Practicing Cultural Competence
1 (one) Contact Hour

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Purpose
The purpose of this continuing education course is to provide healthcare professionals with information about cultural competence and how it applies in their practice settings.

The course includes:

- A definition of cultural competence and a cultural competence model
- Dimensions of culture and individual differences among people
- Approaches to providing culturally competent health care across the continuum of care
- Examples of cultural aspects of patient care

The course presents examples of some cultural influences on patient care frequently encountered in the U.S. Clinicians encounter many more cultures, blends of cultures, and individual variations than one course could possibly describe.

The resources section at the end of the course suggests resources for additional information.

Learning Objectives

After successful completion of this course, you will be able to:

1. Define cultural competence
2. Explain components of a Cultural Competence Model
3. Identify dimensions of culture and individual differences among people
4. Explain approaches to providing culturally competent care in phases of the patient's hospitalization experience:
    - Admission
    - Assessment
    - Treatment
    - End-of-Life Care
    - Discharge and Transfer
5. Give examples of cultural aspects in patient care situations

What is Culture?

Culture is defined as:

- The integrated pattern of human behavior that includes thought, speech, action, and artifacts and depends upon the human capacity for learning and transmitting knowledge to succeeding generations
- The customary beliefs, social norms, and material traits of a racial, religious, or social group

(Merriam-Webster Collegiate Dictionary, 2011)

In its simplest terms, culture is a way of life (Adeniran & Stamm, 2010).

This course encourages healthcare professionals to develop sensitivity to cultural differences. The course will assist you to develop an awareness of practices of some cultural groups. This knowledge may guide the assessment process, but should never lead to stereotyping or assumptions about any individual patient or colleague. Instead, approach each individual person and hear from that person about the values, beliefs, and practices that affect his care.

Take a moment for self-reflection...

What is your "culture"?

- Take a few moments and jot down the different cultural aspects of your life.
- How are you the same and how do you differ from others in those same cultural groups?
- Would others describe your culture as you do?

The Journey Towards Cultural Competence
The National Institutes of Health (NIH) define cultural competence as:

> …the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements, including personal identification, language, thoughts, communications, actions, customs, beliefs, values, and institutions that are often specific to ethnic, racial, religious, geographic, or social groups. For the provider of health information or health care, these elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients (NIH, 2015)

Cultural competence requires an organization and its personnel to:

- Value diversity
- Assess themselves
- Manage the dynamics of difference
- Acquire and institutionalize cultural knowledge
- Adapt to diversity and the cultural contexts of individuals and communities served

(AHRQ, 2010)

Diversity in the RN Workforce
Though greater diversity is developing in the RN workforce, the vast majority of RNs are white, non-Hispanic females.

The demographics of the RN population do not match the demographics of the U.S. population. This phenomenon is known as lack of concordance.

Demographic Group	% of U.S. Population	% of RN Workforce
White, non-Hispanics	67%	83%
Asian, Native Hawaiian and Pacific Islanders (non-Hispanic)	4.5%	5.8%
African Americans (non-Hispanic)	12.2%	5.4%
Hispanics/Latinos of any race	15.4%	3.6%

The percentage of men in nursing has tripled since 1970. In the most recent survey data, male RNs number 33,000 or 9.6% of the nursing workforce (National Institutes of Health, 2015).

Test yourself:
True or False: The cultural demographics of nursing team mimics the cultural demographics of the United States. There is concordance with the two populations.
False
Rationale: While the diversity among nursing is increasing, the predominant race is white, non-Hispanic women.

Individualized Cultural Assessment
First and foremost, it is important to remember that within any religious tradition, there may be a continuum of sects ranging from very conservative to quite liberal in interpreting the tenets of the faith.

In addition, each person most likely represents a blending of ethnic background, religion, generational influences, gender roles, professional roles, and other cultures in which he/she participates. These other cultural influences may include educational influences and influences related to physical or communication disabilities.

Determine what practices are important to the person, without implying a stereotype or a judgment if the person does not adhere strictly to traditions or does not choose to during hospitalization.

Clinicians can provide culturally competent care more capably when they are knowledgeable of practices and traditions common among the populations they serve. Some patients may defer to authority and decline to express their needs. The clinician's knowledge of traditions may guide the questions they ask. Individualized assessment is the cornerstone of culturally competent care.

Culture and Communication
A national survey (AHRQ, 2010) defined poor communication by responses to these questions:

- During this hospital stay, how often did doctors/nurses treat you with courtesy and respect?
- During this hospital stay, how often did doctors/nurses listen carefully to you?
- During this hospital stay, how often did doctors/nurses explain things in a way you could understand?

In addition, the survey results showed:

- 5.9% of adult hospital patients reported poor communication with nurses during their hospital stay, and 5.3% reported poor communication with doctors.
- Compared with whites, all minority groups were more likely to report poor communication with nurses.
- Blacks, American Indians and Alaska Natives, and patients of more than one race were more likely to report poor communication with doctors.
- Compared with non-Hispanic Whites, Hispanics were more likely to report poor communication with nurses but not with doctors.
- Compared with patients with at least some college education, patients with less than a high school education were more likely to report poor communication with both nurses and doctors.
- Compared with patients who speak English at home, patients who speak Spanish at home were more likely to report poor communication with nurses while patients who speak some language other than English at home were more likely to report poor communication with both nurses and doctors.
- Compared with patients ages 18-44, patients ages 45-64 were more likely to report poor communication with doctors.
- Patients age 65 and over were less likely to report poor communication with nurses.

Test yourself
In a national survey, which of the following defined poor communication?

a. How often did doctors/nurses treat you with courtesy and respect
b. How often did doctors/nurses listen carefully to you?

c. How often did doctors/nurses explain things in a way you could understand?
d. All of the above
e. None of the above

Rationale: A survey by the AHRQ in 2010 reported that 5.9% of adult patients reported poor communication with the nurses and 5.3% with physicians based on the way nurses and physicians listened and explained their actions; and treated them with respect and courtesy.

A Transcultural Assessment Model

Before a healthcare worker can accurately assess a patient's cultural needs, information must be gathered about the patient cultural perspectives. The Giger and Davidhizar Transcultural Assessment Model is one way to gather the necessary data for a culturally competent assessment (Giger & Davidhizar, 2004).

Biological Variations
- Appearance
- Genetics

Space
- Personal space
- Modesty
- Response to provider touch

Time
- Rigid adherence to "time-by-clock" versus looser time perception

Environmental Control
- Fatalism versus self-determination
- Access to care
- View of health and illness
- Use of traditional treatments or remedies

Social Organization
- Fatalistic versus individualistic
- Religion
- Gender power differences
- Who makes the decisions?
- Who makes the healthcare decisions?

Communication
- Verbal
- Direct versus indirect style
- Agreement to show respect?
- Nonverbal: eye contact, gestures, body posture

Take a moment for self-reflection...

Assess yourself using the Giger & Davidhizar model.
Awareness of one's own cultural influences is a key step on the journey to cultural competence.
- How do you describe yourself on these dimensions of culture?
- Return to the previous slide for more specific details associated with each attribute.
- Increase your awareness by writing your responses.

Joint Commission Recommendations

The Joint Commission (2010) recommends specific practices to improve effectiveness of communication, cultural competence, and patient and family-centered care during phases of the care

continuum:

- Admission
- Assessment
- Treatment
- End-of-Life Care
- Discharge and Transfer

Cultural Competence: Admission Process

The Joint Commission recommends the following actions during the admission process:

- Inform patients of their rights.
- Each healthcare organization has a patient rights policy. Translate those policy statements into examples that have meaning for the patient population on your unit.
- Identify the patient's preferred language for discussing healthcare.
- Identify whether the patient has a sensory or communication need.
- Determine whether the patient needs assistance completing admission forms.
- Collect patient race and ethnicity data in the medical record.
- Patients may refuse to give the information. The intent is to assist a healthcare organization in describing the demographics of the population it serves so that the organization can develop appropriate services more effectively.
- Identify if the patient uses any assistive devices.
- Ask the patient if there are any additional needs that may affect his or her care.
- Communicate information about unique patient needs to the care team.

(TJC, 2010, p. 5)

Personalizing Admission to the Unit

How to personalize admission to the unit:

- Introduce yourself with the name you wish the patient to call you and your role in his care.
- Ask the patient for the name she prefers you use when addressing her. Some patients, and particularly those who identify as transgender, may prefer to be addressed by a name other than the legal name on the medical record.
- Ask the patient what cultural, religious, or spiritual beliefs or practices may influence care. Nurses assure patients' privacy and limit exposure of their bodies to the minimum necessary for care. In addition, some cultures and religions interpret touching, personal space/distance, and modesty in specific ways and with specific restrictions depending upon the gender or age of the person with whom one is interacting. Use your knowledge of cultural groups your organization frequently serves to focus more specifically on the patient's possible preferences.
- Identify any specific days of religious observance, times of day, or dietary practices that healthcare providers should respect whenever possible in planning care.
- For optimal safety, the patient needs access to whatever assistive devices he uses: glasses, hearing aid, mobility aids, reaching devices, or other aids.

Many patients prefer to be addressed formally as Mrs., Mr., Reverend, or other honorific title with the last name. The family name is a source of pride.

The Patient's Comprehension: Key to Safe Care

Important statistics:

- Nearly 9% of the US population has limited English proficiency (LEP) for healthcare

purposes according to the U.S. Census Bureau, 2007.

- Over 40% of adults have significant literacy challenges and 88% of adults have less than "proficient" health literacy skills (White & Dillow, 2005).

a. The patient may be reluctant to admit language or literacy limitations. The stress of illness and hospitalization may interfere with comprehension of complex medical information regardless of language skills.

- Ask the patient to repeat back to you his understanding of information you communicate.
- Avoid "Do you understand?" Instead ask the patient to explain.
- Use simple terms and when possible models or diagrams to facilitate understanding.
- Ask whether the patient needs assistance with any written information, such as signage, patient-oriented literature, menus, or other written communication.
- Obtain language assistance services when needed. For optimal safety, TJC (2010) and National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001) recommend that consent forms be available in the patient's preferred language rather than sight-translated and using a certified language interpreter is preferred over relying on a member of the patient's family. In some situations, an interpreter of the same gender might be most effective, such as when the genitals or other sensitive subjects need to be discussed.

Test Yourself:
You suspect that your patient does not understand his/her diagnosis due to his/her healthcare language illiteracy. To determine if the patient understands what you have provided education on, you: (indicate all that apply)

a. Get an interpreter if English is the second language
b. Ask the patient to tell you what he/she learned
c. Assume he/she understands as he/she is nodding in response to your teaching
d. Ask the 12 year-old child to interpret for you

Rationale: Obtain language assistance services when needed. For optimal safety, TJC (2010) and National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001) recommend that consent forms be available in the patient's preferred language rather than sight-translated and using a certified language interpreter is preferred over relying on a member of the patient's family. In some situations, an interpreter of the same gender might be most effective, such as when the genitals or other sensitive subjects need to be discussed.

Health Literacy
Health literacy:

- The degree to which one can understand and make decisions based on health information.

Low health literacy constitutes a significant barrier for many individuals - not only when they enter the healthcare system for care, but also when they attempt to obtain insurance coverage. Many persons who became eligible for coverage under the Patient Protection and Affordable Care Act (ACA) encounter difficulties in understanding their options and selecting the coverage most useful for them.

The Institute of Medicine is focusing attention on opportunities to improve health literacy (IOM, 2011).

Languages in the USA
The main languages by number of speakers older than five years of age:

Languages in the USA
2007 US Census Data

English - 215 million	**Vietnamese** - 1.01 million	**French Creole** - 450,000 (Mostly Louisiana Creole French - 334,500)
Spanish - 28 million	**Korean** - 890,000	**Greek** - 370,000
Chinese languages - 2.0 million + (Mostly Cantonese speakers, with a growing group of Mandarin speakers)	**Russian** - 710,000	**Hindi** - 320,000
French - 1.6 million	**Polish** - 670,000	**Persian** - 310,000
German - 1.4 million (High German) + German dialects like Hutterite German, Texas German, Pennsylvania German and Plautdietsch	**Arabic** - 610,000	**Urdu** - 260,000
Italian - 1.3 million	**Portuguese** - 560,000	**Gujarati** - 240,000
Tagalog - 1.4 million + (Most Filipinos may also know other Philippine languages, e.g. Ilokano, Pangasinan, Bikol languages, and Visayan languages)	**Japanese** - 450,000	**Armenian** - 220,000

Additionally, some estimates indicate that American Sign Language is spoken by as many as 2 million Americans.

Communication
When you first meet the patient, establishing an effective means of communication takes priority. Previous slides have identified the important considerations of preferred language, literacy, health literacy, sight, and hearing.

Cultural factors also play a role in establishing effective communication. In some cultures, looking another person directly in the eye indicates disrespect; particularly if the other person is an authority figure.

In some cultures, discussion of bodily functions with a person of the opposite gender is taboo.

When a patient nods in response to communication it may be a sign of respect rather than comprehension or agreement.

Personal space, volume, and emotional expression in communication vary greatly among cultural groups. Some cultural groups rely on nonverbal communication, rather than using words.

Chinese ranks third among languages spoken in the U.S. after English and Spanish. Approximately 50% of Chinese persons in the U.S. speak Chinese at home and speak English poorly (Barnes & Bennett, 2002).

Social Customs: Admission Process
During admission to the unit, you and the patient are establishing some ground rules for your relationship and the patient's relationship with other members of the team. During this process you have an opportunity to gain insight into family influences that may affect care.

Many cultures de-emphasize the individualistic and autonomous orientation and make decisions as a family. In some cultures, a particular person, such as the eldest son, may assume duties of care and protection for his parents. Although a person other than the patient may be involved in the decision-making process, it is important to gather information from the patient without a family member present, particularly about potentially sensitive topics and culturally prohibited practices.

Family members may wish to protect the patient from disturbing information such as a poor prognosis. This value conflicts with clinicians' value of the patient's right to know pertinent information. Consultation with an ethics committee may be needed to resolve this conflict.

Most cultures greatly revere elderly persons.

Gender Roles: A Hispanic Example
The male role often described as ***machismo*** implies manliness and the expectation that a man be physically strong, unafraid, and the authority figure in the family; with the obligation to protect and provide for his family.

The female role, ***marianismo***, refers to a woman who is self-sacrificing, religious, runs the household and raises the children.

Motherhood is an important goal for women in Latino culture. A mother is expected to sacrifice for her children, take care of elderly relatives, and care for the sick; even during hospitalization.

Although acculturation and employment opportunities have affected these gender roles they still persist, especially in low income families.

In a study of strong marriages, men and women shared decision-making in the family and placed their own relationship and nuclear family before the extended family. However, men and women each played a different role in family life.

Couples in the study talked through issues until they came to an agreement. One man stated, "You just talk and talk until you come to a decision." Of the participants in the study, men and women were likely to have traditional roles, with the man providing the income for the family and the woman providing for the care of the children and the home.

Sensitivity in Introductions
Make no assumptions about a patient's sexual orientation or gender identification. When the patient gives you this information, do not assume that the patient is also giving you permission to share this information with others who do not need the information to care for the patient.

Some gay and lesbian people; and particularly older persons, may be very sensitive about the possibility of being "outed," or making their sexual preference known to others. Respect transgender patients by using appropriate pronouns for their gender expression, or simply use their preferred name. Ask the patient to clarify terms or behaviors with which you are unfamiliar. When in doubt, ask!

(Ambrose & Ladewski, 2005).

Introduce yourself with your name and role; not only to the patient, but to visitors. This will invite others to introduce themselves and their roles in relation to the patient. However, if a visitor does not respond, clarify with the patient what role others play and whether the patient wishes specific other persons to receive information about the plan of care.

Never assume that a particular person is the patient's partner or spouse unless the patient informs you that this is the case.

Think it Through….
You are interviewing a patient who is dressed in a masculine fashion and gives "Dana" as the preferred name while speaking in a very deep voice. Upon assessment, you notice that "Dana" is female, despite your first impressions that Dana is male.

- What is your first inclination? Is Dana female or a male in a female body?
- Would you be able to make that determination without further discussion with Dana?
- Would you reveal your findings to the medical team?
- How would you reconcile your feelings regarding transgender patients?

Religious Practices in the Admission Process
Prayer and religious medals play a role in protecting health and healing in many religious traditions. Many find comfort and support in their spiritual beliefs, view God as responsible for healing, and health professionals as God's instruments.

Find out from the patient whether any specific religious beliefs and practices have implications during hospitalization.

Eastern Religions
The principles and philosophy of Confucianism, Buddhism, and Taoism influence many traditions of the Chinese and other Asian people.

Confucian principles

- Emphasize respect for the elderly and people in authority. Maintaining harmonious relationships is the key to life. (Andeniran & Stamm, 2010) The 5 most important characteristics are: benevolence, righteousness, loyalty, filial piety, and virtue (Chen, 2001).

Buddhist principles

- Embrace 3 main values: **mercy**, **thriftiness** and **humility**. Fate and cause-and-effect determine health because when people do good, they are peaceful, which in turn helps promote good health through karma. A person receives good fortune for doing right and bad fortune for doing wrong (Lai & Sunrood, 2009).

Taoism

- Emphasizes selflessness and emotional calm - the need for human beings to be in harmony with nature. Because nature provides the elements needed for life, outdoor exercise gives peace of mind and outside air. To achieve good health, a person must adjust to fit in with the natural rhythm of the universe (Lai & Sunrood, 2009).

Islam: the World's Fastest Growing Religion

- Islam is the second-largest and fastest-growing religion in the world. A large number of

> Muslims in the United States are African American and Asian. Of the roughly one-third of Muslim Americans who are native-born, the majority are converts and African American (Pew Forum on Religion and Public Life, 2008).

Muslims in the U.S. responding to a survey identified themselves as:

- 37% white
- 24% black
- 20% Asian
- 15% "other/mixed race"
- 4% Latino

(Pew Research Center for the People and the Press, 2007)

Muslims face Mecca when they pray which is northeast when one is in the U.S. When death is imminent, a Muslim practice is to turn the patient's face toward Mecca.

Muslim prayer requires a quiet environment. Some Sunni Muslims (90% of traditional Muslims) pray 5 times per day. Shiite Muslims (10% of traditional Muslims) pray 3 times per day. There are also a number of smaller Muslim sects. Traditionally they pray on the floor. However, during illness they may pray in bed. Predestination is a part of traditional Muslim beliefs. Exceptions from traditional practices may be permitted during pregnancy, breastfeeding, illness, or travel, but many Muslims observe the practices regardless of permitted exemptions.

The Jewish Culture

Judaism is one of the world's oldest religions, and was the first major one to recognize one god rather than multiple gods. Judaism has been practiced for thousands of years and eventually gave rise to Christianity and then Islam. As an ethnic group Jews originated in the Middle East several thousand years ago, but throughout history have dispersed across Europe, Asia, and Africa due to political upheavals, war, and ethnic cleansing.

Jews are one of the smallest but most active minority populations in the U.S. Those of European origin are called Ashkenazi Jews, while those of Middle Eastern or non-European origin are called Sephardic Jews. Individual Jews vary greatly from one another in the degree to which they practice cultural and religious traditions (University of Northern Iowa, National Institutes of Health. (n.d.)).

Most Jews observe the autumn holidays of Rosh Hashanah and Yom Kippur. Some may observe particular practices on the Sabbath, extending from sundown on Friday until sundown on Saturday

Health and Medical Practices

People in many cultures believe that nature and spiritual forces play a role in health and illness. Home remedies are popular among Asians, Hispanics, African Americans, Native Americans and others. Some may delay seeking healthcare while trying homeopathic approaches.

American Indian/Alaskan Native persons have a strong sense of family, extended family, community, and connectedness with history. Native Americans have practiced many healing rituals for centuries.

Members of some cultures may be distrustful and skeptical of the healthcare system; particularly persons who have experienced discrimination or learned of a history of discrimination from their

elders. African Americans, Native Americans, and Japanese Americans may be particularly distrustful due to past governmental policies, but any individual may have experiences or attitudes that create suspicion of Western medicine.

Many LGBT persons avoid or delay care or receive inappropriate or inferior care because of perceived or real homophobia, biphobia, transphobia, and discrimination by healthcare providers and institutions (Levitt, 2012).

Suspicions combined with lack of health insurance may cause individuals to delay care and rely on home remedies.

In some cultures, such as Muslim and Mexican, plumpness may be an ideal body type, so that overweight or obese status may not be viewed as a health problem. Asian Indians however, consider overeating to be a threat to longevity.

Members of some cultures do not consult mental health professionals, but keep such concerns within the family. Some may look down on people who have mental health concerns.

Test your knowledge:
True or False: Suspicions regarding healthcare systems, inappropriate or inferior care, lack of insurance, and beliefs in homeopathic/healing rituals often delay medical care.
True
Rationale:
Suspicions combined with lack of health insurance may cause individuals to delay care and rely on home remedies. People in many cultures believe that nature and spiritual forces play a role in health and illness.

Skepticism about the Healthcare System
African-American attitudes may be influenced by a history of discrimination and also of the infamous Tuskegee Experiment which recruited African-American men with syphilis. Researchers promised, but never gave, treatment. This history may lead to a distrust of the healthcare system and experimental approaches, particularly when health professionals encountered are other than African American. Elders are likely to be especially sensitive to any indication of disrespect and suspicious of healthcare personnel because of their personal experiences of discrimination (Campinha-Bacote, 2008).

Native Americans have persevered to survive repeated governmental policies of extermination and genocide. The culture greatly reveres history and elders which keep the history of discrimination well within the awareness of recent generations.

Chinese Medicine
Modern Chinese medicine combines traditional Chinese medicine and Western medicine. Based on Taoism, traditional Chinese medicine includes the mind and spirit as well as the physical body. Treatments include the use of medical herbs, acupuncture, diet, animal secretions and organs, massage to stimulate blood flow and skin scraping to re-enforce body force. A practitioner of traditional Chinese medicine makes diagnoses by observing a patient’s pulse and tongue (Wade, 2007).

Ch’i is energy that flows freely through the organs via 12 main channels when a person is healthy. Disease results when flow of ch’i is obstructed. For example, a cerebrovascular accident may result

from the obstruction of ch'i at a point of vital energy flow in the body (Bowman & Hui, 2000).

The forces of yin and yang work together for harmony. The yin represents the female, cold and negative force. The yang represents the male, hot and positive force. The yin-yang forces are dynamic and complementary. One force cannot exist without the other and an imbalance produces illness. If a patient believes her disease occurred from too much cold, or yin, she may not want to eat food that falls into the cold classification such as cold drinks, fruit, most vegetables and soy products. Generally, foods high in protein, calories and fat are classified as hot. The temperature of food does not determine its classification as hot or cold (Bowman & Hui, 2000).

Wu-hsing associates the five most important organs of the body with five elements of nature. These five elements determine the functions of other parts of the body. Interaction of these five elements represents a productive and conquest cycle. Traditional Chinese medicinal interactions between the body organs and interactions with environmental factors, such as weather and the seasons, affect the human body and emotions (Bowman & Hui, 2000).

Ayruveda Medicine

In Asian Indian culture, Ayruveda medicine is practiced. Ayruveda approaches define causes, remedies, and dietary treatments for a variety of common health problems including fever, headache, common cold, stomachache, diarrhea, constipation, arthritis and joint pains. Plant products are components of Ayruveda remedies.

Ayruveda medicine espouses beliefs similar to the Chinese medicine concepts of balance and of hot and cold as factors in health in illness, based in Hindu beliefs (Bhungalia, Kelly, Van De Keift, & Young, 2000).

Dietary Factors in the Admission Process

During the admission process, inquire about dietary practices and food preferences. Your healthcare organization may not offer a wide variety of choices, or the patient's diet may be restricted as a part of the plan of care. A nutritionist may assist in helping the patient make choices and also assess the potential effects of any foods which family members may bring to the patient.

Many Chinese people and Asian Indian people maintain a vegetarian diet, or consume only small amounts of meat. The hot and cold food classifications associated with yin and yang may also affect food preferences.

During Ramadan, the 9th month of the Islamic calendar, Muslims fast from daybreak until sunset. Observant Muslims may eat only Halal food, food that is humanely slaughtered and blessed, which is similar to Kosher Jewish food.

Jewish patients may follow all, some, or none of the dietary laws related to kosher foods, separation of dairy products from meat and avoidance of certain foods, such as pork. Assess each individual without making assumptions.

Communicating Findings within the Team

During the admission process, you gather important information that can facilitate patient-centered care. However, ALL members of the healthcare team who participate in the patient's care need ready access to this information.

Healthcare organizations employ various methods in the medical record, in signage, symbols,

identification bands, and other means to identify specific needs and risks for patients.

While it is the responsibility of the organization to assure availability of these methods for communicating among staff, staff members must commit to using them.

Patients become frustrated when they find they need to explain the same information to each staff member with whom they interact. A patient may feel disrespected after having given information about cultural practices to a staff member, especially if other staff members fail to act on the information.

Cultural Competence: Patient Assessment
Cultural competence during patient assessment involves the following actions:

- Identify and address patient communication needs
- Begin the patient-provider relationship with an introduction
- Support the patient's ability to understand and act on health information
- Identify and address patient mobility needs
- Identify patient cultural, religious, or spiritual beliefs or practices
- Identify patient dietary needs or restrictions
- Ask the patient to identify a support person
- Communicate information about unique patient needs to the care team

TJC, 2010, p. 5

Assessment
Cultural expressions of pain and attitude toward pain relief vary greatly. Persons of some cultures may suffer stoically and reject the consciousness-altering effects of some analgesic medications. Other cultures have traditions of unrestrained expression of feelings and sensations.

Some patients may resist asking for pain medication out of fear of being disrespectful to those in authority. They may also underestimate pain levels on a scale for fear of receiving too much pain medication.

All patients deserve privacy and exposure of the body only as needed for care. Modesty is a particularly important value in some cultures, such as the Muslim culture. Some Hispanic persons are particularly sensitive about exposing the area between the waist and knees to a person of the opposite gender.

Muslims believe mind-altering substances interfere with a spiritual form of cleanliness and may therefore be rejected; however, morphine is permitted as a part of medical treatment. Non-pharmacological pain relief methods may be indicated.

Skin Assessment
Assessment often involves skin color, such as for pallor, cyanosis, and assessment related to pressure ulcers.

When assessing dark-skinned persons, the recommended practice is to establish a baseline for an

individual's skin color through consultation with family members if possible (Campinha-Bacote, 2009).

Recommendations for assessing skin variations (Purnell & Paulanka, 2003) include:

- Establish a baseline color
- Use direct sunlight, if possible
- Observe areas with the least amount of pigment
- Palpate for rashes
- Compare skin in corresponding areas

The normal color for the lips of some black persons has a bluish-tinge. For dark-skinned persons, pallor may have an ashen coloration; for lighter-skinned black persons, it may appear as a yellowish color.

Cultural Competence: Treatment of the Patient
Cultural competence during treatment of the patient involves the following actions:

- Address patient communication needs
- Monitor changes in the patient's communication status
- Involve patients and families in patient care
- Tailor the informed consent process to meet patient needs
- Provide patient education that meets patient needs
- Address patient mobility needs
- Accommodate patient cultural, religious, or spiritual beliefs and practices
- Monitor changes in dietary needs or restrictions
- Ask the patient to choose a support person
- Communicate information about unique patient needs to the care team

TJC, 2010, p. 5

Think it Through...
Did one of your patients ever use terms unfamiliar to you to describe health-related practices, such as home remedies, bowel habits, or dietary habits?

- If so, how did you clarify the meaning for yourself?
  - How did your approach affect your relationship with your patient?
  - Were any of the practices threatening the patient's health? If so, how did you raise concerns?
- If not, what questions might you ask to respectfully find out what the patient is talking about?

Respecting Cultural Factors: Treatment Plan
In some cultures family members; particularly a man's wife in Hispanic culture, may find it important to show concern by pampering and caring for the patient (Fernandez & Fernandez, 2005). At times, care by family members may interfere with the plan of care if they intervene to discourage prescribed activities which may be difficult or painful for the patient (ambulation, deep breathing and coughing).

Speak with your patient and family members together to explain the critical nature of certain activities to recovery. If you perceive that a language barrier is interfering with communication, secure the services of a certified interpreter. Reinforce the explanation throughout the hospital stay and affirm progress toward engaging in the activities that prevent complications and promote recovery. Gain cooperation from other involved team members, such as a Physical Therapist, in reinforcing the message.

Help the patient's family members to identify ways in which they might "pamper" the patient without impeding his recovery. Family members might walk with the patient in the corridor or hold a supportive pillow over an incision during deep breathing and coughing.

Ethnopharmacology

- Studies the way in which members of different ethnic backgrounds may respond differently to specific medications.

Studies in ethnopharmacology have found that African Americans metabolize many medications differently from other ethnic groups.

These medications include antihypertensives, antipsychotics, and other medications. Overmedication may result even when administering "normal" dosages (Campina-Bacote, 2009).

Culturally-sensitive Treatment: Childbirth Experience

In some cultures, new mothers remain at home for a period of time, for a month or slightly longer. This practice is common among the Chinese, Muslims, Hispanics, and others.

During the period of confinement, Chinese women may avoid cold foods and drinks, wind and water, and any other cold substance. They also may avoid physical work and abstain from certain pleasurable activities, such as sex. Some Chinese women are also prohibited from bathing or washing their hair for a defined period after childbirth (Fok, 1996).

In the Muslim culture, breastfeeding and circumcision are traditional practices though circumcision may be delayed. In the event of stillbirth or neonatal death; taking mementos such as a footprint or lock of hair may be considered desecration.

During the intrapartum period, a Hispanic woman's mother often attends her. The father may decline presence at delivery and see the mother and baby only after both are clean and dressed. Hispanics may believe that babies are weak and susceptible to an envious glance ("the evil eye"), such as an admiring glance or a compliment. Touching the person while giving the compliment neutralizes the power of the evil eye. The evil eye causes misfortune. Staring at a person may also invoke the evil eye.

Pregnancy and Childbirth: Asian Indian Culture

In traditional Asian Indian culture, rituals at specific times during pregnancy are conducted to protect mother and baby from evil spirits.

After birth, the mother is not told the gender of the child until the placenta is delivered. Males are preferred and the belief is that the mother may be so upset by the birth of a girl, that uterine contractions may be inhibited, delaying delivery of the placenta. After delivery of the placenta, the mother sees the baby first, then the father and other family members.

Cultural Sensitivity: Patient Care
Modesty and respect, important values for all patients, are specially emphasized in some cultures. To show sensitivity to the value of modesty always ask permission, explain the need to uncover, and limit exposure to the greatest extent possible.

Many cultures place high value upon visiting the sick. Family members may visit in large groups at one time.

Cleanliness is a very important value for Muslims. Many Muslim patients, both male and female, use a squeeze bottle for perineal cleansing after urination or bowel movements (Pavlovich-Danis & Kahn, 2009).

Cultural Competence: End-of-Life Care
Cultural competence during end-of-life care involves the following actions:

- Address patient communication needs
- Monitor changes in the patient's communication status
- Involve the patient's surrogate decision-maker and family
- Address patient mobility needs
- Identify patient cultural, religious, or spiritual beliefs and practices
- Make sure the patient has access to his or her chosen support person

TJC, 2010, p. 5

Chinese culture

- In Chinese culture, death and dying are taboo subjects, causing bad luck. Many Chinese people wish to die at home in the main hall of the house, symbolically enabling the deceased to join ancestors (Hsu, O'Connor, & Lee, 2009). Families may also believe that patients who die with a full stomach die a good death. The full stomach supports the long journey to reincarnation. Those who starve to death are considered cursed as a result of wickedness that occurred in a previous life (Hsiung & Ferrans, 2007).

Muslim culture

- In traditional Muslim culture, when death is imminent, the dying person's head is turned to face Mecca, a northeast direction in the U.S. A same-gender family member performs post mortem care which includes washing the body with running water and covering it in a white shroud. Make gloves available for the family member and encourage use of gloves if infectious material or blood is present. The family may arrange for the post mortem ritual to be performed at a funeral home. Burial occurs within 24 hours after death.

Asian Indian culture

- In Asian Indian traditions, only family members touch the body after death. If the family observes this practice, healthcare staff should touch the body as little as possible. As in traditional Muslim culture, a family member of the same gender as the deceased cleans the body after death. After washing the body, the family member wraps the body in a red cloth.

Cultural Competence: Discharge and Transfer

Cultural competence during discharge and transfer involves the following actions:

- Address patient communication needs
- Engage patients and families in discharge and transfer planning and instruction
- Provide discharge instruction that meets patient needs
- Identify follow-up providers who can meet unique patient needs

TJC, 2010, p. 5

Culturally-Sensitive Discharge Plans
With shortened hospital stays, compliance with the follow-up plan of care becomes very important. Members of some cultures do not place a high value on timeliness. Many aspects of care after discharge involve a time element, such as medication administration.

African American and Hispanic cultures are particularly associated with a relaxed sense of time and lack of punctuality. However, any individual, regardless of cultural background, may have a history of habitually rejecting time requirements or arriving late for appointments.

Tactfully encourage the patient to maintain prescribed times for medications or other treatments and to keep follow-up appointments in a timely manner, especially for those appointments that will require rescheduling if the patient does not appear on time. Stress the importance of the specifics of follow-up care and how compliance will support full recovery and prevent complications.

Researchers have documented the ***Strong Black Woman*** (SBW) script as linked to women's daily life management and health experiences. (Black & Peacock, 2011).

Researchers identified the themes:

- Self-sacrificial role management (''please the masses'')
- Emotional suppression (''game face'')
- Postponement of self-care (''last on the list'')

The SBW script may create a barrier to self-care, preventive care, and compliance with a plan of care. An African American woman healthcare professional may be effective in facilitating compliance and adherence.

Screening and preventive measures are not necessarily sought or valued in all cultures. Identify specific benefits for the individual to encourage compliance.

Home remedies play an important role in many cultures. In non-judgmental fashion, encourage the patient and family to tell you about remedies that they rely on or plan to use.

Assure that none of these plans create a risk for interaction with medication or interfere with other aspects of care. Once these plans have been investigated, there is no reason to advise against use of any practice if it does not interfere with care or create risk. However, if home remedies create risks, it is critical that the patient understands what specific problems may arise if contraindicated home remedies are used.

Culture: Discharge Teaching
In some cultures, the male plays a dominant role in all matters outside of running the household and caring for children (Skoarand, Hatch, & Singh, 2005). For some female patients, a male relative's commitment to the plan of care may be important in assuring adherence. Ask the patient who else should receive discharge information in order to assist the patient to follow through with post-hospital care.

Some cultures, such as the Asian Indian and Jewish cultures, place great value upon education. Regardless of cultural background, some individuals are more interested than others in the plan of care and the evidence that supports it. Because of the availability of healthcare information on the internet, patients may have considerable information and misinformation related to aspects of their healthcare.

Prepare to engage in a dialogue with patients about the plan of care post-discharge. Rather than a one-way communication to the patient, elicit the patient's views, questions, source of information, and perspectives that may influence that patient's adherence to the plan of care.

Cultural Sensitivity: Adherence
Healthcare professionals may present one-size-fits-all discharge plans to patients. But regardless of how agreeable the patient may appear when receiving the plan, the patient will not make a commitment to initial compliance to ongoing adherence if the plan conflicts with strongly held beliefs or with economic priorities (Brown-Riggs, 2011).

Ideally, a culturally-sensitive care process during hospitalization will have resulted in a plan for care after discharge that has considered cultural and economic factors, leading to a plan which the patient accepts and follows. Unfortunately, this is often not what happens.

Explore the discharge plan with the patient to identify cultural and economic implications. If cultural and economic factors interfere, the patient may reject the plan altogether. But some modification and priority setting may permit the patient to comply and adhere to the most significant aspects of the plan for his own situation.

"Adherence to a medication or a treatment regimen is usually less than 50 percent. But that figure is further exacerbated when there are cultural variations" (Kagawa-Singer in Chen, 2009).

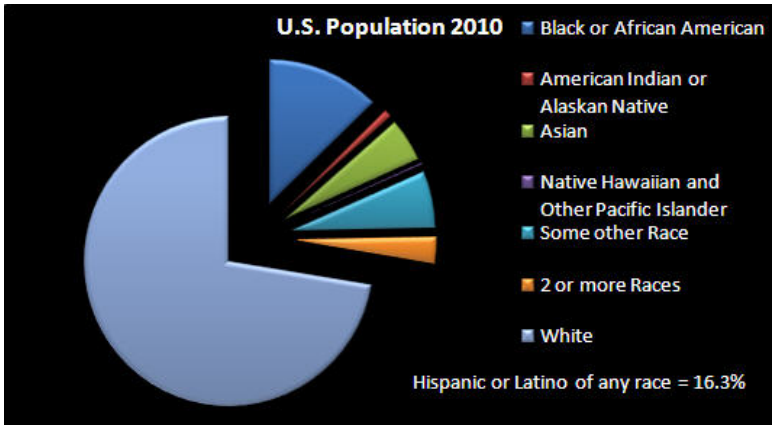
A social worker may assist in identifying resources to meet economic healthcare needs.
Case Study:
A traditional Apache female has been hospitalized for diabetes. She is overweight, eats traditional foods, drinks alcohol on a daily basis, and lives alone on the reservation. Her children, living off the reservation, educated in traditional city schools and are married to Anglo spouses have come to visit with the intention of bringing their mother to one of their homes to live.

What cultures are represented here?
Do you anticipate any collision of beliefs?
How can you educate the patient and the adult children regarding home care and poor outcome prevention?
What if the patient does not want to leave the reservations?
What are her priorities?

Knowing the answers to these and many other questions can help ensure that the type of education

given to all parties will help the patient adhere to her treatment regime.

2010 U.S. Census Data



Think it Through...
The 2010 U.S. Census Data is available at the U.S. Census website. The website below will take you to a page from which you can select any state in the U.S. and view selected census data about the state, including racial composition, age, and gender of the population.

www.census.gov

Go to the website and click the link for your state.

- What do the demographic data for your state imply for patient care in your healthcare organization?
- Do you believe you are well informed about cultural practices and healthcare challenges of the ethnic and age groups in your region?
- What sources can you identify to enhance your knowledge of the cultural groups which your healthcare organization serves?

Specific Culturally-related Health Risks
Low Socio-economic Status: Regardless of ethnic background, persons who live in poverty or have limited financial resources experience poorer health outcomes. Factors that increase their risk include low income, stressful life conditions, lack of access to care, and negating health behaviors.

African Americans experience poorer health outcomes as compared with other ethnic groups. Blacks suffer disproportionately from decreased life expectancy, and increased rates of: heart disease, hypertension, infant mortality and morbidity; cancer; HIV/AIDS; violence; type 2 diabetes mellitus, and asthma.

American Indian and Alaskan Native (AIAN) adults are more likely to have poorer health, unmet medical needs due to cost, diabetes, trouble hearing, activity limitations, and to have experienced feelings of psychological distress in the past 30 days. The AIAN adults are more likely to be current smokers and current drinkers compared with other adults (Barnes, et al, 2010). The infant death rate is almost double that of whites (Office of Minority Health & Health Disparities, 2006).

Asian persons have a higher incidence of hepatitis B infection, liver cancer and cirrhosis than other ethnic groups. In general, Asians living in the U.S. are among the healthiest populations.

Hispanics living in the U.S. are almost twice as likely to die from diabetes as are non-Hispanic whites. Hispanics also have higher rates of tuberculosis, high blood pressure, and obesity than non-Hispanic whites. There are differences among Hispanic populations as well. For example, whereas the rate of low birth weight infants is lower for the total Hispanic population compared with that of whites, Puerto Ricans have a low birth weight rate that is 50 percent higher than the rate for whites (Office of Minority Health & Health Disparities, 2006).

Test Yourself:
Factors that increase the risk of poor health outcomes include which of the following. (Choose all that apply):

a. **Lack of access to care**
b. **Stress**
c. Low cost medications
d. **Low income**
e. Clinics readily available

Rationale: Regardless of ethnic background, persons who live in poverty or have limited financial resources experience poorer health outcomes. Factors that increase their risk include low income, stressful life conditions, lack of access to care, and negating health behaviors.

Diabetes in the AI/AN Population
American Indians and Alaska Natives have the highest age-adjusted prevalence of diabetes among all U.S. racial and ethnic groups, where diabetes is four to eight times more common than in the general population.

Studies have demonstrated that prevention and treatment efforts of the federally-funded Special Diabetes Program for Indians (SPDI) have contributed to significant reductions in diabetes complications in these targeted populations (ADA, 2010).

Visit the websites of the American Diabetes Association and the Indian Health Service for further information and resources.

Specific Culturally-related Health Risks
In India, prevalent problems include malaria, respiratory infections such as tuberculosis and pneumonia, and a host of communicable diseases. Hypertension and cardiovascular disease, rheumatic heart disease, nutritional deficits, and high risk behavior such as alcoholism and cigarette smoking are also common. Poor dental health is also a problem. Sickle-cell disease is prevalent. Prostitution is common and HIV infection is a growing problem. Although Asian Indians who have immigrated to the U.S. may experience better health, they also may travel regularly to India, resulting in exposure to infection.

Jewish people have an increased incidence of cancer (Lynch, Rubinstein, & Locker, 2004) especially breast, ovarian, colorectal, and pancreatic cancer. Genetic diseases also affect Jewish people, including Bloom's Syndrome characterized by photosensitivity and elevated dark red blotches on the skin, growth deficiency, reduced resistance to infectious diseases, and increased susceptibility to tumors; Canavan's Disease (CD) an inherited, degenerative brain disorder; Crohn's disease; Gaucher disease Type 1, the most prevalent Jewish genetic disease, in which the body cannot break down a

lipid called glucocerebroside. Symptoms may include anemia, fatigue, easy bruising and a tendency to bleed, enlarged spleen and liver, bone pain, degeneration and fractures, and neurologic problems such as compression of the spinal cord; Niemann-Pick Type A disease a severe neurodegenerative disorder of infancy (About.com, 2011).

Lesbian, Gay, Bisexual, and Transgender (LGBT) persons may be subject to discrimination, harassment, and isolation leading to depression, stress, and anxiety. Many increase use of tobacco and other substances to cope. GBT men smoke 50% more than other men and LBT women smoke 200% more than other women (Gay and Lesbian Medical Association, 2006).

EAR

The acronym ***EAR*** serves as a reminder for healthcare professionals in building skill in cultural competence.

- **E**xpect differences
- **A**ccept differences
- **R**espect differences

Conclusion

In this course, you learned:

- A definition of cultural competence
- Components of a cultural competence model
- Dimensions of culture and individual differences among people
- Approaches to providing culturally competent care in phases of the patient's hospitalization experience
- Cultural aspects of example patient care situations

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Recommended Resources

General Cultural Competence Resources

The Joint Commission website posts cultural competence resources as a part of its patient safety initiative http://www.jointcommission.org

The Manager's Electronic Resource Center (ERC), produced by Management Sciences for Health, Inc. posts The Provider's Guide to Quality and Culture which contains information about health disparities, cultural groups, and extensive additional resources. http://erc.msh.org/mainpage.cfm?file=9.1.htm&module=provider&language=English

National Council on Interpreting in Healthcare provides information about healthcare interpreters. http://www.ncihc.org

The website of Transcultural Nursing offers a variety of resources including links to other resources. http://www.culturediversity.org/index.html

USDHHS Office of Minority Health website provides information about health disparities and U.S. government resources and programs to support minority health. http://raceandhealth.hhs.gov/

Resources Pertinent to Specific Cultural Groups

Curriculum in Ethnogeriatrics offered by Stanford University contains modules specific to the aged population in several different cultures http://www.stanford.edu/group/ethnoger/

EthnoMed, a website sponsored by the University of Washington, contains information about cultural beliefs, medical issues and related topics pertinent to the health care of immigrants to Seattle or the US. Multilanguage patient education materials are also available. http://ethnomed.org/

The Gay and Lesbian Medical Association posts information and resources concerning gay, lesbian, bisexual, and transgender health and health-related issues. http://www.glma.org/

The Indian Health Service, an agency of USDHHS contains information related to American Indian Health Services and has a section related specifically to diabetes in the American Indian population. www.ihs.gov

Medline Plus, a National Library of Medicine, resource offers information about health specific to gay, lesbian, bisexual, and transgender persons. http://www.nlm.nih.gov/medlineplus/gaylesbianandtransgenderhealth.html

National Library of Medicine resource re: American Indian Health.

http://americanindianhealth.nlm.nih.gov/people.html

Please Read
IMPORTANT INFORMATION: