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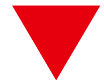
CASES THAT TEST YOUR SKILLS

Mr. V, a Laotian refugee, will not consent to post-amputation wound closure, which would prevent further infection and limb loss. The challenge: to break through cultural barriers and gauge this diabetic patient's mental state.



When culture complicates treatment

History Noncompliance and 'resignation'

Mr. V, 43, has a history of diabetes. He was admitted to the hospital with altered mental status as manifested by confusion, fluctuating sensorium, and disorientation. His altered mental status was most likely caused by septicemia secondary to osteomyelitis from a right plantar foot ulcer that had become necrotic, tracking through the foot bones into the tibia and fibula.

An emergent amputation was performed of the right tibia and fibula approximately 15 cm distal to the patella, with intent to close the wound within 24 to 48 hours; Mr. V also was started on IV antibiotics. The patient, however, refused the closure procedure, stating that he had not been properly informed before the amputation and would not consent to another procedure until he could speak with his elder brothers.

The surgical team noted that Mr. V had signed the consent form before the amputation. The surgeons also feared that not closing the wound promptly could lead to reinfection, further limb loss, or even death.

The hospital's psychiatric consultation service was asked to determine the patient's mental capacity. It should be noted that Mr. V emigrated to the United States from a Laotian refugee camp 12 years prior to admission. He speaks only Hmong, the language of the Hmong people indigenous to Southeast Asia.

Mr. V was diagnosed 12 years ago with insulin-dependent diabetes mellitus and has been hospitalized numerous times for foot ulcers. His chart indicates that he has repeatedly disregarded doctors' orders and has not performed proper foot hygiene.

Previous physicians and caregivers, however, were even more frustrated with the apparent attitude of resignation with which Mr. V has approached his diabetes. He seems to believe that his medical condition is causing his problems and that he cannot prevent diabetic sequelae. He has no history of mental disorders and to our knowledge had never received a psychiatric evaluation.

Why has Mr. V. not complied with diabetes treatment? Is he unable to understand the gravity of his condition?

Dr. Krassner's observations

Noncompliance is a recurring theme in the treatment of Hmong patients,[1-4] as is clinician frustration with their lack of compliance.[5,6] This suggests that cultural differences that could have contributed to Mr. V's noncompliance need to be examined before determining his mental state.

Approaching a culturally sensitive case with an open mind and a respectful attitude will increase the chances of a positive outcome and provide a valuable learning experience for the clinician. You might proceed as follows:

Question your assumptions. Some clinicians assume that psychiatry applies universally to any patient, regardless of cultural background. However, the categories psychiatry imposes on illnesses may not adequately describe an illness as a patient of a different culture experiences it.[7-9]

Find an interpreter—one who speaks the language and has a "lexicon for emotional experience" similar to the patient's.[10] In this case, we wanted an interpreter who not only spoke Hmong, but who understood the complexities of the animistic Hmong spirituality and could reconcile it with our empirically derived Western belief system.

Depending on a family member to translate can be problematic if that person cannot accurately explain the patient's disorder, the need for treatment, or the implications of noncompliance. We found the ideal interpreter: a Hmong registered nurse. If you cannot find an interpreter of the same ethnicity as the patient, at least find one who speaks the same language.

Beware of misinterpretation. A patient from another culture who understands some English may not assign the same meaning to words or phrases that we do. For example, when a Hmong says *yes*, he or she means, "I am listening, and I respect what you're saying." In this way, "yes" can be mistaken for consent; noncompliance by Hmong patients can often be traced to this misinterpretation.[11]

Define "capacity" and its implications. Capacity is always assessed in the context of the question, "capacity to do what?" The context must be explicitly identified, because life decisions require varying levels of capacity. For example, elderly patients with dementia often lack capacity to manage their finances, but have capacity to resolve end-of-life issues (e.g., hospice placement, do-not-resuscitate requests).

For Mr. V, the question was whether he had capacity to refuse the second surgery. To have capacity to consent to or refuse a procedure, a patient must understand the procedure, its risks and benefits, and the risks and benefits of refusing the procedure. The patient also must not be vulnerable to coercion (e.g., by a family member).

Clearly, Mr. V understood the procedure based on his notions of health, illness, life, death, family, social structure, and other concepts.[6,12,13] One might question whether a patient such as Mr. V is ever fully informed before giving consent. Even though he had signed a consent form for the amputation, the signature in *his* eyes did not qualify as consent. Further, having read through our hospital's consent form, I defy anyone to translate its legal subtleties into Hmong.

> A patient from another culture might not assign the same meaning to words that we do

Perhaps even more important, the Hmong adhere to a strict social hierarchy: males are held in higher esteem than females, the elderly higher than the young.[6,11,14] Therefore, Mr. V's desire to ask his brothers for advice before consenting to surgery makes sense within his cultural norms and was not a stalling tactic as the surgeons believed.

Try to understand the patient's concept of illness. We found Mr. V to have capacity within the confines of *his* medical understanding. He knew the operation was major surgery, and he wanted to consult with his elder brothers—all eight of them (most of whom live in Minneapolis)—prior to consenting. Conversely, the surgeons could think only within the confines of *their* cultural and clinical understanding. They wanted to perform the procedure expediently to avoid additional diabetic sequelae.

We discussed these concerns with the patient and surgeons and struck a compromise: the surgeons agreed to defer surgery for 10 days, as long as Mr. V indemnified them against complications secondary to the delay. After that, the surgery would be performed regardless of whether Mr. V had consulted his brothers. Mr. V also agreed to continue IV antibiotic therapy. This compliance is not paradoxical: the Hmong often accept antibiotics because of their relatively rapid efficacy.[6]

For clinicians wishing to understand the Hmong and their view of illness, Anne Fadiman's *The Spirit Catches You and You Fall Down* is an excellent resource.[6] Kleinman's sem-

inal work on treating patients from other cultures also emphasizes the importance of eliciting the patient's understanding in order to diagnose and negotiate treatment.[15] Several good textbooks address transcultural patient care; curiously, most are nursing rather than physician texts (see "Related resources," p. 48).

Treatment Recovery's rocky road

Closure was delayed for 8 days, during which no complications arose. Mr. V tolerated the antibiotics well. He contracted a low-grade fever at times, but septicemia did not re-emerge.

We continued to follow the patient, who on several occasions became delirious. He was neither violent nor agitated, so he was not treated with neuroleptics, which can cause delirium in Hmong patients.[3,4]

The patient contacted his brothers and consented to closure surgery, after which he recuperated well for 3 days. On day four, however, he developed respiratory failure. He was resuscitated, intubated, and transferred to the intensive care unit. He was extubated and returned to the floor 24 hours later, at which time he appeared despondent. He exhibited depressed mood, blunted affect, anorexia, anhedonia, and minimal interaction with family or physicians.

Could a different approach to treatment have produced a more favorable response? Also, would you address Mr. V's depression and, if so, how?

Dr. Krassner's observations

One might argue that being culturally sensitive and exposing Mr. V to the risks of infection and respiratory distress was a poor medical judgment. This argument takes into account only the biological aspect of Mr. V's illness, however. Viewed from a biopsychosocial perspective, Mr. V's course, even with its vicissitudes, was not a "failure" in any sense. He consented to the procedure on his own terms. We identified roadblocks to treatment and unearthed cultural resources (in our case, the patient's brothers) that could enhance or even replace traditional psychiatric treatments.

To treat Mr. V's depression, we first assessed the symptoms. We then tried to understand how he experienced his illness within the context of his culture.[8] Mr. V's symptoms certainly implied depression, but in many Asian cultures, patients with depression often present with somatic complaints.[1]

Also, how were we to know that these symptoms were not due to what Asian cultures refer to as loss of vital energy—or *qi*—because his sadness and frustration compressed on his heart?[1] In order to treat Mr. V's *depression*, we must instead call it qi. Only then can we diagnose and treat the patient in a way that makes sense to him or her.[15]

Even arriving at a differential diagnosis is complicated. For example, if Mr. V were Chinese, we would have to include (in addition to our own narrowly defined depression and dysthymia): *mên*, depressed or troubled; *fan-tsao*, anxious or troubled; *kan-huo*, angry; and *hsin-ching pu-hao*, generalized, nonspecific emotional upset or bad spirits.[15]

Further treatment From grave to grateful

Mr. V was started on sertraline, 50 mg/d, for symptoms of depression. He tolerated the agent well (no GI upset or other side effects). After only 1 week, he had a brighter affect and was more conversant. He expressed thanks for all we had done for him.

The remainder of his recovery was incident-free, and he was discharged 6 days later on sertraline, with psychiatric follow-up arranged with the county mental health services' Southeast Asian Team.

continued

Cultural barriers to treatment extend beyond language because patients perceive and react to illness within the context of their cultures. When treating a foreign-born patient, psychiatrists should find out how the patient views his or her disorder and tailor treatment accordingly.

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Related resources

- Giger JN, Davidhizar RE. *Transcultural nursing: assessment & intervention* (3rd ed). St. Louis: Mosby, 1999.
- Leininger M, McFarland M. *Transcultural nursing: concepts, theories, research & practice* (2nd ed). New York: McGraw-Hill, 1995.
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