Judy Cassidy
EDITOR

Failing the Community

I recently visited a large family I'd known for a long time. When I entered their home, most people, but not all, said hello. Few made eye contact with me—at least not for more than a second. Immediately, I felt uncomfortable—that I had offended them in some way or that they were angry at me for some reason. After a few awkward moments, the silence broke and they began to talk with me in a friendly manner.

The more I thought about it, the more I realized that what to me was odd, or even rude, behavior was simply part of that particular family's pattern of relating. Hadn't I seen them interact this way on many occasions with people other than myself?

At that same gathering, a man who had injured his arm told me about his follow-up visit after surgery. "The staff laughed at my questions and made fun of me," he said. But when he related some of the "offensive" exchanges, my interpretation was that the healthcare professionals were trying to put him at ease and allay his fears, not ridicule him.

Significantly, all the people in these two situations, including the healthcare personnel, are white and probably all were born in the United States. Yet misunderstandings in interpreting words and body language arose despite their shared culture (one in which, for example, eye contact in greeting people is expected). In the first instance, if the family had been of a race or country different from mine, I might have assumed their behavior was a characteristic of their culture—and in making that assumption run the risk of stereotyping them. In the second instance, if the injured man had been of a background different from the caregivers, one might jump to the conclusion that he just didn't understand their culture, or they his.

Because people have individual personalities and experiences, the only way one person can understand another is to get to know him or her personally.

The lesson here is that it is dangerous to make assumptions about people's beliefs, habits, fears, knowledge, motivations, or actions on the basis of generally accepted cultural norms for various groups (lists and descriptions are available). Because people have individual personalities and experiences, the only way one person can understand another is to get to know him or her personally.

In her book *The Spirit Catches You and You Fall Down* (see p. 35), Anne Fadiman vividly demonstrates the consequences of not knowing patients as individuals. Although the outcomes are usually not as devastating as those experienced by the Hmong family she describes, lack of understanding between caregiver and patient virtually always results in care that is not as technically good or as satisfactory to the patient as it could be. A personal approach to all patients, no matter their age, race, religion, or country of origin, would seem to be natural for healthcare organizations that espouse the values of high-quality care, respect for the dignity of each individual, social justice, and healthy communities. But this is a formidable requirement. Cost containment pressures limit the amount of time healthcare professionals can spend talking with patients, and language barriers further impede conversation.

Although no one has yet devised a complete solution for this conundrum, please share your ideas, suggestions, and successes with others in the Catholic health ministry by contacting *Health Progress* staff directly or by answering our question on p. 31. What better way to strengthen our Catholic identity and values than by building relationships with patients, one interaction at a time? Dan Murphy, a physician in Fadiman's book, expressed well the implications for treating each patient as an individual when he said, "When we fail one Hmong patient, we fail the whole community."

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, January-February 1999