

# Carlos's Cough

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## Cultural Sensitivity

### TUTOR GUIDE

**Case Materials:**

- Tutor's Guide
  - Case
  - Slide Set
  - References
- Evaluation Tools
- Tutor's evaluation/prior to presentation
  - Tutor's evaluation/post presentation
  - Student evaluations

**Objectives:**

By the end of this session, clinicians will:

1. Understand how personal and culture-oriented beliefs about health and illness can affect our clinical care.
2. Learn how to take a health beliefs history

**Overview of Cultural Sensitivity Case**

There are many different approaches to health and illness. An individual's approach results from a combination of

- personal psychology and philosophy,
- past experiences,
- inputs from family members and other social support
- underlying cultural beliefs handed down from generation to generation, and modified by the individual based on the specific context.

Understanding this and as well as how to deal with patient's differences in belief is a key to providing good care to a diffuse population.

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## Teaching Guide

### Introduction

To treat a patient appropriately, you must have a way of getting at these issues is to elicit the patient's *explanatory model* for illness (see Kleinman). This includes beliefs regarding

- etiology (e.g.: humoral (hot/cold) beliefs, and the importance of balance—both physical (activity) and emotional (strong emotions))
- time and mode of onset of symptoms
- pathophysiology (e.g.: a commonly held beliefs that “phlegm” is an important and primary issue in the pathophysiology of asthma)
- course of sickness and type of sick role
- treatment

One way of getting at these issues is through a *health beliefs history* (Pachter, *Contemporary Pediatrics* 1997).

Patients/parents and health care personal conceptualize sickness very differently. Physicians are good at identifying and treating *disease* (i.e., a malfunctioning of biological and/or psychological processes). Patients experience *illness* (the biological and psychosocial experience of perceived malfunction, including the affective and social meanings of dysfunction). Disease without illness (e.g., a chronic disease in quiescence, such as asthma between symptoms or exacerbations), and illness without disease (many examples, for instance school avoidance with a “tummy ache”) both present areas where bridging the gap between conceptualizations can be difficult.

### How to obtain information about personal/cultural beliefs and practices in the clinical setting:

Many clinicians feel uncomfortable asking patients about alternative and non-biomedical beliefs and practices.

- It's like opening Pandora's box—once open, you need to know what to do about it!
- Experience and common sense will increase one's confidence regarding what and how to ask about these issues.
- A *health beliefs history* is one approach to gaining an understanding of a patient's explanatory model. Questions such as the following are helpful:
  - “If a friend of yours asked you ‘What is asthma?’ how would you answer them?”
  - “Can you tell me what goes on inside the body when Carlos has an asthma attack?”
  - “What's the first thing you notice when Carlos is about to have problems with asthma?”
  - “Why do you think Carlos has asthma?”
  - “What makes his asthma get bad? What makes him get better when he's sick?”

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- “Can you prevent Carlos from having problems with his asthma?”
- With regard to non-prescribed remedies:
  - first ask about medications that have been prescribed by physicians,
  - then ask about over the counter medications that the parent may administer for the asthma,
  - *then* ask about alternative therapies and home remedies.
    - “Some of my patients have told me that there are ways of treating asthma that doctors don’t know about, but are effective. Usually people in the community, especially older people like grandparents know of them. Some of them might be effective. Have you heard of any of these?”
    - If they say no, leave it at that.
    - If they say yes, ask what the remedies are.

Then ask “Have you ever tried these remedies?” If no, leave it at that. If yes, ask “Have you ever tried it for Carlos’ asthma?”, and then “Are you using it now?”

- This approach goes from the general (“Have you heard of...”) to the specific (“Are you using...”) and is a non-threatening of obtaining sensitive information.
- Care must be exhibited to not “stereotype” individuals, and expect them to use home remedies solely on the basis of ethnic group affiliation (i.e., balance the concept of cultural sensitivity with individual variations and intra-group variability).
- Discussion can also be initiated about general factors that may help the clinician decide whether a particular patient or family may subscribe to cultural beliefs and practices. Assessment of *level of acculturation* is one way to do this (see Pachter, 1994).

### **Strategies for combining aspects of the patient/family beliefs and practices into the clinical care plan:**

Try to find ways of combining the biomedical model with parts of the patient model, instead of wholly discarding the patient model. For example, when discussing the pathophysiology of asthma, instead of saying “Well, asthma really isn’t about the lungs getting filled with phlegm...”, one could say “Your right, part of the problem with asthma is that the lungs produce mucus and phlegm and have a hard time managing them. But *in addition*, the real problem with asthma is also that the breathing tubes become inflamed (swell up) and go into spasm....”

With regard to the use of folk and home remedies: Try to find ways of combining the folk remedy with our biomedical treatment plan.

- “I’m not sure whether the syrup that you are giving Carlos is effective in treating asthma, but I do know that it won’t harm him if given in the amount your presently using. But one thing that I can tell you—if you give him his

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albuterol treatment *right after* the syrup (instead of waiting 15 minutes) it will be much more effective.”

- In this way, you're:
  - 1) acknowledging that mother is doing a good job by recognizing the symptoms of asthma and initiating treatment,
  - 2) placing the correct medical treatment plan in a context that fits with the patient's/parent's beliefs and practices, and thus has a higher likelihood of being followed.
- Harmful remedies/therapies rare.
  - If present, deter usage, but attempt to replace the harmful therapy with another less harmful treatment that fits within the patient/parents explanatory model and belief system.

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### GUIDING QUESTIONS FOR DISCUSSION

1. In what ways are Carlos' mother's beliefs about asthma different than medical knowledge about the illness?
2. Do these beliefs in any way overlap with biomedical beliefs about asthma?
3. Are these beliefs and practices that don't fit into the biomedical paradigm exclusive to "ethnic minorities" or low SES?
4. What is the difference between "illness" and "disease"?
5. What questions can one ask to get at a person's underlying beliefs about sickness, and his or her practices and behaviors regarding an illness episode?
6. What should we do about the mom giving Carlos the syrup to treat asthma?

**1. In what ways are Carlos' mother's beliefs about asthma different than medical knowledge about the illness?**

With regard to this case, the parents understanding of the pathophysiology of the illness includes a commonly held beliefs that “phlegm” is an important and primary issue in the pathophysiology of asthma. Causative agents include humoral (hot/cold) beliefs, and the importance of balance—both physical (activity) and emotional (strong emotions). These are not just abstract concepts—her interventions relate to them (e.g., avoiding extreme changes in weather, having the child rest, massaging him, and giving home-based remedies to “get the phlegm out”).

**2. Do these beliefs in any way overlap with biomedical beliefs about asthma?**

With this question, try to get to the point that no-one—even physicians—has a working model of an illness that is strictly “biomedical”. Ask students about their own or their family's particular humoral beliefs ( e.g., catching a ‘cold’ by being improperly dressed, or going outside with wet hair....) and “home remedies”.

**3. Are these beliefs and practices that don't fit into the biomedical paradigm exclusive to “ethnic minorities” or low SES?**

No. Our “mainstream culture” has many such beliefs. Many people believe that cold weather causes illness, when it's really the fact that during cold weather we don't go outside and expose each other to our own illnesses. Additionally, middle and upper class families use alternative therapies, such as homeopathy, naturopathy, and “New Age” healing much more often. All of these things belong to the same sort of model

**4. What is the difference between “illness” and “disease”?**

Physicians are good at identifying and treating disease, i.e., a malfunctioning of biological and/or psychological processes. Patients experience illness (the biological and psychosocial experience of perceived malfunction, including the affective and social meanings of dysfunction).

Disease without illness (e.g., a chronic disease in quiescence, such as asthma between symptoms or exacerbations), and illness without disease (many examples, for instance school avoidance with a “tummy ache”) both present areas where bridging the gap between conceptualizations can be difficult.

**5. What questions can one ask to get at a person's underlying beliefs about sickness, and his or her practices and behaviors regarding an illness episode?**

Discuss explanatory models, and a health beliefs history as presented above

**6. What should we do about the mom giving Carlos the syrup to treat asthma?**

Ideally you work with the parent to come to a mutually agreeable plan. In this case, one possibility is to convince the mom to use the medicine you are prescribing in

addition to her own remedy. It is also important to get an idea of what the remedy is to determine that she is not using something that is dangerous for the child. Often the remedy contains herbal ingredients that fall in the realm of alternative therapies. Knowing a source of information on such therapies, such as the Holistic Pediatrician by Dr. Kathi Kemper, or the Longwood Herbal Task forces web pages at [www.mcp.edu/herbal](http://www.mcp.edu/herbal) is very usefull.

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## Part 1

Carlos Claudio is a seven year old boy who comes to your office for the first time today. Carlos' family, which includes his mother Doña María, father Don Hernando, and a three year old sister Jenny, have recently moved into your town. Mr. And Mrs. Claudio are originally from Puerto Rico, and moved to New York when Carlos was two years old.

Carlos is brought to the office today because of increasing coughing, which is due to his previously diagnosed. His asthma is usually worse during the winter months. During those times, his Doña María says that he has frequent coughing and wheezing. This has necessitated frequent trips to either the office or Emergency Department. Usually, once he presents, the asthma is easily controlled by two or three "breathing treatments." He has only been hospitalized once for his asthma; that occurred five years ago.

The pediatrician that had previously been caring for Carlos had diagnosed his asthma as mild to moderate, with a strong seasonal component. According to Doña María his therapy consists of "la machina" whenever he gets sick. Further questioning reveals that she is referring to nebulized albuterol at the appropriate dosage. He has required oral corticosteroids on rare occasions.



Part 2

In an attempt to elicit the Doña María's understanding of asthma, you take a health beliefs history. According to her, what happens inside the body when Carlos has an "asthma attack" is that his breathing tubes "tighten down", and his lungs get filled with phlegm. This can be caused by cold air or rapid changes in temperature, exercise, and strong emotions. The first thing that she notices before he has an "attack" is that he becomes less active, and "his eyes look tired." Shortly afterwards, she notes that he begins to cough, and then wheezes. His "chest goes in and out" as well. When Doña María notices these symptoms, she has him sit down and rest. She also often rubs and massages his shoulders, back, and chest with mentholated oil. If after a minute or so this doesn't relieve the symptoms, she gives him "a syrup that her mother told her is effective for asthma." The syrup helps "get the phlegm out." If, after further observation for 15 minutes to half an hour, he still looks "bad", she gives him "la machina."

## **Epilogue**

Carlos' mom and the physician came to a mutually agreeable treatment plan, in which mother would give an albuterol nebulizer treatment right after she gave the syrup. By taking a health beliefs history and coming to a mutual understanding of the early signs that mom identified as the onset of asthma (decreased activity, tires eyes, "chest going in and out"), these therapies were initiated earlier, and with greater success. Mom brings in the syrup at the next visit and you determine that it is not harmful to him. Carlos still has symptoms of asthma, but they are successfully managed at home, without the need to take multiple trips to the clinic or Emergency Department, and he's not needed any prednisone during the past 10 months.

**REFERENCES AND READINGS**

1. Harwood A. "Guidelines for culturally appropriate health care" in Harwood A (ed) *Ethnicity and Medical Care*. Cambridge MA, Harvard U Press 1981: 482-507.
2. Kleinman A, Eisengerg L, Good B. Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*. 1978, 88:251-258.
3. Pachter LM. Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *JAMA*. 1994;271:690-694.
4. Pachter LM. Bridging the gap: the culturally-sensitive physician. *Contemporary Pediatrics*. November 1997.
5. Pachter LM. "Cultural issues in pediatric care." in Behrman RE, Kliegman RM, Arvin AM (eds.) *Nelson Textbook of Pediatrics* ( 15<sup>th</sup> Edition). Philadelphia, WB Saunders; 1996:16-18.
6. Pachter LM, Cloutier MM, Bernstein BA. Ethnomedical (folk) remedies for childhood asthma in a mainland Puerto Rican community. *Archives of Pediatrics and Adolescent Medicine*. 1995;149:982-988.
7. Kemper, KJ. *The Holistic Pediatrician*. NY, NY Harper Collins 1996.

## Module Evaluation

For presenters to fill out before the teaching session

A. I consider myself

- |  |   |                                     |   |             |
|--|---|-------------------------------------|---|-------------|
| 1. A nationally known expert on this topic | 2. A locally known expert on this topic | 3. Very knowledgeable on this topic | 4. to have learned about this topic to teach it | 5. Not sure |
|--|---|-------------------------------------|---|-------------|

B. I spent approximately \_\_\_\_\_ minutes preparing for teaching this topic.

C. Of the time I spent preparing to teach this topic, I used material provided to me as part of the Serving the Underserved Curriculum

1. 100% of the time
2. 75-99% of the time
3. 50-74% of the time
4. 25-49% of the time
5. <25% of the time

D. How appropriate were the educational objectives?

- |              |         |            |         |             |
|--------------|---------|------------|---------|-------------|
| 1. Excellent | 2. Good | 3. Average | 4. Poor | 5. Not sure |
|--------------|---------|------------|---------|-------------|

E. How appropriate were the tutor notes?

- |              |         |            |         |             |
|--------------|---------|------------|---------|-------------|
| 1. Excellent | 2. Good | 3. Average | 4. Poor | 5. Not sure |
|--------------|---------|------------|---------|-------------|

F. How appropriate were the references?

- |              |         |            |         |             |
|--------------|---------|------------|---------|-------------|
| 1. Excellent | 2. Good | 3. Average | 4. Poor | 5. Not sure |
|--------------|---------|------------|---------|-------------|

G. If your answer to any of the above questions (except A) was 3, 4 or 5, please comment.

**Please feel free to write further comments on the back of this sheet.**

Thank you for taking the time to fill out this evaluation.

\*This material was adapted from that created by Janet Hafler, Ed.D.

## Module Evaluation

(For Presenters to use after the teaching session)

Presenter: \_\_\_\_\_

Your responses will help us refine and develop this case.

**A.** Please rate the overall quality of this material as a stimulus for learning.

- 1. Excellent                      2. Good                      3. Average                      4. Poor                      5. Not sure**

**B.** Please rate the classes participation in the learning

- 1. Excellent                      2. Good                      3. Average                      4. Poor                      5. Not sure**

**C.** How comfortable were you with case based teaching

		Not at All				Very Much
<b>1.</b>	<b>Prior to this teaching session</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>2.</b>	<b>During the teaching session</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>3.</b>	<b>After the teaching session</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

**D.** Please list how long you spent on this topic, and how the time was divided

**Total Time** \_\_\_\_\_ **minutes**

**Time spent on case discussion** \_\_\_\_\_ **minutes**

**Please describe how you spent the rest of the time**

**E.** Please Rate each of the following

		Poor			Excellent	
<b>1.</b>	<b>The Educational Objectives</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>2.</b>	<b>The Case Vignette</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>3.</b>	<b>The Tutor Guide, including guiding questions</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>4.</b>	<b>Reference List</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>5.</b>	<b>Handouts</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>6.</b>	<b>Audiovisual Materials</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>

If you answered 1-3 on any of the above, please comment further

**F** What were the cases strengths 1.  
2.  
3.

**G** What were the cases weaknesses 1.  
2.  
3.

**H** What is the single most important thing that you learned from the case discussion?

**I Case Evaluations**

**1.** Do you think facts or data should be added? **1. Yes** **2. No**  
If **yes**, what should be added?

**2** Do you think facts or data should be deleted? **1. Yes** **2. No**  
If **yes**, what should be deleted?

**J. Tutor notes evaluation**

**1.** Did you use the **tutor notes**? **1. Yes** **2. No**  
If **no**, why not?

**2.** What were the **tutor notes** strengths? 1.  
2.

**3.** What were the **tutor notes** weaknesses? 1.  
2.  
3.

**4.** How would you suggest improving the **tutor notes**?

**5.** Do you think facts or data should be added to the **tutor notes**? **1. Yes** **2. No**  
If **yes**, what should be added?

**6.** Do you think facts or data should be deleted from the **tutor notes**? **1. Yes** **2. No**  
If **yes**, what should be deleted?

**K Slide Evaluation**

1. Did you use any of the **slides**? **1. Yes** **2. No**  
If **yes**, which ones

2. How would you suggest improving the **slides**?

3. Do you think more slides would be useful? **1. Yes** **2. No**  
If **yes**, what should be added?

4. Do you think there are slides that will never be useful? **1. Yes** **2. No**  
If **yes**, what should be deleted?

**L** Did you use any other materials **1. Yes** **2. No**  
If **yes**, what other materials?

If supplied by the Serving the Underserved Project, how would you improve the material

**M.** What did you as a teacher learn about this topic?  
#1  
#2  
#3

**Please feel free to write any further comments on the back of this form**  
**Thank you for taking the time to fill out this evaluation.**

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**Module Evaluation**

Presenter: \_\_\_\_\_

Your responses will help us refine and develop this educational material. The person completing this form is:

PGY1                  PGY2                  PGY3                  Fellow                  Faculty                  Other \_\_\_\_\_

A. What is the single most important thing you learned from the case discussion today.

B. Please rate the overall quality of this case as a stimulus for learning.

1. **Excellent**          2. **Good**                  3. **Average**                  4. **Fair**                  5. **Poor**

C. The facilitator

		Not at All			Very Much	
1.	Encourages student direction of teaching	1	2	3	4	5
2.	Stimulated interest in the subject matter	1	2	3	4	5
3.	Encouraged Group Participation	1	2	3	4	5

D. I consider the facilitator

1. A nationally known expert on this topic          2. A locally known expert on this topic          3. Very knowledgeable on this topic          4. a teacher who learned about this topic to teach it          5. Not sure

E. Please rate each of the following components of the teaching session (N/A for not applicable)

		Poor		Good		Excellent	
1.	Case Vignette	1	2	3	4	5	N/A
2.	Case Based/Learner Centered Format	1	2	3	4	5	N/A
3.	Handouts/Supplemental Materials	1	2	3	4	5	N/A
4.	Teacher/Facilitator	1	2	3	4	5	N/A

F. Do you think information should be added?          1. **Yes**                  2. **No**                  3. **Not Sure**  
If **yes**, what should be added?

G. Do you think information should be deleted?          1. **Yes**                  2. **No**                  3. **Not Sure**  
If **yes**, what should be deleted?

H. Comments

**Please feel free to write any comments on the back of this sheet.**

Thank you for taking the time to fill out this evaluation.

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