## MANAGING SUBCLINICAL HYPERTHYROIDISM

**In hypothyroid patients receiving thyroid replacement therapy,** the TSH level should be maintained in the normal range. There is probably no need to reduce the dosage in a patient whose serum TSH concentration is only slightly low (ie, 0.25–0.4 mU/L), as there may be some daily fluctuations in TSH levels, and the risks of slightly low values in otherwise-healthy patients is negligible. In addition, frequent manipulations of the dosage may complicate therapy and increase cost.

**In patients receiving suppressive treatment for thyroid cancer or benign thyroid disease,** the TSH level should be maintained between 0.1 and 0.4 mU/L, unless the patient has aggressive thyroid cancer, in which case the TSH level should be suppressed to undetectable levels (< 0.02 mU/L). In these patients, consideration should be given to the concurrent administration of cardioselective beta blockers, which have been shown to ameliorate most of the cardiac effects of subclinical hyperthyroidism.[7,8]

**Thyroid hormone therapy is the most common cause of subclinical hyperthyroidism**

**In asymptomatic patients with endogenous subclinical hyperthyroidism,** one should recheck the TSH level and also check the $T_3$ level and either the free $T_4$ level or the free $T_4$ index. If the $T_4$ and $T_3$ levels are normal, then the TSH level should be checked again in 2 to 3 months and then every 6 months. If the TSH level is persistently less than 0.1 mU/L or the patient has conditions to which small degrees of thyroid hormone excess might contribute (eg, atrial fibrillation, other atrial arrhythmias, other cardiac disorders, or accelerated bone loss), further workup and management is necessary.

Twenty-four hour radioactive iodine uptake and scanning may help differentiate between subacute thyroiditis with transient hyperthyroidism (in which the uptake is undetectable, and the natural history is characterized by spontaneous remission) vs conditions that are characterized by high radioactive iodine uptake. These latter conditions include a "hot" nodule (toxic adenoma), toxic diffuse goiter (Graves' disease), or toxic multinodular goiter. Since these latter conditions almost always persist, one should consider treating them with antithyroid medications, radioactive iodine, or surgery.

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# Understanding culture clashes in the clinical setting

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IN OUR DIVERSE SOCIETY it is not unusual for physicians to encounter patients and colleagues from a cultural, ethnic, or religious background different from their own. Such differences are often ignored or are only of passing interest when the clinical or collegial encounter is free of problems. For the most part, we assume that other people understand us and that we understand them.

However, occasionally conflict can surface in the form of a "difficult" patient, an "unreasonable" colleague, or a family member who

behaves "inappropriately." Although conflict between people is common, some conflicts can be seen as the result of cultural differences, especially if the disagreeing person's appearance, dress, or speech is different from our own.

Currently the term "culture" often includes differences of class, ethnicity, gender, religion, and relationships of power. In this article, I will focus on how cultural misunderstandings occur and how areas of potential conflict can be recognized in the clinical setting, rather than trying to list specific values of different cultures.

## UNDERSTANDING CULTURAL DIFFERENCES

While the term "culture" has been defined in a variety of ways, Carroll's[1] definition—"the logic by which I give order to the world"—is useful in the clinical setting. In this view, culture is the collection of assumptions about the world: the unexamined, "natural," common-sense premises on which we base our everyday actions and beliefs. The problem is that we each view the assumptions from our own culture as natural and commonsensical, and persons from different cultures see their assumptions as just as natural. These different "assumptions" can lead to misunderstanding or conflict.

Consider, for example, the simple act of nodding one's head up and down. If a relative of a critically ill patient nods her head up and down as the physician explains the patient's condition and a proposed treatment plan, an American physician will often assume that the relative's nodding head signifies agreement. But for persons of certain Asian background, the nodding simply indicates the relative is listening and showing respect, but does not necessarily signify agreement.[2,3]

This situation is similar to what happens in cross-cultural interactions when implicit assumptions are not shared. When a patient from a cultural background different from our own responds in an unexpected way, we may feel surprised, hurt, or angry. Likewise, the patient may experience our "unexpected" behavior as upsetting. Neither party meets the expectations of the other because they do not share the assumptions that to each are self-evident.[1]

Furthermore, because our own assumptions are self-evident to each of us, we do not question them and may not even recognize that we are making assumptions.

Instead, we attribute the conflict resulting from a cultural misunderstanding to a character flaw in the other person—the patient or family member behaves rudely, unreasonably, or inappropriately.[1]

## MEANINGS OF NONVERBAL BEHAVIOR

While cross-cultural differences in verbal behavior are often obvious, differences in nonverbal behavior frequently are misunderstood. It is helpful to try to understand some of the differences in meaning that certain behaviors may hold for the observer or participant.

### Different perceptions of space and time

Some cultural groups may have conceptions of space and time that are different from our American conceptions. The anthropologist Edward T. Hall noted that the average North American stands 22 inches from the person with whom he or she is speaking, while the average Middle Eastern person stands 9 to 10 inches away.[4] Consider what happens when the North American speaks to the Middle Easterner: the Middle Easterner moves closer in an effort to establish a kind of spatial rapport, while the American moves away as he feels the invasion of his personal space.

Likewise, time conceptions may differ cross-culturally. Being on time for a clinic appointment may not be a high priority for those whose cultures do not hold such premises as "don't waste time" or "time is money."

### Differences in the meaning of body language

American clinicians may interpret a patient's failure to make eye contact as a sign of dishonesty, shyness, or low self-esteem. However, patients from some cultures may refuse to make eye contact as a sign of respect for the

**"Difficult" patients may simply have different cultural assumptions**

professional. In addition, senses such as touch, smell, and sound are all used in communication and may be subject to a variety of cultural interpretations.[5]

A challenge for the physician is to remain nonjudgmental and to attempt to understand the meaning of the behavior when a patient's statements or actions do not conform to the physician's expectations.

## AMERICAN CULTURAL MEANINGS

We sometimes have a tendency to think of culture as something others have, especially if someone's physical appearance, dress, or speech is different from our own. These personal values and cultural assumptions are often difficult to recognize because they are our "common-sense" beliefs about the world. Many Americans share certain cultural values that shape their reactions to clinical situations. For example, Americans believe in an individual's freedom and right to make his or her own decisions. Thus, Americans become uneasy when family members of a patient from another culture want to make health care decisions for their competent adult relative or who wish to withhold information from the patient.[6]

**We may not realize a cultural "rule" was transgressed until a conflict arises**

Americans place a high value on children in our society and may be puzzled or shocked when persons from other societies do not share this value. Because of our confidence in medical technology and our ability to fight disease and death, Americans may find it difficult to discuss end-of-life issues with patients or to recognize impending death and provide comfort measures in lieu of aggressive treatment.

We often do not recognize our own underlying cultural values until they are challenged by someone from a different culture during a tense situation or a conflict. With recognition of our own values comes a more tolerant attitude toward others' values.

## WHEN CULTURES CLASH

How can we provide the best care for patients from diverse cultural backgrounds? Often we may not realize cultural "rules" have been transgressed until a conflict arises, but the following general guidelines may be helpful.

### Consider the patient's cultural beliefs about healing

An ability to listen and an openness to the patient's conception of healing is an important part of the doctor-patient relationship and essential in a cross-cultural clinical situation. For instance, are burn scars on a toddler's abdomen a sign of child abuse or a sign of a caring Asian parent who has sought medical treatment for that child within an ancient system of healing?[7]

In a multicultural environment "doing good" and "doing no harm" may require flexibility and creative thinking on the part of clinicians. In one example, such flexibility was demonstrated by transplant team members who facilitated a posttransplant patient's request to return her diseased heart to her for burial after the procedure. According to Jewish law, a limb is buried after amputation out of respect for the human body. In this case, the patient desired an immediate burial for the diseased heart.

### Respecting differences: How far should we go?

Often advocates of cultural sensitivity are thought to be advocating a form of "political correctness," where no moral judgements are made about behavior. Sensitivity to different cultures does not require us to disregard our own values in a clinical setting. Rather, clinicians need to understand how cultural differences can undermine good communication. In addition, they need to consider whether the perceived degree of harm outweighs an obligation to respect cultural differences. So how far should a clinician go in respecting these differences?

Recent media attention to clitoridectomy ("female circumcision"), a tradition in some African cultures, suggests a developing consensus that the degree of physical harm caused by this particular cultural practice makes it impermissible in our society. On the other hand, in a more common example, we can ask what detrimental social or psychological consequences might ensue from imposing our medical viewpoint on an unwilling patient with different cultural or religious beliefs. For example, could forcing a 16-year-old Jehovah's Witness to undergo a life-saving

blood transfusion result in a perception of himself as ostracized by his community?

### Avoid stereotyping

Even though some Chinese-Americans use acupuncture and traditional herbalism when they are sick, it does not follow that all Chinese-Americans do so. Likewise, not all Arabs believe in fatalism and not all Christian Scientists reject medical technology. Although physicians must be aware of the potential for cultural differences with their patients, they must also approach the patient as an individual first rather than as a member of a particular class or group. This can be accomplished by assessing the way the patient speaks about his or her illness, the relevance of religious beliefs, the role of family relationships in health care decisions, and the political and historical context of the patient's cultural group.[8] At the same time, it is important for the physician to identify personal biases and values that may affect communication with a particular patient.

### Dialogue and education

Anthropologists often say that cross-cultural understanding involves making the strange familiar and the familiar strange. As we become more familiar with aspects of a particular culture, the less strange it will seem. Our own medical culture may appear bizarre to the uninitiated. How might the proverbial Martian view the activities that occur in an intensive care unit or operating room, or interpret the way we are born and die in this society?

We can learn about other cultures in a variety of ways, such as conversing with colleagues from other cultural backgrounds who may have insight into subtle differences between American medical culture and their own. Many clinicians who search out every available article about a particular disease may not think to search out an article on the special aspects of caring for the Hmong or Gypsy patient. Yet the medical, nursing, and social science literature offers a wealth of information on most cultural groups. Cultivating openness toward and tolerance of different values, good communication skills, and a sensitivity to one's own values will help to decrease some of the tension involved in cross-cultural communications.

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