



The peacock and the doctor

Of the seven deadly sins, the worst is said to be pride, often represented in allegorical form as a peacock. In this month's *Journal*, Kelly A. Cawcutt, MD and John W. Wilson, MD (page 794), and Nizar N. Zein, MD (page 801) note the rewards and challenges of caring for international patients. Pride, it seems to me, can get in the way of a successful relationship with these patients.

In the United States, we encounter a wide range of international patients, but there are two distinct categories: medical tourists, who come here by choice and often have significant financial means, and immigrants, who come here by choice or necessity and run the gamut of economic status.

The former group generally seeks care at major academic medical centers such as Cleveland Clinic and Mayo Clinic, which have built infrastructures to accommodate them, including paying special attention to the social aspects of the visit. For the medical center, there are immediate financial gains as well as potential long-term benefits, including international networking and philanthropy.

On the other hand, new immigrants, including refugees, generally seek care as needed where they have settled, mostly hoping that medical issues will not arise in the midst of the challenges of resettlement. They deserve and should expect to be able to establish a comfortable therapeutic relationship with a physician in a local medical practice, although one likely dissimilar from what they previously encountered.

For all of these patients, the focal point of interaction is us, the physician next to the examination table. Dr. Zein emphasizes the power of empathy and how our demeanor and choice of words are critical in building the therapeutic relationship. But pride can slip in, and the peacock subtly fans his tail.

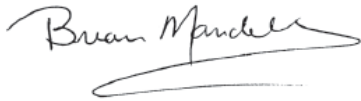
While medical practice in the United States is technologically advanced in terms of tests and procedures, we are not the world leaders in outcomes or cost-effective care. We most certainly do not have a monopoly on delivering compassionate and empathic care or forging one-on-one doctor-patient relationships. We must be careful not to express a demeaning or dismissive attitude about the care our patients' physicians provided in their home countries. That the laboratory and imaging reports are written in a different language, and perhaps reported in different units, should not imply any lower standard. We should also recognize that many of our physical examination skills have atrophied as we have come to over-rely on imaging studies. The apparent omission of an echocardiogram may in fact be an act of commission—a careful and confident physical examination may have resulted in a thoughtful decision to save the patient money. Careless words or a casually chauvinistic attitude can be disruptive to building a comfortable ongoing doctor-patient relationship.

At the same time, international patients come to see us with significant expectations (they may even have read our hospital's marketing materials). But they may not be accustomed to their physician openly expressing a lack of certainty about a diagnosis. They may never have heard their at-home doctor say, "I don't know." The concept

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of patient involvement in the treatment plan may be totally foreign and discomforting to some, while others will expect that the entire family entourage (filling the exam room) will have an active role in decision-making.

Cultural awareness is critical as we sort these issues out so they do not stand in the way of successfully caring for the patient in front of us. We should avoid being too self-confident in our entrenched approach to healthcare delivery in the exam room (as well as in the redesign of our healthcare system). The peacock can be an attractive impediment.



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