TEACHERS’ TOPICS

Enhancing Cultural Competency in a College of Pharmacy Curriculum

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The objective of this study was to describe the pedagogies used in the University of Minnesota pharmacy curriculum to improve students’ abilities to provide culturally competent care to patients. A cultural competency curriculum was introduced in fall 2003 that included a variety of pedagogies: a small group activity, case discussions, BaFa’ BaFa’ cultural simulation game, and the reading and discussion of cultural narratives. Most activities were associated with a reflective writing assignment.

In addition, preintervention survey instruments were administered to 52 entering first-professional year PharmD students in fall 2003, with 48 postintervention survey instruments administered in spring 2004, followed by evaluation of the survey findings. Based on survey results and analysis of reflective papers, students gained an appreciation for the importance of acknowledging cultural differences and understanding how to overcome the barriers that these differences present. Using a variety of effective pedagogies, pharmacy students were able to demonstrate increased understanding of and ability to provide culturally competent care.

Keywords: cultural competency, curriculum, multicultural health care

INTRODUCTION

Colleges and schools of pharmacy are responsible for educating future pharmacists to successfully care for all patients, many of whom will come from diverse cultural backgrounds. Currently, immigrants make up 11.5% of the US population, an increase from 4.7% in 1970. Further, approximately 1.5 million immigrants arrive in the United States each year.1 These immigrants bring their own culture and health care beliefs with them to the United States. In addition to new immigrants, existing minority populations also may have health beliefs that differ from those of “Western” biomedical culture, which is based on the theory that the human body is a mechanically functioning machine and that all reality can be observed and measured.2 According to the US census of 2000, approximately 30% of the population was of a race other than white, and 17.9% of the population spoke a language in their home other than English.3 In order to prepare pharmacy students for the important roles they will have, pharmacy curricula must be devoted to introducing, developing, and nurturing students’ understanding and ability to work with patients from different cultural backgrounds.4,5 Providing health care to individuals from different cultures can be challenging, but graduating pharmacy students need to be able to effectively care for patients and build strong relationships with them.

The University of Minnesota College of Pharmacy has addressed cultural competency in various formats over the last several years, but these were limited to a small portion of the curriculum within the pharmaceutical care learning center (PCLC). The PCLC is a required, 5-semester sequence that introduces students to pharmacy practice and patient-centered pharmaceutical care. The faculty members involved with the PCLC curriculum felt that improvement could be made in this area, so in the summer of 2003, they attained funding to make improvements in teaching cultural competency. A review of the pharmacy literature was conducted to determine approaches used by other pharmacy schools. Although other health care disciplines have produced much literature around the topic of culturally competent care, the pharmacy literature is greatly lacking in this area. One successful elective course at UCSF devoted to cultural competency has been thoroughly described in the literature.6 Most literature available in this area of pharmacy has only been published in abstract form.7,8

The cultural competency curriculum was previously included in the PCLC in the fall semester to introduce first-professional year students to the integral role that health care beliefs play in patient care and the diversity

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of these beliefs among various cultures. The educational activities included the reading of *The Spirit Catches You and You Fall Down,* as well as the reading of cultural case examples as a portion of a laboratory session in the PCLC. This totaled approximately 2-4 hours of classroom exposure to the topic, in addition to the hours the students spent reading the book. Although these activities were contributing to the students’ basic understanding of other cultures, more educational activities were needed to expand their ability to be empathetic and gather cultural information from individual patients.

The majority of the educational methods described were used by both campuses of the University of Minnesota (Minneapolis and Duluth), although this paper most thoroughly describes those used on the Duluth campus. In addition, the results of the student assessment survey instruments described below are limited to the Duluth students. At the start of this revision to PCLC curriculum, there were 52 students enrolled in Duluth and 116 enrolled in Minneapolis.

The objectives of the course were to describe the pedagogies used in the University of Minnesota pharmacy curriculum to improve students’ abilities to provide culturally competent care to patients. Specifically, students would be:

1. patient-centered and empathetic to a patient’s emotions and needs.
2. sensitive to patient’s culture, and able to incorporate a patient’s health care belief into the patient’s care plan.

### INSTRUCTIONAL DESIGN

During the 2003-2004 academic year, a variety of cultural competency enhancements were developed and added to the curriculum in the PCLC. Several different types of teaching strategies, such as readings, role playing, videos, case discussions, and reflective writings were employed and presented during a 2-semester sequence in the first-professional year of the pharmacy curriculum. Specific activities included reading *The Spirit Catches You and You Fall Down,* participating in a patient sensitivity activity, discussing case examples of explanatory models, participating in a cultural simulation game, viewing case examples using *Worlds Apart* videos, and reading *La Doctora.*

### The Spirit Catches You and You Fall Down

One way to improve students’ awareness of cultural differences in health beliefs was to have them read a true story illustrating these differences. By exposing the students to these examples in the literature, their sensitivity to patients of other cultures was expected to improve. *The Spirit Catches You and You Fall Down* by Anne Fadiman is the true story of a young Hmong child’s clash with the American healthcare system. The book details the struggles of the Lee family to deal with their daughter, Lia’s, epilepsy treatment in a system that is both foreign in language and in basic health beliefs. Fadiman weaves Lia’s tragic story with a running dialogue of Hmong history, culture, and beliefs. This book was chosen both for its ability to bring to light issues of cultural competency and because of its relevance to the large Hmong population in Minnesota. In the book, Fadiman also introduces the work of Arthur Kleinman. Kleinman developed a set of questions decades ago that can be used to tactfully gain insight into an individual’s health beliefs. Fadiman uses the story of Lia to illustrate how effective these questions could have been in helping the health care team to care for Lia. The students were required to read the book over the course of the fall semester, attend a 2-hour class discussion about the book (during a pharmaceutical care learning activity), and write a 3- to 4-page reflective paper addressing specific questions.

Prior to attending the class discussion session the students were also required to read a review of the book by a Hmong woman, Mai Na M. Lee, and the article “Fadiman and Beyond: the Dangers of Extrapolation” by Linda Barnes and Gregory Plotnikoff, to get a glimpse of 2 differing opinions regarding the quality of Fadiman’s book. The class discussion session included an opportunity for students to share their responses in a reflective paper, and then participate in a discussion centered on the following questions:

- Did any of Mai Na M. Lee’s book review surprise you? What was your reaction to the book review (written by a Hmong individual, posted on a Hmong website)?
- What is the point being made in “Fadiman and Beyond”? Do you agree/disagree? Why or why not? Is this important? Why/why not?

Following the discussion, students were asked to work in groups to discuss various members of the health care team caring for Lia, and answer the following:

- Was this practitioner successful in working with the Lee family? Why or why not? What criteria are you using for “success?” What examples can you give?
- How would you describe the Lee family’s medication experience?
- How do you think Lia Lee’s case would have been helped by asking Kleinman’s questions (see Table 1)?

The final Fadiman book activity, the reflective paper, asked students to address specific issues related to the interactions between the Lee family and the American
Table 1. Kleinman’s Questions*

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?


healthcare system. They were asked to describe their overall reaction to the book, its influence on their beliefs, and how the book may motivate them as they consider their future practice as pharmacists. Students were also asked to provide details on their impression of the Lee family’s experience with healthcare in America, considering issues of the success of various team members, the source of and potential solutions for Lia’s drug therapy problems,16 the major challenges the healthcare providers faced in caring for Lia, and what could have been done differently to improve Lia’s outcomes. Finally, the students were asked to address the issue of one healthcare provider that was missing in this book: what would they have done if they had been Lia’s pharmacist?

Activity for Improving Students’ Sensitivity Toward Patients

In order to maintain an open mind about cultural differences in health beliefs, the students should first understand and recognize what, if any, stereotypes and feelings of prejudice they have already internalized. In addition, they should recognize how utilizing generalized beliefs about other cultures may or may not be beneficial.

One activity in the fall semester of the PCLC sequence had been dedicated to the topic of patient/cultural sensitivity. This activity was redesigned to incorporate active and collaborative learning. Students were asked to read “Cultural Considerations in Patient Assessment,”2 which provides a good foundation of examples of differing views of health and illness. As part of this reading, students were asked to define the following terms prior to class: culture, race, ethnicity, ethnocentrism, prejudice, and stereotype. The definitions were discussed in class, with several examples of each provided. Following that discussion, students were given 5-10 minutes to record their own “culture” by defining their health beliefs and practices, family relationships, communication rules, and thoughts on health care and medication use. The students were then given published tables, each of which provided overviews of a broad range of cultures, (eg, European American, Hispanic American, etc) and some specific culture groups (eg, Italian Catholic, Norwegian Lutheran, etc).2,17 The students were asked to find a culture group to which they belonged and compare the descriptions they wrote with the generalizations made about their culture in the matrices. A matrix was created for the Somali and Hmong cultures using information from Ethnomed, a website from the University of Washington with extensive information on the health beliefs of various cultures,18 and the Hmong Homepage, a website describing beliefs and practices of the Hmong,19 to accommodate students from these cultures who were not adequately addressed in the textbook matrices. Through this collaborative learning activity, students began to recognize that the generalizations others may make about their culture may or may not be true. In addition, students recognized that differences in generations can lead to cultural changes. For example, some students felt that the descriptions of their culture published in textbooks somewhat fit their grandparents, but did not fit them personally. These realizations laid the groundwork for a discussion about the benefits and drawbacks of using generalizations when engaging in patient care activities with patients from different cultural backgrounds. It is these generalizations that can lead to stereotyping, as the generalizations may or may not be accurate.

The students were then asked as a group to create a list of characteristic beliefs they would attribute to biomedical culture (“Western” medicine) and the culture of the pharmacy profession. Students identified the pharmacy culture as being mysterious for patients (strange codes written on a piece of paper), and highly regulated, with pharmacists serving as the “gatekeepers” of medications. Characteristics of biomedical culture included a focus on measurable/observable parameters, a lack of value placed on spiritual issues, a belief in progress, and a belief that diseases are caused primarily by biological factors. Once the lists were compiled, the students were led through the first 6 questions of Kleinman’s questions (see Table 1).12 For each question, the instructor asked the group how we, as members of the biomedical culture, would answer the question compared to how the Lee family in Fadiman’s book would answer the question.9 The class session ended with a summary of the students’ thoughts on methods to accommodate patients with differing health beliefs and a brief discussion of the cultural diversity in Minnesota.
Case Examples of Explanatory Models

While the PCLC learning activity on patient sensitivity was ongoing in the learning center, a complementary lecture period was devoted to example cases and discussions on patient explanatory models. An explanatory model is a perception, or explanation of why and how a particular illness developed. Often a patient’s explanatory model is different than the biomedical model of their health care providers. Examples used in class were drawn from the literature, and from the faculty member’s personal experience. The objectives for this lecture period were to understand the variety of influences that culture can have on health care and recognize the importance of discussing a patient’s beliefs when constructing a care plan.

The 50-minute class period was spent giving 4 examples of patient cases. The cases used in the class are included in Table 2. After presenting the patient case, the students were asked to discuss possible reasons for the patients’ behavior. Student participation was strongly encouraged and each case received approximately 6-7 minutes of discussion, before the case “solution” was revealed. This timing was adequate for these concise cases. Thus, prior to learning the actual “solution,” many potential explanations for the situation were developed. The solutions included the actual reason for the patient’s unusual or unexpected behavior or clinical sign.

BaFa’ BaFa’ Cultural Simulation Game

One of the learning objectives for the students was for them to be empathetic towards their culturally diverse patients. By exposing students to a situation that may be similar to situations their patients experience, it was hoped that they would recognize the discomfort and uncertainty that can arise out of exposure to an unfamiliar culture.

The first 2-hour skills laboratory session for the PCLC in the spring semester gave students the opportunity to apply the cultural competency concepts they had learned in the fall by participating in the BaFa’ BaFa’ cultural simulation game. The game was played during 2 class sections, with 25 students in each section. After an initial briefing, the 25 students were divided into 2 cultures. The Alpha culture was a relationship-oriented, patriarchal society with strict rules governing social behaviors. The Beta culture was a highly competitive trading society that utilized a complex language system for communication. After the participants learned the rules of their culture and began living it, observers and visitors were exchanged. After each visit to the “foreign” culture, the visitors returned to their home culture and informed others of what they had experienced. This process helped the visitors build on each other’s observation of the “foreign” culture. After all participants had the opportunity to visit the “foreign” culture (approximately 1 hour) the participants were “debriefed” in a large group discussion session. During the 1-hour debriefing, the cultures were described and discussion ensued regarding stereotyping, misperception, and the personal experiences of the participants.

The game took between 60 and 90 minutes to play with 1 to 3 hours additional time required for debriefing. A minimum of 12 participants are necessary to play the game, but it works best with at least 30 participants. The game, BaFa’ BaFa’ is available from Simulation Training Systems (Educational edition, $225; Simulation Training Systems, Del Mar, Calif, www.stsintl.com).

Case Examples Using Worlds Apart Videos

Continual exposure to various examples of differences in health beliefs is important for students’ sensitivity and empathy to culturally diverse patients to continue to increase. Up until this point, examples had been given through readings and class discussions; videos were yet another means by which to reach the students.

During the spring semester, 2 more 50-minute class periods were devoted to discussion of cultural competency. These discussions were stimulated by the use of a video series entitled, Worlds Apart, A Four-Part Series on Cross-Cultural Healthcare (available from Fanlight Productions, 4196 Washington Street, Boston, Mass 02131, www.fanlight.com). The objectives for these class periods were for students to understand the uniqueness of the American culture through others’ eyes; develop a greater sense of curiosity, empathy, and respect toward patients who are culturally different; and gain a deeper understanding of the impact that can occur when cultural beliefs differ between a health care provider and patient.

One of the videos (14 minutes in length) details the story of a 63-year-old male Afghani immigrant who had been diagnosed with cancer and had surgery to remove the tumor. During a follow-up visit in which his youngest daughter served as an interpreter, the daughter did not translate to her father that there was still some cancer remaining. The patient and the rest of his family believed that the cancer had been entirely removed and he was cured. Over time, the patient learns that the cancer is still present and growing, and the subsequent decision of whether or not to pursue chemotherapy also requires the patient, his family, and the health care providers to confront cultural and communication barriers.
Table 2. Pharmacy Students’ Responses to Questions on a Survey Instrument Administered Before and After Participating in a Course on Cultural Competency

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean Pre-Response* (n = 52)</th>
<th>Mean Post-Response* (n = 48)</th>
<th>P†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I believe that it is important to understand the cultural differences that may exist in the patients I will care for.</td>
<td>4.38</td>
<td>4.60</td>
<td>0.04</td>
</tr>
<tr>
<td>2. A health care provider working with a patient from a culture different than his/her own must be able to effectively communicate (this may include use of interpreters) with the patient.</td>
<td>4.61</td>
<td>4.71</td>
<td>0.22</td>
</tr>
<tr>
<td>3. A health care provider working with a patient from a culture different than his/her own must be able to effectively communicate with the patient’s other health care providers, which may include alternative health care providers such as natural healers.</td>
<td>4.02</td>
<td>4.21</td>
<td>0.11</td>
</tr>
<tr>
<td>4. I have thought about my own health care beliefs.</td>
<td>3.71</td>
<td>4.14</td>
<td>0.0004</td>
</tr>
<tr>
<td>5. I understand my own health care beliefs, including how they were developed.</td>
<td>3.61</td>
<td>3.96</td>
<td>0.0062</td>
</tr>
<tr>
<td>6. A wide variety of health care beliefs exist within our own country.</td>
<td>4.23</td>
<td>4.67</td>
<td>0.0006</td>
</tr>
<tr>
<td>7. Health care disparities do not exist between culture groups.</td>
<td>1.75</td>
<td>1.625</td>
<td>0.199</td>
</tr>
<tr>
<td>8. In order to effectively care for patients, a practitioner needs to know the patient’s individual beliefs and cultural background.</td>
<td>3.81</td>
<td>4.27</td>
<td>0.0009</td>
</tr>
<tr>
<td>9. If cultural differences exist between the patient’s goals and the practitioner’s goals, the practitioner should not compromise, but instead persist to achieve their own goals.</td>
<td>2.27</td>
<td>2.0</td>
<td>0.034</td>
</tr>
<tr>
<td>10. Health professionals such as pharmacists should be able to successfully care for patients from diverse cultural backgrounds.</td>
<td>4.23</td>
<td>4.47</td>
<td>0.02</td>
</tr>
<tr>
<td>11. Immigrants should be integrated into their new country. ‡</td>
<td>3.38</td>
<td>3.44</td>
<td>0.78</td>
</tr>
<tr>
<td>12. Immigrants should assimilate themselves into the culture of their new country. ‡</td>
<td>2.88</td>
<td>2.92</td>
<td>0.84</td>
</tr>
<tr>
<td>13. Different cultures can be successfully blended. ‡</td>
<td>3.83</td>
<td>3.96</td>
<td>0.367</td>
</tr>
<tr>
<td>14. The color of your skin does not define your culture. ‡</td>
<td>4.42</td>
<td>4.31</td>
<td>0.406</td>
</tr>
<tr>
<td>15. Minority members of a population should conform to the customs and values of the majority. ‡</td>
<td>2.02</td>
<td>1.91</td>
<td>0.52</td>
</tr>
<tr>
<td>16. Foreigners going to live in a new country should let go of the culture of the country from which they have come. ‡</td>
<td>1.86</td>
<td>1.69</td>
<td>0.17</td>
</tr>
<tr>
<td>17. Foreigners going to live in a new country should adapt to their new country, but not necessarily change their own culture. ‡</td>
<td>4.250</td>
<td>4.25</td>
<td>1.0</td>
</tr>
<tr>
<td>18. Pharmacists need to be aware of the different cultures that exist within their practice. ‡</td>
<td>4.42</td>
<td>4.52</td>
<td>0.19</td>
</tr>
</tbody>
</table>

*Student responses based on a 5-point scale ranging from 1 = strongly disagree to 5 = strongly agree
†One-tailed student t test
‡Statements taken from Dogra N. The development and evaluation of a programme to teach cultural diversity to medical undergraduate students. Med Educ. 2001;35:232-241
This case produced discussions with/among the students on the following topics:

- How culture influences the way patients and families discuss medical information and make medical decisions
- How immigration and acculturation affects family dynamics and beliefs
- How language and communication barriers can impact patients’ decision making and their health outcomes
- How cross-cultural negotiation can be conducted to establish a patient care plan that is acceptable to both patient and health care provider

The second video (13 minutes in length) was the story of a 60-year-old Puerto Rican woman who has been living in a low-income building in New York City for the past 18 years. She has several chronic medical conditions, including diabetes, asthma, and hypertension. Her life is turned upside down when a corrupt apartment manager evicts her from her home, and she becomes depressed and unwilling to take care of herself. She is also using some home remedies to treat her medical conditions. To further complicate the case, the patient believes that her mother died from using too many medications, so she is reluctant to take multiple medications. This case produced discussions on the following topics:

- How the patient’s perspectives on chronic disease influenced her ability for self-care
- How social stressors and support networks play a critical role in patients’ health care choices
- How patient’s fears of the consequences of medication use can lead to non-adherence, as well as identifying other reasons for non-adherence
- How patient’s bring their own beliefs to their care with the use of alternative medical therapies, such as home remedies

**Reading La Doctora**

During the spring semester, the students had the opportunity to complete an optional activity to further their cultural competency skills and understanding. Twenty-one of the 52 students chose to participate in a cultural book club. The students were asked to vote for one of the following books: *La Doctora* by Linnea Smith, *The Scalpel and the Silver Bear* by Lori Arviso Alvord, or *The Dancing Healers* by Carl A. Hammerschlag. The majority of the students chose *La Doctora*.

*La Doctora* is the autobiography of Dr. Linnea Smith, who is an American physician who sets up a clinic in a rural Amazon area of Peru. She shares her multitude of experiences working in this region, from finding supplies and receiving aid from US-based service organiza-

**DISCUSSION**

Outcome data were collected on most of the individual activities, as well as for the overall impact of the activities. Students wrote reflective papers on the following experiences: *The Spirit Catches You and You Fall Down*, *BaFa’ BaFa’, Worlds Apart Videos*, and *La Doctora*. The students’ discussions during the patient sensitivity PCLC activity are recorded below. Lastly, the students completed a preintervention and postintervention survey instrument to assess the overall impact of the cultural competency curriculum.

**Reflective Papers**

Each set of reflective papers were analyzed by documenting the key themes identified by each student. These themes were grouped into broader ideas, if appropriate, and then ranked in order of most commonly occurring to least commonly occurring.

The reflective papers on *The Spirit Catches You and You Fall Down* indicated a recognition and understanding of the following concepts: the significance of the impact of cultural and language barriers on health care for both patients and practitioners, the magnitude of the emotional response of being surrounded by an unknown culture, and the importance of getting to know and embracing the diverse cultures of our patients.

In the student’s reflective papers on participating in *BaFa’ BaFa’,* several themes were observed. During the game, students reported feeling hurt, confused, and frustrated while visiting the “foreign” culture. They also noted that ethnocentrism emerged: they viewed the other group’s assigned culture negatively, and felt that their assigned
The students generated the following lists of ideas to describe biomedical culture (“Western medicine”):

- Diseases have a biological or psychological cause;
- Medications exist to treat biological and psychological diseases;
- The body is a mechanically functioning machine;
- All reality can be observed and measured;
- Decisions regarding healthcare can be made autonomously;
- Linear cause and effect relationships exist in relation to disease/health;
- Objective evidence is valued; and
- Belief in universal, unchanging, natural law.

Students expressed concern that biomedical culture often ignores the spiritual side of their patients and is not always receptive to other health belief systems (such as acupuncture as an alternative medicine practice). They also identified that a “pharmacy culture” exists in which there is a unique language (the “codes” found on prescriptions), pharmacists are seen as the “guardians” of medications, and third parties are seen as being responsible for paying for medications. Overall, the students were somewhat surprised to see the potential areas for “disconnect” between their health beliefs and the beliefs of their future patients. Students expressed their desire to be more open to differing health belief models and to attempt to accommodate patients whose beliefs may not meld well with the biomedical and pharmacy cultures.

A statistically significant difference between the pre-intervention and postintervention survey results was found in 4 areas, including (1) the importance of understanding cultural differences (question 1, \( p = 0.04 \)), one’s own health beliefs (question 4, \( p = 0.0004 \) and question 5, \( p = 0.0062 \)), and the individual patient’s beliefs, (question 8, \( p = 0.0009 \)); (2) recognizing the existence of differing health beliefs in our country (question 6, \( p = 0.0006 \)), (3) adjusting the care plan to meet the beliefs of the patient (question 9, \( p = 0.034 \)); and (4) the importance of being able to care for patients of diverse cultural backgrounds (question 10, \( p = 0.02 \)).

**SUMMARY**

By utilizing a variety of teaching techniques, first-professional year pharmacy students gained an understanding of the importance of providing culturally competent healthcare. This understanding included an appreciation of the potential dangers of unresolved cultural clashes in health care, an increased understanding...
of the variations in health care views, and an increased ability to emphasize with diverse cultures.

ACKNOWLEDGEMENTS

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Appendix 1. Case examples of explanatory models

Case Examples of Explanatory Models

Case 1*

60-year-old white Protestant grandmother is recovering from pulmonary edema secondary to atherosclerotic CV disease and chronic CHF in the hospital. Her cardiac status improved and she became asymptomatic, but began inducing vomiting and urinating frequently in her bed. She became angry when told to stop. Psychiatric consultation was requested.

Solution:

- Patient’s parents and husband were plumbers
- Patient was told that she had “water in her lungs”
- Patient’s concept of human “plumbing” differed from actual human anatomy

Case 2†

78-year-old Somali woman is being evaluated for hypertension. Her BP is 194/110 (much higher than past readings). She is currently being treated with atenolol, 50 mg daily, and hydrochlorothiazide, 25 mg daily.

Solution:

- Patient was currently recognizing Ramadan, an Islamic religious holiday during which fasting is required during daylight hours. Therefore, patient had not taken her medicines because she wanted to wait to take them with food
Case 3†
68-year-old Laotian woman suffers from an upper extremity DVT. She is hospitalized, treated with heparin and started on warfarin therapy. Her INR is in the therapeutic range (2-3) when she is discharged from the hospital. Patient is seen in the clinic 3 days after hospital discharge and her INR is >10 (exact value unmeasurable by laboratory)
Solution:
- Patient had been taking warfarin, 5 mg BID, instead of once daily as prescribed
- Because of a language barrier, she had simply misunderstood the instructions for taking the medication

Case 4*
56-year-old Tongan-American man recently diagnosed with DM Type 2, and is referred to the pharmacy for glucometer training and counseling on lifestyle, includine meal planning. At his follow-up visit 6 weeks later, glucose levels are still well above goal. Patient was not following the meal plan as recommended.
Solution:
- Patient was not familiar with some of the food choices included in the meal planning, such as bagels, turkey, and yogurt.

†Adapted from S. Westberg’s clinical experience.