

CULTURAL COMPETENCE IN HEALTH CARE



COURSE DESCRIPTION

The culturally diverse health care populations in the United States provide health care professionals with tremendous opportunities to bridge cultural gaps, incorporate new treatments and disease prevention strategies into their practices, and learn about different cultural values and cultural belief systems.

The goal of this course is to provide health care professionals with an overview of specific cultural characteristics of major cultural groups in the United States; explore the relationship between language, culture, and health care; identify health beliefs and health care systems; describe cultural competence; and identify specific culturally competent practices.

COURSE OBJECTIVES

Upon completion of this course, you will be able to do the following:

1. Describe specific characteristics about the composition, cultural aspects, and unique health care issues concerning African Americans, Asian Americans, Hispanics/Latinos, and American Indians/Alaskan Natives.
2. Explain the meaning of language and culture.
3. Explain the relationship between culture and health care.
4. Identify major health belief systems.
5. Identify major health care systems.
6. Define cultural competence and explain why it is important in the delivery of health care.
7. Identify The Joint Commission's cultural, religious, and spiritual guidelines for assessment and treatment of patients.
8. List guidelines for achieving cultural competence.

INTRODUCTION



Individuals of diverse cultural backgrounds create a rainbow of colors and cultures that impact health care. The advancement of technology, travel, and communication systems has allowed increased contact between people of many different cultures. The United States is a unique nation, created from a blending of many native and non-native peoples. Never before has there been such a wide mix of ethnicity, race, culture, and nationality.

This diversity of cultures and peoples has a powerful impact on the delivery of health care services, our understanding of disease and illness, and the challenge it presents to health care providers.

Today's health care professional must provide a level of care that meets the guidelines of cultural competence and respects different cultural values and cultural belief systems. Only when we provide this level of care will we be able to truly care for patients; to advocate for them appropriately, thoughtfully, and sensitively; and to demonstrate that we are clinically as well as culturally competent.

DIVERSITY IN AMERICA



There are 210 nations represented in the United States. The U.S. census for 2010 allows for approximately 66 different racial and ethnic category combinations. The growth in culturally diverse populations in the United States is dramatic (Office of Minority Health [OMH], 2014a). The percentage of the United States population that is white has decreased since the 1970s, due partly to increasing numbers of Asian Americans and Hispanic/Latino immigrants and partly to a higher population growth rate among blacks/African Americans (Luckmann & Munoz, 2005).

The diverse population of the United States and the resulting cultural mix are the result of many factors, including the following (Engebretson, 2013):

1. The climate, food availability, and resources of a particular area
2. Migration patterns determined by climate, environmental conditions, political, and economic situations (such as famine, political uprising, or overpopulation)
3. Changing social roles of women
4. Changing value orientations and beliefs (including changes in beliefs about humankind's relationship to nature and to other persons)
5. Technology
6. Communication patterns and methods
7. Diverse health care beliefs

Because these factors are often influenced by the individual's ethnic orientation, a brief overview of the major ethnic groups in North America follows.

MAJOR CULTURAL GROUPS IN THE UNITED STATES

“Culture refers to the unique behavioral patterns and lifestyles shared by a group of people that distinguishes that group from others. Culture is characterized by a set of views, beliefs, values, and attitudes toward life that is transmitted from generation to generation” (Tseng & Streltzer, 2008, p.1).

Blacks/African Americans



The 2012 Census Bureau report estimated the number of black/African Americans in the United States to be approximately 43 million people (OMH, 2014c).

The term *black* lumps together a group of highly diverse people who arrived in the United States from all over the world, including the Caribbean, Haiti, the Dominican Republic, and Africa. The terms *African American* and *black* are often used interchangeably but this may be incorrect since many blacks/African Americans did not come from Africa (Engebretson, 2013; Luckmann & Munoz, 2005). In this course, the terms *black* and *African American* will be used interchangeably. However, the authors recognize that some readers may wish to differentiate between the two terms.

Cultural Issues

The black/African American culture is distinct and encompasses values that differ from mainstream white American values. Many black/African Americans experienced and struggled against racism and, because of a perceived need for solidarity, have sought strength in their family, church, and community (Engebretson, 2013; Luckmann & Munoz, 2005).

Many have also experienced social injustice, societal inconsistency, and personal impotence, which have had a profound impact on character development. The core

elements of the black/African American character include the following (Leininger & McFarland, 2002; Management Sciences for Health, 2008):

- **Self-identity** is tied inseparably to that of the group. The self is considered an extension of the group. The extended kinship group is very important even though the individual is socialized to be in control and independent at an early age.
- **Knowledge** includes what is known through the senses and in an extrasensory manner. For example, rituals, symbols, and language are ways in which knowledge is transmitted from one generation to another.
- **Emotions** are expressed naturally and spontaneously in response to experiences. Blacks/African Americans are highly expressive people as a result of their sense of oneness with life and of harmony with nature. Their physical movements are also characterized by a rhythmic sense of balance.
- **Behavior** is expressed through subtle patterns of verbal and body language.
- **Communication** may be expressed in *black English*. When communicating, blacks/African Americans may maintain eye contact while speaking to someone but look away while listening to that same individual.

The strengths of the black/African American include (Management Sciences for Health, 2008)

- a religious or spiritual orientation,
- a sense of racial pride,
- resourcefulness,
- family unity and strong kinship bonds,
- a strong desire for education, and
- community involvement.

However, because of many cultural disruptions, the black/African American today experiences an increasing vulnerability as a result of the following (Management Sciences for Health, 2008.):

- A weakening of cultural bonds, values, and sense of community
- A growing class/status-based identity
- An increasing sense of hopelessness and powerlessness
- A pervasive sense of isolation from and abandonment by the larger community

Health Care Issues



Violence, alcohol and drug use, and weakened family structures have been the result of these cultural disruptions. Other health problems for this group include the following (Management Sciences for Health, 2008; OMH, 2014c).

- The infant mortality rate in the United States has declined, but the infant death rate among blacks/African Americans is still more than double that of white Americans.
- Heart disease death rates are more than 30% higher for blacks/African Americans than for whites.
- African American adults are over 30% more likely than their white adult counterparts to have a stroke.
- The death rate for all cancers is 30% higher for blacks/African Americans than for whites; for prostate cancer, it is more than double that for whites.
- Black/African American women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for white women.
- The death rate from HIV/AIDS for blacks/African Americans is more than nine times that for whites. About 64% of all women with new HIV infections in any given year are African American.
- African Americans have a higher incidence of hypertension, diabetes, and sickle cell anemia than the majority population.
- The rate of homicide for blacks/African Americans is six times that for whites.

Many of the folk remedies of African Americans come from the time they spent as slaves in the United States. Since physicians and nurses were often unavailable to the slaves, the slaves depended on remedies that they had brought with them from Africa. African Americans may seek assistance from folk practitioners and faith healers with a reliance on the professional health systems used only during extreme injury or illness (Leininger & McFarland, 2002).

Some blacks/African Americans believe that “hexes,” “sins,” “disharmony,” and the supernatural can impact their health. Individuals with curative power include the “old lady,” “Granny,” “voodoo priest,” or “root doctor.” Treatments include the following:

- The use of teas and cod liver oils
- The effect of dietary choices
- The use of laxatives for purging
- The wearing of amulets, and copper or silver bracelets

Delivering culturally competent care to the black/African American means recognizing the following (Leininger & McFarland, 2002; Management Sciences for Health, 2008):

- Individual and community dysfunction results from the dislocation or disruption of core cultural systems.
- The term *healthy* needs to be applied to the community as a whole, and not just to the individual.
- This culture believes in the connection between God, health, and illness. There is diversity in religious beliefs of African Americans as some are Christians, some are followers of Islam, some are Jewish, and others belong to various groups.
- Individuals and communities need to be empowered, instead of “fixed.”
- Cultural heritages need to be celebrated and individuals must be assisted in reestablishing their “village.”
- It is important to help blacks/African Americans expand their personal vision of possibilities for their future so they avoid destructive behavior.
- Points of intervention need to be appropriate and timely.
- Cultural arrogance on the part of the provider must be avoided.

Asian Americans and Pacific Islanders



In 2012, the Asian American and Pacific Islander population was comprised of approximately 18.1 million people in the United States. This group is the fastest growing of all major racial/ethnic groups. California, New York, Hawaii, Texas, and New Jersey have the largest Asian American populations (OMH, 2014d).

The Asian American culture involves individuals from more than 20 countries who speak more than 100 different languages and represent more than 60 ethnicities. Nearly three-fifths of Asian Americans are foreign-born and originate from the following countries (Luckmann & Munoz, 2005; Management Sciences for Health, 2008):

- China
- India
- Japan
- The Philippines
- Korea
- Laos
- Cambodia
- Vietnam
- Thailand

Pacific Islanders include people from Polynesia, Micronesia, and Melanesia. These land areas are comprised of thousands of islands with enormous differences in historical backgrounds, languages, cultural norms, and lifestyles. Micronesia alone has at least 12 different languages and as many cultural patterns (Management Sciences for Health, 2008).

Cultural Issues

Traditional Asian values are based on traditional religious beliefs, greatly influenced by Buddhism, Taoism, Christianity, Confucianism, and Hinduism. These values place a

higher worth on the interests of the family than on those of the individual. Education, a strong sense of community, and “keeping up appearances” are also extremely important (Luckmann & Munoz, 2005).

The guiding values of Pacific Islanders include the following (Management Sciences for Health, 2008):

- An emphasis on the patrilineal family and the well-being of the community over that of the individual
- A definition of the family that includes both living and dead relatives related by blood, marriage, and adoption; spirituality and ancestral communication may involve immortals taking the form of animals or even rocks
- An emphasis on reciprocity and interdependence but with clearly defined roles and responsibilities for both gender and age; mutual obligations to others, working and living cooperatively, and group harmony are key elements
- Holism and a multidimensional approach to life and health
- The concept of “right behavior” (group harmony, support, and well-being), which is connected to maintaining and sustaining friendships, familial bonds, community, and a life lived with interdependence and in perfect order
- Rituals, such as storytelling, that are powerful therapeutic activities
- The use of food, alcohol, and kava/sakau for festive and ceremonial occasions (and particularly by men) to relax, bond, foster interdependence, or for medicinal purposes
- The strategy of seeking a knowledgeable patron or mentor/elder who protects the younger individual from misfortune or erroneous ways

Health Care Issues



The health care practices of Asian Americans are profoundly affected by the Buddhist philosophy of life. This philosophy encourages respect for elders and those in authority (such as health care providers) and it teaches that life is a cycle of suffering and rebirth. Therefore, suffering may be seen as something that must be endured and the Asian American may delay seeking health care remedies because of this belief. In the Buddhist philosophy, healing is spiritual as well as scientific and some individuals may believe that their illness is a result of karma as well as biology (Management Sciences for Health, 2008).

Another profound influence on the health of the Asian American is the traditional health practices of Chinese medicine. Practiced for more than 3,000 years, Chinese medicine views the mind, body, and spirit as an integrated whole in which each component affects the other. Many Asian Americans believe that the universe is composed of opposing forces: yin and yang, or hot and cold. Health is achieved when each element is in balance (Management Sciences for Health, 2008).

Herbalists and shamans are considered healers, and they utilize specific foods to maintain harmony with natural forces. Massage, pinching, and cupping (the application of cups to the skin to create a vacuum and increase circulation to an area) are techniques used for healing.

Ayurveda (which means “knowledge or science of life”) is also a traditional Asian approach to health care. This Indian system of holistic healing views the body as a combination of three forces, or doshas. The basic principle of Ayurveda is to prevent illness by maintaining a balance in the body, mind, and spirit through yoga, meditation, herbal medicine, and dietary recommendations specific for each individual. Ayurveda is based on ideas from Hinduism, one of the world’s oldest and largest religions, as well as on ancient Persian beliefs (Sharma, 2011).

Health risk factors for the Asian American can include the following (Management Sciences for Health, 2008; OMH, 2014d):

- The stress of acculturation by Asian immigrants and refugees, especially if the individual is elderly
- The desire to “keep up appearances,” which may delay treatment for mental illness, drug abuse, and domestic violence
- Lack of knowledge of risk factors for diseases such as high blood pressure or cancers or of the preventive behaviors for such diseases
- Differing expectations of health visits that may deter many Asian Americans from obtaining care
- Common sites of cancers among Chinese men include the liver, colon, stomach, and nasopharynx.
- Newcomers to the United States may have hepatitis, intestinal parasites, malaria, and/or Hansen’s disease.
- Asians are 20% less likely than non-Hispanic whites to die from diabetes.
- Overall, Asian/Pacific Islander adults are less likely than non-Hispanic white adults to have heart disease.
- Among Asian/Pacific Islanders, sudden infant death syndrome (SIDS) is the third leading cause of infant mortality.
- A higher rate of new cases of hepatitis and tuberculosis among Asian Americans and Pacific Islanders living in the United States than among whites

When providing culturally competent health care for Asian Americans it is important to remember the following (Management Sciences for Health, 2008):

- Looking straight into the eyes of some Asian elders may be equated with disrespect.
- A limp handshake may be a way of showing humility and respect.
- Physical contact (such as a handshake or hug) between a man and a woman may be viewed as a sexual overture or advance.
- Addressing the oldest male in a family or group first, before greeting other members, may be appropriate for some Asian subcultures.

- Observing facial expressions may provide little or no information; little emotion may be shown in the faces of some Asian groups, especially if they have experienced torture, genocide, war, slavery, or political oppression.
- Health care services may be more readily accepted if they involve community-based organizations or community leaders.
- Approaching health care from a holistic perspective may be more effective than the traditional western approach.
- When working with Asian American clients, observing nonverbal cues (such as body language) can often provide important information.
- Because of a cultural tradition that emphasizes self-humility, some Asian Americans are uncomfortable with giving and receiving compliments or saying “thank you” and may even ignore the compliment with silence or by turning their head away from the speaker.

Barriers to health for Pacific Islanders include the following (Management Sciences for Health, 2008):



- Lack of available facilities
- Inadequate, untrained personnel
- Health care systems that are not responsive to cultural norms
- Spiritual despair and depression as a result of negative health, social, educational, and economic experiences

- Desire to keep problems in the family and “take care of their own”
- A loss of cultural identity and sense of place since many have been displaced from their homelands or have experienced successive occupation by other cultures

For those interacting with Pacific Islanders, the following suggestions will help ensure that culturally competent care is provided (Management Sciences for Health, 2008):

- Foster the individual’s cultural identity and cultural pride.
- Promote and preserve cultural identity, values, and traditions.
- Include the family in intervention and treatment efforts.
- Recognize the importance of spirituality in their lives.
- Involve community and traditional leaders when improving accessibility and acceptability of services.
- Incorporate elements of rituals in the treatment process.

Hispanic/Latino Americans

The Hispanic/Latino population in the United States includes more than 53 million people. This ethnic group includes any person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race (Office of Minority Health [OMH], 2014f).



Hispanic is a broad term that refers to groups with cultural and national identities arising from the Caribbean, Cuba, Mexico, Puerto Rico, Central, and South America. The predominant religions are Catholicism and Pentecostalism.

Cultural Issues

Hispanics greatly value the family, and the needs of the family are often placed above individual needs. Hispanics have large extended families with close interpersonal relationships. Family members are often present during a hospitalization and they are often involved in decisions about their loved one's care. Hispanics traditionally value religion and believe in self-sacrifice, giving rather than taking, and the acceptance of fate (Leininger & McFarland, 2002; Luckmann & Munoz, 2005).

The Hispanic culture has certain unwritten rules that govern social interactions. These serve as strengths and protective factors for Hispanic patients, their families, and their communities and include the following (Management Sciences for Health, 2008):

- **La familia** (the family), including parents, siblings, grandparents, aunts, uncles, cousins, compadres, close friends, and godparents
- **Respeto** (respect) and deferential behavior toward others based on age, sex, social position, economic status, and authority
- **Personalismo** (the importance of personal relationships and community)
- **Confianza** (trust)
- **Espiritu** (spirit), mind, and body

Health Care Issues

Specific health care issues that may affect the Hispanic client include the following (Management Sciences for Health, 2008; OMH, 2014f):

- A stigma toward mental health in which this disorder is viewed as a sign of weakness (Hispanics have a high incidence of mental health problems, especially depression, anxiety, and substance abuse; contributing factors include the stress caused by immigration, acculturation, and biculturalism)
- Disease is thought to result from either supernatural or natural causes. The mind and body are thought to be one, and achieving balance in all aspects of life is sought.
- Stressors related to social adjustment (acculturative stress, socioeconomic stress due to inadequate financial resources and limited class standing, and minority stress as a result of racism)

- Environmental health problems from high-risk exposure to ambient air pollution, worker exposure to chemicals in industry, indoor pollution, and pollutants in drinking water
- Alcohol and substance abuse (especially high in Mexicans and Puerto Ricans)

Consider the following statistics (HHS, 2000; Management Sciences for Health, 2008; OMH, 2014f):



- Hispanics and Latinos have a disproportionately high prevalence of asthma, chronic obstructive pulmonary disease (COPD), HIV/AIDS, and obesity.
- Diabetes is twice as prevalent among Hispanics as among the majority population.
- The leading causes of death for Hispanics are heart disease, cancer, accidents, cerebral vascular accidents, and diabetes mellitus.
- Hispanics living in the United States are almost twice as likely to die from diabetes as are non-Hispanic whites.
- The incidence of cervical cancer in Hispanic women is double that of non-Hispanic European-American women.
- Hispanics have higher rates of high blood pressure and obesity than non-Hispanic whites.

- The rate of low-birth-weight infants is higher for the total Hispanic population compared with that of whites, and Puerto Ricans have a low-birth-weight rate that is 50% higher than the rate for whites.

When providing culturally competent care to Hispanic Americans, it is important to consider the following (Leininger & McFarland, 2002; Management Sciences for Health, 2008):

- Religion is an important part of the social structure of Hispanic Americans and faith is the major sustainer against the trials of daily life.
- Understand that many Hispanics believe illness may be a punishment for sins or the result of witchcraft or the evil eye.
- Involve family members, since they are likely to be involved in the treatment and decision-making process for a patient.
- Show respect for patients without being condescending.
- Address elders in traditional ways (such as looking below eye level if the patient is older than you are).
- Indirectly ask personal or private questions about alcohol use, mental problems, violence, stressors, or sexual practices (for example, "Have you seen ads about the use of condoms?").
- Indicate interest in Hispanic clients by leaning forward when talking to them, or giving them a comforting pat on the shoulder.
- Ask about their life (family, friends, and work) and share life stories and pictures with them.
- Converse with all members of the family but be respectful of gender.
- Do not give the impression of being too familiar.
- Encourage questions, since many Hispanic patients will avoid disagreeing with or expressing doubts with health care providers out of respect.
- Ask local leaders for their opinions about the types of community services needed by their community.
- Respect traditional healing practices, including the use of spiritual elements such as the worship of saints or the use of talismans.

American Indians/Alaskan Natives



The American Indian/Alaskan Native (AI/AN) population is growing rapidly, is young, and is geographically scattered. This racial group includes people having origins in any of the original peoples of North America, South America, and Central America, who maintain tribal affiliation or community attachments. As of 2012, there were an estimated 5.2 million people who were classified as American Indian and Alaska Native alone or American Indian and Alaska Native in combination with one or more other races. This group constitutes 1.7% of the total U.S. population. (OMH, 2014e).

American Indians may also be called Native Americans, and both terms are used in this course. This diverse group includes approximately 569 tribal groups plus an unknown number of tribes that are not federally recognized. Each has its own language, beliefs, customs, health practices, and rituals. Tribes exist as sovereign entities, but federally recognized tribes are entitled to health and educational services provided by the federal government.

Indian Health Services (IHS) is responsible for serving the health needs of these populations but more than half do not permanently reside on a reservation so have limited or no access to IHS services. Geographic isolation, economic factors, and suspicion toward traditional spiritual beliefs are some of the reasons why health among these groups is poorer than other groups (OMH, 2014e). Tribes or clans are the primary social unit and may or may not be blood relatives. They are a strong source of identity and support.

Cultural Issues



Traditional AI/AN healing systems are holistic ones that focus on balancing mind, body, and spirit within the context of the community. These healing systems have been practiced for thousands of years and involve a deep sense of connection with place and land. These traditional healing practices also focus on benefits to the emotional, spiritual, psychological, and cultural aspects of the tribe. Often, large communal ceremonies serve as the method of promoting the well-being of the entire tribe as the tribal healer reaffirms the group's cultural values (Management Sciences for Health, 2008).

AI/AN tribes have survived despite repeated governmental policies of extermination and genocide. These tribes have strong networks, with a deep sense of tribal purpose. They respect and share all ways of healing for all sorts of ills. The strengths and protective factors in Native American families and communities include the following (Management Sciences for Health, 2008):

- A strong identification with their culture
- A central role of the family in the development of children
- A deep connection with the past through native stories, group learning, ceremonies, and traditions
- The use of traditional ceremonies (such as sweat lodge ceremonies, vision quests, talking circles, and spirit camps) that contribute to the healing of the individual, reaffirm community norms, and continue the training and practices of the ways of traditional healing
- Adaptability, strength, and the wisdom to survive
- The wisdom of and respect for the elders
- Core values of harmony, sharing, hospitality, and giving thanks

- A belief that illness is due to a lack of harmony, evil spirits, fear and jealousy of other nations, or failure to live according to the code of life

Health Care Issues

The five leading causes of death for Alaska Natives include heart disease, cancer, unintentional injuries, diabetes, and stroke. In addition, AI/ANs have a disproportionately high prevalence of mental health issues, obesity, substance abuse, and sudden infant death syndrome (OMH, 2014e).

Additional health care issues related to this group include the following (Indian Health Service, 2006; Management Sciences for Health, 2008):

- American Indians and Alaska Natives born today have a life expectancy that is 2.4 years less than the U.S. all race populations (74.5 years to 76.9 years, respectively).
- Safe and adequate water supply and waste disposal facilities are lacking in approximately 12% of American Indian and Alaskan Native homes, compared to 1% of the homes for the U.S. general population.
- Native Alaskan men and women suffer disproportionately higher rates of colon and rectal cancers compared to European Americans.
- Lactose intolerance is common among Native Americans.
- American Indian and Alaska Native infants die at a rate of 8.5 per every 1,000 live births compared to 6.8 per 1,000 for the U.S. all race populations.

Obtaining effective care for the AI/AN population is often difficult because of the following barriers (Leininger & McFarland, 2002):

- A paternalistic health care delivery system that fosters dependency
- Forced cultural change
- Interference from the *wasicu* or white man
- Lack of economic opportunity
- Failure of the community to believe that they can make a difference in their own health
- Tribal leadership that may not make health a priority

Providing culturally competent care for American Indians and Alaskan Natives involves consideration of these issues (Leininger & McFarland, 2002; Management Sciences for Health, 2008):

- Recognizing the differences between the Indian concepts of personal insight, individual awareness, and self-actualization and the traditional view of the world

- Understanding the profound importance of family and community in healing and illness prevention
- Understanding the communal effect of traumatic experiences (such as formal boarding schools, imposed religions, economic oppression, or other community events such as an accident, suicide, or death of an elder)
- Understanding and respecting tribal practices and health belief systems
- Understanding that, for some Indians, eye contact may be avoided and touch may be limited
- Incorporating traditional healing practices into care
- Listening to community members and adjusting your thinking and approaches based on their input
- Becoming part of the circle of healing and fostering relationships with the rest of the healers in the circle
- Respecting the village, since it identifies the person
- Waiting and being patient, since the village and its members move at a pace that recognizes the physical and demographic realities of its members
- Empowering your clients so they become self-reliant
- Helping communities prepare leadership that strives to achieve and maintain health for its members

Muslim Americans



The Muslim American population is a mosaic of ethnic, linguistic, ideological, social, economic, and religious groups. The size of the Muslim American population has proved difficult to measure because the U.S. Census does not track Muslim Americans to date. Estimates vary widely from 2 million to 7 million. What is clear, however, is that the Muslim-American population has been growing rapidly as a result of immigration and a high birth rate (America.gov, 2013).

Native Muslim Americans are well integrated into American society, while many new to the United States are just beginning to adapt to American life. In terms of religious devotion, Muslims range from highly orthodox to moderate to secular. Muslims resemble Christians, Jews, Hindus, and other American religious communities in that many of them seek full political and social integration, while others prefer to live primarily in the context of their communities and cultural practices. Many of the immigrants come from Muslim-majority countries and inevitably go through a period of adjustment as they learn the ways of a pluralistic society (America.gov, 2013).

Muslims believe that dying is a part of living and an entrance to the next life. Part of their faith in God is that “to God we belong and to Him is our return.” Maintaining a terminal patient on artificial life support for a prolonged period in a vegetative state is not encouraged. Muslims have specific postmortem rituals for washing, dressing, and positioning the body at the end of life (America.gov, 2013).

Cultural Issues

Important aspects of culturally considerate care include the following (International Strategy and Policy Institute, 2013):

- Respect modesty and privacy.

- Limit eye contact.
- Do not touch the person while talking.
- Some Muslim women want to cover their entire body except for the face, hands, and feet at all times. Some examinations may be done while a patient wears a gown.

Health Care Issues

Religious values and beliefs are intricately linked to cultural norms and practices, and shape the concepts of health and illness, influence expectations of encounters with healthcare providers, affect adherence to physicians' recommendations, guide medical decision-making, and influence health outcomes (Padela, Gunter, & Killawi, 2011).

- Halal (Islamically slaughtered) food is an important healthcare accommodation.
- Prayer space is an important healthcare consideration due to prayer's role in healing and as a ritual five-times daily obligation.
- Patients should be asked if they prefer same-gender providers.

LANGUAGE AND CULTURE

The United States is a country of many races and cultures and each year the challenge of providing care to clients with diverse linguistic and cultural backgrounds becomes more difficult. Understanding health and illness from a cultural perspective is important because they affect and are affected by all the elements of culture.



Language is the way that human beings communicate with each other. Oral language is a part of every society.

Culture is the whole of ideas, customs, skills, arts, and other capabilities of a people or group, although as a whole, it is more complex than any one of these elements. Culture helps us define who we are and what we believe. It influences the way we address life, death, birth, childbearing, child-rearing, illness, disease, dietary habits, relationships, and health behaviors (Hitchcock et al., 2002).

Culture is learned from birth through language and socialization; it is dynamic and changing; and it continually adapts to the environment, social and historical context, technology, and resources. Culture is generally unexpressed or discussed at an unconscious level. Most cultural actions are based on implicit cues instead of written or spoken rules.

Language and Health Care

When working with clients in the health care setting, many different languages may be encountered. Consider the following (Luckmann & Munoz, 2005):

- More than 14% of the population of the United States speaks a language other than English at home.
- Over 6,000 languages and dialects are spoken worldwide.
- Learning a new language is difficult. Even after years of proficiency, effective use of medical terminology and an understanding of medical concepts may be deficient.
- In times of emotional or physical stress, most individuals for whom English is a second language will revert to their native language.

The ability to handle limited-English-proficient (LEP) patients is a challenge that may include the following:

- A delay in making appointments because of the difficulty of communicating by telephone
- A delay in keeping appointments if the staff does not understand the client
- Advancement of the disease process because of a delay in getting or keeping an appointment
- Potentially serious misunderstandings about the medical condition because of the difficulty in completing a clearly understood physical or psychological assessment
- Unnecessary or inaccurate tests because of a difficulty in determining an accurate diagnosis

- Patients who are physically or psychologically unprepared for sometimes frightening or painful procedures
- Ineffective compliance with medical advice because of language difficulties

Whenever a health care provider is involved in an exchange with an individual from another culture, six dimensions must be considered (Luckmann & Munoz, 2005):

1. How and when to start a conversation
2. How best to be understood (for example, you may need an interpreter)
3. How to respond to a patient's gestures or questions
4. How to be sensitive to the patient's reactions
5. How to listen to the patient's concerns
6. How to take the patient's illness and health-related beliefs into consideration as you plan care

While oral language is one of the most common ways in which people communicate with each other, body language is an equally important method of communication. Cultural differences and similarities in body language must be considered when communicating with patients from other cultures (Luckmann & Munoz, 2005).

Culture and Health Care



Culture has a significant impact on health care and health practices as well as health behaviors, health problems, and actions taken to promote, maintain, or restore health. Culture also influences the relationship and communication between the client and the care provider.

Both the health care provider and the client bring their own unique cultural background to every encounter. For example, many cultures do not have an understanding of the primarily biological definition of disease dominant in western medicine. Instead, they may have cultural assumptions about the disease. They may believe that informing patients of the potential medical risks of certain procedures needed to treat the disease may influence the outcomes or pose a risk to their health (DiversityRx, 2003).

In addition, hospitals and health care institutions are daunting places, even for those individuals who have a health care background. If these individuals are admitted to the hospital, for example, they put their lives into the hands of physicians, nurses, and other allied health care providers. Their daily routines are disrupted. They often experience a sense of helplessness, lack of control, and fear. If the individual comes from a culture that differs from the traditional western medical culture, or if they have poor or insufficient communication skills in English, their experience may be terrifying. It is the responsibility of the health care staff to make the individual's experience as comfortable and stress-free as possible by becoming culturally competent.

It is important to obtain as much accurate information about specific cultures as possible to enhance understanding, since cultures and cultural issues are complex and dynamic. Superficial knowledge may lead to stereotyping. In addition, both the client and the health care provider may experience tension as their conflicting belief systems confront one another. Anger, fear, anxiety, or wariness may result. Nevertheless, an awareness of personal cultural biases is a beginning step in developing cross-cultural competence (DiversityRx, 2003).

DIFFERING HEALTH BELIEF SYSTEMS



Every culture has its own specific belief system. This belief system provides a framework that influences how individuals view the world, including the cause, prevention, and

treatments of illness and the promotion and maintenance of health (Luckmann & Munoz, 2005).

Health belief systems fall into three major categories (Luckmann & Munoz, 2005):

1. In a **scientific or biomedical health belief system**, “health and illness are controlled by a series of physical and biochemical processes that can be analyzed and manipulated by humans” (Habel, 2001, p. 4).

Four main concepts characterize this type of system:

- **Determinism**—the view that a cause-and-effect relationship exists for all natural phenomena
- **Mechanism**—the view that life is similar to the structure and function of machines, and control can be achieved through mechanical or engineered interventions
- **Reductionism**—the view that all life can be divided into isolated smaller parts, such as the division of the mind and the body, and this facilitates the study of the whole
- **Objective materialism**—the view that only that which can be observed and measured is real

Disease is believed to be caused by physiologic disturbances and is viewed as the “enemy,” with the body as the “battlefield” and the physician as the “general.” Traditional treatment usually involves isolating the faulty “system” and repairing it by placing the individual in a foreign environment (e.g., the hospital) and administering medication or performing surgery. The health care systems of the United States and many western industrialized societies are based on this belief system.

2. In the **magicoreligious health belief system**, “people believe that supernatural forces influence health and illness” (Habel, 2001). The fate of the world depends on God, gods, or supernatural forces. Disease or illness may be viewed as a sign of weakness, a punishment for evil-doing, a retribution for shameful behavior, a breach of taboo, a loss of the soul, the result of sorcery, or from the possession of the body by evil spirits. Examples of this type of belief system include the Christian Science religion, as well as many Hispanic, African, and Caribbean healing practices. For example, people from some African-Caribbean cultures believe that parts of a person, such as hair, fingernails, or blood represent the person and can be used in healing.
3. In the **holistic belief system**, “the forces of nature must be kept in natural balance or harmony” (Habel, 2001). The major premise of this system is that natural laws govern everything and every person in the universe. This system emphasizes health

rather than the treatment of disease. Wellness and health exist when the person is in harmony with the natural laws. Illness results from disequilibrium or disharmony. Chinese medicine and Native American medicine are two examples of this type of health belief system. Traditional folk care systems are also holistic and depend on home and community resources to help the individual heal or to provide care. Going to a hospital is done only after all else has failed.

In **medical pluralism**, some individuals from certain cultures use both their traditional healers and western physicians to diagnose and treat illness.

DIFFERING HEALTH CARE SYSTEMS



Four health care systems relate to the health belief systems previously described (Luckmann & Munoz, 2005):

1. The **biomedical health care system** combines the western biomedical health belief system with traditional American values of self-reliance, individualism, and aggressive action. Practitioners receive specialized biomedical training and are legally recognized professionals (e.g., MDs, RNs).
2. The **popular health care system** involves self-treatment, and is the first source of care most people use regardless of their culture. It involves the personal and social networks that determine when to seek care, whom to consult, whether to follow suggested treatments, and how to evaluate the usefulness of such treatments. An individual who goes to a drugstore for over-the-counter flu medication is an example of this type of health care. Groups such as Alcoholics Anonymous and cancer support groups, while often overlooked by biomedical health care professionals, provide a major source of care for many types of health care problems.

3. **The folk sector or traditional medical system** includes folk healers, such as shamans, curanderos, herbalists, acupressurists, and acupuncturists, as well as healing devices. These healers use a holistic approach to care, are highly trained for their roles, and have a high status in their cultural group. Individuals may use a variety of these health care systems and seek biomedical care only if the other approaches fail or, conversely, initially seek biomedical care and then seek out healers from other health care systems if biomedical treatments fail.
4. The **alternative health care system** includes interventions such as diet therapy (megavitamins and macrobiotics), mind-body control methods (relaxation, hypnotherapy, and prayer), bodywork therapies (chiropractic, massage, and therapeutic touch), and pharmacologic and biologic therapies (chelation therapy and antioxidants).

CULTURAL COMPETENCE



Cultural competence is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations.

- It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups” (Management Sciences for Health, 2008).

Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines:

- How rights and protections are exercised

- What is considered a health problem
- How symptoms and concerns about health problems are expressed
- Who should provide treatment for the problem
- What type of treatment should be provided

Competence implies having the capacity to function effectively as an individual and as an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

The demand for cultural competence arose because health care delivery systems did not adequately respond to all population groups. Initially, the emphasis was on cultural sensitivity. During the 1980s, however, this emphasis shifted to a demand for skill-based competencies.

Cultural and linguistic competence means that health care providers and organizations understand and respond effectively to the unique cultural and linguistic needs exhibited by patients during the health care encounter.

The development of culturally competent care is a process that involves five components (Breier-Mackie, 2007; Ndiwane et al., 2004):

- Open-mindedness about other worldviews and a desire to learn and appreciate the norms and uniqueness of clients from diverse cultures
- Awareness of one's own cultural values and an examination of one's own biases so one can sensitively appreciate others' cultures
- An understanding of the dynamic differences among cultures
- A basic knowledge about a client's culture and a willingness to seek and obtain diverse cultural information and education in order to better understand the client's perspective
- Adaptation skills that include being receptive to different cultures, actively seeking advice and consultation from individuals of that culture, and incorporating those ideas into one's health care practices

Cultural competence may encompass four major challenges for health care providers (Breier-Mackie, 2007):

- Distinguishing clinical differences among people of different ethnic and racial groups (such as the risk of hypertension among African Americans or diabetes among Native Americans)

- Communication variations (nuances and expressions or the use or non-use of technology) and the need for translators or interpreters (since some cultures have “taboo” subjects such as sexual activity or death)
- Ethics and ethical practice (including the respect for belief systems and the effects of those beliefs on the well-being of individuals within a particular culture)
- Trust and the perception within some cultures that authority figures (including caregivers) are immediately mistrusted (sometimes for good reasons since they have been the victims of atrocities at the hands of authority figures in their homelands)

Why Is Culturally Competent Care Important?



Imagine that you are vacationing in a foreign country where the national language is not your own. You suddenly become ill and are admitted to the local hospital.

While you may be confident that the hospital has high standards of health care, you may also wonder about the following:

- What is everyone saying?
- What is my diagnosis?
- What is my prognosis?
- How does the health care system work here?
- What if they don't understand what I am saying?
- How will I be able to get what I need?
- Can I trust them with my life?

Health care practitioners bring their own familial and cultural values, as well as education and life experiences, to the healing profession. It is important for health care

providers to be aware of their own values, beliefs, expectations, and cultural practices and consider how these impact a client from a different culture.

When health care practitioners do not consider cultural health care practices, they may order more or fewer diagnostic tests because they may not understand or believe the patient's description of the symptoms. Patients may not adhere to medical regimens if they do not clearly understand the health care practitioner.

Knowledge of cultural diversity is important at all levels of health care and for all practitioners, regardless of where they practice. The delivery of culturally and linguistically appropriate care leads to improved health outcomes, increased efficiency in the delivery of services, and increased client satisfaction (OMH, 2001). A lack of respect for persons of differing cultural values can lead to potential and real harm, culturally, psychologically, physically, or spiritually.

Consider the following examples of care that were *not* delivered in a culturally sensitive manner (Habel, 2001):

A Navajo woman gives birth in a large area hospital. After the birth, the nurses dispose of the placenta and umbilical cord as part of their routine care. When the mother is ready to go home, she requests both the placenta and umbilical cord and is devastated when she discovers that the staff has destroyed them. She assumed that the staff understood the significance of the placenta and umbilical cord to her native traditional practices. She and her family leave the hospital in great distress.

An elderly Chinese woman who had just had surgery was told by the nursing staff to "force fluids." The patient refused to drink any water from the water pitcher left at her bedside and was threatened by the staff that if she did not drink fluids orally, an intravenous line would need to be started. The staff labeled the woman "uncooperative." When the patient's daughter came to visit, she told the nursing staff that about the Chinese belief in the use of hot and cold foods and beverages in healing. She stated that her mother could drink hot herbal tea but not cold water.

Unfortunately, many health care providers do not feel they have clear guidelines on how to prepare for, or behave in, such situations.

Cultural Competence Guidelines



Prior to 2001, no comprehensive national standards on cultural or linguistic competence existed. Instead, many variations had been developed by organizations and individuals about what constitutes culturally competent care and how it should be delivered (OMH, 2014b). In 2001, however, the OMH and the United States Department of Health and Human Services stated that cultural competence could be achieved if specific guidelines are implemented for providers, policymakers, accreditation and credentialing agencies, purchasers, patients, advocates, educators, and the general health care community.

These guidelines, developed in 2001, are based on an analysis of key laws, contracts, and standards currently used by federal and state agencies and other national organizations (OMH, 2014b):

1. Health care organizations should ensure that patients/consumers receive from all staff members' effectively understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of culturally and linguistically appropriate service (CLAS) related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information system, and periodically updated.
11. Health care organizations should maintain a current demographic cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in

implementing CLAS standards and to provide public notice in their communities about the availability of this information.

Assessment



According to The Joint Commission (2010, p.15) the patient's cultural, religious, or spiritual beliefs and practices that influence care should be identified during an assessment. Cultural, religious, or spiritual beliefs can affect a patient's or family's perception of illness and how they approach treatment. In addition, patients may have unique needs associated with their cultural, religious, or spiritual beliefs that staff should acknowledge and address.

- Ask patients if there are any cultural, religious, or spiritual beliefs or practices that may influence their care.
- Ask patients if the hospital environment is welcoming to their cultural and religious or spiritual beliefs. Some religious-based hospitals display items in patient rooms that reflect the organization's religious tradition and may conflict with the culture, religion, or spirituality of the patient and family. Consider removing the items, if possible, or covering them if necessary.
- Respect the patient's needs and preferences for modesty by assigning appropriate providers, uncovering only the parts of the body necessary for examination and treatment, providing privacy in toileting and washing, and using full gowns or robes for walking and transport. Many cultures and religions have restrictions on touching, proximity, and nudity, which may affect care allowed by providers of the opposite sex or staff who are younger or older than the patient.
- Determine if the patient uses any complementary or alternative medicine practices and consider incorporating these into the patient's care, if appropriate.

- Consult a professional chaplain, if available, to complete a spiritual assessment. The chaplain may have screening questions to identify religious practices, relaxation techniques, and other coping resources that may influence care.
- Provide an area or space to accommodate the patient's need for spiritual practice. In addition, ask the patient if there are specific times of day to avoid scheduling tests or procedures in order to respect the patient's religious or spiritual practices.
- Note any cultural, religious, or spiritual needs that influence care in the medical record, and communicate these preferences to staff.

Treatment



According to The Joint Commission (2010, p.21) the patient's cultural, religious, or spiritual beliefs and practices that influence care should be identified before treatment. The patient's beliefs and practices can affect the perception of illness and how he or she approaches treatment. Staff should accommodate the patient's unique needs whenever possible.

- Communicate any cultural, religious, or spiritual beliefs or practices staff identified during the admission or assessment process to the care team.
- Respect the patient's needs and preferences for modesty by assigning appropriate providers, uncovering only the parts of the body necessary for examination and treatment, providing privacy in toileting and washing, and using full gowns or robes for walking and transport.
- Many cultures and religions have restrictions on touching, proximity, and nudity, which may affect care allowed by providers of the opposite sex or staff that are younger or older than the patient.

- Provide an area or space to accommodate the patient's need for spiritual practice. In addition, ask the patient if there are specific times of day to avoid scheduling tests or procedures to respect the patient's religious or spiritual practices.
- Work with the patient and family to develop mutually agreed on solutions to patient requests regarding cultural, religious, or spiritual beliefs or practices. For example, in some cultures, the patient's family may want to light candles under the patient's bed.
- The use of candles may not be permitted in the hospital; however, one potential compromise is to suggest that the family use battery operated flashlights instead of candles.
- Note any cultural, religious, or spiritual needs that influence the patient's care in the medical record and communicate patient preferences to staff.

What Else Can Be Done?



Theoretical knowledge about cultural competence is not enough. Practitioners must have the tools to assess their own competence and address diverse patient populations. But how do health care professionals acquire the knowledge, skill, and respect for differences that lead to cultural competence?

As a health care professional, you can improve your care by implementing the following suggestions (Breier-Mackie, 2007; Management Sciences for Health, 2008):

1. Examine, honestly, your personal cultural beliefs and attitudes, biases, and behaviors to discover how these factors have (consciously or unconsciously) influenced the care you provide to clients as well as your interactions with colleagues and staff from diverse racial, ethnic, and sociocultural backgrounds.

2. Maintain a sense of humility and self-understanding. Each encounter with a client is a cross-cultural encounter. Maintaining “cultural humility” helps you understand your clients’ historical, familial, community, occupational, and environmental framework.
3. Understand that there is no one way to treat any specific racial or ethnic group. Within each group is a tremendous amount of diversity. “Cookbook” strategies for working with patients from diverse backgrounds or stereotypes and generalizations about groups can be dangerous. Researching a cultural group and finding out as much as possible about the group’s culture is a start. Understanding builds trust. Begin by being formal with patients and, with the exception of treating children or very young adults, using the patient’s last name when addressing him or her.
4. Develop proper transcultural communication skills. This develops trust and allows you to obtain accurate information from the client. Even if an individual speaks English fluently, information may be subject to misinterpretation. Poor English speaking skills does not indicate a hearing disorder or lack of intelligence, so raising your voice does not mean you will be better understood.
5. Identify yourself clearly with a readable nametag, and communicate with a smile and a friendly attitude. Tone of voice; body language; taking your time; and calm, patient, gentle actions can convey reassurance to a frightened individual.
6. Don’t make any assumptions about the individual’s level of understanding. Speak clearly and slowly and ask the client if he or she would like more clarification (e.g., writing down words that are not clear). Repeat important information, make things simple and clear, avoid the use of jargon, do not use double negatives, and do not sound condescending.
7. Listen to the client and observe his or her body language. The same body language in different cultures can mean entirely different things. In some cultures, for example, smiling is a sign of apprehension. Be sensitive to your own body language. Be aware of the cultural variations in personal space and comfort with proximity to others. For example, in western culture, there are three zones: intimate (less than 18 inches); personal (18 inches to 3 feet); and social (3 feet to 6 feet). Do not be offended if the patient fails to use eye contact or ask questions about the treatment. In many cultures, it is considered disrespectful to look directly at another person or to make someone “lose face” by asking questions.
8. Exercise sensitivity when using interpreters. Some patients may not want intimate information revealed in front of a third party, especially when it includes common taboo subjects such as sexual behavior, contraceptive use, abortion, or menstruation. The use of professional interpreters varies widely among organizations. A professional “qualified” interpreter should be someone who “can demonstrate a high level of expressive and receptive skills and a thorough

knowledge of the Code of Ethics on interpreting, or a person who speaks English and other language fluently enough to accurately and effectively enhance communication . . . fluency includes an understanding of nonverbal and cultural patterns to effectively communicate in a language” (OMH, 2001, p. 29). Professional interpretation requires a minimum level of proficiency in two languages and the demonstrated ability to convey complex messages by using the appropriate words and grammar for both provider and patient. Family, friends, and “informal” interpreters are more likely to modify what the patient actually says in order to be helpful (Management Sciences for Health, 2008).

When using a translator, keep the following guidelines in mind:



- Orient the client to the process and purpose of the translator
- Orient the translator to the topics to be discussed, the client’s situation, and the need for accuracy
- Sit down so the client can make eye contact and observe the body language of the health care professional and the translator
- Observe the client for nonverbal communication that does not match the intended message and clarify as necessary
- Slow the communication process down
- Limit the use of jargon, slang, and metaphors
- Consider the differences in gender, socioeconomic status, and educational level between the translator and the client

- Ask the translator to translate in the client's own words and ask clients to repeat the information communicated to ensure accuracy

The error rate of untrained interpreters (including family, children, and friends) is sufficiently high that their use is actually more dangerous in some circumstances than having no interpreter at all. Using an untrained interpreter provides a false sense of security to the client and the health care provider. Extra care should be taken when telephone interpretation is used.

9. Obtain a comprehensive cultural assessment. This assessment should include information about the following factors:
 - The individual's birthplace
 - Time since immigration (if appropriate)
 - Ethnic affiliation and its strength
 - Primary and secondary languages
 - Speaking and reading ability
 - Family organization, structure, role differentiation, and child care practices
 - Social support networks and relationships
 - The importance of religion in the individual's daily life
 - Food preferences and prohibitions
 - Exercise and physical activities
 - Health and illness beliefs and practices
 - Customs and traditions pertaining to birth, illness, and death
 - Coping and communication styles
 - Spiritual beliefs, rituals, and practices
10. Develop an awareness of the barriers to care (such as ethnocentrism, lack of exposure to other cultures, and inaccurate information about cultural values, beliefs, and health care practices). This is the first step in eliminating them.
11. Do not make assumptions about the patient's ideas concerning ways to maintain health, the cause of illness, or the means to prevent or cure it. Develop a style of questioning that will help determine some of the patient's central beliefs about health, illness, and illness prevention. Allow the patient to be open and honest. There may be times when patients are afraid to say they have utilized both Western treatment and alternative remedies or folk medicine because they have been ridiculed in the past.
12. Determine the value of involving the entire family in the treatment since in many cultures the immediate or extended family is involved in decisions about medical care. Appropriately involving the family in the patient's care may increase compliance.

13. Refrain from delivering bad news or providing details about complications that can arise from treatment since many cultures do not have the “need to know” aspect of care. Watch for signs that the patient has heard as much as he or she can manage. Some cultures believe strongly that if someone says that death is a possible outcome of a procedure that speaking the very words can make it come true. This must be addressed in the legal and ethical context of informed consent.
14. When developing a plan of care, be sure to incorporate (as appropriate) the patient’s folk medicine or beliefs. This can enhance trust between the patient and the caregiver and help ensure compliance.

Cultural Use Of Complementary And Alternative Health Care



In the United States, growing use of complementary and alternative medicine (CAM) reflects an increasing diversity in health care practices, both among individuals from diverse cultures and among the general population. This increased use is seen among individuals who are native to the United States and those who are newly arrived.

The extensive use of CAM practices among such a wide number of clients provides a tremendous challenge to health care providers. Health care providers must realize that many CAM practices originated in traditional medicine. Acupuncture, herbal medicine, massage, therapeutic touch, prayer, and other spiritually oriented healing practices are just a few examples. A culturally competent provider respects these traditions and, when appropriate, integrates them into the treatment plan (OMH, 2012).

Culturally sensitive health care can be provided only if health care professionals use their knowledge of diversity to develop and implement culturally sensitive care. With cultural competence and the appropriate knowledge of specific CAM therapies, the health care professional can determine CAM’s compatibility with biomedical therapies.

SUMMARY

The composition of the population in the United States and the resulting health care services are changing rapidly. These changes provide health care professionals with tremendous opportunities to bridge cultural gaps and incorporate new ways of treatment and disease prevention into their practices.

Theoretical knowledge about cultural competence is not enough. Health care professionals must acquire the knowledge, skill, and respect for differences that lead to cultural competence. By incorporating culturally competent care and CAM modalities with more traditional methods of healing, new partnerships and improved ways to restore and maintain health will be created. Both the health care provider and the client will benefit as a result.

REFERENCES

Breier-Mackie, S. (2007, March/April). Cultural competence and patient advocacy: The new challenge for nurses. *Gastroenterology Nursing*, 30(2), 120–122.

Engebretson, J. C. (2013). In B. Dossey & L. Keegan *Holistic nursing: A handbook for practice* (6th ed.). Sudbury, MA: Jones and Bartlett Learning.

Hitchcock, J. E., Schubert, P. E., & Thomas, S. A. (2002). *Community health nursing: Caring in action* (2nd ed.). Clifton Park, NY: Delmar.

Leininger, M. & McFarland, M. R., (2002). *Transcultural nursing: Concepts, theories, research, and practice* (3rd ed.). New York: McGraw-Hill.

Luckmann, J. & Munoz, C. (2005). *Transcultural communication in nursing*. Albany, NY: Cengage Learning.

Management Sciences for Health. (2008). *The provider's guide to quality and culture*. Retrieved September 29, 2014, from <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

Ndiwane, A., Miller, K. H., Bonner, A., Imperio, K., Matzo, M., McNeal, G., et al. (2004). Enhancing cultural competencies of advanced practice nurses: Health care challenges in the twenty-first century. *Journal of Cultural Diversity*, 11(3), 118–124.

Office of Minority Health (2014a). *The Center for Linguistic and Cultural Competency in Health Care*. Retrieved October 1, 2014 from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=34>

Office of Minority Health. (2014b). *National standards on culturally and linguistically appropriate services (CLAS) in health care*. Retrieved October 1, 2014 from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>

Office of Minority Health. (2014c). *Profile: African American*. Retrieved October 1, 2014 from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61>

Office of Minority Health. (2014d). *Profile: Asian American*. Retrieved October 1, 2014 from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=63>

Office of Minority Health (2014e). *Profile: American Indian and Alaska Native (AI/AN) populations*. Retrieved October 1, 2014 from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62>

Office of Minority Health. (2014f). *Profile: Hispanic/Latino Americans*. Retrieved June 12, 2012 from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64>

Padela, A., Gunter, G. & Killawi, A. (2011). Meeting the healthcare needs of American Muslims: Challenges and strategies for healthcare settings. Retrieved October 2, 2014 from http://www.ispu.org/pdfs/620_ispu_report_aasim%20padela_final.pdf

Sharma, H. (2011). *Ayurvedic healing: Contemporary Maharishi Ayurveda medicine and science*. London: Singing Dragon.

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Oakbrook Terrace, IL, The Joint Commission 2010.

Tseng, W. S. & Streltzer, J. (2008). *Cultural competence in health care*. Spring Street, NY, Springer Science+Business Media.