



# The Power of Cultural Sensitivity

BY MONICA S. VAVILALA, MD

Informed consent is required prior to many nonemergent medical procedures.<sup>1</sup> However, language barriers and limited English proficiency (LEP) significantly challenge the intent and process of informed consent, thereby hindering both patient safety and the patient–physician relationship. Onsite interpreter services remove some of these barriers to high-quality medical care by facilitating timely and safe transfer of intent and language content between patients and their physicians, but data suggest that even with onsite interpreters, documentation of informed consent is often missing.<sup>2</sup>

More than the issue of documentation, however, is the under-recognized vulnerability that patients experience when they lack the most empowering tool: that of communication. Perhaps one has to experience a near miss to really understand the value of interpreter services for LEP patients.

## A Case in Point

It was 12 PM on a Sunday afternoon. As the anesthesiologist on duty, I was reviewing a busy operating room schedule when my phone rang. It was David Wilson (not his real name) from the primary service, asking to schedule an anesthesia-assisted procedure for a patient who required a lumbar puncture (LP).

“Is this Dr. Vavilala?” he asked. He told me that Mr. O, a 75-year-old Cambodian patient who was admitted with altered mental status and was now receiving treatment for meningitis, had been rather uncooperative when the procedure was attempted on the last two nights. “So, you need me to help you sedate him and confirm treatment effect?” I asked; he agreed.

At 6 PM, the postanesthesia care unit was full of patients recovering from general anesthesia. Mr. O, a small-framed, frail, and bald gentleman, lay supine on the hospital stretcher, his chest and abdomen covered with a plain white hospital blanket. A saffron shawl, barely visible, peeped out from under his shoulders. The nurse asked me whether she should give Mr. O some sedation.

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David assembled his procedural tray, and the nurse asked a series of questions:

“Should I give him some Versed?”

“Should I give him some propofol?”

“Should I hook up the monitors?”

“Should I access the peripheral IV?”

“No,” I replied, feeling unable to prevent the naturally and rapidly occurring chain of events that I felt was premature. The questions kept coming, but I could not slow down the flow of events. I felt that the push to sedate him was so strong and that the questions were coming so fast that I could not even slow down to consider whether he needed sedation.

I said hello to Mr. O, and he smiled back peacefully. Then came the interpreter, with whom I had worked many times. We learned that Mr. O was oriented to person, place, and circumstance. So, what was the issue?, I wondered. Over the next five minutes, Mr. O had moved himself into the fetal position, ready for his lumbar puncture.

“He won’t hold still,” they said.

“He’s elderly, and I want to give this a try,” I said. I was thinking about trying to prevent delirium and confusion, but somehow was not able to get the message through.

“Let’s just leave him alone and see what happens,” I responded, aware that my approach to Mr. O appeared to the others unnecessary, and maybe even wrong, as it had already been deemed that he needed sedation for his procedure and this delayed the work flow processes already in motion.

I wanted to talk to Mr. O. I leaned over to ask him some questions when, suddenly, the interpreter’s hand stopped me. “You know he is a monk, and women shouldn’t touch him, right?” queried the soft-spoken interpreter, with brows slightly furrowed.

In fact, Buddhist monks are forbidden to touch or be touched by a woman, or to accept anything from the hand of one. If a woman has to give anything to a monk, she first hands it to a man, or put it on a plate provided. I apologetically moved back, and asked Mr. O to tell us the details of the attempted and failed procedures of the previous day. It was true! Most of his health care providers during the last two days had been female, including the anesthesiologist who had performed a history the day before. He said he tried to tell them not to touch him, but they thought he was confused. Who knows, maybe he was confused, or maybe there was no interpreter, or maybe the right questions weren’t asked.

And now, he had almost received unnecessary sedation for his LP.

We collected the needed cerebrospinal fluid. There was no increased intracranial pressure, and we presumed treatment success. All through the lumbar puncture, Mr. O had dozed off. He slept all the way back to his room.

The candida meningitis was likely due to his uncontrolled diabetes, I concluded. I then asked the primary service to order Mr. O a meal, as he was now allowed to eat. With amazement, the interpreter stated, “Monks don’t eat after 10 AM.”

## Reflections

I am an Indian immigrant with some cultural similarities to those of Mr. O—perhaps it is that background that stopped me from sedating him. And yet even I didn’t make the connection that the saffron shawl that was visible had signified something more special. In the rush of it all, I had leaned over a bit too much and a bit too fast, and had made him uncomfortable. Had it not been for the interpreter, I would have violated some very important boundaries.

Children, the elderly, and patients with limited English proficiency are all vulnerable populations. Mr. O was a patient, a spiritual

person—but was nearly assaulted by the need to move things along and get things done. Upon reflection, I had the following thoughts:

- ❖ What must Mr. O have felt? Should I dare ask him?
  - ❖ How easy would it have been for me just to sedate him for the LP?
  - ❖ How many violations had occurred—for example, had he been examined by female physicians?
- ❖ Did he get to eat or drink the day before, or was his tray of lunch delivered at noon, just like everyone else's?

I share this as an example of the powers of language and of interpreters—what would vulnerable patients do without them, and without providers' having cultural awareness?

As an anesthesiologist who spends much time “doing,” it was an important reminder that often it is better to *not* do.

On to the next case. ❖

#### References

1. Roberts CM. Meeting the needs of patients with limited English proficiency. *J Med Pract Mgmt* 2001;17(2):71–75.
2. Schenker Y, Wang F, Selig SJ, Ng R, Fernandez A. The impact of language barriers on documentation of informed consent at a hospital with on-site interpreter services. *J Gen Intern Med* 2007;22 Suppl 2:294–299.