also make several conversions: first, inches to centimeters and then convert the resulting centimeters to feet. So it would take him much more time than it should with an American. But the doctor does not know this and thinks the head injury is the problem.

Consider a sample of the kind of tests all head-injured patients are given whatever their nationality. Two questions consider money transactions.

1. Mr. Jones walked into the bank with a \$20.00 bill and he told the teller that he wanted to change it for smaller bills. The teller gave him back seven bills equaling \$20.00. What was the denomination of each bill?

2. Match these things with what you would expect to pay for them.

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| a. a ticket to a movie                         | 1. \$275.00  |
| b. bus fare in this city                       | 2. \$2500.00 |
| c. rent for one month in a 2 bedroom apartment | 3. 60 cents  |
| d. new 1996 compact car                        | 4. \$3.75    |
| e. good 1985 used car                          | 5. \$8000.00 |

These kinds of tests may not be valid enough for foreign patients with a head injury because they do not show accurately the extent and the possible complications of their brain damage. Here we have an overlap of the intellectual and the cultural spheres.

Specific tests aside, viewing the general demeanor of foreign patients through the prism of American behavior is ill-advised. In my relative's case, he was somewhat critical of the doctors lacing his responses to them with irreverent sarcasm. To a doctor not familiar with Russian life, this attitude may have been attributed to the injury. But scabrous irony and rarefied sarcasm are as Russian as borsch (a tradition Russian beet soup), a behavior evolved over centuries of submission to irrational regimes. This emotional peculiarity can be understood (or misunderstood) in everyday talk. Another instance when this is a reaction to what a physician says or what a patient says to a physician. Any misunderstanding in this case is of vital importance.

The question of human responses in nursing was given broad attention in recent medical literature. Rogers (26) argues that describing human responses in nursing is fundamental to the implementation and evaluation of therapeutic interventions. Nurses should use concept analysis in formulating nursing diagnoses and in documenting care. Concepts, such as pain, fear, adaptation, loneliness, hope, and others have to be analyzed and guide assessment and interventions. He goes on to explain how concept analysis facilitates care planning, communication, nursing diagnoses, and clinical nursing research.

Also, native speakers use many phraseological expressions, modern slang. Since it is a very quickly changing layer of vocabulary, it can not be controlled in the process of foreign language teaching. Foreigners may have a rather good command of English, but some phraseology and slang might be unknown to them.

My relative's experience revealed a deficiency in medical and nursing services delivery. It could be considered an example of how foreign language users have encountered misunderstanding due to cultural reasons.

In conclusion I would like to summarize my points:

1. Health care professionals must be ready for some culturally-explainable behavior changes in foreign patients;

2. Nurses, while interacting with foreign patients, should take into account the patients' linguistic background and cultural peculiarities (e.g., not to misinterpret foreign patients' behavior); things that can have some specific meaning in the American culture may mean nothing in the culture the patient belongs to and vice versa;

3. It is desirable to introduce a person in every hospital or one for several hospitals who will deal with the problems of foreign patients who will help them to receive health care within the context of their cultural and linguistic background and who will make the patients' communication with the hospital staff more efficient;

4. While talking to foreign patients it is better to use simple sentences, simple grammar, and many internationally used words.

Because my relative was fluent in English the doctors equated his language ability with full cultural knowledge. Clearly the two are distinct concepts and it is remarkable that a seasoned professional would confuse the two giving evidence that the understanding of the need of foreign patients is quite limited.

#### Endnotes

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