Speaking for Ourselves

Lost in translation: Cultural barriers and the challenge of care

BHAVIK BANSAL

During my rotation at a large tertiary care centre in the USA, we had the opportunity to care for an African refugee who had relocated to the USA with the assistance of a charity organization. This gentleman, upon first glance, immediately conveyed the hardships of his social background. Throughout his hospitalization, he posed unique challenges that underscored the importance of cultural context in medicine, demonstrating how deviations from established norms can complicate care.

During our first visit, it was challenging to overlook his visibly frail body, exhibiting signs of severe malnutrition, along with the presence of what appeared to look like a diseased eye. He spoke only Dinka, a dialect of Swahili, a language for which we lacked readily available in-house physical interpreters. Consequently, we had to rely on a tele-interpreter, who himself appeared to be located in another part of Africa, amidst distracting background noises. This patient presented with a vague medical history, citing episodes of spontaneous nasal bleeds (epistaxis), continuous diarrhoea for months, severe wasting, and intermittent febrile episodes.

The reason he was admitted to our service was an episode of syncope and consequent deteriorating health following a planned outpatient colonoscopy as part of the evaluation for his diarrhoea. On presentation, he had mild anaemia, probably owing to his restricted diet over the recent past, but no signs of coagulopathy or overt immunodeficiency. We obtained a complete diarrhoea evaluation along with stool microscopy. The lack of prior medical history, along with his past as a refugee in a third-world country, raised suspicion for a range of infections, all the way from cryptosporidiosis to explain his diarrhoea to onchocerciasis for his eye findings. We knew we were focussing on his refugee status a bit too much, but the lack of record and the lack of establishing a proper communication precluded us from having other things to base our differential diagnosis. Chest imaging, as part of our routine evaluation, revealed concerning nodules across the middle lung lobes, prompting us to initiate isolation protocols until tuberculosis could be ruled out. Airborne isolation protocols in the USA for suspected tuberculosis were intense, a surprise given my experience in medicine at a tuberculosis-prone country like India. It included negative pressure rooms, white disposable gowns and N95 masks at all times.

Among our prime suspects were a range of infectious diarrhoea, like chronic *Giardia* infection, which can persist for several years, causing diarrhoea, particularly in malnourished individuals with limited healthcare access, and strongyloidiasis, a hyperinfection syndrome, which can present with persistent diarrhoea, malnutrition, and pulmonary involvement. We had also considered the possibility of undiagnosed coeliac disease, which could cause diarrhoea and malnutrition and could be triggered by the potentially wheat-rich food he recently had from humanitarian aid. Intestinal tuberculosis could also present as chronic diarrhoea, weight loss, and anaemia in such patients and can be notoriously difficult to diagnose. A final but deeply concerning differential diagnosis was advanced HIV/AIDS with multiple opportunistic infections. His chronic diarrhoea, lung nodules, malnutrition, and weight loss were all red flags and could suggest undiagnosed HIV with cryptosporidiosis, histoplasmosis, tuberculosis, or *Pneumocystis* pneumonia, all of which can lead to major morbidity.

During our interactions, he expressed a desire to leave against medical advice. Initially, his suspected infection prohibited discharge, but as his condition improved, discussions shifted to his capacity to make informed decisions. Capacity, as I understood it, involved 4 components: Ability to understand the information provided, to clearly communicate a choice, to appreciate the consequences of the choice and to provide a rationale for the decision. Each morning, we struggled to convey the relevance of imaging and diagnostic tests, as his primary concern remained, 'Give me medicines, get me well, and get me out of here.' We were unsure if he understood our plan, but testing before therapy seemed to be a constant wonder for him; the large, noisy machine and the painful blood pricks did not help our cause. His gestures, which may have been culturally appropriate for him, were interpreted differently (threateningly) by American standards, further complicating communication and warranting violence codes, including necessitating sedation at times. What was to be interpreted as confusion and what was just a difference in his way of thinking was a question we pondered over daily. Reflecting on my experiences working with patients in India, I recognize similar challenges stemming from cultural differences in understanding healthcare, where many individuals prioritize medication over diagnostic procedures. Just as we adapted to those realities working in small Indian villages, we needed to reconsider our own definitions of clarity and coherence when caring for patients like him.

On one occasion in the midst of our daily rounds, the patient remarked, 'I feel like I am in heaven.' His words lingered in the air, compelling me to step into his perspective. I imagined the life he had left behind, perhaps long, uncertain years in a refugee camp, where every day was a battle for survival, where food was scarce, and the future uncertain. And now, here he was, in a spacious room with pristine white walls, where trays of food arrived four times a day, and masked figures in white coats, almost angelic in their presence, stood over him, observing, caring, healing. To him, it must have felt like stepping into an entirely different realm. Each morning, we debated his orientation,

Division of Cardiology, Department of Internal Medicine, University of Texas Southwestern Medical Centre, Dallas, Texas, USA; *bhavik.bansal@utsouthwestern.edu*

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questioning whether his sense of reality was intact. But standing beside him, listening to his quiet conviction, I wondered what if he wasn't confused at all? If this place, with its warmth and certainty, was not heaven compared to what he had endured, then truly, what was? Are stories of alien abduction for experimentation inevitable, given the stark differences in circumstances and interpretations? Despite having access to interpreters and medical knowledge, navigating cultural nuances proved challenging not only in providing care but also in preserving our own well-being.

After an extensive workup, the patient was ultimately diagnosed with chronic *Giardia lamblia* infection and healed histoplasmosis. His chronic diarrhoea was due to *Giardia*, a common protozoan parasite that can persist for years and cause watery diarrhoea. The lung nodules, initially raising concerns for tuberculosis, were instead consistent with healed histoplasmosis, an opportunistic fungal infection endemic to certain parts of Africa and the Midwest in the USA. Treatment involved a 2-week course of metronidazole for *Giardia* and nutritional rehabilitation with vitamin and iron supplementation. Slowly, his diarrhoea resolved, his strength returned, and his overall condition improved significantly. Within 2 weeks, he no longer required intravenous fluids, and his albumin levels showed signs of recovery. Despite his initial reluctance to remain in the hospital, he became more cooperative as he physically improved. The social work team arranged follow-up care and food assistance to ensure his dietary restrictions were met. He was discharged in stable condition, with an outpatient plan for infectious disease, gastroenterology, and nutrition follow-up.

This patient emphasized the importance of a broad differential diagnosis in global health medicine. Missing any of the alternate differential diagnoses could have had fatal consequences. It also highlighted how cultural barriers, access to healthcare, and patient perceptions of illness play a profound role in medical decision-making. For this patient, the hospital environment was an unfamiliar, even alien experience, leading to misinterpretations of both his behaviour and our medical intentions. The challenge was not just in diagnosing him but in earning his trust, in bridging the cultural and linguistic gap, and in ensuring that whatever treatment we provided would actually reach him beyond the hospital walls. And perhaps, that is what makes medicine both the most humbling and the most humane of sciences.

Conflicts of interest. None declared