We Cannot Allow
Cultural Barriers
To Limit Our Ability
To Meet The Needs
Of
Our Customers

Cultural Competency & Cultural Diversity

For Health Care Providers

Provided By:
Pima Health System

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The Mission of Pima Health System

To improve the quality of life for the Community and the people Pima Health System services through an integrated system of health and social services

Commitment of Pima Health System

To provide quality health care services to members without regard to race, sex, age, religion, national origin, genetic information, sexual orientation, physical or mental disability, source of payment, life style or limited English proficiency.

Pima Health System's Goal

Our goal is to achieve and help support a better understanding of culturally diverse populations within the health care system, to appreciate and respect individual differences, to eliminate racial & ethnic disparities that promote effective interactions between the Client and Health Care Provider for positive outcomes.

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Origin

The Civil Rights Act of 1964, Title IV and its supporting regulation seek to ensure no person is subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal funding. On August 30, 2000 the Office of Civil Rights clarified the responsibilities of providers of health and social services who receive Federal Financial Assistance from the U.S. Department of Health; providers must take adequate steps to ensure such persons receive free of charge the oral and written language assistance necessary to afford them meaningful access to services. The policy guidance specifically states that the use of family members or friends as interpreters is not considered an adequate means of guaranteeing access.

The steps taken by a covered entity must ensure the Limited English Proficiency Person (LEP) is given adequate information, is able to understand the services and benefits available, and to receive those in which eligible. The covered entity must also ensure that the LEP person can effectively communicate the relevant circumstances of their situation to the service provider.

What is Cultural Competence?

Cultural Competence refers to values, skills, attitudes, and behaviors that bring strength to organizations for effective cross-cultural work environments.

It is awareness and knowledge of the health related beliefs, customs, practices, religion, social economics, sexual orientation, education, disabilities, and form of communication of clients and their families.

It is the ability to incorporate these differences to improve services, increase community awareness, and adapt Health services to fit the cultural diversity of the community served.

Where does Cultural Competence begin?

Cultural Competence begins with an honest "self assessment" and "self awareness" that does not allow biases, prejudices, negative assumptions or stereotypes to keep us from treating every person with respect.

We need to be aware of our own personal attitudes, beliefs, biases, and behaviors, besides our values as medical providers, that conscientiously or unconscientiously influence our interactions and the care of patients, our working relationships with colleagues and others persons from diverse backgrounds.

We must constantly challenge ourselves to be aware of our inner level of cultural competence, to understand and break down barriers in efforts to provide continuing quality health care.

It is through a committed understanding and a continuum of learning that we can become empowered to help eliminate racial and ethnic disparities in health care.

Disparities in Health Care

In 2002 a publication by the Institute of Medicine reported that racial and ethnic minorities received lower quality care than non-minorities, even if patients carried insurance and had an income. The study committee found that stereotyping, biases, and uncertainty of the provider attributed to unequal treatment.

Patients may not seek medical care for fear of being culturally misunderstood or disrespected, and may not adhere to medical interventions because they do not understand or do not trust the provider.

Providers may order fewer diagnostic tests because they do not understand the patient's symptoms, or they order more tests to compensate for not understanding what the patient is saying.

Health Care Providers must understand the beliefs that form a patients attitude toward health and illness. They must be aware of the patient's healing traditions & practices as health care interventions must be accepted to be successful.

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Organizations

Organizations have the responsibility to comply with Federal, State, and Local regulations regarding cultural diversity of communities and client's served. They should develop systems that ensure delivery of culturally competent health services to diverse cultures in their community, including participation of Limited English speaking ability. Organizations must meet the needs of the patients they serve.

Being aware of cultural differences and improving communication reduces risk for Health Care Providers for liability and malpractice claims due to negligence, absence of informed consent, and failure to understand their patients health care beliefs & practices.

Guidelines for Providing Culturally Competent Care

- Be aware of our own personal biases, attitudes, prejudices, behaviors and beliefs that influence us conscientiously or unconscientiously.
- Be aware of providers and the health care systems barriers to care.
- Become familiar with the cultural groups that you see in your practice.
- Develop basic understanding that will build trust and credibility with the patient.
- Learn from observation of your patients, i.e., languages they speak, family interactions, behaviors, if greeting is formal or not formal, eye contact, body language, etc.
- Avoid stereotyping. Information about cultural groups is to help better understand the patients we serve, but it is important to individualize the medical interventions to the patient and family.
- Welcome use of traditional beliefs and health practices in treatment plan.
- Find out the patients own traditional health beliefs and practices.
- Hire diverse staff that can communicate with patients effectively.
- Have interpreter services in place and available as needed.
- Have health care information available in different languages to meet the need of the cultural groups served.
- Keep a current list of community services available to give to patients.
- Be aware that people from different countries or regions in a country may have different beliefs, health practices, and specific health issues.
- Limit the use of facial expressions and gestures as they may confuse the patient and be interpreted differently.
- Listen. Be understanding & non judgmental. Be patient and empathetic.
- Obtain a Cultural Assessment that will help provide information regarding the patient cultural beliefs.
- Consider the patients preference of a provider of the same gender due to cultural beliefs.

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Relocation of Refugees and Immigrants to the U.S.

Many immigrants and refugees have come to the United States for many reasons: better economic opportunities, education, safety from violent torn countries, persecution, terror, and possible torture or imprisonment. They may be depressed from the feelings of despair, isolation, and loss of family left behind. Many are disappointed that they face new obstacles in the U.S; different from the perceptions of the new life they envisioned.

Stages of Adjustment

- Euphoria
- Negativity
- Gradual Adjustment
- Biculturalism

The time in each phase will vary per individual and some will remain in the negativity or adjustment phase for years, and others may never adjust. Children and others that adjust quickly move into the Biculturalism stage which may cause intergenerational cultural conflict and stress.

Common Beliefs and Cultural Practices

Folk Medicine and Traditional treatment is still used by many individuals. Folk Medicine and Traditional treatments may be used alone or concurrent with modern health care.

Health Care Providers need to be aware and sensitive of the impact that Folk or Traditional medicines have on patient's health care in order to provide appropriate treatment.

It is important not to stereo-type a patient from a specific cultural group as they may not follow traditional beliefs.

For patients using traditional medicine the word ETHNIC can be a symbolic aid for Health Care Providers eliciting information from patients

E -xplanation — Why do you think you may have the problem?
Do you know anyone that has had or now has this kind of problem? What does it do to you?
What do you call your illness?
Have you heard about this problem?
What are your concerns? What do you fear?

T –reatment — What home remedies or other medicines have you tried?
What kind of treatment are you seeking from me?
Explore social and family context, money issues, family support, and ability to read label directions.

H –ealers — Have you sought advice from healers or anyone else who are not doctors? What did they tell you? What did they do for you?

N –egotiate — Try to find solutions that incorporate patient beliefs. Set realistic goals.
What kind of treatment do you think you need?

I –ntervention — Decide on an intervention with your patient and with the family support that incorporates alternative treatment, i.e. spiritual, healers, religion, and other cultural practices.

C –ollaboration — Coordination of care with family, healers, health care team, and community resources.

Patient

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Patient Cultural Assessment Tool

To have a better understanding of the patient's medical history, cultural beliefs and health practices, these questions may be helpful in obtaining pertinent information.

1. Where were you born?
2. What cultural group do you feel connected with?
3. Where have you lived and when?
4. How does your culture view birth? Death?
5. Who are the healers or health care providers in your culture?
6. Do you have a preference if your Health Care Provider is male or female? Younger or older than you?
7. How does your culture view aging? Do elderly have certain roles?
8. How is modesty expressed by men and women?
9. What parts of your body are you modest about?
10. How can we respect your privacy?
11. Is your culture generally reserved or expressive?
12. What languages do you speak?
13. What language do you prefer to use to communicate with me?
14. Would you like an interpreter?
15. Are you comfortable with eye contact?
16. Do you prefer a provider from your culture?
17. Are there religious practices to help in your health? How is your religion involved when you are ill? Are there special rites or blessings?
18. Do you eat certain foods to keep healthy? Do you abstain from certain foods?
19. Do you drink alcohol?
20. Do you change your diet for religious purposes?
21. How does your culture view people with mental illness?
22. Who is the most important person in your family? Who makes most of the health care decisions?
23. Who is the principal wage earner? Are there other sources of support?
24. Do you prefer to read and write in another language other than English?
25. Are there specific genetic or acquired medical conditions in your culture?

Guidelines for Using Interpreters

It is recommended that qualified trained medical interpreters be used as they have the ability to communicate a more accurate message.

Qualified Medical Interpreters have the skills to work in a health care setting. They have basic knowledge of medical terms, diseases, anatomy & physiology, and procedures in specialty areas.

Qualified Interpreters know the language, culture, common beliefs and practices for specific cultural groups.

It is not recommended that children, family members, friends, or non medical staff be interpreters. Family members and informal interpreters are more likely to interject their own opinions and modify what the patient actually said.

The following are useful pointers when working with Interpreters:

- Allow enough time for interpreted visits without interruptions.
- The interpreter should be the same sex as the patient.
- Brief the Interpreter on any background needed for understanding.
- Limit use of gestures and facial expressions as the patient may be confused by them and interpret them differently.
- Speak in a normal clear tone of voice.
- Ask one question at a time.
- The Patient, Interpreter, and Health Care provider should sit as to form a triangle for better verbal and visual communication.
- Address the patient, not the interpreter.
- Be prepared to repeat yourself in different words if you are not understood.
- Expect the Interpreter to interrupt if needed for clarification.
- Speak in short simple sentences. Do not use jargon or technical words.
- Dealing with the patient's cultural differences and personality are the health care provider responsibility, not the interpreters.
- Remember if the patient has problems grasping concepts and your way of thinking; you will have the same problem grasping theirs.
- Only in emergencies and when necessary a non professional interpreter should be used.
- Ask for patient feedback to ensure understanding when appropriate.
- Remember the interpreter is there to facilitate communication between the health care provider and patient.
- Listen, be patient and understanding. Do not stereotype.

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Blinking – in
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Hugging – In
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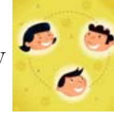
Cultural Differences with Non-Verbal Communication

Various forms of non-verbal communication have different connotations in different cultures. Examples:



Smiling – demonstrates happiness in most cultures. Chinese may smile when sad or uncomfortable.

Winking – In some Latin cultures winking is romantic or a sexual gesture. Chinese may consider it to be rude and in Nigeria, Yorubas may wink at their children for them to leave the room.

Blinking – in Hong Cong blinking conspicuously may be a sign of disrespect or boredom.

Pointing - some Filipinos may point by shifting their eyes to the object or pursing their lips to point, but do not use their hands. Some Venezuelans may use their lips as pointing with their finger is impolite. Many Chinese and people from India use the entire hand to point as pointing with a finger is rude.

Shaking hands –in some cultures shaking hands between the opposite sex is acceptable. In certain African countries generally persons of the same sex shake hands and those of the opposite sex do not touch. In the Middle East and some cultures in Africa the left hand is used for bodily hygiene and is not used to shake hands or eat with, as it is considered unclean. In Arab countries it is not uncommon to see male friends holding hands. Women from India will shake hands with a female but not a male and a western woman should not offer her hand to men in India.

Eye contact – in certain cultures failure to have direct eye contact may mean the person is distrustful or suspicious. In Somalia and with Vietnamese direct eye contact is considered rude. In Ghana for children to look at adults in the eye is defiance. Not to look at Chinese in the eye is considered respectful.

Kissing – in some cultures the opposite sex may kiss on the mouth or cheek, and it is unacceptable for men to kiss if not family. Bosnian males may kiss on each cheek and Congo-Brazzaville men may kiss each other on the cheek when meeting.

Hugging – In certain cultures embracing is common behavior. Latin American males may embrace as females do.

Cultural Differences with Non-Verbal Communication

Touch – Vietnamese consider it inappropriate to touch a persons head as it's considered the center of the soul. Elders may touch a child's head.

People from Latin America and Eastern Europe find it acceptable to touch an arm of someone they just met. Asians prefer less contact. In other cultures it may indicate affection to touch someone.

Space – Standing close may seem rude in one culture but appropriate in another. Latin's will sit or stand in close proximately to a person they do not know. Middle Easterners are comfortable to stand close when talking. Some Muslin women may find it uncomfortable for a male to be too close.

Pain – in some cultures to cry and show pain is a sign of weakness. It is more appropriate to be stoic and suffer.

Posture – In many cultures poor posture is disrespectful. Showing the bottom of ones dirty shoes is impolite. In Argentina standing with hands on the hips may indicate anger.

Hand Gestures – A "Thumbs up" in Iran is a vulgar connotation. The **"**OK" sign with index finger and thumb touching is a sign **for** money in Japan. In other countries like France, Belgium, Italy, Greece, and Portugal it means "zero", but in some Eastern European cultures it is offensive indicating a bodily orifice. In Latin America a shrug with palms up may be a vulgar gesture and in Columbia tapping fingers on the underside of the elbow indicates stinginess.

Time – There are cultures that place less importance and have less of a perception of being on time. Yet, they place importance of spending time on social interactions and relationships. These countries include; Saudi Arabia, Egypt, Mexico, and the Philippines. In contrast, the United States and western culture is structured, and one is expected to be on time.

Nodding of the Head – Certain cultures, like the U.S., nodding of one's head may indicate agreement. In Asian culture, where harmony is important, the nodding of one's head does not mean they agree.

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Family Involvement

In many cultures the patient's health problems are also the family's problems. Their support of the treatment plan is important for patient compliance.

Caution must be taken when involving family members as it can be culturally unacceptable to discuss medical issues in front of the opposite sex

If permitted by the patient the family can offer pertinent information and insight regarding the patient's medical issues, cultural beliefs, alternative medicine, etc.

In certain cultures, family members may take on different roles, i.e. a spouse may speak for his wife, and husbands may be excluded from childbirth

Understanding Cultures Served by PHS

Please be advised that this is basic information; not a comprehensive review of each culture, and does not intend in any way to stereotype these cultural groups.

Remember, each patient must be considered on an individual basis.

- **Hispanic American Culture**

  Hispanic culture includes people from Cuba, Mexico, Spain, Puerto Rico, South America, and Dominican Republic.

  Family Involvement—Family and friends are very important. Children are loved and valued. Grandparents are well respected. Elderly will usually move in with the oldest child when they are unable to live on their own, as nursing homes are not thought of. Respect and formality are important to older adults. They prefer not being addressed by their first names as this indicates lack of respect. In elderly dementia or memory loss may be described as Locura (craziness) or Nervios (nerves).

  Birth – the expectant mother may prefer to have a female relative, usually their mothers in the delivery room, rather than the husband. With cross cultural middle class couples the expectant father may wish to be present for the birth. (Newly immigrated expectant mothers may have high anxiety especially in the perception to experiencing considerable pain and little control.)

- **Hispanic American Culture**

Birth - Delivery and post natal care is usually provided by a Mid-wife or partera. Female family members will provide care and support to the mother and newborn for the post-natal period or la cuarentena (40-41 days) which traditionally during this time the mother and newborn remain at home. In addition the female family members prepare meals and care for the husband and other children as well.

Dying – The priest will give the Sacrament of the Sick; this includes confession and communion. If the person has expired the priest will come and anoint the deceased. The family wants to protect the patient from knowledge of terminal illness, with a strong belief in mind – body connection that worry will worsen progress. Seriousness of the illness may be handled by an older family member. Religious medallions and rosary are to be with the patient. They believe the illness is "God's Will or punishment and their strong religious beliefs, prayer, and devotion to Saints may bring healing. Curanderos (healers), herbal medicine, and the hot and cold theory may be practiced.

Death – The majority of Hispanics are Roman Catholic. Immediate family usually meets with a priest to discuss funeral services that include a wake with a rosary prayer and mass. After the Mass of Burial, family and friends follow in procession to the cemetery for the burial. Expressions of grief are encouraged. Family and friends will gather at the family home after the burial to eat and celebrate the deceased life. The one month and yearly anniversary of the death is celebrated with a mass.

- **African American Culture**

Family Involvement – Family is close and affectionate. Friendship is valued. The father is usually the decision maker. Older parents live with and are cared for by family members. Elderly are respected for their insight and wisdom. They are usually formally addressed as Mr. or Mrs. The Grandmother usually becomes the main resource for financial support and caring for grandchildren.

Birth – Varies with health care education of individuals. Traditionally only females were in attendance.

Dying – Prefer to have family conference, or talk to family elder or minister. Patient may have oldest relative selectively reveal poor prognosis.

- **African American Culture**

Dying – Prejudice and distrust of the medical professional causes poor acceptance of their diagnosis and leads to inappropriate treatment. Organ donation is seldom considered due to religious beliefs. Strong spiritual beliefs in "God" and church networks are used for coping and healing. Elderly may choose not to complete an Advance Directive if there is bad feelings with any of their children. HIPAA Regulations may become an issue as they find it disrespectful to ask someone to leave the room, without first asking the patient.

Death – A Pastor and Funeral Director assists in preparation of the service. A wake as "Home-Going" to Jesus is celebrated with music and hymns. A funeral service with the religious faith of church observances is followed by a burial. Many African - Americans mourn by dressing in white as a sign of resurrection. They may believe in the living dead whose spirits live in the memories and thoughts of those still living and will help those that die cross to the next world. A gathering of family and friends at the home of the deceased to offer support and share a meal is celebrated after the wake and burial. Grief may be expressed with great physical emotion. Cremation is less common.

- **American Native Culture**

Family Involvement – Family is supportive and plays an important role in decision making. Tribe members look to Tribe Elders for wisdom and advice.

Birth – Practices vary with tribe. Some may have a female relative be a birth attendant in a normal delivery. Expectant fathers being present for the delivery and ritual practices will also vary with each tribe.

Dying – Many believe that Medicine People have the ability to heal through ceremonies with prayer and spiritual powers given by ancestors. Different tribes perform different ceremonies but all believe in the Creator that centers on the natural world; the earth, animals, trees, and the natural spirit. Some religious ceremonies rid the body of impurities. A "sweat" is performed to provide spiritual and physical cleansing. Many tribes have traditions and beliefs against disposal of the body parts including hair. The belief is they may never rest.

Death – Many follow both Christianity and traditional religious beliefs. The Spiritual leader leads the funeral service. Some tribes call for their ancestors to come help the deceased transition over, and that the person's spirit never dies. The person's spirit may be associated with a particular facet of nature.

- **American Native Culture**

  Death – Family may wish to be left alone to prepare the body for burial. In some tribes pipes are smoked at the gravesites and significance to burying people with symbolic reference to a circle. In certain tribe cultures the family will take the body home to be cleaned and dressed to spend the last night on earth, and for visitation.

- **Somali Culture**

  Family Involvement – consists of family and clan group and traditionally lives in multi households. The father is usually the decision maker and in his absence it becomes the responsibility of the older male relative. Children are highly valued and a women's status is based on the number of children she has. Elders are respected and have an active role.

  Birth - Somali women marry early and start a family shortly after. They have a strong network of women for support. Traditional birth attendees assist with the delivery. Birth attendees have had training with an experienced midwife. Traditionally the expectant father is not present at birth, but this is now changing in the U.S.

  Dying – Somalis view dying as a religious experience as salvation. It is considered uncaring to discuss the terminal illness with the person. The family is to be told, and they will tell the patient if they feel it is necessary depending on the seriousness of their illness.

  Death –When death is imminent a special portion of the Koran is read, called Yasin, at the bedside. At death a skeik of the same sex as the deceased is called to prepare the body. They will clean, perfume, and place it in white clothing.

- **Russian Culture**

  Russian culture may include people from Russia, Ukraine, Bashkir, and Chuvash.

  Family Involvement – Rely on close network of family, friends, and co-workers. They are very caring and share what they have. 90% of women are in the work force, take on most of the responsibility at home, and are very nurturing.

  Birth – Traditionally the expectant father is not in the delivery room, only a close female family member. The new mother is expected to rest for 15 days and is taken care of by female relatives.

- **Russian Cultur**

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- **Asian Culture**

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  Death – Famili
  Amulets and clot

- **Russian Culture**

Dying – It is preferred that the family be informed first of the terminal illness and they will decide whether to tell the patient. The family prefers the patient to be at peace and not worry about their illness.

Death - Depending on the religion some family members prefer to wash the body and put special clothes on the deceased. They believe the body is sacred and do not believe in organ donation or autopsy.

- **Asian Culture**

Asian cultures include people from China, Korea, Vietnam, Japan, Philippines, Asian Indians, and Pakistan.

Family Involvement – Extended family are very important. Elders are well respected, "Filial Piety" to honor parents, and are integrated within the family. Caring for aging parents is written in civil code. It is not uncommon for two to three generations to live in the same household**.** Many foreign born have come to the U.S. as elders not only having to deal with a new way of life and disappointment, but the intrinsicties of a modern health care system. Older people are consulted in decision making for important family matters.

Birth – Usually female family members are present during birth. The expectant father and other males do not play an active role.

Dying – Many Asians believe in the balance between Yin and Yang (complimentary opposites within a greater whole that may manifest more strongly in different objects or different times) it is the primary guideline of traditional Chinese medicine. Asians practice preventative care with use of herbal medicine, acupuncture, cupping therapy, yoga, and Tai Chi, as they believe western medicine is too harsh. Korean's believe in Naikan Therapy of reflection, goodness, and love. Filipino's believe in "Hilot" a massage healer. Dementia by Asian cultures may be considered a form of "Madness", "Loss of Soul", or "Possession by the Spirits" that will bring shame and stigma to the family. Family prefers to be involved when information is addressed regarding a terminal illness. Usually the eldest male of the family should be present. Family may not want to talk about the terminal illness and prefer the patient not know. Belief in "Fatalism" if you talk about it; it may happen.

Death – Families may prefer to bathe their family member after death. Amulets and cloth may be placed on the body.

➢ **Asian Culture - Continued**

Other Practices – In certain Asian cultures it is customary to remove ones shoes at the door since they eat, sit, or sleep on the floor. Socks should be worn as bare feet are considered offensive.

➢ **Arab Culture**

Arab culture includes people from Algeria, Bahrain, Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Sired, Tunisia, United Arab Emirates, and Yemen

Family Involvement – Family loyalty, honor and respect are very important. Fathers and elders dominate the family. The father has the first and last word. Male children are favored as they are expected to care for their parents, and daughters will marry to belong to their husband's family. Large families are common as they bring economic relief and a father's prestige of virility. Women are typically subordinate to men, but to which degree, varies within different Arab countries. Women usually have control in the home and over the children. Amulets are worn for various reasons for protection from the "evil eye"

Birth - The father does not participate and only female family members are present during labor and birth. The mother will only accept a female doctor and staff to assist. Due to modesty the mother prefers to be clothed during labor and the delivery. A woman's first birth is viewed as initiation into womanhood. A mother is greatly valued and per tradition of the Prophet Muhammad "heaven is underneath the feet of woman"

Dying – It is important not to bypass the elder figure as hierarchy has significant value. Prior funeral arrangements are considered interference of the person's passing and God's will. A provider that suggests making prior funeral arrangements is viewed by the family as incompetent. A religious belief is that fate is controlled by the will of God. Arabs may be of Muslim, Christian, or Jewish faith.

Death – Death is viewed as having returned to God. Belief that the person's life is sealed and they will go forward to afterlife for judgment. The body is cleaned, perfumed, and dressed in a white garment by the family. It is preferred the body be buried the same day or as close as possible to the day of death. Autopsies and cosmetics are usually refused.

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Family Involvement – Immediate and extended family are a priority for all, but most important, are the children that are adorned and spoiled. Relationships between parents and children may be stronger, than between spouses. Children are raised to follow tradition and rules. Politeness and respect is given to higher positions in the hierarchy. Traditionally the Iranian culture was patriarchal with the father making all the decisions, being the bread winner, while the wife stayed at home to raise the children. With the more modern classes many of these traditions have begun to change. Family connection is for influence, power, position, and security.

Birth – Is viewed as a blessing. Traditionally marriage was for procreation. Having boys was preferred over girls. The gender of newborns would decide the status of the mother in the household, if there was more than one wife. Only females are present during birth. With modern times these traditions are changing. Expectant father's are involved and present in the birthing experience, and female family members are present for support. Women may demonstrate varying degrees of crying and pain; for the more suffering the greater gift they will receive from their husband, especially if the baby is a boy.

Dying – It is uncaring to tell the patient of their terminal illness, but it is acceptable to inform the family. It is important to respect and speak to the higher position in the hierarchy of the family. The dying person is placed in a comfortable position facing Mecca. A few drops of spiritual water are placed in their mouth to bless the dying person. Friends and family will gather around to pray.

Death – The time of death is very important, unless the death occurs late evening or night, the body will be prepared for a daylight burial within several hours to 24 hours. The body will be washed, purified, perfumed, and wrapped in a white cloth (kafan) by someone of the same sex. If death occurs late evening on, candles and lights will be burned around the body to protect it from evil spirits that attack the dead. Specific hymns and prayers are recited by the friends and family. If segregation of sexes is still practiced, women may not attend the funeral of male relatives. Black is worn by family members for forty days to a year until an elder changes colors, indicating the mourning period has ended. It is important to keep in mind that the different Iranian religions may have varying traditions and rituals. Modern Iranian's, especially those living outside Iran may have acquired new practices from the old traditions.

Social Groups Have Their Own Culture

We need to become more sensitive to the differences of culture with respect to various ethnic and racial populations.

We also must keep in mind that other social groups of different religions, sexual orientation, disabilities, socio economic status, education, military status, just to mention a few, bring with them their own culture and health issues.

Two social groups that will be discussed further are Disabilities and Sexual Orientation.

Disabilities

There are over 650 million people throughout the world with some form of emotional, mental, or physical disability. One in five (5) people has a disability either when born, through illness or accidents, and those developed with age. Everyone regardless of race or ethnicities will experience a disability sometime in their life. The World Health Organization describes disability as "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure, an activity limitation is a difficulty encountered by an individual executing a task or action, while a participation restriction is a problem experienced by an individual in involvement in life situations".

Wheelchairs, walkers, crutches, etc. were symbols for disabilities, but many people with disabilities do not depend on this type of equipment. There are "Invisible" illnesses that have no outward signs to others. The person may look normal and well, but may have a psychiatric, neurological, chronic pain, digestive disease, or autoimmune illness. Forms of Invisible illnesses are pain, muscle weakness, cognitive impairment, vertigo, depression, anxiety, impaired vision or hearing, poor tolerance to sitting or standing, frequent need to use the bathroom, alcohol & drug addiction, headaches, allergy intolerance, and difficulty communicating with others.

Most persons with disabilities can, and will work, play, learn, and enjoy healthy lives. Disabilities make it harder to take part in normal daily activities, it does not mean **unable,** only that extra time or help may be needed.

Persons with disabilities are as healthy as anyone else; however they are at greater risk for developing health issues related to their disability. The same kind of disability can affect each person differently, but even though all disabilities are different to the individual that experiences them; the challenge and effort are similar.

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The American Disability Act (ADA) was enacted to guarantee equal opportunity for people with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications. The law prohibits discrimination against individuals with disabilities.

The Center for Disease Control and Prevention has made the following suggestions for health care providers in caring for individuals with disabilities:

- See the whole person, not just the disability
- Speak directly to the person
- Speak to adults as adults and children as children
- Ask the person if they need help – do not assume
- Be aware of patient needs, i.e., extra time for a person with a disability to walk, move, or even speak.
- Respect what the person with a disability can do.
- Understand not having access to work, school, shopping, appointments, or recreation activities can cause more problems than the disability itself.

Sexual Orientation

Sexual Orientation is a term used to describe a person's emotional, sexual, or romantic attractions to another person. A person attracted to the same sex is said to have homosexual tendencies and may be referred to as gay or queer if female or male, or lesbian if female. A person attracted to both males and females is referred to as bi-sexual and gender identity refers to the internal feeling of being male or female.

The Lesbian, Gay, Bisexual, and Transgender (LGBT) culture consists of people that identify themselves as being lesbian, gay, bisexual, or transgender. There are also subcultures within the LGBT culture.

Mental Health and medical organizations have affirmed after several decades of research and clinical trials that these sexual orientations are normal in human behavior and bonding. Even though in the past twenty years, the publics' opinion of LGBT 's is more positive, there still remains a strong stigma against homosexuality due to misunderstanding. Compared to other social groups in the nation, the gay and lesbians are one of the most targeted social groups to experience hate crimes and prejudice. Bisexuals are distrusted among both the gay and straight population due to the belief that they are in denial of their true feelings.

Sexual Orientation - Continued

Health Issues among the LGBT culture are:

- HIV/Aids
- Kaposi's Sarcoma
- Pneumocystis Carinii Pneumonia
- Human Papillomavirus (HPV)
- Depression
- Anxiety
- Lung cancer due to increase rate in smoking
- Cervical and anal cancer due to increase of HPV
- Overweight
- Hepatitis B
- Eating Disorders – bulimia, purging, binge by young gay men.
- Transgender Care not taught in medical school.

Many fail to seek medical care or disclose personal information due to fear of insensitivity and discrimination. Other barriers for seeking care are financial; fear that employers that carry their own medical insurance will become aware of their sexual identity, and insurances not extending coverage to same sex partners.

Healthy People 2010 is the federal plan for improving the nation's health. The U.S. Department of Health and Human Services states it is to include those identified by sexual orientation and gender identity.

Professionals need to be continually aware, knowledgeable, and sensitive to LGBT medical issues to eliminate health care disparities.

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Advanced Directives

The Federal Patient Self Determination Act 1990 requires that any health care provider is to advise patients of the right to accept or reject medical care and treatment, and inform them of the right to Advance Directives. Health Care providers are required to hand out information on patient informed consents, disclosure, and advance directives.

Health Care providers need to open discussions and encourage their patients to complete an Advance Directive that will provide family and health care providers with the person's own wishes when they can no longer make decisions for themselves.

There are many barriers for failure to completing an Advance Directive. The patient's culture, which will influence their feelings and decisions, must be taken into consideration. The Health Care providers understanding of culture diversity through an assessment process can help change outcomes and acceptance.

Many cultures value non disclosure. Disclosure is viewed as disrespectful, unnecessary and cruel, that it will provoke anxiety, depression, and hopelessness. Discussing the terminal illness makes it a reality.

Spiritual and religious beliefs, practices, and rituals play a large part in one's decisions. Some view suffering and death as part of life's journey, or the will of God. Others view it as a Continuum of Life, or Afterlife.

The role of family relationships, communication, and involvement play an important role in decision making, as well as accepted modern health care practices by either patient or family.

Patients may have distrust and lack of knowledge of what they are signing, especially if it is not in their language and the perception that advance directives are difficult to complete.

Advanced Directives

There are many other reasons for reluctance to discuss death and complete an Advance Directive. They fear their wishes will not be respected or followed, they do not find it important, concerns of not being treated as well as others if their decision is for less aggressive care, they prefer the family or physician to initiate discussion or make decisions, or prefer collective decision making rather than alone. Lack of family decision making is due to fear, grief, and guilt in making a decision that could end the life of someone they love.

Health Care providers can begin to change outcomes by showing compassion, building trust, and crossing barriers by taking an interest in the patient's cultural beliefs.

Health Care providers can start by initiating questions that may lead to an open discussion by using similar interview questions as the following examples:

– Some people want to know everything about their medical condition and prognosis. What is your preference?
– Do you prefer to make your own medical decisions or would you prefer someone make them for you?
– Would you prefer if I spoke to your spouse, son, daughter, etc., alone or would you like to be present?
– Sometimes people are uncomfortable discussing these issues with a doctor who is of a different race or culture. Are you comfortable with me treating you?
– Will you please tell me if there is anything about your culture that would be helpful for me to know in working with you or your family member?

For Health Care providers to encourage completion of Advance Directives, they should provide an Advance Directive form that is easy to understand, easy to complete, and in the patient's primary language. A form that has been used and is highly recommended as the first "Living Will with a Heart" is the Five Wishes*. Other forms may be obtained online or at office supply stores, but are not as user friendly. Patients should seek legal advice, if necessary.

*Five Wishes talks about the person's personal, emotional, spiritual, as well as medical wishes. It is easy to complete by checking boxes or circling choices and writing a few sentences. Five Wishes is available in 23 languages and Braille. For more information visit: www.agingwithdignity.org.

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Testing Your own Cultural Competence

1. T F Cultural misunderstanding between patient and provider can lead to mistrust and frustration, but are unlikely to have an impact on objectively measured clinical outcomes.
2. T F When a provider expects that a patient will understand a condition and follow a regimen, the patient is more likely to do so than when the provider has doubts about the patient.
3. T F A really conscientious health care provider can eliminate his or her own prejudices or negative assumptions about certain types of patients.
4. T F When a patient has not adhered to a treatment plan, but states she cannot afford her medication, it is appropriate to assume financial factors are the real reason and not explore it further?
5. T F If a family member speaks English, as well as the patient's native language and is willing to act as an interpreter, this is the best possible solution to the problem of interpreting.
6. T F Out of respect for patient privacy the provider should begin by seeing the adult patient alone and then bring in family if needed.
7. T F Minority and immigrant patients in the U.S. who go to traditional healers and traditional medicine, generally avoid conventional western treatments.
8. Which are the correct ways to communicate with a patient through an interpreter?
    a. Making eye contact with the interpreter when you are speaking, then looking at the patient while the interpreter is telling the patient what you said.
    b. Speaking slowly, pausing between words.
    c. Asking the interpreter to further explain the patient's statement in order to get a more complete picture of the patient's condition.
    d. None of the above.
9. When taking a medical history from a patient with a limited ability to speak English, which of the following is the **least** useful?
    a. Asking questions that require the patient to give a simple "yes" or "no".
    b. answer, such as "Do you have trouble breathing?" or "Does your knee hurt?"
    c. Encouraging the patient to give a description of her/his medical situation, and beliefs about health and illness.

   d. Asking the patient whether he or she would like to have a qualified interpreter for the medical visit.
   e. Asking the patient questions such as “How has your condition changed over the past two days?” or “What makes your condition get better or worse?”

10. During a medical interview with a patient from a different cultural background, which is the **<u>least</u>** useful technique?
    a. Asking questions about what the patient believes about her or his illness—what caused the illness, how severe it is, and what type of treatment is needed.
    b. Gently explaining which beliefs about the illness are not correct.
    c. Explain the “Western” or “American” beliefs about the patient’s illness.
    d. Discussing differences in beliefs without being judgmental.
11. Which of the following statements is **TRUE**?
    a. People who speak the same language have the same culture.
    b. The people living on the African continent share the main features of African culture.
    c. Cultural background, diet, religious, and health practices, as well as language, can differ widely within a given country or part of a country.
    d. An alert provider can usually predict a patient’s health behaviors by knowing what country she / he comes from.
12. Which of the following is good advice for a provider attempting to use and interpret non-verbal communication?
    a. The provider should recognize that a smile may express unhappiness or dissatisfaction in some cultures.
    b. To express sympathy, a health care provider can lightly touch a patient’s arm or pat the patient on the back.
    c. If a patient will not make eye contact with a health care provider, it is likely that the patient is hiding the truth.
    d. When there is a language barrier, the provider can use hand gestures to bridge the gap.

Testing Your Own Cultural Competence Answers

1. **False** Low levels of cultural competence can impede the process of making an accurate diagnosis, cause the provider to order contraindicated medication, and reduce patient adherence to recommended treatment.
2. **True** This is an adaptation of the "Pygmalion theory" which has proven that students generally live up—or down—to the expectations of their teachers (Rosenthal and Jacobson 1968).
3. **False** Most of us harbor some assumptions about patients, based on race, ethnicity, culture, age, social and language skills, educational and economic status, gender, sexual orientation, disability / ability, and a host of other characteristics. These assumptions are often unconscious and so deeply rooted that even when an individual patient behaves contrary to the assumptions, the provider views this as the exception to the rule. A conscientious provider will not allow prejudices to interfere with making an accurate diagnosis and designing an appropriate treatment plan.
4. **False** In addition to exploring payment options with the patient, it is Important for the provider to inquire about cultural and psychological factors that may impede adherence to the prescribed treatment.
5. **False** This is an inappropriate responsibility for families to take on and may actually place the provider in violation of the Civil Rights Act of 1964 and the August 30, 2000 Office for Civil Rights (OCR) Policy Guidance. The rationale for using professional interpreters is clear. Professional interpreters have been trained to provide accurate, sensitive two-way communication and uncover areas of uncertainty or discomfort. Family members are often too emotionally involved to tell the patient's story fully and objectively, or lack the technical knowledge to convey the provider's message accurately.
6. **False** In many of the world's cultures, an individual's health problems are also considered the family's problems, and it is considered threatening to exclude family members from any medical interaction. The provider should ask the patient whether she/he would prefer to be seen alone or with the family. It should be the provider's goal to help the patient to express her/his true preference about this—without offending any family members. The provider might ease any tension around this issue by assuring family members that they will be asked to return to the examining room in a short time.

7. **False** In the US, some individuals from minority and immigrant groups use traditional treatments before turning to conventional Western medicine, or use both concurrently.
8. **d** Although it may seem natural to look at the interpreter when you are speaking, you want the patient to feel that you are speaking to her / him, so you should look directly at her/him, just as you would if you were able to speak her / his language.
9. **a** While it may seem easier to ask questions that require a simple "yes" or "no" answer, this technique seriously limits the ability of the patient to communicate information that may be essential for an accurate history and diagnosis. The most effective way to put the patient at ease and to ensure that the patient provides essential information about his or her symptoms is to combine two types of questions: 1) open-ended questions such as "Tell me about the pain in your knee" and 2) more direct questions, such as "What makes the pain get better or worse?" Always get a qualified interpreter when possible.
10. **b** Although the provider may be tempted to correct the patient's different beliefs about illness, this may lead the patient to simply withhold her/his thoughts in the future and interfere with building a trusting relationship. It is more effective to be nonjudgmental about differences in beliefs. The provider should keep in mind two goals: 1) the patient should reveal her/ his medical history and symptoms to help the provider make an accurate diagnosis, and 2) the patient should develop trust in the provider's medical advice and be willing and able to adhere to that advice. To accomplish these goals, it is essential to treat the patient with respect, openly discussing differences in health beliefs without specifying "correctness" or "incorrectness".
11. **c** The only assured similarity among people from around the world who come to you for care is the fact that they are your patients and they hope to be treated with respect and with concern for their individual health needs. As a health care practitioner, it is important to have a basic understanding of your patient's cultures—and to recognize the similarities and differences among people from the same region of the world and the same country. Differences in cultures within a region can be pronounced. Each patient is the product of many cultural forces. People from the same continent, the same country, the same part of the country, and even the same city, may have major differences in cultural heritage, traditions, and language, as well

as differences in socioeconomic status, education, religion, and sexual orientation. It is the combination of all of these factors that make up a person's "culture".

12. **a** Although smiling is an expression of happiness in most cultures, it can also signify other emotions. Some Chinese, for example, may smile when they are discussing something sad or uncomfortable. The other pieces of advice are incorrect. The use and interpretation of body language depends entirely on the patient's culture and personal preferences. What is appropriate in one culture may be embarrassing or offensive in another culture. Interpersonal greeting behaviors, for example, vary widely from one culture to another. Beliefs about touching are also highly variable, with some cultures placing a high value on physical contact, and others believing that physical contact of any kind is a sign of intimacy. Similarly, some cultures perceive direct eye contact as a sign of respect, while in other cultures, eye contact with elders and authority figures is to be avoided. Hand gestures in particular can lead to serious misunderstandings. For example, the "ok" sign, widely used in the US, is the symbol for coins or money in Japan. In several other cultures, the gesture represents a bodily orifice and is highly offensive.

Congratulations

For taking the interest and time to read this pamphlet. You are now on your way to providing better care and understanding of cultural diverse populations within the health care system.

RESOURCES

Other resources on Cultural Competency are available online.

CyraCom International—Language services toll free access number 1-800-481-3293. http://www.cyracom.com/getting_started.

Tucson Unified School District — Interpreter/Translator Service
TUSD 1010 E. 10th St. Tucson, AZ 85719
www.tusd1.org/contents/depart/interpreter/index.html

Free online translation services — Search for "Free Translation"

RESOURCES OF MULTILINGUAL HEALTH INFORMATION AND RELATED HEALTH TOPICS

Arizona Health Science Library
Sources of Foreign Language/Multicultural
Health Information Materials
www.ahsl.arizona.edu/consumer.webinar

Arizona Health Information
www.azhealthinfo.org

Ethomed
www.ethomed.org

United States Committee for Refugees (USCRI)
www.refugees.org

Refugee Health Information Network (RHIN)
www.Rhin.org

Utah Multicultural Health-Multilingual Library
www.health.utah.gn/cmh/multilinguallibrary.htm

Multicultural Resources-CIBC Centre for Patients and Families
Http://www.centreforpatients.vch.ca/multicultural.htm

U.S. Department
Health. http://wv

Bureau of Primary
Competence. http

National Center o
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Cultural Diversity
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http://www.aafp.o

GENERAL RESOURCES

U.S. Department of Health and Human Services Office of Minority Health. http://www.omhrc.gov/omhome.htm

Bureau of Primary Health Care—National Center for Cultural Competence. http://www.georgetown.educ/research/gucdc/nccc

National Center on Minority Health and Health Disparities National Institute of Health. http://www.ncmhd.nih.gov

Limited English Proficiency. A Federal Interagency Website. LEP.gov Provides information, tools, and technical assistance regarding limited English proficiency and language services for federal agencies, recipients of federal funds, and users of federal programs.

Cultural Orientation Resource Center
http://www.cal.org/co/coexchange/index.html

Cross Cultural Health Care Program (CCHCP)
http://www.xculture.org
Offers a variety of training opportunities on Cultural Competency.

Honoring Cultural Diversity at End of Life
http://www.socialworktoday.com/novdec2007, p36.shtml

Cultural Diversity at the End of Life:
Issues and Guidelines for Family Physicians
http://www.aafp.org/afp/20050201/515.html

REFERENCES

E — **Pocket Book For Caring For Hispanic Patients**
http:/itdc.Ibcc.educ/chispa/pocketbook.html

The Customs of Somalia
http://www.somaliculture.net/customs/index.html

Overview of Somali Culture Chapter 2
http://www.cdc.gov/tb/ethnographic guides/Somalia/chapters/
chapter2.pdf

American Indians and Alaska Natives Health Disparities
http://erc.msh.org/provider/informatic/aian_disparities_adherence.pdf

Rules and Regulations August 2005 CyraCom Newsletter
http://www.CyraCom.com/default.aspx page/d=471

Understanding Cultural Issues in Death NASP Resources
http://www.nasponline.org/resources/principles/culture_death.aspx

Cultural and Medical Traditions
Somal Culture and Medical Traditions
Children's Hospitals and Clinics of Minnesota
http://xpedio02.childrenshc.org/stellent/groups/public/@xcp/@web/
@clinicsanddepts/documents/policyreferenceprocedure/web025020.as

The Iranian Culture, Catherine L. Lewis, 2003
http://www.usm.maine.edu/lac/ot/divman/Iran.pdf

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http://cultureofiran.com

Wikipedia – The Free Encyclopedia
http://en.wikipedia.org/wiki/yin_and_yang

Arab- American Culture and Health Care
http://www.cwru.edu/med/epidbio/mphm439/Arab-Americans.htm

Guide to Arab Culture: Health Care Delivery to Arab-Americans
http://www.asesscommuniyy.org/site/DocServer/
health_and_research_center_21.pdf

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http://www.fas

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World Health (
www.who.int/tc

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The History of
www.agip.org/g

Medline Plus
www.ncbi.nlm.n

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Office of the Deputy Chief of Staff for Intelligence
U.S Army Training and Doctrine Command
FT. Leavenworth, Kansas
http://www.fas.org/irp/agency/army/arabculture

Suite101
http://disabilty_advocay.suite101.com/article.cfm/invisible

World Health Organization
www.who.int/topics/disabilities/en/

Office of Disability Employment Policy
http://www.dol.gov/odep/pubs/fact/comucate.htm

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www.agip.org/gap1_history

Medline Plus
www.ncbi.nlm.nih.gn/pubmed/19958064?tool=medlineplus

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Culture & Nursing Care: A Pocket Guide
San Francisco: UCSI Nursing Press, 1996

The Providers Guide to Quality & Culture MSH Management Sciences or Health
http://erc.msh.org/mainpage.cfm?
=2.0.htm&module=provider&language=English&ggr

Cultural Competency for Health Care Providers
http://www.cvahec.org/documents/cultural competency for health care providers 2007_11.8.07.pdp

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