Intraethnic Characteristics and the Patient-Physician Interaction: "Cultural Blind Spot Syndrome"

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Ethnic variation in the beliefs, expectations, and illness behavior of patients has dominated cultural studies of medical care. A widespread supposition, referred to as "cultural blind spot syndrome," assumes that similarities in the ethnic backgrounds of patient and physician invariably enhance clinical communication, thereby resulting in improved outcomes. The author's experience as a Western-trained Chinese physician attending to a wide spectrum of Chinese patients challenged this simplistic assumption. The cultural identity of the Western-trained physician and intraethnic variation among people of a common cultural heritage emerged as two key considerations from this analysis of patient-physician interaction.

Two cases representing extremes in patient-physician interaction were chosen and analyzed with respect to each of six essential elements of patient-physician interaction. Common ethnicity does not ensure a positive patient-physician interaction. A good match among intraethnic descriptors of patient and physician enhances communication and thereby may improve outcome. However, the match between the patient's explanatory model and expectations of the physician and the physician's actual persona and practice is equally important in determining outcome.

Ethnic variation in the beliefs, expectations, and illness behavior of patients has been well documented in the literatures of medical anthropology and sociology. These cultural studies of medical care include research in health-seeking behavior,[1-3] illness behavior manifested by presenting complaints,[4] response to pain,[5] attitudes toward medical care,[6] and explanatory models.[7,8] The field of medical anthropology has recently blossomed with texts that systematically describe several ethnic groups and suggest culturally appropriate medical care for each.

The general acceptance of ethnic considerations as important determinants of clinical interaction

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has given rise to a popular assumption that cultural barriers are eliminated and clinical care is improved when patient and physician share a common ethnic background. The author's experience as a Western-trained Chinese physician caring for a wide spectrum of Chinese patients challenged this simplistic supposition. In spite of a common cultural heritage, the quality of the patient-physician interactions still spanned the spectrum from gratifying success to dismal failure. This experience led to the concept of "cultural blind spot syndrome" and underscored the importance of intraethnic determinants such as socioeconomic status, educational level, and religion. These determinants have not received the attention they deserve. Cultural stereotyping results in superficial generalizations that are often misleading in the care of individual patients.

Through case analysis and literature review, this paper presents a conceptual framework for analyzing patient-physician interaction in any cultural context. A set of essential components of clinical interactions is presented as an analytical tool to aid the clinician in determining which aspects of the interaction are amenable to change so that the therapeutic alliance can be enhanced.

The following two cases were chosen from the many Chinese patients in the author's residency practice at Group Health Cooperative, Seattle, Washington, because they represent extremes in patient-physician interactions.

Case Illustrations

Patient 1

Ms. S.Y., a 39-year-old Cantonese seamstress, first met me at a local community clinic serving predominantly Asian patients. Subsequently she came to the family practice residency clinic for an exacerbation of intermittent right knee pain with slight swelling. The patient spoke Cantonese only. Her husband translated between Cantonese and Mandarin, with which I am familiar, as neither of them spoke any English. After a detailed history and physical examination, the diagnosis of traumatic synovitis resulting from overuse of her right knee while operating a power sewing machine at work was explained to the patient and her husband. She responded with arched eyebrows and disbelief, arguing that she had been a seamstress in Canton previously and operated a sewing machine there without knee pain or swelling. She even laughed when I recommended the treatment of bed rest for one week, a knee brace, and an oral anti-inflammatory agent. My feelings of being unappreciated and scorned grew to indignation when I recalled the special care I had taken in explaining to her in detail the pathophysiology of traumatic synovitis and the therapeutic effects of anti-inflammatory drugs and in demonstrating the use of a knee brace.

Ms. S.Y., who grew up in a peasant family in rural Kwangtung, had a third-grade education and was married to an unskilled factory worker. The couple and their four teenage children immigrated to the United States eighteen months previously. They claimed no friends or relatives in North America. Ms. S.Y. was the sole breadwinner of their household, her husband being unable to find employment. As a seamstress in a "sweatshop," without union protection, she risked losing her job if illness interfered with her performance at work.

A few days after her first visit, the patient and her husband came to the clinic again, demanding to be seen because her knee pain had not subsided. The nurse explained that clinic was very busy and suggested that they wait until their previously scheduled follow-up appointment. Her husband justified the drop-in visit by stating that it was her day off and, therefore, more convenient for her to see the physician.

They also wanted a "specialist" to evaluate her knee. Amazingly, her aggressive and disdainful behavior changed to obsequious appreciation when she met the older, white, male orthopedist. For diagnostic purposes, a small amount of synovial fluid was aspirated and an arthrogram was obtained. Both studies proved to be normal. She failed to keep subsequent appointments. I heard no news from her until months later, when an encounter with her husband revealed that her knee pain had improved markedly since the "needle" and the "x-ray." They were convinced that the synovial aspiration and arthrogram were instrumental in her cure. He also stated that they were looking for an older physician. I walked away feeling hurt and unfairly treated yet a little relieved

because I no longer had to care for this difficult patient.

Patient 2

Ms. L.T., a 29-year-old Taiwanese housewife, was referred with the following problems: (1) recurrent thyrotoxicosis, (2) numerous somatic complaints, (3) "hysterical overlay," and (4) presumed language and cultural barrier between the patient and her referring endocrinologist. Coincidentally, I had met Ms. L.T. during an obstetrics rotation a few months earlier when I delivered her second child.

Ms. L.T. grew up in a middle-class family and had a college education. She and her husband, a bank clerk, had immigrated to the United States three years earlier. Her daily activities were confined to their modest apartment, where she cared for their two small children.

Soon after their arrival in the United States, her illness began with tremulousness, nervousness, palpitation, weight loss, neck pain, and itching, all suggestive of thyrotoxicosis. With propylthiouracil her thyroid functions normalized, but her diverse complaints persisted. The language barrier between the Chinese-speaking patient and her English-speaking physicians further compounded the diagnostic difficulties and resulted in her physicians' increased reliance on tests (eg, a computerized tomographic scan for evaluation of her headache and a radioactive iodine uptake for assessment of her thyroid function). Both tests were normal. Hence, she was referred to me for evaluation of the influence of linguistic and sociocultural issues on her medical complaints.

In the course of taking a detailed history in Taiwanese, she revealed to me and to herself for the first time that her back pain occurred after she had been lifting her children a great deal, and her dizziness was most noticeable around the hectic dinner time, when she had to serve her hungry children and tired husband simultaneously.

In spite of the association of her dizziness with a demanding family situation, the referring specialist requested an ear nose and throat consultation, and she was sent to the university hospital for an electronystagnogram (ENG). I was subsequently called by a resident who contemplated admitting Ms. L.T. for treatment of pulmonary embolism because she was found dyspneic and tachypneic after the ENG, and her arterial blood gases were equivocal for hypoxia. The suspicion that Ms. L.T. had somatized her anxiety and fear of the elaborate test in an unfamiliar setting and hyperventilated was confirmed by normal repeat arterial blood gases. Further iatrogenesis was prevented.

Her symptoms were well controlled on propranolol, but recurred after a few months. Aware of the tendency of Chinese patients to consult both traditional and Western practitioners,[9] an inquiry into her use of Chinese herbs was rewarded with a frank description of the herbal treatment for hyperthyroidism she had just begun. She asked for advice. We negotiated the issue and decided against simultaneous use of Chinese herbs and propranolol. She agreed to alert me to the return of any symptom that might indicate resuming propranolol.

Thereafter, our interactions have been characterized by trust and openness. She even showed her appreciation by bringing me traditional homemade cakes on Chinese holidays. Over the course of two years, her health has steadily improved and her visits have become rare.

Case Analysis

These two contrasting cases inspired the central question: Given similar ethnicity, what were the salient differences that led to the success of the patient-physician interaction in the second case, and what caused the failure in the first case?

Heretofore, the literatures of medical anthropology and sociology have included various models for understanding the patient-physician interaction: Parsons' social system model,[10] Bloom's total transactional system,[11] Mechanic's description of illness behavior,[12] and Kleinman's research of components in clinical transactions.[13] Based on a review of literature and clinical observations, the following six elements emerged as important determinants of patient-physician interaction: (1) the patient, (2) the illness, (3) the patient's pathway to physician, (4) the physician, (5) the setting of the

clinical encounter, and (6) the clinical interchange.

These elements provide a framework for analysis and demonstrate significant differences beneath a surface of apparent ethnic similarity.

The Patient

Important intraethnic variations occur in characteristics such as age, sex, personality traits, political orientation, socioeconomic class, rural or urban background, region of origin, dialect spoken, religion, occupation, educational level, and family composition. Recent ethnomedical research focusing on variations in health beliefs and behavior within ethnic groups has indicated that health beliefs and behavior vary according to socioeconomic status, with individuals of lower socioeconomic class tending to display more ethnic differences than members of high socioeconomic standing.[14]

In comparing patients 1 and 2, distinct variations are seen. The former spoke Cantonese only, came from a rural peasant background, and had minimal education. The latter was younger, more cosmopolitan, had a middle-class urban background, spoke Taiwanese, Mandarin, and a little English, and had a college education. Furthermore, when the characteristics of the patients are compared with those of the physician, the differences along socioeconomic, educational, and linguistic dimensions are far greater between patient 1 and the physician than between patient 2 and the physician. This is consistent with the observations made by Brown over 30 years ago:

> The degrees to which the qualities ideally defined as essential to the therapeutic process (mutual trust, respect, and cooperation) will be present in a given relationship tends to vary inversely with the amount of social distance between clinician and patient.[15]

Although both patients are first-generation Chinese immigrants, patient 2 is much more acculturated into mainstream American culture. The extent of acculturation can be determined by (1) age at the time of immigration, (2) ability to speak English, (3) extent of intraethnic association, (4) maintenance of traditional lifestyle, diet, and folk medical beliefs, and (5) familiarity with etiquette of Western medicine.

The Physician

In addition to those demographic characteristics already described for the patient, features to examine in a physician include the ability to empathize, the stage of medical training, and the type of specialty training with respect to the use of a biopsychosocial or a strictly biomedical approach. Other equally important considerations are the physician's motivations for entering the medical profession (eg, intellectual curiosity, ideological inclination to serve the disadvantaged, or search for prestige and financial incentives). The cultural, socioeconomic, and educational background of the physician, in addition to personal characteristics, contribute to the ease of establishing rapport with the various subgroups of the patient population. Furthermore, indoctrination into the medical subculture may isolate the physician from the patient's perspective and encourage technical idioms that inhibit effective communication.

Patient's Pathway to Physician

It is well established that the majority of illness episodes are cared for outside the formal medical care system.[16,17] A lay health system provides resources for the ill, integrating popular and folk beliefs and practices. The health-seeking process, as described by Chrisman,[1] consists of five steps: (1) symptom definition, (2) illness-related shifts in role behavior, (3) lay consultation and referral, (4) treatment actions, and (5) adherence. Social, economic, and cultural factors and the nature of the illness determine the course of a patient's pathway to physician. Different pathways to the physician set the stage for distinct sets of expectations. From these examples, patient 1 met her physician while seeking care at a low-cost community clinic. In contrast, patient 2 was referred to the physician

by a respected endocrinologist for management of sociocultural problems beyond his field of expertise.

The Illness

The nature of the illness, its perceived severity, urgency, chronicity, course, and outcome, all influence the therapeutic relationship. Patient 2 had a known disease with easily measured objective parameters and an established effective treatment. The initial control of her symptoms enlisted her trust and predisposed her to favorably accept her physician's diagnosis of somatization as the cause of her other complaints. In contrast, patient 1 had a chronic complaint with a diagnosis that is difficult to confirm and an expected slow course of recovery, variably responsive to available treatment.

Setting of the First Encounter

The initial contact is crucial in providing the tone of subsequent interactions. The setting is framed by the reputation of the physician and the clinic, its physical plan, and decor. The pace of the clinic, the waiting time, and the length of the appointment affect the patient's attitude toward the care provided. The timing of the appointment with respect to the physician's workday also exerts an influence. For example, an early appointment may find the physician rested and energetic with patients, whereas late appointments may find the physician harassed and fatigued.

The attitudes of the auxiliary health staff and their linguistic and sociocultural backgrounds also shape the therapeutic interaction. For example, the nursing staff at the residency clinic, who were white and monolingual, interacted better with patient 2, who was more acculturated and abided by the etiquette of Western medical care. They could not communicate with patient 1 and felt uncomfortable with her. Patient 2 initially presented in rapidly progressing labor, complicated by a language barrier. The author appeared in time to deliver her healthy infant and received credit for the joyous event which she shared in a native dialect. In contrast, patient 1 waited over 30 minutes for her short appointment and was greeted by an overworked and unsympathetic nurse and a pressed and fatigued physician.

Table 1 juxtaposes the differences between the two patients with respect to the above components, and underscores the greater similarity between the physician and patient 2.

The Clinical Interchange

Crucial to the therapeutic relationship is the degree of concordance between the clinician and patient regarding the explanatory model and treatment expectation that each applies to the illness episode. As Kleinman et al[8] have described, explanatory models address five basic issues in a sickness episode: (1) etiology, (2) onset of symptoms, (3) pathophysiology, (4) course of illness, and (5) treatment regimen. Among patients these conceptions often present as a vague and evolving amalgam of beliefs from religious, lay, ethnic, and scientific sources.

The integration of these conceptions into illness behavior is mediated by the numerous factors previously described. The idiom of communication can be predominantly psychologic or somatic. The latter is more commonly associated with patients who are of lower socioeconomic class, less educated, of rural origin and fundamentalist religious background, and traditional in ethnic orientation.[18,19] Patient 2 had adopted the biomedical explanatory model of hyperthyroidism as presented by her previous physicians. However, she somatized and initially attributed her diverse symptoms to "her thyroid acting up." Subsequently the explanatory models became more concordant as she added a psychological perspective after discovering an association of emotional distress with her symptoms of dizziness and headache. On the other hand, patient 1 either could not or would not state her explanatory model. She disagreed with and derided the physician's explanation of her knee pain.

Patients differ in their expectations of treatment

Table 1. Comparison of Patients

	Patient 1	Patient 2
Personal Characteristics		
Age	39 yr	29 yr
Sex	Female	Female
Appearance	Plain clothes	Fashionable attire
Personality traits	Reserved, skeptical	Open, respectful
Socioeconomic status*	Working class	Middle class
Rural/urban origin*	Rural	Urban
Religion	Unknown	Buddhist
Occupation	Seamstress	Housewife
Educational level*	Third grade	College graduate
Region of origin	Canton	Taiwan
Native dialect*	Cantonese	Taiwanese
Indicators of Acculturation		
Age at immigration*	38 yr	26 yr
Intraethnic association*	Extensive	Limited
Lifestyle, diet	Traditional	Traditional
Folk medical beliefs	Unwilling to disclose	Subscribes heavily
Familiarity with Western medicine*	Unfamiliar	Familiar
Proficiency in English*	None	A little
Type of Illness	Chronic with recent exacerbation	Chronic
Pathway to Physician	Arbitrary selection of available care at community clinic	Referred by another physician
Setting of First Encounter	Busy clinic	Labor and delivery

*Sociocultural parameters along which physician demonstrates greater similarity to patient 2 than to patient 1

modalities, the patient's role in therapy, the time course, and the outcome as well as the physician's persona (eg, age, sex, appearance; behavioral approach and conduct toward patients, such as an authoritarian vs egalitarian style). Patient 1 preferred an older physician and showed more respect to a male physician. Congruent with popular Chinese expectation, she anticipated Western medical intervention to employ potent agents and invasive techniques in order to achieve rapid relief of symptoms. Moreover, she placed the responsibility for achieving cure solely on the physician. The "needle" and the "x-ray" performed by the specialist gave patient 1 rapid relief according to her expectations, whereas the prescribed treatment involving her use of a knee brace, an oral anti-inflammatory medication, and bedrest proved too slow and ineffective. In contrast, the expecta-

Table 2. Patient-Physician Comparison—Cognitive Parameters Demonstrating Greater Similarity Between Physician and Patient 2

	Patient 1	Physician	Patient 2
Explanatory Model	Rejected the physician's, expressed none	Scientific, with biopsychosocial approach	Biomedical, somatization evolved into psychological insight
Therapeutic Expectations			
Image of physician	Older, respected male	Self	Accepted young, female physician
Behavior of physician	Paternal, dominant	Flexible	Directive, negotiative
Medications	Potent with rapid effect	Gradually efficacious for both	Potentially harmful, gradually effective
Procedures	Desirable, effective	Unnecessary for both patients	Feared
Locus of responsibility	Physician only	Physician, patient, and social network	Physician mainly
Time course of recovery	Rapid	Chronic in both cases	Chronic
Therapeutic goal	Total cure	Palliative in both cases	Palliative

tions of patient 2 more closely resembled those of the physician (Table 2).

Social and Cognitive Distance

The above analysis demonstrates three principles:

1. Shared ethnic background alone is not sufficient to ensure an effective interaction between physician and patient.

2. The foundation for establishing a therapeutic alliance is built upon the match between the clinician's and the patient's explanatory models and therapeutic expectations. When the distance is great, a negotiative approach can bridge it.

3. Resemblance in demographic characteristics (eg, language, education, socioeconomic status) and the extent of acculturation are key intraethnic determinants of clinical outcome.

The concept of a cultural blind spot refers to the simplistic assumption held by many health professionals that ethnic similarity alone is sufficient to ensure successful therapeutic alliance. There is a corresponding neglect of intracultural differences in expectations, beliefs, and certain demographic and behavioral characteristics. This blind spot frequently channels referrals of ethnic patients to physicians of the same cultural background. Many such physicians are similarly misled by ethnic stereotyping and may later find themselves frustrated when the intraethnic differences become obstacles in forming a therapeutic alliance. Ethnicity does not in and of itself guarantee

a physician's cultural awareness and sensitivity, either to members of his own ethnicity or to those of other ethnic groups. A conceptually sound and clinically practical cultural approach to health care needs to be learned and practiced by all clinicians, those from minority cultures as much as members of the American mainstream culture.

Strategies for Improving Clinical Interaction

Although some of the described components of patient-physician interactions are unalterable, several can be transformed by the clinician to enhance therapeutic relationships. These are the setting of the clinical encounter, language, explanatory models, and therapeutic expectations.

The following steps are suggested to improve the clinical interactions:

1. Educate each member of the health care team regarding the cultural habits, health belief systems, and patterns of health-seeking behavior of the ethnic groups represented in the patient population.

2. Learn the predominant languages of the minority groups being served, or arrange for well-trained translators.

3. Identify those patients who are less acculturated through use of the Cultural Status Examination proposed by Pfeifferling, as cultural considerations play a crucial role in their health care.[20]

4. Schedule more time for these patients.

5. Elicit explanatory models and clarify therapeutic expectations. In addition to gathering clinical data, this demonstrates the physician's interest in and respect for the patient's view and encourages critical development of an appropriate explanatory model. Above all, empathy develops more readily when the patient's views are grasped in detail.

6. Engage in therapeutic negotiations[21] for a mutually agreeable approach. In a few instances the differences in expectations may be too great to be resolved, and the patient may need to be referred to a more suitable clinician.

The systematic application of this conceptual framework in any cultural context will decrease the social and cognitive distances between patient and physician. These distances exist *within* as well as *across* ethnic boundaries. The appreciation of clinically relevant intraethnic variations will overcome the "cultural blind spot syndrome." This will do as much to advance the understanding of therapeutic relationships generally, as the awareness of ethnocentrism has done for cross-cultural interactions.

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