

Topic 5: Multiculturalism¹

Overview

The clinical merit of understanding psychosocial factors is well-established in geriatric care, where clinicians address complex physiological, psychological, and social issues in treating older persons with multiple chronic diseases and functional impairments. Health care providers and patients do not need to share the same cultural, ethnic, or social values; but addressing these factors establishes a therapeutic relationship, determines the best approaches to care, improves patient satisfaction, and adherence to treatment regimes. Culturally sensitive health care can improve access and appropriate health care delivery to all older persons.

Objectives

- Understand the necessity of developing cultural competency.
- Identify some requirements of cultural competency in interactions.

Cultural Assessment

Culture encompasses such a broad range of beliefs, behaviors, and definitions, that the notion of conducting an assessment seems daunting. A symbolic construct through which social life is patterned, acted, and perceived culture can be observed as the enactment and outcome of behaviors in a changing environment and throughout the lifespan. There is a dynamic, adaptive quality to this “cognitive map;” cultures are not static. Texts describing cultural patterns should be used with caution. Broad, heterogeneous categories, such as Asian/Pacific Islander, which represents more than 25 ethnic groups, some from the same countries of origin, do not meaningfully reflect intragroup or individual variation in ethnicity and life experience. The cultural patterns referenced in this article describe a range of beliefs. As in any clinical situation, the focus should be on the individual; stereotyping to a group should be avoided.

Providers should be aware of the cultural and historical experiences of their older patients in determining their health care expectations for cure, treatment, palliative care, or reassurance about particular conditions. Since practitioners and clients may not share the same perception of illness, their expectations for healthcare may also vary. Older rural African Americans, as well as older Filipinos and older Mexican Americans may conceive health as an attribute of personal spirituality. The former may believe that prayer and faith are more significant than preventive health measures. The latter two may perceive poor health as a punishment or the result of malevolent witchcraft. These perceptions suggest that illness should be tolerated until its impact on function is too severe for informal care. Coping skills developed over a lifetime in response to racism or other inequalities may hinder evaluation and diagnosis. These include reluctance to divulge information, especially about alternative therapies or dissatisfaction with western biomedicine. Whereas geriatricians typically seek information about social support for individual patients, clients may not envision themselves as the center of a family or community support

¹ Topic 5 is compiled from: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.). Encyclopedia of elder care, New York: Springer Publishing Company (in press).; Fasser, C. (1999). Interdisciplinary team training curriculum resource document. New York: The Geriatric Interdisciplinary Team Training Resource Center of New York University.

network. Allocentrism, emphasizing the importance of the group over the individual, is a common cultural value shared by many older Hispanics and Asians. The notion of autonomy in decision-making is not universal.

Culture-bound syndromes have received attention, although their significance is not well understood. Cultural norms define illness and its expression. Among western Europeans, there is a higher frequency of stomach ailments among Germans, liver ailments among French, and headaches among English. Hispanics might describe shortness of breath as fatigue, "fatiga;" back pain as a kidney pain, "dolor de los riñones." Asian Pacific Islanders might complain of a "weak kidney" to indicate sexual dysfunction, because the kidney is believed to be the site of libido. Native American Indians might describe stress in their family support system as the patient having a "bad heart," indicating the lack of harmony with caregivers. Whereas patients experience illness as a cluster of symptoms that impact on functioning in the social context of their daily lives, physicians tend to redefine symptoms as disease, devoid of social context. Recognition of the culturally mediated experience of poor health is a significant element in a culturally sensitive patient interview.

Conducting Cultural Assessment and Reducing Access Barriers

Health care providers often do not have the time or the training to conduct a comprehensive assessment during a single encounter. As with other diagnostic tools, cultural assessment is linked to the level of care and professional domain. Physicians use cultural assessment to inform their evaluation of symptoms, choice of screening instruments, discussion, and selection of treatment options with a patient (and/or family), care plans, advance directives and placement options.² Nurses and other allied health professionals use cultural assessment to implement care plans, assess health status and pain, respond to personal care issues, and provide appropriate emotional and spiritual support to patients and families.³ Psychosocial assessment of the patient in the context of their family and community is a core social work skill. Their care planning is based on assessment of beliefs about disease, efficacy of treatment, and potential for rehabilitation, as well as the impact of disease on quality of life.

The basic elements of cultural assessment, asked or observed, include personal and medical history, health practices and preferences, information needs, and communication styles. Personal history includes place of birth, length of residence in U.S. if foreign-born, economic status, major support systems, ethnic affiliation and strength of that association, religious belief, and importance of that belief to daily life. Clinicians should assess the type, depth, and complexity of information a patient wishes to be told, and by whom. Dietary preferences, prescriptions, proscriptions, and lifestyle changes should be noted with respect to their potential conflict with cultural values. Differing value about the appropriateness of informal home care or institutional care for specific conditions (e.g., cognitive impairments, continence, and advanced age) may have to be explored. Communication styles include primary and secondary language, speaking and reading levels, print and oral traditions, and nonverbal expression. Patients' descriptions of symptoms using culture-bound references may need to be interpreted, even if

² Espino, D.V., Bedolla, M., Perez, M., & Baker, F.M. (1996). Validation of the geriatric depression scale in an elder Mexican American ambulatory population: a pilot study. *Clinical Geriatrics*, 16:55-67. Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.). *Encyclopedia of elder care*. New York: Springer Publishing Company, (in press).

³ Lipson, J.G., Dibble, S.L., & Minarik, P.A. (1996). *Culture and nursing care: a pocket guide*. San Francisco, CA: UCSF Nursing Press. Cited by: Kramer, B. J. Cultural assessment. In M. Mezey (Ed.) *Encyclopedia of elder care*. New York: Springer Publishing Company, (in press).

provider and patient speak the same language. When translators are used, clinicians should speak in short phrases and use simple nontechnical language. To verify accuracy of the translation, encourage the interpreter to report exactly the patient's own words, check for accuracy by asking the patient to repeat information or instructions and monitor nonverbal communication (e.g., facial expression, body language). When using a family member as a translator, first discuss the purpose of the session with that translator, ascertain comfort level with sensitive topics (e.g., anatomical function -- especially across gender and generations -- or bad news) and, if necessary, determine patient's preference for a more appropriate relative or for a professional interpreter.

A culturally sensitive medical history and examination should not differ from any thorough examination. The art of patient interviewing may diverge from the structured medical model if patients voice multiple complaints or divulge important symptoms only at the conclusion of the interview. Past medical history should be reviewed thoroughly and discussed with the possibility that foreign-born patients may have been exposed to treatment strategies that are not familiar to U.S. physicians and that patients may not have the same information about diseases in their country of origin. Medications that are well controlled in the U.S. may be sold over-the-counter or prescribed with few safeguards in other countries. Histories of drug allergies may be more complex to elicit from foreign-born elders. Clinicians may need to schedule several visits before a trusting relationship is established.

Effective communication is always a key to good patient care. Cross-cultural barriers to access often occur unintentionally. At first meeting, clinicians may habitually introduce themselves, shake hands firmly, and promptly determine the reason for the patient encounter. In some cultures, this businesslike attitude would be offensive. Native American Indians, for example, would likely prefer a light touch to an aggressive handshake. In other cultures, traditional (i.e., indigenous or folk) medicine incorporates the healing arts of counseling and talk therapy in the encounter. Patients from diverse cultures relate that their traditional doctors "really knows them as a person;" they feel distrustful of an abrupt and impersonal approach.^{4,5,6}

Providers may misinterpret patients' expressions of respect. Avoidance of direct eye contact is a common form of respect shown by Native American Indians, Mexican Americans, and African Americans, and should not be interpreted as furtiveness or untrustworthiness. Giving respect and feeling distrust may overlap, as when an African American patient avoids direct disagreement with a doctor's recommendations. Silence and failure to report adverse reactions or unsatisfactory responses to treatment may simply be a way to respectfully avoid direct confrontations, or may be the patient's way to shield the clinician from humiliation associated with treatment failure. Silence may indicate respect, acknowledgment of the discourse, or an opportunity to carefully weigh a response. It does not necessarily indicate discomfort or anger and should be an expected element in pacing an interaction. While the clinician carefully schedules patient care by the clock, many cultures do not share a similar orientation to time.

⁴ Garrett, J.T. (1990). Indian health: values, beliefs and practices. In M.S. Harper (Ed.), *Minority aging: essential curricula content for selected health and allied health professions*. Washington, DC: US Govt. Printing Office, HRS (P-DV-90-4). Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.) *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

⁵ Pourat, N., Lubben, J., Wallace, S., & Moon, A. (1999). Predictors of use of traditional Korean healers among elderly Koreans in Los Angeles. *The Gerontologist*, 39(6):711-9. Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.) *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

⁶ Rhoades, E.R. (1990). Profile of American Indians and Alaskan natives. In M.S. Harper (Ed.). *Minority aging: essential curricula content for selected health and allied health professions*. Washington, D.C.: U.S. Government Printing Office; HRS(P-DV-90-4). Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.). *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

This may be due to practical difficulties of arriving at a destination at an exact time or to the irrelevance of exact timing to most activities. Clinical questions about symptoms' occurrence, intensity, effect on patient and his/her social life may initiate a discussion about cultural values. In addition to avoiding harm in the physician-patient relationship, learning about cultural norms can be an enjoyable aesthetic experience for providers.

Simple forms of etiquette are effective. Most cultures afford respect to elders as well as to health care practitioners. Appropriate terms of address, such as "Mrs. Brown" instead of a first name or a term of endearment may indicate treating clients with respect. Personalized relationships are important to many cultures and are established through noncommercial transactions. Clients may offer food or other token gifts to reduce the formal barrier and create a more personal relationship; refusal would be treated with suspicion. Establishing this type of relationship may also be accomplished by the provider offering a personal disclosure, such as initiating a conversation about a mutual interest (which may entail responding to personal questions) in order to reduce communication barriers. Clinicians should avoid any temptation to relate to clients of different cultures by using terms that are not in their own vocabulary, such as "Black English" to African American elders or putative honorifics that may actually be offensive, such as "chief" to a Native American Indian. Clinicians may have to adjust their medical and anatomical vocabulary as appropriate to the patient's education and language — but need to check that the information provided is understood.

Advance Directives and End-of-Life Care

In a multicultural society, concern for justice brings ethical issues to the forefront. Several studies in the United States identified significant differences between ethnic/cultural groups on completion of advance directives and end-of-life decision-making strategies.^{7,8,9,10} For example, African Americans tend to want all possible life-sustaining treatments; they distrust advance directives as authorizing neglect or inferior care based on racial and socio-economic factors. Korean Americans may voice a personal wish for a natural death (i.e., no life-prolonging technology) but expect their children to insist on all possible lifesaving measures. To set the context for ethical decision-making, clinicians need to ascertain if patients are reluctant or responsive to discussing end-of-life care. In addition, clinicians should attempt to understand beliefs about death, spiritual issues associated with dying, the nature of the social support system, and attitudes of patients and their families to the health care system. In many cultures, the direct, frank, structured discussions of death implied in advance directives and end-of-life care planning are considered harmful to the patient's well-being, insinuate hopelessness, increase suffering, and hasten the inevitable outcome. Among Native American Indians, for example, the issue is best initially addressed indirectly, talking about others who have died

⁷ Blackhall, L.J., Murphy, S.T., Frank, G., Michel, V., & Azen, S.P. (1999). Ethnicity and attitudes toward patient autonomy. *JAMA* ; 274(10):820-25. Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed). *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

⁸ Caralis, P.V., Davis, B., Wright, K., & Marcial, E. (1993). The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatment, and euthanasia. *Journal of Clinical Ethics* 4(2):155-65. Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed). *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

⁹ Hornung, C.A., Eleazar, G.P., Strothers, H.S. 3rd, et al. (1998). Ethnicity and decision-makers in a group of frail older people. *Journal of the American Geriatrics Society*, 46(3):280-86. Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.). *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

¹⁰ Klessig, J. (1992). The effect of values and culture on life-support decisions. *Western Journal of Medicine*, 157(3):316-22. Cited by: Kramer, B.J. Cultural assessment. In M. Mezey (Ed.). *Encyclopedia of elder care*. New York: Springer Publishing Company; (in press).

(using referent term rather than personal name) to elicit responses about what would constitute a “good death.” Clinicians who can address these issues over time are more likely to successfully reach an understanding of their patients’ wishes.

Concepts of autonomy vary and imply different norms in disclosure of information and decision-making. Ethiopian and Persian immigrants believe that bad news should be conveyed to the patient by a family member or close friend, not by a health provider. In these circumstances, doctors confront the dilemma of concealment of information, truthfulness in diagnosis or prognosis and protection of patient confidentiality. Some physicians manage the dilemma by asking patients to tell them how much information they want to know, who else they wish to inform, and whom they want to make decisions with or for them. Another strategy is encouraging patients to ask questions over several visits in order to absorb information.

The role of decision-maker varies with cultural norms. Daughters might be the first choice among Hispanics and African Americans, sons among Asians, and spouses among Anglo-Europeans⁹. In general, Native American Indian cultures strongly support autonomous decision-making and children are unlikely to interpose their wishes. However, if an elder is without capacity, a family spokesperson would likely emerge to represent the elder’s authentic wishes. Clinicians should avoid directing information to, and expecting decisions from, the best educated family member; this person may not necessarily be culturally empowered with the decision-making authority.

Demographics of the General Population by Race/Ethnicity^{11,12}

Although nearly three-quarters of the population were non-Hispanic white in 1995, this group will contribute only about one-quarter of the total population growth during the next 10 years. From 2030 to 2050, the non-Hispanic white population will contribute nothing to the nation’s population growth because it will be declining in size. The non-Hispanic white share of the U.S. is expected to fall from 72% in 2000 to 64% in 2020, and 53% in 2050. For each year from 1997 to 2050, it is projected that less than half of total U.S. population growth will occur in the combined black and white non-Hispanic populations.

The race/ethnic groups with the highest rates of increase will be those of Hispanic-origin and the Asian and Pacific Islander populations, with annual growth rates that may exceed 2% until 2030. In comparison, even at the peak of the baby boom era, the total U.S. population never grew by 2% in a year.

From now to 2050, the population is projected to be those of Hispanic-origin. In fact, after 2020 the Hispanic population is projected to add more people to the United States every year than all other race/ethnic groups combined. By 2010, the Hispanic-origin population may become the second-largest race/ethnic group. By the year 2030, the non-Hispanic white population may be less than half of the U.S. population under age 18. In that year, this group would still comprise three-quarters of the 65 and over population.

¹¹ U.S. Bureau of the Census. (1996). Population Projections of the United States by Age, Sex, Race, and Hispanic Origin: 1995 to 2050. Current Population Reports, P25-1130. Washington, DC: U.S. Government Printing Office.

¹² Federal Interagency Forum on Aging Related Statistics. (2000). Older Americans 2000: Key Indicators of Well-Being. Available at <http://www.agingstats.gov/chartbook2000/population.html> [access date August 24, 2000].

A combination of three factors will likely contribute to the shift in population distribution over the next six decades:

1. Differential fertility
2. Differential net immigration
3. Differential age distributions among the race and Hispanic-origin groups

Higher fertility rates and net immigration levels will elevate the increased proportions of the expanding groups (black, Asian, American Indian, and Hispanic Populations). At the same time, the non-Hispanic population will experience an increase in the number of deaths as more and more of this population enters older age groups where the risk of mortality is highest.

By 2050, 75% of the population is expected to be white; 15% black; 1% American Indian, Eskimo and Aleut; and 9% Asian and Pacific Islander. The Hispanic-origin population is expected to increase to 25% and the non-Hispanic White population would decline to 53%.

Hispanics were the youngest population group in 1995, with about half younger than 26 years. As the total U.S. population ages, the Hispanic population is expected to age more quickly than either the Asian or black populations.

The non-Hispanic white population is projected to continue to be the oldest segment of the population, increasing from a median age of 37 in 1995 to a median age of 44 in 2050.

Demographics of the Older Population by Race/Ethnicity

The racial and ethnic composition of the elderly population will change profoundly in the next 50 years. As shown in Table 5.1, Hispanics are expected to constitute 17.5% of the elderly population in 2050, as compared with the 4.5% estimated for 1995. Furthermore, during this time period, the proportion of elderly within the Hispanic population will increase from approximately 6% to a little more than 14%. The proportions of blacks and "other races" in the elderly population are also expected to increase. In particular, the proportion of "other races" will more than triple in this period. Conversely, the proportion of whites in the elderly population will decrease, from 90% to 82%. If we calculate the percentages for the non-Hispanic white population, the shift is even greater, from 85% to 66%, meaning that in 2050 about one-third of the elderly population would be black, Hispanic, or in the "other races" category.¹³

¹³ Source: Seigel, J. (1966). Aging into the 21st century. National Aging Information Center ; May 31, 1996 (This special report was prepared by Jacob Siegel under contract number HHS-100-95-0017 with the Administration on Aging, U.S. Department of Health and Human Services.)

Table 5.1. Projections of the Percentage of Persons 65 Years and Over in the Total Population, by Age, for Race Groups and Hispanic Origin: 2000 to 2050¹¹

Age and Year	Percent of All Ages ^a				Percent by Race ^b			
	White	Black	Other Races	Hispanic Origin ^c	White	Black	Other Races	Hispanic Origin
65+								
2000	13.7	8.1	7.2	6.0	88.9	8.3	2.8	5.4
2010	14.4	8.6	8.7	6.9	87.3	8.7	4.0	7.2
2050	21.9	14.2	15.0	14.3	81.7	10.9	7.4	17.5
75+								
2000	6.7	3.4	2.7	2.4	90.4	7.3	2.3	4.5
2010	6.8	3.5	3.5	3.0	88.9	7.6	3.5	6.8
2050	12.5	6.9	7.9	8.0	83.6	9.4	7.0	17.6
85+								
2000	1.7	0.9	0.6	0.6	90.7	7.4	1.8	4.3
2010	2.1	1.0	0.9	0.8	90.1	7.0	2.9	6.1
2050	5.2	2.6	3.1	3.4	84.7	8.6	6.7	17.8

^aRepresents the percent of the age group in the total population of all ages for the particular race/Hispanic group

^bRepresents the percent of the race/Hispanic group in the total population of all races for the particular age group

^cHispanics may be of any race.

Major Systems of Culturally Based Health Beliefs, Values, and Attitudes¹⁴

Conventional (modern, “Western”, allopathic) Biomedicine

Conventional medicine and nursing, the primary healing system of the dominant culture in the United States and much of the industrialized world, developed in a specific cultural milieu. This was primarily scientific reductionism as it emerged in Western Europe during the Enlightenment and Industrial Revolution, although the roots are in the Middle East and Ancient Greece. Conventional medicine as we know it today is only about 100 years old and has been influenced profoundly by the dominant Anglo-American culture of scientific materialism, technological progress, and capitalism. It is characterized by: a mechanistic model of the human body; separation of mind and body, and discounting of spirit or soul.

American Indian Cultures

These health beliefs predated European immigration and were preserved primarily through oral traditions. Although the systems varied by tribe, many are characterized by mind-body-spirit integration, shamanism, and use of herbs from native plants. Harmony with natural environment

¹⁴ Yeo, G., Hagen, J., Levkoff, S., et al. (1999). . Core curriculum in ethnogeriatrics. Washington, D.C.:U.S. Department of Health and Human Services.

(animals, plants, sky, and earth) was important for health. Illness was sometimes seen as a result of an individual's offenses, to be treated by a ritual purification ceremony or a ceremony by a medicine person.

African Traditions

Diverse beliefs were preserved in the U.S. from various African traditions and frequently integrated with American Indian, Christian, and other European systems. Common characteristics include: 1) belief that harmony with nature provides power and energy; illness is disharmony; 2) healing power of religion, Christian in some cases; and 3) use of herbs (rootworking). In some of the Caribbean islands, African traditions evolved into strong beliefs in power of spirits and use of shamans to maintain health and treat illnesses.

Asian Traditions

Tenets of Traditional Chinese Medicine (TCM) are over 3000 years old and have influenced health beliefs in Japan, Korea, and Southeast Asia. These are characterized by: 1) need for balance between yin and yang to preserve health, especially through the use of foods and herbs; 2) unblocking the free flow of qi (chi), or vital energy, through meridians in the body by acupuncture, tai chi, moxibustion, and cupping; and 3) interaction of basic elements of the environment (e.g., water, fire, earth, metal, and wood) and their analogues in the organs of the body.

In parts of Asia, Taoism and Buddhism have influenced the healing traditions. Taoism emphasized the need to adapt to the order of nature, and Buddhism emphasizes meditation for spiritual and physical health. In some areas, especially Southeast Asia, Buddhist traditions include health through shamanism.

Ayurvedic medicine has been widely practiced in India for centuries. It has been shaped by Hinduism and traditional Indian culture. The basic elements of the environment (e.g., air, water, and wind) have analogues in the body. It is characterized by the use of yoga, meditation, herbs, and by integration of mind-body-spirit.

Traditional Hmong health beliefs are characterized by: 1) interventions of a wide variety of spirits that promote health or cause illness; and 2) risk of loss of soul that brings illness. Healing ceremonies are performed by shamans, frequently involving animal offerings to spirits.

Latino Traditions

Various traditions from populations of Central and South America and the West Indies represent syncretic blending of many diverse influences in Latin America and the Caribbean, including European folk medicine, native Indian traditions, and Christianity. Many are characterized by: 1) religious healing and appeal to saints or use of religious symbols to maintain health; 2) importance of balance of hot and cold elements for health; 3) illnesses caused by strong emotions, such as envy or fright; 4) use of herbs; and/or 5) use of native healers

Other European and American Traditions

Folk healing systems were part of most European countries before the development of scientific biomedicine. Aspects of some of these traditions are still practiced in the U.S. Many included religious healing and use of herbs.

Variations of the belief systems of allopathic medicine, or competing health philosophies have emerged in the US in the past century. Some of the major ones are: 1) osteopathy, which is similar to allopathic medicine but deals with the “whole person” and emphasizes the interrelationship of the muscles and bones to all other body systems; and 2) homeopathy, which emphasizes the healing power of the body and relies on the “laws of similars” to choose drug therapy.

Medical Pluralism in the U.S.

Elders from any one ethnic background may or may not know, or may not espouse, the health beliefs connected with their traditional heritage. It is important for providers to be familiar with the range of belief systems found in the U.S. but not to assume, based on language spoken on ethnic background, that any individual maintains those beliefs.

Techniques to Develop Cultural Sensitivity¹⁵

- I. Engage trainees in exercises designed to uncover their cultural heritage
 - A. Describe community in which they grew up.
 - B. Name two or three important values they learned from their family.
 - C. Indicate the ethnic/racial/cultural/spiritual groups they identify with.
 - D. Name some source of strength/pride they derived from their heritage.
 - E. Indicate ways in which they experienced prejudice because of background.
 - F. Describe how they know and learned what to do when they have a headache.
 - G. Describe how they know and learned what to do when they have abdominal pain

- II. Engage trainees in exercises to assess their level of cultural competence
 - A. Explore advantages/disadvantages of being this person in team setting.
 - B. Explore advantages/disadvantages of being this person in majority community.
 - C. Explore advantages/disadvantages of being this person in minority community.
 - D. Explore how illness behaviors have changed since becoming care provider.
 - E. Explore how wellness behaviors have changed.
 - F. Explore how perception of health care system has changed.
 - G. Explore conflicts between personal and professional cultures.
 - H. Explore experiences had in working with people from different socioeconomic, ethnic, religious, age groups.
 - I. Explore a rewarding and difficult experience had in working with people from different socioeconomic, ethnic, religious, age groups.

- III. Introduce a framework for understanding the cultural influences brought by another to the caring interaction between provider, patient, and family.

¹⁵ Fasser, C. (1999). Interdisciplinary team training curriculum resource document. New York: The Geriatric Interdisciplinary Team Training Resource Center of New York University.

- A. Determine the person's age and birth locale.
 - B. Define the person's ethnic background.
 - C. Clarify the person's religion.
 - D. Determine the person's ordinal position in the family.
 - E. Understand what hobbies and activities are part of the person's free time.
- IV. Introduce the Explanatory Model for understanding illness in the context of culture.
- A. Ask person what they think caused their problem.
 - B. Ask them why they think it started when it did.
 - C. Ask them what they think their sickness does to them.
 - D. Ask them how severe they think their sickness is.
 - E. Ask them about the kind of treatment they think they should receive.
- V. Apply LEARNING mnemonic to ensure a culturally sensitive response.
- A. Listen – to person's explanation of what's wrong and what caused it.
 - B. Explain – what you think may have caused the problem.
 - C. Acknowledge – areas of agreement and differences.
 - D. Recommend – your treatment or course of action.
 - E. Negotiate – for what is most important.
 - F. Involve – person in the interaction.
 - G. Never Negate – other person's beliefs or views.
 - H. Gather – the family or decision makers when ever necessary

Exercises

1. Cultural Competency¹⁶

This is an exercise designed to create a better understanding of how culture influences decision-making in teams. As a series of tasks, students will assess their own heritage, understand their professional culture and those in their team, summarize their own personal health beliefs, and describe their experiences with other cultures.

Facilitator's Notes

- 1. Instruct the students to select items from the attached table that best describes them and is most important to them at this point in their lives.*
- 2. Write them separately in a list.*
- 3. Have the students answer the four questions and sub-questions to complete the exercise.*
- 4. After finishing each question, have students pair up to share and compare their responses. Make sure that partners change after each sharing session.*

2. Case Study: Mr. Seaung⁷

This case portrays the difficulties that are created by servicing clients with diverse cultural backgrounds. Throughout the case, students are familiarized with the specific challenges that the interdisciplinary team would face while servicing a client such as Mr. Seaung.

Facilitator's Notes

- 1. Have students read the case.*
- 2. Administer the Summary Questions for the students to complete individually.*
- 3. Bring the responses from the students back as a group and collect them on a common flip chart or board.*
- 4. Make sure to note the differences in priority of care plan (question #2) as they are shared by students from different disciplines.*

3. Case Study: Cross-Cultural Issues in Institutional Care¹⁷

This case portrays the difficulties clinicians encounter while trying to insert cultural awareness into the culture of medicine. Students should consider how to change the culture of the organization to meet the needs of a diverse patient population.

- 4. See also Topic 3 – Care Planning, Minnesota Complex Case #10: Mrs. Trang*

¹⁶Grant, R.W., Finocchio, L.J., & California Primary Care Consortium Subcommittee on Interdisciplinary Collaborative Teams in Primary Care. (1995). A model curriculum and resource guide. San Francisco, CA: Pew Health Professions; Cited in: D. Long, & N. Wilson (Eds.). (2001). Houston Geriatric Interdisciplinary Team Training Curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging (www.hcoa.org, 713-798-5804).

¹⁷Rush Geriatric Interdisciplinary Team Training Program. (2000). Case study—Cross cultural issues in institutional care. Chicago, IL: Diagram in Ethics and Ethics Consultation.

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GITT Exercises: Topic 5

Cultural Competency Exercise

Select items in each of the four columns in chart below that best describe you and write them in a list. Place a check mark next to the items that are most important or significant to you at this time in your life. *To better understand how culture influences decision-making in a team, perform the four tasks below by answering the questions laid out with each one on the following page.*

A	B	C	D
Economic Class	Anglo-Saxon	Female	Professional
Lower	American	Male	Employee
Middle	Anglo		Student
Upper	White	Married	Provider
		Divorced	Healer
Militant	Black	Single	Technician
Radical	African- American	Separated	Educator
Liberal	Negro		Business person
Conservative		Wife	Worker
Reactionary	Hispanic	Husband	
Apathetic	Latino	Mother	Other
	Chicano	Father	
Republican	Latin American	Stepparent	
Democrat	Spanish-Speaking	Grandparent	
Independent		Aunt, Uncle	
	Asian American	Daughter, Son	
Other:	Asian	Sister, Brother	
	Oriental		
	Other:	Straight	
		Gay	
		Bisexual	
		Other	

(Adapted from Grant et al., 1995)

1. Assess your cultural heritage.
 - What are the advantages and disadvantages of being this kind of person in a health care team setting?
 - What are the advantages and disadvantages of being this kind of person in the majority community?
 - What are the advantages and disadvantages of being this kind of person in the minority community?
2. Understand your professional culture.
 - How have your illness behaviors changed since entering training in the health professions?
 - How have your wellness behaviors changed?
 - How has your perception of the Western health care system changed since becoming a provider?
 - What conflicts in health beliefs between your professional cultures have you experienced?
3. Describe your personal health beliefs.
 - What do you do when you have a cold?
 - What special foods do you eat when you are sick?
 - When do you feel the need to seek professional help for illness? Under what circumstances do you visit a health professional when you are well?
 - What did your mother or father do for you when you were ill as a child?
4. Describe your experiences with other cultures.
 - What experiences have you had in working with people from ethnic groups, socioeconomic classes, religions, age groups, or communities different from your own?
 - What were those experiences like? Give an example of a particularly difficult experience and a particularly rewarding experience from working with a patient from a very different background.

Case Study: Mr. Seaung

Rom Seaung is a 75-year-old widower from Cambodia who arrived in the United States in 1981. He lives with his 50-year-old widowed daughter, Ms. Veth, and his three grandsons, aged 19, 20, and 22. His 20-year-old grandson's wife attends the University of Houston studying business administration, works, and also lives in the home. The total number of persons in the three-bedroom Heights' pier and beam home is six. Mr. Seaung's 72-year-old sister lives with his niece in Southwest Houston.

Mr. Seaung, who is unable to speak English, has his daughter interpret in broken English. She is the one who made the clinic appointment for her father. Ordinarily, he frequents the traditional pharmacy and visits a shaman for health problems. Mr. Seaung prefers to visit the traditional healer rather than utilize the Western medical system.

Ms. Veth reports that her father refuses to bathe, is not eating, and has bladder incontinence. She also reports that he has insomnia and at one time was diagnosed at an emergency room as having a stomach ulcer. The traditional healer removed the evil spirits, according to Mr. Seaung, and his ulcer problems seemed to dissipate. Mr. Seaung appears disheveled; he appears to be quite skinny and reluctant to participate in the examination. Ms. Veth reports that she wants her son's wife to assist with respite and supervision of her father. You feel uncomfortable because the daughter seems to be answering for Mr. Seaung and also seems, in your opinion, to intimidate her father, although you cannot be sure. Ms. Veth continues to complain that her daughter-in-law will not assist in bathing Mr. Seaung or providing assistance with her grandfather-in-law's care.

Mr. Seaung is living on Supplemental Security Income (SSI) and also has a Medicaid card. He also benefits from his family's payment of most of his household expenses. His daughter is presently unemployed. In Cambodia, she was a seamstress and used those skills from 1985 to 1990 in the United States. She left work to take care of her sick husband who died a year later (1991) and then never returned to work. She appears to be the only person providing informal support for her father.

Mr. Seaung's 18-year-old grandson is completing his last year of high school and is working to save money to attend a college out of state. His 22-year-old grandson graduated from Houston Community College and is working as a draftsman, while his 20-year-old grandson is also working and pursuing his premedical studies at the University of Houston. He hopes to attend medical school next year.

Upon examination, the nurse practitioner discovers that this patient has bruises up and down his arms and back. The bruises resemble large hematomas. Mr. Seaung's blood pressure is 100/60 mmHg and he has a slow, irregular heart beat and a temperature of 101°F.

The providers caring for Mr. Seaung will need to go beyond simple knowledge of Western medicine. Among different religious, socioeconomic, racial cultural groups there are varied beliefs about health care. The power of healers, prayer, specific food, and folk medicine are all important in the lives of many individuals. Communication and the development of a care plan can be difficult when patients feel they have an illness that is not defined within the biomedical paradigm (Pachter, 1994). If health care providers do not recognize these values or beliefs, any care plan they devise will probably not be effective for the patient. The same problem can occur

if the patient does not recognize the values and beliefs of the health care providers. Effective communication is maximized when each shares their beliefs about the sickness.

Culturally sensitive health care is care that is sensitive to intragroup variations in beliefs and behaviors and avoids labeling and stereotyping (Pachter, 1994). Many of the ideas presented in Topic 5 on communication can be helpful in increasing effective patient-health care provider communication, including cultural blocks. Agreeing with each others' beliefs is not the goal; mutual respect and acknowledgment are needed to develop a care plan that will truly benefit the patient.

Diversity of professional skills and interpersonal skills among professionals of a health care team is essential to the development of a complete care plan.. Cultural diversity can be another attribute of good teamwork and indicate that communication is occurring. It will be imperative for the success of the team that members be able to explain their beliefs and views as they relate to each case and that other members respect and acknowledge these beliefs and views.

Resources can help develop knowledge of a particular cultural, religious, or socioeconomic group. Didactic classes are growing and there are many print resources available, including the following: examination of the effects of the constructive conflict in culturally diverse groups (Kirchmeyer & Cohen, 1992); folk illnesses beliefs and behaviors and their implications for health care delivery (Pachter, 1994); multicultural learning exercises for students (Grant et al., 1995) information on specific ethnic and religious groups (Spector, 1991); diversity training in health care (Waite, Harker, & Messerman, 1994).

Summary Questions

1. List the cultural issues in this case that will have a bearing on the care plan for this client.
2. What suggestions would you offer to the care team concerning these cultural issues when developing a care plan?
3. List three attributes of cultural competency as defined by Grant et al., 1995.

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Rush GITT Case Study

Cross-Cultural Issues in Interdisciplinary Care

You have been recruited to work at the Center for the Health of Aging Native Americans (CHANA), a community health center in a small midwestern city. Although CHANA is a small agency serving about 400 clients per year, you took the position because you were impressed with the center's commitment to interdisciplinary care and to its reputation for providing culturally sensitive health services. The Center was established 10 years earlier by a group of Native Americans working with the school of social work at the nearby state university.

On your second week on the job, you come upon Tom Smith, the Center's part-time nurse practitioner, having a heated discussion with Robert Johnson, the Center's occupational therapist. As you walk up you hear the nurse practitioner say:

"I tell you, I don't think I can stay here anymore. Last week, Mr. Whitefeather came in with a complaint of chest pain that wasn't getting better even after he had taken two of his nitroglycerin tablets. He looked pale, although his pulse was 80 and regular, and his blood pressure was OK. Well, the man is 71 years old, so naturally I was worried about his heart. I told Mary Lewis at the front desk to call 911 and arrange to take him to the hospital immediately. When I came back half an hour later though, Mr. Whitefeather was still sitting there. Mary said that she and Ann McCarthy (the social worker and the Center director had spoken to Mr. Whitefeather, and they decided that his daughter should come and bring him to her house for a few days to recuperate. They said that he was frightened of the hospital and would not go. Instead of pushing him to go and explaining to him what was wrong, they just accepted what he said! But if anything happens to him, just see who's gonna get sued!"

The occupational therapist nodded, and said:

"I know what you mean. Every time I recommend some adaptive device, it seems that Mary ends up lecturing me about how 'our people don't trust machines and Western medicine' and how 'our people believe that they must work with nature and not against nature.' She's always saying that I am trying too hard to change the patients. I complained one time to Dr. Green (Jennifer Green is the Center's physician consultant), but she just said that I needed to understand the Native American world view, whatever that is."

The two continued their heated conversation and you continued walking. Over the next few days, you begin to pick up bits and pieces of a long-simmering conflict within CHANA. The Center director, Ms. McCarthy, is respected by all of the staff for her work in establishing the agency. During your orientation meeting with her, she expresses frustration about the "medicalization" of the Center:

"More and more, there is too much focus on diseases and not enough on prevention and the psychosocial well-being of our clients. We need to learn from the experience

of the Native Americans and not try to impose every Western medical treatment on them.”

Ms. McCarthy had hired Dr. Green to help modify this about 6 months ago. Dr. Green had a background in anthropology before going to medical school and had previously spent 2 years with the American Indian Health Service on a reservation in Arizona. At this time she is working full time towards an MPH, and only sees patients about 4 hours a week in the Center.

In working with Dr. Green, you have heard her commiserate with an elderly patient, Mr. Lakota, about "how inflexible Mr. Smith is. " Mr. Lakota had complained to Dr. Green that the nurse practitioner was always checking his blood sugar, asking about his diet, and encouraging him to exercise more. Dr. Green told Mr. Lakota that "Mr. Smith tries hard, but he believes that the blood test is more important than the patient." Dr. Green then talked to Mr. Lakota for half an hour about his family and life, and at the end of the interview, spent 5 minutes talking about how Mr. Lakota could avoid sweets and other "junk food" in his diet.

You share your observations over lunch with another member of the interdisciplinary team, James Wilson, the pharmacist. As you have gotten to know the staff better, Mr. Wilson seems to be respected by everyone in the Center for his ability to work with the patients and his fund of knowledge. He shares your concern, but notes:

“This place has been like this since I got here 4 years ago. I used to think I could change it but now I've given up. It's just part of CHANA's culture. Other than that, though, it's a great place to work.”

In general, you have to agree with Mr. Wilson; CHANA provides you with good professional opportunities and everyone has been pretty welcoming to you. Mary Lewis, the Center's receptionist, has been particularly supportive and has taken time to introduce you to patients and families, along with explaining different Native American beliefs about health. In your first meeting with her she said:

“I was one of the original activists who fought for this clinic. I didn't like the way my grandfather was treated at the hospital when he was old and sick. If the doctors and nurses respect my people and our traditions like Dr. Green does, then I am happy to work with you. Otherwise, just watch out! I lose patience quickly when professionals think they are better than everyone else.”

Summary Questions

Despite Mr. Wilson's suggestion that the conflicts are just the way that this agency works, you are reluctant to accept the status quo.

1. What conflicts exist at CHANA? How might they affect the agency's ability to deliver effective care to the elderly?
2. What forces maintain the conflict?