Considering Culture, Complementary Medicine, and Spirituality in Pediatrics

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Introduction

Pediatric practice exists within the larger biomedical culture as well as local, regional, and national cultures. Culture includes many dimensions of belief and behavior such as religious practices and spiritual understanding, diet, art, language, and health behaviors. The cultural aspects of our lives are so ingrained, particularly for those from dominant cultural groups, that their impact is often difficult to discern unless one steps outside one's own culture or lives within a small or non-powerful subculture. Books, such as *The Spirit Catches You and You Fall Down* illustrate the problems that arise when cultures clash. This book describes the life of a Hmong baby born in America who is seen by her family as being special, with a possible future as a shaman, but who is seen by her doctors as having developmental delay and seizures; it dramatizes the tragic consequences of misunderstood differences between cultures from opposite ends of the earth. Most often, however, differences in culture, spirituality, and health practices are more subtle, although not necessarily less problematic for those involved.

Culture in any one place and time consists of the interactions between dominant beliefs and practices and non-dominant cultures; members of different non-dominant cultural groups also interact in complex ways. Generally speaking, members of a dominant group tend not to think of themselves as having a cultural background. In the United States, for example, such persons are likely to think of themselves as "American" rather than as "Something—hyphen—American." It is not uncommon, therefore, for this group to assume that matters of "culture" pertain primarily to more recently arrived groups, and not to them. This kind of assumption characterizes any position of social privilege, in which one is rarely confronted with the consequences of one's cultural difference in ways that jeopardize one's access to social status or resources. Comparable differences arise in the medical context between biomedical practitioners and practitioners of complementary and alternative medical therapies (CAM).

Those from non-dominant cultures (including gender and religious subcultures) struggle to achieve and maintain status, prestige, power, and personal and group identity while living and working within the dominant culture. Members of such groups may respond to the surrounding majority culture in a variety of ways. Some may try to meet the measures of success as defined by the dominant culture. In such cases, success involves acquiring and demonstrating the language and behaviors of the dominant culture. Others may remain in cultural enclaves, partly because to do so allows them to live in a culturally more familiar context, and partly because of the racial and economic ghettoization that characterizes many American cities. Still others may assert their differences, adopt a publicly oppositional stance, and challenge discriminatory practices directed toward their cultural community. It is also possible that a given per-

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son may combine parts of these different strategies, depending on the situation. For example, a person interested in holistic healing may attend medical school and complete an accredited residency program (dominant culture), yet seek out continuing education programs devoted to complementary therapies (cultural enclave) and try to persuade the medical school curriculum committee to include CAM therapies and therapists (challenge the system). Patients may seek care from mainstream physicians at tertiary care hospitals, yet rely on home remedies to treat common ailments and bring challenging materials from the Internet to their physician with questions about dietary supplements and herbs.

During periods of stress, such as those generated by illness, the individual or family often turns to the comfort of their own language, beliefs, and traditional behaviors. However, openly exhibiting non-dominant beliefs and practices runs the risk of being ridiculed, rejected from positions of power, or even rejected from the profession or care by professionals. Thus, many patients do not confide in their physicians about the implications of cultural difference in relation to their understanding of illness or their related use of CAM remedies; likewise, many physicians who recommend CAM therapies behind closed doors of their clinic may not mention them to colleagues.

Culture is fluid rather than fixed; it is constantly affected and modified by contact with other cultures. This is the case in the United States, which has historically been characterized by cultural pluralism. For example, as the country has assimilated new immigrant groups, dietary practices have changed from wild game and wild plants to English foods from cultivated gardens and farms to Italian, Mexican, Ethiopian, and Chinese cuisines. As American culture has become more oriented toward science and technology, practices that were once dominant in medicine, such as using herbs and massage to heal, move into non-dominant positions, viewed as complementary or alternative therapies. Practices that were once foreign and alternative, such as acupuncture, move into mainstream hospitals. As biomedicine becomes more secular, spiritual healing may also be seen as non-mainstream, even though these practices are embraced by the majority of the religious cultures in the United States.

In the medical literature, cross-cultural issues, spirituality, and complementary medicine are frequently addressed as separate topics. In the experience of patients, families and clinicians, however, they often do not divide so neatly. The purpose of this article is to provide cases for reflection and discussion, illustrating the complexities of providing sensitive and appropriate care in a culturally and spiritually diverse healthcare system in which patients and clinicians have ready access to a variety of complementary therapies and healers.

The usual format for medical cases involves the presentation of a patient with constellation of signs and symptoms for physician consideration. However, for these narratives, we invite readers to assume the role of the different persons portrayed—the clinicians and other staff, patients and family members. Readers may wish to join with colleagues to role-play the different situations and discuss possible options in responding to the scenarios presented. All of these narratives are based on actual clinical situations, but names and minor circumstances have been changed to protect confidentiality. The cases are challenging, but are not black and white; there are no "good" guys. "bad" guys or right answers. Instead, each one offers challenges to clarify and enhance understanding, communication and care. For each narrative, consider the impact of cultural and spiritual beliefs, social power, assumptions and communication skills; what strategies can be employed to better understand and respond to differences? How can different members of the healthcare team facilitate improved communication? We hope that these cases provide grist for reflection and discussion among clinicians, colleagues, patients and families and that these discussions serve to enrich and edify the diversity of pediatric practice.

Physician Cases

1. You are Susan Smith, a second-year pediatric resident. Over the past 3 weeks, one of your inpatients, a 20 year old with end-stage cystic fibrosis, has been most important to you. She is on the lung transplant waiting list, and has been making good-bye gifts for family and friends, writing farewell letters, and requesting daily visits with the hospital chaplain and her own minister; you admire her courage, her faith, and her grace. As you leave on Sunday morning, you ask Bill Jones, who is covering for you on your day off, to call you if her condition changes.

When you return on Monday morning. you hear Bill, another male resident, two male medical

students, and one of the male pulmonary attendings talking and laughing about yesterday's football game. You slip past to go check on your patient. Her room is empty; the cleaning person tells you she died yesterday evening. You feel tears welling up and want to go the hospital chapel for a few minutes, but there is no time before work rounds begin. On rounds, Bill says he didn't want to ruin your day off by calling you with the bad news. You do not want to appear to be an "emotional girl," but a competent, effective member of the inpatient team who promotes sensitive communication. What do you do?

2. You are Alison Smith, a middle-aged pediatrician with osteoarthritis of the neck; after trying numerous therapies, you have found significant pain relief and restored range of motion, to your surprise, with acupuncture treatments. You are seeing a 16-year-old patient you have observed since her infancy; she is the star of her tennis team, but today she has a classic case of tennis elbow that bothers her despite rest, anti-inflammatory medications and ice treatments. Her mother, who is 8 months pregnant, says that her fetus is in the breech position, and she is worried about needing a C-section. Several months earlier, she reported significant relief from her morning sickness when you mentioned that acupressure bands might be helpful. Although you have not kept your experience with acupuncture exactly a secret, you have not broadcast it either. You are aware of a randomized controlled trial reported in the *Journal of the American Medical Association* supporting the use of acupuncture to help turn breech babies to normal positions for delivery. However, you have never recommended acupuncture for this condition, nor for tennis elbow, and you are not sure how your patient, your colleagues, or the medical student who is rotating with you will react. What do you do?

Health Professional Cases

1. You are Jim Smith, a physical therapist at the Children's Hospital. Over the past 2 years, you have been taking classes at the local massage school and weekend workshops in a distant city on craniosacral therapy. You have surreptitiously started incorporating some of these techniques in your hospital practice. One of your patients who was being treated for a sports injury had dramatic relief from her migraine headaches after you did some craniosacral treatments (without additional charge) during her therapy sessions. Pleased with the results, she told her physician how much better she's been since you started the craniosacral work. The physician was angry and called your supervisor, asking if the physical therapy department was going to start referring patients to chiropractors next. Your supervisor has called you in for a little chat. What should you do?

2. You are John Lee, a licensed acupuncturist with 20 years of experience who has been on the faculty of an acupuncture school for over 10 years, has published research on the clinical effectiveness of acupuncture, and received numerous referrals from an academic medical center where you have been credentialed for the past 4 years. Six months ago, a new physician at your hospital announced that she received some training in acupuncture. In your state, physicians are not required to have specific training or to undergo specific testing before practicing acupuncture because it is covered under the physician's scope of practice. This physician has been actively soliciting patients in the doctor's lounge and at hospital conferences. Over the last few months, you notice that referrals to you have dropped off sharply, and there is a notice in the paper that the hospital is starting a physician-run acupuncture clinic. The doctor has not responded to your invitation to have lunch and talk. What should you do?

Patient/Family Cases

1. You are Amy Nelson, a vegetarian Seventh Day Adventist mother of an 18-month-old baby. On a routine screening examination, the baby is found to be mildly anemic. The doctor, who congratulated you on breastfeeding for a full year, and supplementing with cereals, vegetables, and fruits at appropriate ages, recommends that you increase the baby's meat intake. The busy doctor has not inquired about your religious beliefs. What do you do?

2. You are Terry Keeyani, a 15-year-old Native American living on a reservation. Your great grandfather is a medicine man who uses tobacco in his ceremonies. The local ice cream store where you work after school has an old poster featuring Ronald Reagan promoting Chesterfield cigarettes. All your friends, your mother, your older brother, and your 12-year-old sister smoke cigarettes; your father died in a car accident last year. Your oldest brother was shot during an argument with a friend, which leaves you feeling that no matter what

you do, life may turn out to be painfully short. Your doctor tells you not to smoke because it can cause lung cancer and heart disease in old people. What do you do?

Summary

Whether or not it is apparent, cultural and spiritual diversity exist in many clinical encounters, both with patients and with colleagues. These issues may cloud other concerns, contribute to inadequate or misleading communication, and affect lifestyle and therapeutic choices. Given the rapid rise in complementary therapies and the growing diversity in North America, the challenges of providing sensitive, compassionate, comprehensive care are compounded. Reflecting on the ways cultural backgrounds, religious beliefs and complementary medicine affect physicians, colleagues and patients may enrich, clarify, deepen, and improve the effectiveness of our clinical practice. The cases presented here offer an opportunity for role playing and reflection to support this process.

Suggested Reading

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