

efficient and timely way of providing accurate written information. Recommendations for influenza vaccination have again recently been published (*J*). In addition, it is prudent for Federal agencies to continue to work closely with other public and private organizations to promote the health and welfare of American people through broader use of safe and effective vaccines.

*Robert E. Windom, MD, Assistant Secretary for Health*

**Reference**.....

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**Physician-Patient Communications: Sensitivity Is What Breaks Cultural Barriers**

In their article "Acquired Immunodeficiency Syndrome and Black Americans: Special Psychosocial Issues" (*Public Health Reports*, March-April 1987), Mays and Cochran identified several cultural factors affecting black patients. I discuss a case of a black IV drug user, who suffered a massive heart attack, in support of the authors' contention and suggest how health care providers may deal with the problem.

The patient was a 30-year-old black male who was admitted to the coronary care unit (CCU) of a major teaching hospital in Pittsburgh, PA. I was a medical resident on cardiology rotation in the CCU and saw the patient as a consultant. As I obtained historical information from the patient, it became obvious that he was telling me more than he had admitted to earlier.

Both emergency room (ER) and CCU admitting notes revealed that the patient had denied having previous chest pain; his electrocardiogram (EKG) was suggestive of an old myocardial infarction. He admitted to me a visit to another ER 4 weeks earlier with similar chest pain (EKG was not done on that visit). He had admitted to a drug use history of only 6 months; he admitted to a 5-year history to me. He had admitted to using mainly cocaine with occasional use of heroin; he admitted to me the habitual use of cocaine and heroin mixture. In fact, he explained in detail how the drugs were ground and "cooked" for IV injection. He also used a third drug—Preludin—in the mixture, which he had not mentioned to previous interviewers. He further told me how he bought Preludin from obese women, who got it through physician prescription for weight loss; how and where he bought cocaine and heroin; and the ritual of drug injection by needle-sharing at "drug bars."

The obvious conclusion is that I got the other information because I am black, but that is not the whole truth. I am a native of Ghana, and during 16 years of living in the United States, most of my educational and social encounters have been with whites.

I do not speak or even understand "the vernacular used by blacks." I believe my success with this patient had more to do with how I approached him than my skin color.

I told him right away that I was there as a consultant to collect information so that I could advise the doctors taking care of him. It was absolutely necessary that I got the truth. I implored him to trust me fully; my only purpose was to help him. It was after establishing rapport and trust that I proceeded to interview the patient.

I agree with Mays and Cochran's contention that health educators need to be sensitive to "differences in the vernacular used by blacks to describe sexual behaviors and methods of intravenous drug use." However, white physicians should not feel impotent in educating black drug users because of cultural barriers. I believe all patients can be reached if approached in a compassionate, respectful, understanding, nonjudgmental, and above all, patient manner.

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**Authors' Reply: Status Characteristics and Patient-Physician Communications**

Accurate disclosure of relevant health information by patients is extremely important (*1*). To the extent that this information involves sexual behavior (*2*) or illicit drug use, patients may be less than forthcoming. This issue is of particular concern in dealing with persons who may be infected with the human immunodeficiency virus (HIV).

We agree with Dr. Duh on the importance of patient-physician interactions by which the physician communicates a genuine interest in the patient as a person to encourage accurate reporting. However, this does not address the question of what factors tend to affect development of this rapport. In our article, we suggest that knowledge of the exact meaning of language used by the patient in describing either sexual or drug use behavior may facilitate patient care.

Problems in patient-physician communications may arise when the patient or the physician does not fully comprehend the meaning of the language used by the other (*3,4*). This can occur from cultural or social class differences or the overreliance on medical jargon by the physician. Other factors that erode the quality of communication include asking questions in a style that inhibits patients' responses or failure to provide sufficient explanatory information to the patient (*3-5*). Research studies indicate that several status characteristics (ethnicity, gender, social class) may be partially responsible for these difficulties (*3,6*).

During admission interviews, one difficulty lies in distinguishing effects of social factors (that is, religious,

economic, political) on symptom reporting, degree of disability, perceptions of severity, or use of illicit substances (3,7). For example, it has been noted that blacks may evidence reticence in disclosing symptoms as a way of testing the competence of the physician (8). Physicians, too, can contribute to problems in communication by failing to understand the subtle effects of ethnic differences on their nonverbal interactions with patients (7).

Rapport is facilitated when patients perceive the physician as sharing similar beliefs, attitudes, and values, as caring about the patient, and as accepting the patient as a worthwhile person despite current circumstances (9). Black Americans interface with a health care system where physicians within that system, for the most part, do not share a similar cultural or ethnic background (7). For the black patient, initial rapport may be more readily accomplished when there is perceived racial similarity. Yet the importance of the physician's ethnic background is controversial (3). When ethnic differences are present, verbal and nonverbal behaviors that communicate sensitivity and concern are often the first and critical bridge to developing rapport (7).

While we cannot comment on the relevance of Dr. Duh's ethnicity in facilitating disclosure by his patient, it does appear that something in his approach may have differed from that of the physicians in the ER or CCU. It is possible that Dr. Duh's manner, and not his ethnicity, established a common ground for communication. We also agree that ethnic differences between patients and physicians should not function to justify possible avoidance of these issues because the physician experiences discomfort in transcending cultural barriers.

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## Choking Victims: Back Blows and Chest Thrusts Are Hazardous, Even Lethal

In a letter to the editor (1), Dr. William H. Montgomery of the American Heart Association (AHA) and Dr. Joseph Greensher of the American Academy of Pediatrics (AAP) provide inaccurate information in defense of their recommendation that chest thrusts be used to treat a choking infant. They state that the 1986 AHA Standards and Guidelines (2) resulting from the 1985 AHA national conference "were reviewed and approved by key individuals such as Dr. Heimlich . . . ." That statement is not true.

Dr. Montgomery, Chairperson of the 1985 AHA conference, knows through written communications to him, to editors of the *Journal of the American Medical Association*, and to the AHA that I disapproved of chest thrusts in infants and repeatedly advised that the 1986 AHA Standards and Guidelines must warn of the proven dangers of backslaps and chest thrusts. My opinion remains that excluding those facts will lead to additional injuries and deaths.

Doctors Montgomery and Greensher (1) acknowledge that chest compressions during CPR "have produced complications." They then contend that chest thrusts to relieve foreign body airway obstruction and external chest compression during CPR "are not the same and should not be compared. This is very clear to those who teach or are taught CPR and management of foreign body airway obstruction." In a letter to the editor of *Pediatrics*, June 6, 1983, Dr. Montgomery (3) made the same claim: ". . . chest compressions as performed during CPR are not chest thrusts and the comparison should not be made to mislead the reader." My response in the same issue of *Pediatrics* revealed that, according to the following quotes from the 1980 AHA Standards and Guidelines (4), chest thrusts and CPR chest compressions are identical and can be lethal:

Page 465: The hand position for an application of chest thrust is *the same as* [my emphasis] that for applying closed-chest heart compression, i.e., in the adult, the heel of the hand of the lower half of the sternum, see "Introduction" p. 453 and Frontispiece, lower panel [diagrams for chest compression as performed during CPR].