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Cultural Competence in Critical Care: Case Studies in the ICU

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Abstract: It takes years to develop clinical competence in critical care and trauma surgery. We learn, relearn and are tested every day. How do we develop our communication skills and competence in cross-cultural communication, though? This, too is through immersion and daily practice. Here, though, we learn from our patients and their families perhaps more than our own backgrounds and formal training.

The case studies in this paper provide insight into the many and varied wavelengths at which intensive care unit, ICU, staff must communicate in order to effectively deliver care and earn the trust and cooperation of their patients at their most vulnerable. Dealing with illness and death is difficult in any environment but in Trauma and the ICU illness may come as a surprise and a shock, patients conditions change minute-by-minute and anxious families hang on every word we say, hoping that they heard good news, trying often not hear the bad news.

In this account, we describe some of the special considerations in communication in the ICU and how to communicate at the wavelength of the patient and their family in testing, uneasy but urgent circumstances.

Keywords: cultural competence, communication, intensive care unit, critical care, trauma, surgery

1. Introduction

Cultural competence is crucial in acute and critical care, where emotions are running high, there is a sense of alarm and urgency, there are high-stakes decisions being made, consent may be problematic, key decisions, progress and bad news needs to be effectively communicated and expectations managed in what, for many, is a protracted, often stormy, course.

The following account focuses on the challenges of culturally competent interaction in the critical care environment, in particular, informed consent and end of life care. We emphasize patient-centered practice and care of the individual within a *dominant culture*, which though traditionally, representing the majority culture in a society, in this account may actually more usefully apply to the culture within an institution, or indeed, the intensive care unit (ICU).

2. Defining Cultural Competence

Betancourt (2006) defines a culturally competent healthcare system as one that “acknowledges and incorporates — at all levels — the importance of culture, assessment of cross-cultural relations, vigilance toward

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the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs." He goes on to explain that "a culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviours, disease prevalence and incidence, and treatment outcomes for different patient populations."

3. Our Culture

Inherent in our thoughts is a preconception of difference and a tendency to categorize individuals as belonging to a particular cultural group that may be foreign to us. We, therefore, make assumptions about how patients and their families think and feel. We know from living in multi-cultural societies, however, that there *are* no real cultural characteristics (stereotypes) and that our individual nursing of patients in the ICU implies individualized and not stereotyped interactions.

Describing the components of culturally competent nursing in the ICU should be no different, therefore, from listing the attributes of any successful relationship with a patient. The difference in the ICU is the added uncertainty and gravity in prognosis and the clear need to address the suffering and vulnerability of a patient who is critically ill. Our patient centered approach may actually mean that a lot of our conversation is with the family and not the patient. This can sometimes put nurses and the families of patients in conflict, especially where there is cultural diversity (Høye, 2010).

4. Language

We begin with a discussion of the most basic premise in conversation: talking in an understandable language. Language whether shared or interpreted is crucial. Words and phrases have different meanings in different contexts; they *take on* different meanings depending on what has just happened and what we believe we were expecting from each other. Relatives of critically ill patients hang on every word. Accurate comprehension on both sides is key in the most trivial of conversations, let alone in breaking bad news, for example, as this creates the communication environment within which we work and builds understanding that is both dependent on and that promotes personal, cultural and professional sensitivity.

For a patient who is acutely ill, we can only imagine the level of disorientation and fear that they must experience. A polytrauma patient, for example, may be overwhelmed by the number of healthcare workers in attendance, the bright lights in the emergency department, the number of voices around them, their clothes being cut away, clinical examination by a multi-disciplinary team, voices talking to them from all angles. Does silence indicate how seriously injured the patient might be or is the patient stunned? It is not unusual for a patient in the Trauma unit who should, according to his injuries, be able to communicate, to be entirely unresponsive. We see this again and again in regions of the world affected by conflict where patients and doctors may represent different ethno-cultural groups.

5. Non-verbal Communication

In the environment in the ICU, where the lights are on continuously, there may be continuous background noise and activity, sleep is invariably disturbed and disorientation is compounded by illness. Nursing care provided by a small team of familiar nurses may alleviate some of this distress and give reassurance. Cultural

awareness with regard to hygiene and grooming is crucial here, where patients may not have the strength to express their wishes or give verbal consent, but may be aware of all physical contact.

6. Cultural Adaptations in Conversation

When we do discuss what might be wrong, it is usually with the patient's family long before we are actually able to talk to the patient. The explanation may not be straightforward: some people need to conceptualize a disease; they can comprehend the disease process more easily when using culturally familiar metaphors.

Exemplar I

After admitting patient to the ICU after abdominal surgery, I met the family. The first question the son asked me was "Can you tell us whether the tumor was male or female?" Not knowing what he meant I asked "Can you tell me what you mean by a male or female tumour?"

He then informed me "A female tumour has children while a male tumour stands alone". In other words, female tumours spread while male tumours are localized. With this knowledge I was able to adapt my explanation.

7. Consent

Informed consent is an arena of cultural and linguistic diversity in all clinical and research environments. In the ICU, however, this is compounded by the fact that, although consent from the patient and family is not necessary for life-saving procedures, as senior doctors in attendance take responsibility for decision making in the best interest of the patient, no health professional is likely to embark on an intervention without consultation with family if they are also in attendance (Davis, 2003; Fisher, 2004; Schweickert, 2005). Just listing the issues at stake gives an idea of the complexity of consent: establishing a rapport with the patient (who may be in variable levels of consciousness), establishing a rapport with the family, gaining their trust, understanding with whom to communicate within large families, establishing who the 'head' of the family might be, understanding the specific implications of involving family members in clinical decisions and an awareness of family dynamics, conversing with the nominated decision maker in the family, who is often not the family member most frequently at the bedside, communicating in culturally competent language (as we see from the example above), dealing with a spectrum of interaction from "doctor, you know best, please do whatever you think is best for my mother" to "you doctors, you are just playing God with my mother" and lastly communicating end of life decisions or raising the possibility of organ donation which in some cultures is a religious and cultural taboo while in other cultures perceived as a moral obligation to, at least, consider.

The best guide here is to establish a relationship with the family from the outset that permits a candid and sensitive discussion of these issues as each intervention becomes necessary through the clinical course.

8. Religion in Communication

In some societies, culture and religion are intrinsically linked. Religious custom shapes social norms and even national legislation. When faced with medical decisions people often turn to their religious leaders for advice and seek comfort in their authority. For example, among the Jewish Haredi (a religious ultra-orthodox community) members follow the rabbi's instructions when accessing healthcare. They verify healthcare recommendations with their rabbi and may even defer crucial decisions to him.

Exemplar II

In our ICU we treated a severely burned and septic six year old girl from a religious (Haredi) background who needed extensive skin grafts. The parents, in accordance with their faith and traditions, sought counsel from their rabbi who advised against their daughter having the surgery. The parents, dependent on emotional support and guidance from the rabbi, accepted this decision, sat by their daughter's bed and prayed. The child continued to deteriorate, developed septic shock and required increasing vasopressor support. The ICU team watched in frustration, their hostility toward the family increasing day by day. Eventually a nurse suggested that the healthcare team speak directly to the rabbi. He listened and counselled the family again and it was agreed to proceed with surgery and skin grafting.

People sometimes make the distinction between organized religion and adherence to a particular faith. The association between faith and health has been studied extensively. There are well over a thousand papers describing a possible association. Positive health benefits include protection from illness, reduced anxiety (Koenig, 2002), improved coping, hope, reduced isolation (McClain, 2003), less loneliness and depression, enhanced mechanisms the facilitate dealing with pain, faster recovery from illness and perhaps even reduced mortality (Strawbridge, 1997). These benefits may be due to spirituality and faith, or possibly attributed to protective relationships, social support and healthy behaviours and lifestyles (Whooley, 2002; Borders, 2010; Mellor, 2010) that are associated frequently with people who adhere to particular faiths. Although the predominant effect is a positive one, negative effects associating illness with evil or judgement also exist, especially in mental illness (Sims, 2009).

9. End of Life Care

Research has identified three basic dimensions in end of life treatment that vary culturally: communication of bad news; the locus of decision making; and, attitudes towards advance directives and end of life care (Searlight, 2005). In some cultures the emotional reaction to *being informed* of serious illness itself may be considered directly harmful to health. It is thought that a patient who is already in pain should not have to suffer the trauma of receiving bad news as well, even if this is to inform them of their diagnosis and prognosis (Matsumura, 2002).

Should culturally competent nurses be allowed to allude to spiritual powers to comfort patients at the end of their life? It is well recognized that many people turn to religion at times of personal distress or the loss of a loved one (Ano, 2004; Chen, 2006), however, nurses offering to pray for patients have found themselves in trouble in the UK (BBC News, 2009). Guidance on the religious implications of nursing is available (Taylor, 2012). Clearly the initiative here lies with the patient and what they declare their needs and desires to be.

Some key questions and interventions that nurses need to consider in promoting respectful and dignified care for patients at the end of life include:

- "What is important for us to know about your faith or spiritual needs?"
- "How can we support your needs and practices?"
- "Where do you find your strength to make sense of this experience"
- Encouraging customs or religious rituals which give meaning, security and solace to patients and their families in times of need, during crises and death, i.e., praying.

Exemplar III

A 16 year old polytrauma patient with severe injuries underwent surgery for massive bleeding. He remained

unconscious and unstable postoperatively in the ICU as surgical teams from multiple specialties and the ICU physicians deliberated together how best to stabilize the patient. Still bleeding, a collective decision was made to return to theatre in a last attempt to save his life. His family, distraught, of course, consented; their desperation probably matched by that of the surgeons and ICU physicians' alike, and, at the same time, their reservations that the outcome was grave both with and without surgery. The patient was taken back to the operating theatre. The bleeding could not be stopped. The patient died on the table. The grief both professional and familiar was overwhelming. It seemed the entire hospital knew about this patient.

As the surgeons talked to the family afterwards, words, perhaps seemed futile. What comfort can a professional offer parents in so much pain? A senior surgeon, ethnically the same, but a different religion, leaned forward and said softly "Allah must have loved your son and that's why he took him. He did not want him to suffer any longer". In so many contexts might this have invited criticism; but, is cultural competence a checklist, a learned behaviour to get through the day, or is it simply sincerity, empathy and the right thing to say or do when our patients and their families most need for us to be on their wavelength, to reach out to them when they are really at their most vulnerable and in anguish? Religion for many offers comfort and gives reason and meaning to what might otherwise seem futile and hopeless. If we *realize* that this will help our patients, is it not incumbent on us to reach out to them and offer them what hope and relief from pain that we can?

10. Dreams

Dreams hold particular significance in different cultures. Have your patients ever related their dreams to you? Dreams are an excellent vehicle towards understanding our patients' culture and, otherwise, unexpressed fears and desires (Nordin, 2011). Dreams and dream beliefs are important as they contain subconscious thoughts that may have real significance to patients. The content of dreams remains within the realms of patients' real experiences, fully conscious, sedated, delirious or confused; exploring them may, therefore, be of real value. Dreams frequently relate to concerns about the future and about health anxieties (Nordin, 2011).

Exemplar IV

We treated a suicide bomb blast victim who described dreaming about the smell of burning flesh that she had obviously experienced while waiting to be evacuated from the scene. This is what she recollected:

"While unconscious and ventilated in the ICU I experienced recurrent dreams. In all my dreams, a strong smell was present. This scent was unfamiliar to me. I tried to recall experiencing this strong smell. I dreamt that I was in a concentration camp and then I found a solution and a place for the smell of burning flesh. I have a Moroccan background, no one in my family had experienced the concentration camps and I never heard personal stories about them. I only learned about the camps in school - I don't know why I dreamt this."

This woman was unconsciously re-experiencing the blast and simultaneously trying to make sense of what had happened to her.

11. Summary

The critical care environment is a challenging environment to work in both physically and emotionally. As we try to optimize the physical environment for stabilization and healing we are increasingly aware that communication, explanation, information, counsel and consolation are as much our work as setting up intravenous

infusions, turning patients and tending their wounds. There is no doubt that clinical competence in the ICU environment is crucial; cultural competence is an equal partner and without this we do just work by numbers.

References

Ano G. and Vasconcelles E. (2004). "Religious coping and psychological adjustment to stress: A meta-analysis", *Journal of Clinical Psychology*, Vol. 61, No. 4, pp. 461–480.

BBC News. Nurse suspended for prayer offer. Published: 2009/02/01, http://news.bbc.co.uk/go/pr/fr/-/2/hi/uk_news/england/somerset/7863699.stm.

Betancourt J. R. (2006). "Cultural competency: Providing quality care to diverse populations", *The Consultant Pharmacist*, Vol. 21, No. 12, pp. 988–995.

Borders T. (2010). "Religiousness among at-risk drinkers: is it prospectively associated with the development or maintenance of an alcohol-use disorder?", *J Stud Alcohol Drugs*, Vol. 71, No. 1, pp. 136–142.

Chen Y. Y. and Koenig H. G. (2006). "Do people turn to religion in times of stress: Examination of change in religiousness among elderly, medically ill patients", *J Nerv Ment Dis.*, Vol. 194, No. 2, pp. 114-120.

Davis N., Pohlman A., Gehlbach B., Kress J. P., McAtee J., Herlitz J. and Hall J. (2003). "Improving the process of informed consent in the critically ill", *JAMA*, Vol. 289, No. 15, p. 1963.

Fisher M. (2004). "Ethical issues in the intensive care unit", *Curr Opin Crit Care*, Vol. 10, No. 4, p. 292.

Høye S. and Severinsson E. (2010). "Professional and cultural conflicts for intensive care nurses", *Jour Adv Nurs*, Vol. 66, No. 4, pp. 858–867.

Koenig H. G. and Cohen H. J. (Eds.) (2002). *The Link between Religion and Health: Psychoneuroimmunology and the Faith Factor*, London, Oxford Press.

Matsumura S., Bito S., Liu H., Kahn K., Fukuhara S., Kagawa-Singer M. and Wenger N. (2002). "Acculturation of attitudes toward end-of-life care: A cross-cultural survey of Japanese Americans and Japanese", *J Gen Intern Med*, Vol. 17, No. 7, pp. 531–539.

McClain C. et al. (2003). "Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients", *Lancet*, Vol. 361, No. 9369, pp. 1603–1607.

Mellor J. and Freeborn B. (2010). "Religious participation and risky health behaviors among adolescents", *Health Econ*.

Nordin A. (2011). "Dreaming in religion and pilgrimage: Cognitive, evolutionary and cultural perspectives", *Religion*, Vol. 41, No. 2, pp. 225–249.

Schweickert W. and Hall J. (2005). "Informed consent in the intensive care unit: Ensuring understanding in a complex environment", *Curr Opin Crit Care*, Vol. 11, No. 6, p. 624.

Searlight H. R. and Gafford J. (2005). "Cultural diversity at the end of life: Issues and guidelines for family physicians", *American Family Physician*, Vol. 71, No. 3, pp. 515-522.

Sims A., Powell A. and Cook C. (2009). *Spirituality and Psychiatry*, RCPSYCH Publications (via Turpin Distribution for the trade), available online at: http://www.rcpsych.ac.uk/publications.

Strawbridge S. (1999). "Counselling and psychotherapy as enabling and empowering", in: C. Feltham (Ed.), *Controversies in Psychotherapy and Counselling*, London: Sage.

Taylor E. J. (2012). *Religion: A Clinical Guide for Nurses*, Springer Publishing Company.

Whooley M. et al. (2002). "Religious involvement and cigarette smoking in young adults: The CARDIA study — Coronary artery risk development in young adults study", Arch Intern Med 2002 Jul 22.