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81 – Developing Culturally Sensitive Services in Primary Care

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The capacity for migration has increased in the 21st century due to the expansion of international relations, opening of borders, and the development of democratization processes in modern society. The reasons for migration differ with every case and may include; international expansion or work abroad, family reunion, return to the native land, looking for better quality of life, education, economic reasons or simply, a more peaceful life. The process of migration results in a population that has a variety of religious and cultural characteristics that must be considered during the provision of medical care.

The importance of cultural sensitivity was initially emphasized in providing services to members of ethnic minority groups, especially given the language and cultural barriers faced by non-English-speaking immigrants and the ethnic and economic barriers (8). Patients may not understand a prescription or general health recommendations correctly which may lead to low adherence to treatment (3). Patients may be prevented from discussing their problems as a result of language barriers or religious prohibitions.

The family doctor should start with the principles of individual liberty, human ethics and deontology, respect for beliefs, feelings and rights of patients, be aware of the cultural religious characteristics of its population, know manners, rituals and norms of behaviour, and consider them when providing medical care (1-3, 7). For example, the various cultures and religions have different attitudes to abortion, vaccination, euthanasia, blood transfusion, organ transplantation, resuscitation, autopsy, artificial insemination, sterilization, etc. Euthanasia and abortion are rejected by most religions, including Catholicism, Judaism, Buddhism, Christianity and Islam. Abortion is prohibited in most religions, but Muslims believe that the soul of the foetus appears in the first week of the fourth month of pregnancy, so abortion is allowed within that time frame. Artificial insemination is not recognized in Buddhism, but allowed by the Orthodox. In Buddhism and Islam, organ transplants and blood transfusions are only allowed from a living donor of the same religion and with his consent. The Jewish faith is against autopsy and organ transplantation, unless permission was given by the patient and his family before death. Buddhism and Judaism also deny artificial continuation of life, when medical equipment and intensive therapy prevent natural death, however, the physician should make every effort to preserve and save human life according to the Hippocratic Oath.

In daily life, there are also many occasions when it is necessary to be aware of religious and cultural diversity in the provision of health services, such as religious restriction diet, fasting, hygiene, possibility of examination etc (7-8). For example, religious restriction of food (fasting, restriction of meat) may lead to deficiency disease and decreased immunity. Also, religious diet restriction can influence prescribing therapy. Thus, Islam forbids the use of any products derived from pork. In India the cow is sacred, so medications based on bovine serum (some vaccines,

regenerating drugs etc.) cannot be used. In Judaism, only kosher products are allowed to be ingested, and accordingly, all drugs employed should be kosher.

The family physician must also consider that the need to perform religious rites and duties can lead to physical torture and psychological disorders, including depression (4). Some religious rituals can contribute to the development of certain syndromes and diseases, and lead to the spread of infections. Ignorance of them causes difficulties in diagnosis, false diagnosis and ineffective treatment. For example, eating traditional dishes from certain kinds of raw or insufficiently processed meats or fish, offal or animal brain can lead to the development of prion, helminthic diseases and different infections. Such lifestyle habits are transmitted from generation to generation without suspicion that it may cause harm to health.

On the other hand, the violation of religious and cultural features can lead to extremely negative consequences not only to patient, but also to doctor, leading to criminal liability. For example, blood transfusion without consent of the patient or his relatives is a crime in some Muslims countries and African states. In Muslim countries, male doctors, especially non-Muslim, may examine women and deliver babies in the absence of her family.

Nevertheless, the family doctor should remain patient, observe human ethics, compassion and empathy, do no harm and try to find a way to provide the necessary medical care as outlined in the Hippocratic Oath (1-3, 7).

It is clear that the education of family doctors should pay attention to the development of religious and culturally sensitive care to avoid mistakes and problems such as misdiagnosis, misunderstanding, non-adherence, and recidivism (1-3). In 1996, the Society of Teachers of Family Medicine published curriculum guidelines for teaching culturally sensitive and culturally competent health care to family medicine residents and other health professions students. Cultural Sensitivity permits us to respond with respect and empathy to people of all nationalities, classes, ethnicities, religions, ethnic backgrounds and other groups in a manner that recognizes, affirms, and values their worth (4-7). As a result, it is necessary to form culture competence in the family doctor, which is measurable as an important quality indicator of care. Quality indicators must incorporate principles and measures of cultural competence focusing on the policies, procedures, and resources needed to provide linguistically appropriate and culturally relevant services at all points of client contact within a system (1-3, 8). Several existing quality improvement tools have the potential to incorporate dimensions of cultural competence and can be used to define and track outcomes of interest for populations at risk (3).

Take home messages

- The patient's religion, their cultural and personal features need to be taken into account in health care as much as possible. This will avoid confusion, medical errors, misdiagnosis, misunderstanding, non-adherence and recidivism.
- The family doctor should be aware of cultural religious characteristics of his population, know manners, rituals and norms of behaviour, and consider them when providing medical care, observing human ethics and compassionate empathy.
- Cultural competence training should focus on empathic listening and development of communication skills that work across cultures and have to be monitored with special tools.

Original abstract

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