

Tradition and treatment: The impact of cultural beliefs on medical decision making

Joycelyn Becenti; Keren H. Wick, PhD

Ms. X, a G2P1 23-year-old pregnant Navajo woman, came with her mother to an Indian Health Service clinic on the Navajo reservation. Her complaint was a bloody discharge for 1 week, and Ms. X and her mother were very concerned. The patient had been receiving regular prenatal care but had missed her last appointment. There was a slight language barrier, as her primary language was Navajo. Ms. X grew up on the Navajo reservation, and like the rest of her family, she utilized Navajo traditional medicine. She participated in Navajo traditional ceremonies and consulted medicine men and women, but she also sought medical care from providers of Western medicine.

A fetal gestational age of 23 weeks had been determined from Ms. X's last menstrual period. An ultrasound was performed, which showed no fetal activity and no cardiac activity. Further examination of the fetus revealed a gestational age of 17 weeks, according to femur length. The patient and her mother were informed of the ultrasound results and told that the fetus should be removed. They immediately requested a second opinion.

The patient received a second opinion from a medicine woman, who told her, "The doctor is lying, and the baby is alive. The baby had a hard time breathing but is fine now." The medicine woman told the patient to wait 2 days and then return to the hospital, at which time the doctors would realize they were wrong. The patient returned to the clinic and reported the second opinion to the doctor. The provider proceeded to explain the findings of the ultrasound. Ms. X. and her mother informed the doctor that they were very traditional people and did not appreciate the provider delivering such a negative statement. Based on the consultation with their traditional healer, they believed the baby was very much alive and well.

Joycelyn Becenti is a student and Keren Wick is Director of Research and Graduate Programs, both at MEDEX Northwest Division of Physician Assistant Studies, Physician Assistant Training Program, University of Washington School of Medicine, Seattle. They have indicated no relationships to disclose relating to the content of this article. F.J. Gianola is a member of the MEDEX faculty.

The ethical question

How can the provider handle this case in a way that both respects the patient's beliefs and practices and responds in a medically appropriate way to the death of the fetus?

Discussion

Medical indications In this case, the medical indications are based on the ultrasound results, which show fetal demise. This occurs in approximately 15% to 20% of clinically verified pregnancies,¹ and current medical treatment—removal of the fetus to avoid further complications,

Clinical ethics and cultural considerations

Applied clinical ethics should be viewed contextually within the milieu of present American society and all its tensions. The United States has always been a multicultural society. There are an estimated 11 million undocumented people in America. In May 2006, National Guard members were sent to patrol the southern border—an effort that seems to have fueled the subtle undercurrent of xenophobia within American society. Racism can be described as a form of xenophobia.

Recently defined competencies for the physician assistant profession include two major requirements within the following categories:

- Professionalism: sensitivity and responsiveness to patients' culture, age, gender, and disabilities
- Practice-based learning and improvement: recognize and address gender, cultural, cognitive, emotional, and other biases; gaps in medical knowledge; and physical limitations in themselves and others.

The AAPA's Guide for Ethical Conduct for Physician Assistants states that "physician assistants should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, or sexual orientation."

Societal pressures outside of the examination room doors and occasional frustrations with communication inside the exam room mean that tensions can be heightened and ethical dilemmas are common. The accompanying case presents a conundrum encountered recently.

— F.J. Gianola, PA

such as sepsis, disseminated intravascular coagulation, depression, potential loss or failure of reproductive organs, and maternal death—is highly successful, in most instances with no sequelae.^{1,2} If the patient decides against removal, sepsis could develop and her future fertility could be at risk. These potential outcomes were explained to the patient, and she understood the risks involved.

Patient preferences Ms. X's preference is to receive care from both Western medicine providers and traditional Indian medicine providers. As someone from a Native American cultural background, she has the right to practice her cultural beliefs and traditions; but at the same time, the provider is obligated to keep the patient's best interests in mind. The provider had trouble understanding the cultural practices and beliefs of the patient. As Jonsen and colleagues note, "persons from cultural traditions differing from the prevailing culture may view the medical practices of the prevailing culture as strange and even repugnant."³ When patient and provider do not understand each other's cultural practices, miscommunication is sure to occur.

The provider also assumed that the patient wanted to have another child. The provider informed the patient of all the potential negative outcomes of not having the fetus removed. The information distressed the patient somewhat, and her mother even more, and as a result they were unwilling to hear the provider's recommendations. Many Navajo patients believe "discussion of negative information to be a dangerous violation of traditional Navajo values."⁴ However, from the viewpoint of Western medicine, "explicit and direct discussion of negative information between health care providers and patients is the current standard of care."⁵ Their differences in cultural beliefs and practices could potentially lead the provider to question the patient's mental capability.

The patient's belief about her pregnancy was based largely on her visit to the traditional healer. She was told that her fetus was viable, which convinced her and her family to disregard the Western medicine provider's assessment.

Quality of life Ms. X should have a high quality of life with treatment, which would lower her chances of devastating outcomes significantly. She is a young woman, and she has years to think about having more children. Her decision not to seek medical treatment for her condition could be very detrimental. She could possibly become septic and eventually die. She may not be able to carry a child in the future. This could affect not only her own well-being, but also her relationship with her partner if her partner wanted to have another child.

On the other hand, appropriate treatment could still render her susceptible to a retained product, infection,

and other complications. If she were to proceed with the recommended treatment, it might also negatively affect her traditional Indian medicine beliefs and practices in the future. She could begin to question her traditional practices and the healers and wonder why the medicine woman told her that her fetus was alive. This might adversely affect her relationships with other family members who also practice traditional medicine. Navajo families rely heavily on one another for moral support.

It is vitally important for providers to understand cultural practices that their patients might follow.

This experience could also have a significant impact on the provider's view of traditional Indian medicine and could affect how the provider treats other patients in the area who follow traditional practices. Any resulting bias would put a strain on the provider-patient relationship. The provider is fully aware of the medical complications that could affect the patient's future quality of life.

Contextual features Traditional beliefs and practices are very important in this case. The patient clearly has moral support, primarily from her family. It is common in the Navajo culture for a person's decisions to involve the input of various respected elders in that person's family.

The clinical indications for fetal demise have been met. Therefore, according to medical standards, the pregnancy has ended and the removal of the fetus is necessary. The situation becomes controversial when cultural beliefs play a significant role in the patient's decision. The traditional healer's assessment contradicted the Western provider's assessment, and Ms. X's cultural beliefs were a major factor in her rejection of the Western medical provider's advice.

Other factors that could have played a role in the patient's decision include language barriers and education level. The patient's first language was Navajo, and she had not completed high school. These factors limited communication and understanding between the provider and the patient. Finances were not a concern; the patient was a beneficiary of the Indian Health Service.

Case analysis This case is an example of how different groups of people view health, medical care, and treatment. When health care providers have educated themselves about local culture, practices, and beliefs, such cases can be approached more thoughtfully. When the positions of the Western medical provider and the

traditional Indian medicine healer contradicted one another, the provider knew that she could not discount her patient's cultural beliefs and practices. In this case, differences in cultural practices between the patient and provider raised the issue of whether or not the fetus was viable. The provider used the appropriate tools and methods to determine fetal demise. The patient-provider relationship could be impacted severely if disrespect became an issue. It is vitally important for providers to attain an understanding of traditional cultural practices that their patients might follow.

Conclusion

In addition to receiving care from western medical providers, many Navajo, like Ms. X, also seek care from traditional healers, who have been part of Navajo culture for centuries. The healing powers, healing songs, and prayers have been passed down through the generations to the "chosen" ones. No one knows exactly how they are selected, and the Navajo are taught not to question the "chosen" ones.

This case must be viewed from the perspectives of both Western medicine and traditional Indian medicine. The provider's treatment plan was clear and straightforward from a Western approach. The patient also held traditional beliefs that needed to be respected. Two specific factors may have influenced the patient to challenge the treatment plan. First, the provider was of a different background, and the patient may have seen this as negative or threatening. She repeatedly told the provider, "You don't understand because you are not a native, and you don't believe in my beliefs." The provider's only response was again to explain the results of the ultrasound and what they meant. This is normal conduct for a provider when considering issues of informed consent, truth-telling, and advance care planning.⁵ Second, the patient's lack of education could have contributed to her level of understanding. Her reaction might have been partly due to denial.

This case also led to some concern on the part of the PA student (Becenti) assigned to the facility. A Navajo herself, this student could not understand why the traditional healer told the patient that the baby was alive. The student began to question the practices of the traditional healer and whether the healer who had been consulted was authentic. This question could not be resolved.

The PA student, who takes advantage of both Western and traditional medicine, intervened by discussing the case with the patient and her mother. They were surprised when the student explained her use of both approaches. This provided the patient and mother with a sense of connection. The student explained that the provider who was caring for the patient most certainly had the patient's best interests in mind. She reminded them that they had presented to the clinic

because they were concerned about the bloody discharge, which indicated that they must have known something could possibly be wrong. The student gave them time to consider the question: "Where do you think the blood is coming from?"

The provider then suggested performing another ultrasound. The provider described in detail what the ultrasound should look like if the fetus were viable. The provider repeated the ultrasound and took the time to explain exactly what she was doing and seeing. She welcomed questions and comments. The mother and daughter finally accepted the reality of the situation. They embraced in tears and were now willing to hear the treatment options.

Any difference in cultural beliefs and practices between provider and patient can present an ethical dilemma. It is beneficial for providers to educate themselves about the practices, beliefs, and traditions of various groups of people. This is especially important if a patient panel is composed largely of a particular cultural group.³ Translators and others with knowledge of and ability to communicate in the context of the patient's beliefs should also be utilized when possible.³

Carrese and Rhodes' suggestions for delivering negative news to Navajo patients include using positive language and discussing an illness in a way that does not focus on the patient.⁴ Campinha-Bacote developed a model to aid health care providers working with diverse populations.⁶ The mnemonic ASKED (awareness, skill, knowledge, encounters, desire) provides a framework for building cultural awareness in clinical practice:

- **Awareness:** Am I aware of my personal biases and prejudices toward cultural groups that are different from mine?
- **Skill:** Do I have the skill to conduct a cultural assessment and perform a culturally based physical assessment in a sensitive manner?
- **Knowledge:** Do I have knowledge of the patient's world view and the field of biocultural ecology?
- **Encounters:** How many face-to-face encounters have I had with patients from diverse cultural backgrounds?
- **Desire:** What is my genuine desire to "want to be" culturally competent?⁶

REFERENCES

1. Kilman HJ. Intrauterine fetal death. UpToDate Online. 2005 [update 14.1, 2005]. Available at: <http://www.uptodateonline.com>. Accessed November 27, 2006.
2. Conway SC. Early pregnancy loss. In: Lemke D, Pattison J, Marshal LA, Cowley DS. *Current Care of Women: Diagnosis and Treatment*. New York, NY: Lange Medical/McGraw-Hill; 2004:605-612.
3. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 5th ed. New York, NY: McGraw-Hill; 2002.
4. Carrese JA, Rhodes LA. Bridging cultural differences in medical practice. The case of discussing negative information with Navajo patients. *J Gen Intern Med*. 2000; 15:92-96.
5. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation. Benefit or harm? *JAMA*. 1995;274:826-829.
6. Campinha-Bacote J. Many faces: addressing diversity in health care. Online J Issues Nursing [serial online]. 2003;8(1):[manuscript 2]. Available at: <http://nursingworld.org/ojin>. Accessed November 27, 2006.