A Course for Health Professionals on Cultural Competence in Aging

Diana Gurley, PhD, MPA; Bette Bonder, PhD, OTR/L;
Julia Rose, PhD; Elizabeth O'Toole, MD

Cultural Competence in the Health Professions

Acknowledgements

This curriculum has been developed by the Western Reserve Geriatric Education Center as a way to address vital concerns associated with health care for older adults. Funding was made available through DHHS, HRSA Bureau of Health Professions grant HP70113.

Primary authors of this series are Diana Gurley, Ph.D., Senior Research Associate and Director, National Technical Assistance Center for Geriatric Education, Case Western Reserve University, and Bette Bonder, Ph.D. OTR/L, Associate Dean, College of Science and Professor of Health Sciences and Psychology, Cleveland State University; Julia Hannum Rose, Ph.D., Associate Professor and Director, WRGEC, Case Western Reserve University; Elizabeth O'Toole, M.D., Associate Professor and Co-Director, WRGEC and Director of the Division of Geriatrics and Palliative Care, Department of Medicine, MetroHealth Medical Center, Case Western Reserve University. Joining the authors in planning and editorial oversight of the material were the Rev. Sala W.J. Nolan, Minister for Human Rights, United Church of Christ National Office; . . .

Purpose

The purpose of this course is to examine the ways health professionals interact cross-culturally with older adult patients. Our hope is that if we attend to cultural differences and improve our cultural competence in the workplace, we will provide better care.

In developing a better sense of cultural variety, you will improve your abilities . . .

- to look for risks for disease that might be informed by the customary behaviors of our patients.
- to recognize limitations in older adults' access to care, with an awareness of the accumulating effects of those limitations on our patients' well-being.
- to be aware of disparities in treatment of disease within our health care system so that we can extend ourselves to patients who may have received inappropriate treatment.
- to encourage older patients, their families, and health professionals to work together to understand a patient's conditions and possible treatments.
- to develop meaningful discussions between older patients and health professionals about treatment goals, and to encourage mutually acceptable treatment plans and regimens.
- to encourage adherence to mutually agreed upon care.
- to help to maintain a good quality of life for older adults.

The Course Series

This is the first of a series of learning modules that focus on case histories, skills, and clinical applications. In this introductory segment, we provide explanations for the importance of cultural competence in health care, including data on the realities of diversity, health disparities and discrimination in America. We offer a historical case study examining the long-term consequences of cultural abuse in medical care, and frame this background information with a structure for thinking about culture and how it works in a medical practice.

The series emphasizes these clinical skills and case applications:

(1) How to understand a patient's way of thinking about health and illness (this module),
(2) How to set the stage for meaningful and respectful care,
(3) How to develop partnerships in medical encounters,
(4) Ways to conduct history-taking and physical examinations,
(5) Negotiating treatment, and
(6) Following through with care.

We invite you to keep an electronic journal about your own experiences as you go through the course. Use it to reflect on your sense of culture, and how it changes as you learn. You will have opportunities to test your knowledge and try your hand at a case applications, and you will be given printable guides to resources and professional guidelines.

Learning Objectives for the Introduction

1. To identify health consequences of cultural misunderstandings between providers and patients.
2. To establish a historical understanding of health disparities and how they can arise in clinical encounters.
3. To understand a theory – or a way to organize our thinking – about the interaction between culture and health care.

Learning Objectives for Clinical Application 1: Explanatory Models

1. To define "explanatory model of illness"
2. To establish clinical skills to identify an individual patient's explanation of his or her illness.
3. To identify several ways a patient's explanatory model of disease may affect health outcomes.

CULTURAL ISSUES IN MEDICAL ENCOUNTERS

Test Your Knowledge

1. Cultural competence is important for health care providers in order to:
   a. be politically correct
   b. reduce health disparities
   c. improve health outcomes
   d. a & c
   e. b & c

2. Which of the following is not culturally mediated?
   a. view of independence
   b. religious beliefs
   c. innate personality
   d. dietary preferences

3. The Tuskegee Syphilis study is an important historical event because it:
   a. led to mistrust of the health care system by African Americans
   b. ultimately encouraged careful consideration of research ethics
   c. demonstrated the serious consequences that can result from lack of cultural awareness
   d. all of the above.

4. Which of the following does <u>not</u> describe the nature of culture?
   a. Culture is based on discrete interactions.
   b. Culture is learned.
   c. Values are embedded in culture.
   d. Culture is fixed, or generally unchanging.

5. Mr. Jones is a white male. He is 73 and presents in your practice complaining of back pain. He has worked as an engineer throughout his career. What would be realistic to expect regarding the impact of culture on Mr. Jones' care?
   a. It would have no effect, since he comes from a majority group.
   b. Age would be a more important factor than culture.
   c. You cannot know without further information.
   d. Back pain is not culturally mediated, so it would not be important.

Why Is It Important To Be Culturally Aware?

The Reality of Diversity

The fastest growing subsets of the American population are people of color. In 2003, individuals who identified themselves as White and not Hispanic or Latino comprised 69% of the population. By 2020, this group is likely to be reduced to 52%, while the proportion of people of color will increase from 31% to 48%. For Americans 65 and older, also a burgeoning population, the same trend exists.

SLIDES 1,2,3 ABOUT HERE (Population Distributions)

People who constitute minority groups must accommodate in some ways to majority groups in any country, whether by learning the language, or adjusting to dominant customs in public education, government, or health care. We believe that, as a general rule, people who constitute the dominant culture or majority group (especially if it is a large majority) can opt for less engagement with other cultural groups, but as their cultural dominance decreases, their need to learn about and accommodate to other groups becomes more visibly urgent.

The U.S. Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Office of Management and Budget, 2001 lists five categories for "racial" groups: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White. It also uses two categories for "ethnic" groups: Hispanic or Latino, and not Hispanic or Latino.

General descriptions such as these have been criticized because they reinforce the concept of "race" as reflecting genetic or biologic differences, they fail to reflect the fluid nature of sociopolitical identity, and they fail to reflect the way we define ourselves. Institute of Medicine, 1999. The Unequal Burden of Cancer: An Assessment of NIH Programs and Research for Minorities and the Medically Underserved. MA Haynes and BD Smedley, eds. Washington, DC: National Academy Press Despite these limitations, we will use these words to describe some elements of enculturation, mainly because this is how statistics tend to be kept, and because using them will help to illustrate some larger social trends.

Generalities do not begin to describe the richness of our heritage. "Hispanic or Latino" encompasses recent immigrants from the Dominican Republic, Mexican Americans whose families lived in the Southwest long before the land was claimed by the United States, and Americans who practice and strongly identify with Puerto Rican culture. "American Indian or Alaska Native" could refer to any of over 500 tribal nations, each with its own language, traditions, and kinship patterns. "Asian" includes upland tribal people of the Hmong, those whose ancestry is East Indian or Pakistani, people of Indonesia, and those of China, Korea, and Japan, among others; they may be recent immigrants, or from families that have lived in the U.S. for many generations. "Black or African American" may mean second generation Afro-Cuban or Caribbean, Panamanian, someone descended from slaves, a member of a Southern family or of a family that migrated from South to North in the large transitions of the 1950s and 1960s, a descendant of pre-Civil War free Blacks of Philadelphia, or any combination of these and other heritages. "Hawai'ian or Pacific Islander" refers to ancestors who probably lived thousands of miles apart.

Amish patients may not be able to refrigerate medications.

People of Muslim faith will not use insulin if, as is often the case, it is made from pork.

Faith traditions further complicate this picture. Religious diversity is also growing in the United States, with substantial increases in Muslim and Mormon populations, among others.

It is important to remember that "race" and "ethnicity" are social ideas, and as such, they are moving targets. Compare ideas about ethnicity in the U.S. today to those in the generations when your parents and grandparents were coming of age. Were immigrant populations different then? What was the social sense of being Irish or Italian or Eastern European in America, compared to now? Ideas about race and ethnicity change over time, as is evident from the 2000 census, when respondents were asked to check all the categories that applied, instead of selecting just one.

At the same time that the populations of people of color and of certain faith traditions are increasing in numbers and proportion, health care professionals with advanced degrees remain predominately white, non-Hispanic/Latino, and otherwise represent dominant groups in the U.S. Nursing aides, however, tend to represent minority groups. In general, there are significant cultural mismatches between providers and consumers. The federal government is attempting to correct this mismatch by encouraging the ethnic and racial diversity of health care professionals.

Western medicine has its own language, customs, beliefs, and rules.

It is a culture.

Do your clients share it?

The differences between health care providers and the people who receive that care may raise many potential issues related to cultural differences, but the most crucial cultural difference between patients and providers may be the least visible. Medicine is a culture with its own language, rules, beliefs, and customs. To the uninitiated, it can be profoundly confusing.

Health Disparities

There are tremendous disparities in health, risk for disease, and access to care across cultures. Many of them result in negative health outcomes, especially for minority groups, which is why they are so important to address. These disparities exist because of differences in genetic predisposition, because of different behavioral patterns that put people more or less at risk for accidents and disease, and because of historical patterns of prejudice and discrimination. They exist because discrimination persists in society, and it is reflected in systemic discrimination within social institutions. Disparities exist because access to care is limited by geographic proximity, patients' ability to afford care, and individuals' trust or distrust of the biomedical health care system. In medical encounters, health disparities can arise when providers and patients do not communicate clearly with each other, or when there are significant differences in their understanding and interpretations of situations.

We often think of health disparities in terms of race and ethnicity, and indeed there are significant differences in health status across racial and ethnic groups. Life expectancies are much lower for people in some groups than in others. In 1960, African American men

experienced an average life expectancy of 61 years, compared to 67 years for their white male peers – a gap of 6 years. By 1996, the gap had increased to 8 years, with white men expecting, on average, to live to 74, and African American men to 66 years. During the same periods, American Indian men from some regions of the country could expect to live only into their mid-fifties. Collins, Hall, and Neuhaus, 1999

SLIDE 4 ABOUT HERE (Life Expectancies at Birth, 65, 75)

As people grow older, the gaps in life expectancies grow smaller and less significant. For example, at age 65, white women can expect to live another 20 years, while African American women can expect to live 18 years longer – a difference of two years. For those who reach the age of 75, this gap entirely disappears: both white and African American women can expect to live another 12 years.

As we age, the differences in life expectancy by race become less pronounced, or even disappear.

Why would this happen?

Some call it a "survival effect"—

the idea that the strongest and most resilient people are most likely to survive the stresses that create health disparities to live successfully into older adult life.

There are also tremendous disparities in health care. For example, it has been demonstrated that minority individuals in America are less likely to undergo bypass surgery or to be given appropriate cardiac medications, and they are less likely to receive kidney dialysis or transplants. Several research studies have shown that there are significant racial differences in who receives appropriate diagnostic tests and treatments for cancer. Individuals from minority groups are less likely to receive more sophisticated treatments for HIV infection to delay the onset of AIDS, and are more likely to receive lower limb amputations for diabetes. These differences persist regardless of income and insurance coverage. An excellent resource for more detailed information on health and health care disparities can be found in the book, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, (2002), edited by Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson and published by the National Academy Press, National Academies of Science Institute of Medicine. This material is available in book and CD formats, and can also be accessed online at http://national-academies.org.

SLIDE 5 ABOUT HERE

One tremendous social attempt to address disparities has been the institution of Medicare and Medicaid, which opened opportunities for health care for minority Americans that had previously been unavailable. It is clear that these two programs have greatly reduced some forms of disparity in care. At the time they were enacted, white Americans were hospitalized 27% more often than members of minority groups, and in the case of older Americans, the racial gap reached 70%. By 1975, this gap had narrowed to 4% overall, and to 14% among older adults. Davis and Schoen, 1978; Rosenbaum, 2003 Still, the number and kinds of interventions used by Medicare beneficiaries continues to be affected by factors of race and income, leading researchers to conclude that "Medicare coverage alone is not sufficient to promote effective patterns of use by all beneficiaries." Gornick ME et al, 1996

Health and health care disparities do not only occur by race and ethnicity, but also by gender, circumstances, and health behaviors – such as diet and exercise – that are culturally influenced.

They occur according to geographic region, rural or urban location, sexual preference, environmental circumstances, political shifts in policy, education, community isolation or connectedness, and financial resources. They also are influenced by religious positions toward health care and treatment interventions. There are many cultural elements in life, and all of them can influence people's access to care, treatment, health behavior choices, and support.

For older adults, it is important to know that health disparities can change over the lifespan, and their effects can accumulate throughout life, beginning with prenatal care. Infant mortality is higher among African Americans, native Hawaiians, and American Indians than among non-Hispanic Whites. Environmental stressors and unsafe conditions are more prevalent in poorer neighborhoods, and children living below the poverty threshold are much less likely to be immunized for diphtheria, tetanus, polio, measles and mumps. About 6% of children under 18 have no usual source of health care, which also differs by ethnicity, and in 2001, between 15% and 20% of children under 18 had no visit to a doctor or clinic in the past 12 months. Chartbook on Health, United States, 2003 Access to primary care depends on its close availability, transportation, insurance coverage or ability to pay, and the presence of enough health care providers to serve a geographic base.

SLIDE 6 ABOUT HERE (Infant Mortality)

Working age adults living below the poverty level are twice as likely as families living 200% or more over the poverty line to have no usual source of health care; Hispanic and Latino people are more than twice as likely (44%) than white, non-Hispanic (21%) and African American (22%) people to have no usual source of care. Occupational injuries are more prevalent in transportation, communication, utilities, and construction industries. Lack of health insurance coverage varies greatly by geography, with higher rates of uninsured adults in the Southwest and lower rates in New England and the Midwest. Chartbook on Health, United States, 2003

Less than 10% of working-age adults are uninsured in Massachusetts, Rhode Island, Wisconsin, Iowa and Minnesota.

In Florida, Louisiana, Oklahoma, Texas, Arizona, New Mexico, and California, the uninsured rate is 20% or higher.

The end result of accumulated health disparities for most minority groups and for the poor is earlier death, more complex diseases and conditions, and fewer appropriate treatment options.

SLIDE 7 ABOUT HERE (Chronic Health Conditions by Age Group)

Just as there are differences among people that lead to poor health outcomes, there are differences that can be extremely positive. Family support, embeddedness in the community, healthy dietary practices, meditation and prayer, and traditional healing methods such as acupuncture and herbal remedies can enhance care in important ways. Providers who are not sensitive to cultural factors miss these positive opportunities for treatment support. And although providers rarely ask older adults about their use of these mechanisms, Rose and O'Toole, 1998 research into cultural modalities in health outcomes is growing, enhanced by the recently created Center for Alternative Medicine (CAM) in the National Institutes of Health. For more information and links, go to http://www.nccam.nih.gov.

Discrimination

Just as individual values, beliefs and behaviors develop within a dominant culture, so do the values, tenets and behaviors of institutions. The aggregation of individuals' ways of being emerge in system-wide patterns that support or hinder good health care. Discrimination in health care needs to be addressed at several levels, including not only patient behaviors and institutional patterns, but also provider actions in the clinical encounter.

So what is discrimination? Discrimination is the differential and negative treatment of individuals on the basis of their race, ethnicity, gender, age, or other group membership. Institute of Medicine (2002), Unequal Treatment, p. 95 Some people might describe discrimination as having both the element of prejudice – a way of thinking differently about a whole group of people – and the element of power – that is, greater resources for what is needed.

The sociologist Lawrence Bobo describes and supports with research findings five somewhat contradictory trends in race relations: Bobo L.D. (2001), Racial Attitudes and Relations at the Close of the Twentieth Century, in Smelser N.J., Wilson W.J., Mitchell F, eds., America Becoming: Racial Trends and Their Consequences, Vol. 1. Washington, D.C.: National Academy Press, pp. 264-301.

- Americans' attitudes toward the goals of integration and equality improved steadily over the three decades from 1970 to 2000.
- This trend has not resulted in increasing public support for policies or significant efforts to improve educational, employment, housing, or other opportunities for U.S. minority groups.
- White Americans continue to express support for negative stereotypes of minority groups in large numbers, even though few of these individuals would identify themselves as racist.
- White and non-white Americans perceive racial discrimination in the U.S. in significantly different ways.
- Minorities' attitudes about race relations suggest a deepening level of alienation.

Given these trends, it is not surprising that white and non-white Americans have very different views of the reality of racial and ethnic stereotyping and discrimination in the U.S.

SLIDES 8 & 9 ABOUT HERE (Perceptions of & Actual Discrimination by Race)

The reality for many minority groups in the U.S. is systemic discrimination in mortgage lending, housing, employment, and criminal justice. All of these areas have ramifications for health and health care.

In an analysis of the 30 largest U.S. cities, Massey (2001) found that residential segregation is most consistent and deep among African Americans, but is also significant among Asian and Hispanic/Latino Americans

This finding occurs independently of social class, for rich and poor.

In 6 metropolitan areas – Cleveland, Chicago, Detroit, Gary, Newark, New York – the average African American lives in a neighborhoods that is more than 80% Black.

Massey calls this "hypersegregation."

Systemic contributions to health disparities include problems of access due to health care coverage and geographic isolation, language barriers, reduced availability of specialty care, fragmentation of services, and clinical bureaucracies that must be worked through for appropriate treatment. The pattern of emergency room use by people without insurance coverage for regular care means that underserved populations will tend to see different providers with each health care encounter, compounding miscommunications and issues of continuity of care. Sporadic consumers, because they do not receive continuous primary care, are not likely to be represented in the development of health care policies that will meet their needs. Patterns of coverage can encourage groups to overuse some services and underuse others, leading to institutional policies that restrict some services because of inappropriate use. Economic circumstances influence the kinds of services that are allowable. Emphases on profits for goods and services contribute to the cost of medications, home care, and hospitalization.

According to the U.S. Bureau of the Census, more than 1 in 4 Hispanic or Latino individuals in the U.S. live in a linguistically isolated household.

As health care providers, we need to remember that systemic practices that lead to health disparities are really an accumulation of individual encounters. That is how we can discover what we can do to change circumstances so that we reduce discrimination and improve well-being for everyone.

So, as health professionals, what should we be noticing and changing?

Even well-meaning people who do not seem overtly biased can demonstrate unconscious negative attitudes. This is especially true in clinical encounters, where time constraints and a focus on particular health problems increase the probability that stereotyping will occur.

Stereotyping is a process that uses social categories (like gender or ethnicity or regional background) to acquire, use, and recall information about people. In the clinical encounter, stereotyping can seem very useful, and given time constraints and the volume of encounters we have to deal with, stereotyping can come to seem a necessary thing to do. Categorizing helps providers organize and simplify complex situations, and helps us deal with uncertainty. It can be useful for predicting and planning to resolve problem situations. However, as useful as general attitudes and stereotypes may be, it is imperative for health professionals to understand

that our attitudes and ways of categorizing people are also shaped by cultural elements. The most troublesome ones may be the ones we cannot see in ourselves.

We all have positive and negative attitudes that, if unguarded, can lead to stereotyping, which in turn can result in discriminatory practices. One form of stereotyping that has potentially profound implications for problems in the medical encounter is a provider's negative assumptions about older people. Nussbaum et al, 2000 Robert Butler coined the term "ageism" to describe the widespread discrimination that arises from these kinds of assumptions about older adults. Butler, 1969 In 1982, Palmore summarized the main conclusions of a large body of research on discrimination in aging, as follows:

1. Ratings of old age tend to be more negative than ratings of other age categories.
2. Most people have mixed feelings about old age, and tend to rate older adults both positively and negatively.
3. There are more stereotypes associated with older adults than with younger adults.
4. Many negative stereotypes are held by a majority of people.
5. These attitudes are resistant to change, but we can reduce misconceptions about aging by improving knowledge about aging. Palmore, 1982

One mechanism by which stereotypes can function is this: Age-related cues in older adults, like gray hair or wrinkles, can activate a set of expectations on the part of another person. This person then modifies her behavior based upon those expectations. For example, common sets of expectations about older adults may be that they have physical or cognitive impairments making it difficult to hear or to understand; the other person may modify his behavior by speaking slowly, or as has often been noted, by speaking in a kind of secondary "baby talk". The older person is then constrained by the behavior of the other person, which changes the dynamic of the conversation. Nussbaum et al, 2000 In focus groups, older adults have made it clear that patronizing speech and "baby talk" most often arises in three settings: in health care situations, in disputes with family members, and in public places when older adults are moving more slowly than younger adults. Hummert, Weismann & Nussbaum, 1994; Culbertson and Caporael, 1983

There is sound evidence to indicate that bias, stereotyping and prejudice on the part of health professionals may contribute to differences in health care access and treatment. Institute of Medicine, 2002. Unequal Treatment In one study, for example, Schulman et al. assessed physicians' recommendations for management of chest pain after they viewed vignettes of "patients" (actors) who complained of symptoms of coronary artery disease. The actors presented the same symptoms, but varied in race (Black or white) and gender. The researchers found that physicians were less likely to recommend cardiac catheterization for women than for men, and for African Americans as compared to whites. Schulman KA, Berlin JA, Harless W, Kerner JF, et al. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization, New England Journal of Medicine 340:618-626.

SLIDES 10, 11 ABOUT HERE (Photos of Actor "Patients")

Research has shown consistent discrepancies in recommendations for treatment according to social group. Heart patients have been differently recommended for angiography Weitzman et al. (1997), catheterization Giles et al., (1995), aspirin therapy and beta-adrenergic blockade Allison et al. (1996) , and revascularization Carlisle et al. (1995), Blustein, Arons, and Shea (1995). African Americans with cerebrovascular disease are given lower rates of diagnostic and therapeutic procedures; renal patients receive disparate triage for transplants; and people from minority groups who have HIV/AIDS are less likely to receive antiretroviral therapy. IOM (2002)

In a study of Hispanic and non-Hispanic white patients with long bone fractures, physicians assessed the severity of pain similarly for both groups, but consistently prescribed less analgesia for the Hispanic patients. Todd, Lee & Hoffman (1994)

Prejudice and discrimination exist. They shape all of our attitudes, and they are a substantial source of stress for people who live in communities dominated by cultures other than their own.

What is Culture?

Culture is about shared experience. It occurs wherever people hold in common values, beliefs, language, symbols, customs, and expectations that guide their behavior. Each of us takes part in many cultures, and our cultures are always moving and changing. Some are large, like the dominant culture of the country we live in. Some are micro-units, such as our families with their particular structures and beliefs, or our professions. Some cultures change quickly: Consider the shifting trends of popular music. Others change more slowly, as with established institutions and laws. Medicine as it was practiced in the 18th century might seem familiar to you in some important ways, but it was not the same medicine you practice today.

JOURNAL PAGE 1 GOES ABOUT HERE.

SLIDE 12 ABOUT HERE (Concentric Circles of Cultural Influences)

Culture emerges out of shared experiences across the full spectrum of a person's life. Many of these experiences can occur simultaneously, and they can be contradictory. While ethnicity plays an important role, especially where ethnic ties are strong, each person is also responding to the dominant culture in which he or she lives, and to other cultures of smaller units -- for example, the culture of an extended family, a profession, an age group such as adolescence, or a disability. Personality influences behavior, as well. Knowing an individual's self-identified primary cultural affiliation does not, by itself, tell you all you need to know about an individual's beliefs and values.

What is your cultural background? Consider…

race, ethnicity, age cohort, your family's country of origin, languages you speak, where you live, gender, profession, community, sexuality, friendships, education and training, interests, resources and income

Cultural Wealth

We have raised concerns about risk factors and the effects of cultural disconnection on health and health care, but culture is also a potent force in encouraging and maintaining the well-being of older adults.

Are you engaged in health education? You need to know the support systems for clients you are trying to reach. How can you engage neighborhoods, churches, activities centers, families, the arts, and educational groups in health promotion and mutual care?

Are you a first responder to emergencies? Find out who knows your citizen base. Who will be aware of the resources available to them should an emergency arise? Who are the best communicators for training in emergency preparedness?

Do you have patients with complex diseases and conditions? You need to be informed about who is engaged in their care. Who assists in acquiring and distributing medications, and making sure they are taken correctly? Who deals with bills? With appointments? Who is checking on your patient on a regular basis? Who will tell you if something is wrong?

Do you have clients with reduced mobility? If your focus is on function, you can find ways to enlist friends and family to ensure that your client has a decent quality of life. Who can assist in rehabilitative exercise? Transportation? Meal preparation? Cleaning? Who can provide enrichment and stimulation?

Because culture is inherently social, any relational aspect of health and health care has the potential to be strengthened and improved by cultural resources. Consider the effect bringing these resources to bear could have on prevention, treatment, recovery, and overall well-being.

Consider, also, how the cultural resources your clients bring to the medical encounter can enrich you. Providers with an understanding of a wide range of human responses to illness have an expanded sense of what is normal and not normal, and can imagine opportunities for care that may otherwise be disregarded, to the detriment of those for whom we care.

Finally, consider that the experiences older adults bring to your practice represent a part of your own heritage, and are a living history for you. They can bring a richness of meaning to your practice and to your life, if you listen.

What are the Consequences Of Cultural Misunderstandings?

A health professional's attitude plays a large part in provider-patient communication, agreements to treatment plans and modalities, adherence to care, and the supportive or isolated milieu in which health care consumers are expected to maintain the regimens we suggest. This is true for providers regardless of discipline, although the culture of each discipline will influence the ways health professionals provide care. As health professionals, we need to be thoughtful about these factors, because they have consequences.

When health professionals are not knowledgeable about the various cultures in which they work, they will miss opportunities to explore important risk factors for diseases and conditions. Symptoms, as explained by patients, may be misunderstood or ignored by clinicians. Clinicians may also fail to determine what non-Western herbal remedies an individual might be using that could affect medication efficacy – an especially important consideration for older immigrants, and particularly those closely aligned with the practices of the places where they were raised.

Treatments preferred by providers may interfere with fundamental family and social values. A provider may breach taboos in clinical examinations, testing, or treatments, to the extent that a patient may withdraw from care without ever saying why. These are important concerns with older patients, who may be more compliant and less openly communicative than younger adults.

You ask a patient if she minds if a student doctor observes her exam. She says it's fine.

Is it? How can you be sure?

JOURNAL PAGE 2 GOES ABOUT HERE.

Language barriers may inhibit good communication. Translations by family members may be guided by what family members want the patient to know, or how they understand (or misunderstand) what the provider is saying.

An effective translator will position herself behind or beside the patient, so she will not come between patient and provider in their communication.

Patients and providers may differ in generational assumptions about the seriousness of conditions or the efficacy of treatments. Different assumptions can lead to a lack of agreement on treatment regimens, or to non-adherence to a treatment plan.

What diseases define your generation?

An older person who has lived through an influenza pandemic or who has lost loved ones to tuberculosis may hear words like "flu" or "chronic cough" differently than you do when you say them.

The living situations of individuals may or may not be highly supportive of the provider's choice of care, and the provider may rely on support systems that are not present. Eating habits, nutrition, or environmental conditions that create risks for injury or disease or that promote good health may go unnoticed by the practitioner.

Do you know your patient's living circumstances?

Many people go through periods of financial reversals and periods of homelessness.

Does your patient live alone, or with children or with others who need substantial care?

Are his living conditions stable and healthy?

Failure to establish a genuinely trusting relationship may lead a patient to withdraw from regular care and to seek care sporadically, even when conditions become complicated and extreme. They may also choose intermittent care from locations (such as emergency rooms) that are expensive and least suitable to address their health concerns.

SLIDE 13 ABOUT HERE (The Role of Clinical Discretion)

Because there are so many possible ramifications for cultural misunderstanding, and because the potential consequences are so severe, many health professional associations and the government entities that fund health professions have established guidelines for cultural competence. You can access many of these guidelines by the links shown on this page.
Links to Professional Guidelines, here and under Resources

JOURNAL PAGE 3 GOES ABOUT HERE.

Throughout the history of health care, there are examples of abuse or neglect of particular groups based on race, ethnicity, or other cultural factors. Abuse and neglect have led to serious health problems for the individuals involved, and in many cases, they play out for generations afterward in suspicion and distrust, alienation, and anger. When the level of distrust is high, it can lead to avoidance of needed care, the development of chronic and complex conditions that might never have emerged had they been treated in appropriate and good routine care. Complex conditions result in poorer quality of life and increased health care costs for large groups of people. Ultimately, high levels of distrust based on real historical experience can put an entire population at risk.

A Case Illustration from History: The Tuskegee Experiment

Among the best known examples of abuse and neglect that stem from cultural insensitivity is the Tuskegee Syphilis Study, which was implemented in Alabama from 1932 to 1972. Six hundred African American men were the research participants. 399 were infected with syphilis without their knowledge or consent. Their syphilis went untreated because researchers wanted to study the effects of the disease. Participants were not told the purpose of the study, but instead were informed that they were being treated for “bad blood.” Among African Americans of this generation, “bad blood” is a term often applied to such disorders as anemia.

JOURNAL PAGE 4 GOES ABOUT HERE.

In 1972, the advisory panel for the study recommended its immediate cessation. A class-action lawsuit that started in 1973 ultimately resulted in a settlement of $9 million, and the establishment of a Tuskegee Health Benefit Program that made medical services available to the survivors and their families.

The financial settlement did not resolve the sense of betrayal and mistrust generated by four decades of deception. To this day, many African Americans remain suspicious of the health care system and are reluctant to seek care. This mistrust has complicated efforts to treat sexually transmitted diseases, including AIDS, in this population. Worse, the story has been generalized by many people to include almost all aspects of health care and health research, making ethical and beneficial treatments and investigations much more difficult, and reducing potentially good care for large numbers of people.

For more information about the Tuskegee Study and its consequences, visit the following sites and texts:

- CDC National Center for HIV, STD, and TB Prevention (2004). The Tuskegee Syphilis Study: A hard lesson learned. http://www.cdc.gov/nchstp/od/tuskegee/time.htm.
- Wadler, A. (2002). Navigating the social landscape: Cultural sensitivity in Public Health Education.
- Burson-Marsteller http://www.bm.com/pages/insights/pubs/articles/as-spring2002.
- Cargill, V. (2001). Keynote: Clinical challenges: HIV/AIDS. American Journal of Multicultural Medicine. 38-39.
- Bonhomme, J.J.E. (2001). African American attitudes toward the health care system and disparities in health care utilization. Presented at the American Public Health Association Annual Conference. http://apha.confex.com/apha/129am/techprogram/paper_28350.htm.

JOURNAL PAGE 5 GOES ABOUT HERE.

Culture Emergent: A way to structure our thinking about these issues

One helpful approach to culture is to view it as emerging in the everyday interactions of individuals. Bonder, Martin, & Miracle, 2002. This way of thinking emphasizes both group patterns and individual variation. It explains that people experience multiple cultural influences, and those influences interact with biological and psychological aspects of the person. Rather than focusing on particular behaviors of large cultural groups, this approach suggests that the way individuals behave is based on an array of influences, both general and unique to the person.

Culture Emergent theory takes into account the process of change in culture over time. Clifford, 1986. Since we all have had different experiences in life, personal models always vary at least slightly, even among individuals who live in similar environments and share many similar experiences.

This framework for thinking highlights five important characteristics of culture: Culture is 1) learned; 2) localized; 3) patterned; 4) evaluative; and 5) has continuity, but changes.

1. Culture is Learned

Culture is transmitted from one generation to another through the process of enculturation – that is, the acquisition of knowledge that allows one to function as a member of a particular group.

The learned aspect of culture sets it apart from biology. Kuper, 1999. We learn culture through formal instruction, but also through observation and modeling. You have learned your professional culture through specific instruction during your education, but you also learned from watching your mentors and instructors. But even within the culture of medicine, there is great variation. Consider, for example, the knowledge base and priorities of surgeons as compared with family practitioners, nurses with social workers, and occupational therapists with physical therapists.

The learning process is ongoing, and new behaviors, beliefs, and values emerge as we acquire new information. This process does not stop as we grow older. We continue to learn and to incorporate the world around us, and our breadth of vision tends to grow with experience.

Further, because culture is learned, it is shared by those from whom it is learned and those to whom it is taught – both teachers and students. This interactive sharing and mutual reinforcement has the effect of binding an individual to the group.

JOURNAL PAGE 6 GOES ABOUT HERE.

2. Culture is Localized

Culture is created and expressed through discrete interactions with specific individuals in particular locations. Rosaldo (1999) suggests that "all knowledge is local" even in an era of mass electronic communication around the world. Rosaldo, 1999, p. 31; Abu-Lughod, 1999

Professional settings offer well-defined environments for the emergence of localized knowledge. Local patient populations influence clinic organization. In a given clinic, the disciplines of various providers will also influence its organization. Social workers have different priorities and work requirements than orthopedic surgeons, and these differences will be reflected in such variables as scheduling patterns, length of visits, staffing, and patient wait times.

> ***How do you think about time?***
>
> ***If you are Northern European working with a Native American population in a rural area, how will you schedule appointments?***
>
> ***You will have to adjust to issues of long distance travel, and people lacking consistent access to transportation.***
>
> ***You will also have to think differently about what time means.***

Interactions in multiple social settings provide multiple contexts for learning culture. Consider the living experiences of people in long term care settings. What cultures exist in institutions? How do they blend the varied experiences of residents?

> ***Try this interesting exercise:***
>
> ***Observe the culture of a residential institution during routine business hours.***
>
> ***Come back at night and observe again.***
>
> ***What do you see?***

Every individual embodies many cultural expressions -- some based on ethnicity, race, or country of origin, and others based on life experiences in professional, geographic, religious, social, or family settings. In every interaction, only part of an individual's identity is being exhibited, making information about that identity incomplete. Holland, Lachicotte, Skinner & Cain, 1998.

3. Culture is Patterned

Patterns help minimize ambiguity and relieve us from having to renegotiate every interaction from scratch. Rosaldo, 1999 Repeated patterns establish the customary expectations that we use to interact with each other. That is, individuals can repeat behaviors so often that they become ingrained, and the behaviors seem like empirical reality. Consider the meaning of this idea for older adults who have spent a lifetime practicing patterns. Through ritual, daily routine, and habitual behaviors, individuals express their cultural identities and affiliations, as well as their individual preferences and characteristics.

> ***Think about a clinic that is familiar to you. What are the routines?***
>
> ***Did you ever think about patterns in a clinic as an expression of clinical culture?***
>
> ***Do coworkers use short-hand language?***
> ***How is the space organized?***
> ***How do you deal with issues of privacy?***
> ***What are the protocols and habits?***

4. Culture is Evaluative

In some cultures of care, it would be incorrect for a healer to accept money.

In others, healers are given gifts of food, and healing is meant for the community rather than for the individual.

Values are embedded in culture and are reflected in individual behaviors and choices. Kuper, 1999 This aspect of culture is often evident in health care encounters. For example, the way an individual follows (or doesn't follow) the advice of the provider will stem from the individual's view of independence, and the value he places on the provider's advice. While a nurse or nutritionist may have clear values about the importance of particular health habits, such as frequent washing or dietary choices, clients may have very different views on the subject due to their beliefs or the realities of their living circumstances. A provider might be uncomfortable if an Asian client offers her a gift if she is not aware of the importance the client places on reciprocity.

Individuals are shaped by their cultures, but socialization is not the same for all members of a given group. Gender, age, innate skills, and social position are among the variables affecting an individual's socialization. Rosaldo, 1999 One area in which values have important consequences is in how aging is perceived. Some cultures are reputed to be supportive of older adults, and to value them as repositories of great wisdom. In others, notably mainstream culture in the U.S., aging is viewed rather negatively, with media images of foolish or unattractive older individuals being common.

Compare the benefits and shortcomings of public health and corporate hospitals.

What do you value?

Values also change over the life-course, a particular concern when dealing with elderly individuals. Their value orientations may differ from the provider's not only because of particular needs and experiences, but also because of what they have learned by interacting with the cultures that surround them.

5. Culture has Continuity, but Changes

Cultures are relatively stable through time, but they are far from static. They are constantly evolving. Abu-Lughod, 1999 They would disappear if they did not adapt to life circumstances. This is not to suggest that cultural differences are disappearing. Even in the face of global communication, differences persist, and in some cases are even sharpening. Sahlins & Service, 1960 Similarly, an individual's cultural knowledge and values change over the life course as she encounters new situations. Individual experiences shape each unique person. Clifford, 1986 At the same time, many individuals across a society may experience forces for change almost simultaneously and may respond in similar ways. Demographic changes at a societal level produce organization change at an institutional level. Martin & Bonder, 2004 For example, an aging U.S. population is resulting in changes in laws, policies, housing accessibility, commerce, and the pharmaceutical industry.

Where were you when the World Trade Center collapsed on September 11?

This is a memory you share with others.

JOURNAL PAGE 7 GOES ABOUT HERE.

In summary, the way of thinking we call *"Culture Emergent"* suggests intervention strategies that can be applied in any situation, regardless of the particular cultural and individual characteristics of the patient. They include getting to know the cultural histories of the areas where we practice, and learning and keeping current with disease prevalence and treatment efficacy for the culture groups we encounter regularly. We can increase our awareness of the diversity of our patients by listening carefully to what they say about their living circumstances, beliefs, and preferences. We can reflect on our own cultural identities, acknowledge differences, elicit patient perspectives, and apply what we know about medicine in a way that takes individuals' beliefs and circumstances into account.

SLIDE 14 ABOUT HERE (Strategies)

What Did You Learn?

1. Cultural competency is important for health care providers in order to
    a. be politically correct
        (Too many individuals avoid the necessity to understand others by labeling that necessity with a pejorative term. Cultural competency has nothing to do with political correctness, and everything to do with your clinical skills. Try again.)
    b. reduce health disparities
        (Those who understand others greatly increase their odds of diminishing disparities. This is one correct answer. Try for both.)
    c. improve health outcomes
        (Effective communication with your clients can improve care. This is one correct answer. Try for both.)
    a & c
        (Political correctness is problematic in trying to acquire cultural competency. The notion reflects a negative mind-set about difference. Try again.)
    * b & c
        (This is the best answer, as both improved health outcomes and reductions in culturally-based disparities are goals of cultural competency.)

2. Which of the following is not culturally mediated?
    a. view of independence
        (This is definitely culturally mediated. Try again.)
    b. religious beliefs
        (This is definitely culturally mediated. Try again.)
    c. *innate personality
        (Of the factors listed here, innate personality is not culturally mediated. Keep in mind, though, that personalities can be influenced by culture as individuals learn about the world around them.)
    d. dietary preferences
        (This is definitely culturally mediated. Try again.)

3. The Tuskegee Syphilis study is an important historical event because it
   a. has led to mistrust of the health care system by African-Americans
      (There is no question that mistrust of health care and health care providers is a lingering legacy of this study.)
   b. ultimately encouraged careful consideration of research ethics
      (Many of our current informed consent and other procedures emerged from concerns about this kind of research abuse.)
   c. demonstrated the serious consequences that can result from lack of cultural awareness
      (Lack of concern about the African-American subjects of the Tuskegee study led to serious, long-term damage to that community and to society more generally.)
   d. *all of the above.
      (All of the statements here are true.)

4. Which of the following does <u>not</u> describe the nature of culture?
   a. Culture is based on discrete interactions.
      (Even in an era of mass communication, culture is created and expressed through discrete interactions, and in specific locations. Try again.)
   b. Culture is learned.
      (Culture is transmitted from one generation to another through teaching and learning skills that enable a person to be part of a group. Try again.)
   c. Values are embedded in culture.
      (Values are embedded in culture and reflected in individual choices that represent that culture. Try again.)
   d. *Culture is fixed, or generally unchanging.
      (Cultures are relatively stable through time, but they are not static. They evolve constantly. This answer is correct.)

5. Mr. Jones is a white male. He is 73 and presents in your practice complaining of back pain. Mr. Jones has worked as an engineer throughout his career. What would be realistic to expect regarding the impact of culture on Mr. Jones' care?
   a. It would have no effect since he is part of a majority group.
      (Everyone has cultural identities. Even someone who appears to be from a large majority group may have a wide ranging background and important identities you cannot see at first glance. Sometimes it is harder to be culturally sensitive with those who seem to come from the mainstream. Try again.)
   b. Age would be a more important factor than culture.
      (Age is certainly important. In fact some have argued that age has its own culture. However, without more information, you can't determine the relative weight of various personal factors in the patient's background. Try again.)
   c. *You cannot know without further information.
      (Cultural competency relies on gathering information and incorporating it into treatment. This is the correct answer.)
   d. Back pain is not culturally mediated, so it would not be important.
      (Pain is an example of a symptom with considerable cultural variation. Some more stoic cultures might not even complain about "twinges" while others might be incapacitated. Try again.)

How Do People Understand Illness?

Unit1. Explanatory Models

Before you begin, test your knowledge:

1. The best definition of "explanatory model" is:
    a. each individual's understanding of what is wrong and what caused it
    b. diagnosis based on lab findings.
    c. synthesis of laboratory and clinical findings regarding patient complaints
    d. flow-chart for making clinical decisions

2. Which question is NOT important to ask in assessing an explanatory model?
    a. What do you call the problem?
    b. What do you think the illness does?
    c. What do you think the natural course of the illness is?
    d. What lab tests would you like to have done?

3. According to the hot-cold system, which of the following is most important for good health?
    a. Consumption of hot drinks every morning, and cold food at night.
    b. Avoidance of excessive heat or cold.
    c. Avoiding heat in the winter.
    d. Appropriate balance of substances attributed to be either hot or cold.

What is an Explanatory Model, and How Do I Find It?

One of the most important clinical skills to develop and apply in our clinical encounters is the ability to elicit and understand the explanatory models used by our patients to understand their most common conditions.

JOURNAL PAGE 8 GOES ABOUT HERE.

The questions you just answered reflect your *explanatory model* -- that is, your belief system about what constitutes health, what causes illness, and what kinds of interventions are likely to be helpful. Since you are a health care provider, it is likely that you labeled your illness based on your discipline and scientific knowledge. For example, if your most recent illness was characterized by a scratchy throat, runny nose, head congestion, and cough, you may have labeled it "acute rhinitis." You might believe that acute rhinitis is caused by a virus, and that there is no cure except time. So you may have treated symptoms with medications (decongestants, throat lozenges, cough suppressants) to help you feel more comfortable until the symptoms abated.

There are other possible constructions of that illness, however. Your mother might have taught you that this particular constellation of symptoms is a "cold." You might find yourself avoiding drafts, or not going outside with wet hair as a way to avoid a cold or minimize its impact. And you might have treated the symptoms with chicken soup, or with tea and honey.

Everyone has these kinds of explanatory models for health and illness. It is entirely possible that a particular individual might hold two models at the same time. So as a scientist, you might believe the virus theory, but still find yourself avoiding drafts and taking chicken soup. And more

than one explanatory model might prove to have some validity. Recent research on the effects of chicken soup have demonstrated that it does, indeed, have chemical compounds that help reduce symptoms of acute rhinitis/colds.

The idea of explanatory models was first proposed by Arthur Kleinman. Kleinman, Eisenberg & Good, 1978 He indicates that effective care requires that the provider understand the patient's construction of illness and healing. Such understanding greatly increases the probability that the provider will be able to construct a treatment plan that is acceptable to the patient, and that the patient will follow through with recommendations. Kleinman suggests asking the following questions:

- What do you call the problem?
- What do you think the illness does?
- What do you think the natural course of the illness is?
- What do you fear?
- Why do you think this illness or problem has occurred?
- How do you think the sickness should be treated?
- How do want us to help you?
- Who do you turn to for help?
- Who should be involved in decision making?

Obviously, the answers to these questions are not, in themselves, sufficient to formulate treatment. If a patient believes his illness is due to possession by spirits, the physician or physical therapist is not required to do an exorcism. However, knowing that this is the patient's belief, the provider may be better able to explain his or her recommendations, and to help the patient find alternative strategies for dealing with the belief in spirit possession that might impede healing.

Explanatory models are more challenging in older adults with complex conditions, comorbidities, or cognitive impairment.

Ask your patient to tell you the story of the problem that brought him to you.

How did it get started?

What is her most important concern?

For more information and a description of Kleinman's view of explanatory models, go to http://www.mywhatever.com/cifwriter/library/eperc/fastfact/ff26.html. This website shows how standardized questionnaires are often insufficient to elicit explanatory models, and discusses limitations in care based solely on patients' explanatory models. http://bjp.rcpsych.org/cgi/content/full/181/6/535-a. To learn more about how to gather information about an older client's explanatory models, go to www.stanford.edu/dept/medfm/ebooks/Mod_Four.pdf.

JOURNAL PAGE 9 GOES ABOUT HERE.

An Ancient and Modern Example of Health Explanations: The Hot-Cold System

More than 5,000 years ago, traditionally dated before 4000 BCE and scientifically established to at least 1500 BCE, Ayurveda was established as a natural healing system by the same sages who produced the original systems of Yoga and meditation. The traditional healing system of India, Ayurveda originated as part of Vedic Science as a method of addressing problems with the physical body. It identifies three elements of life force in the body which, in Sanskrit, are called *Vata,* or air, "that which moves things" and which governs sensory orientation, comprehension, and mental balance; *Pitta,* or fire, "that which digests things" and is responsible for metabolic transformation, and which governs our ability to understand things as they are; and *Kapha,* or water, "that which holds things together" and provides substance and support, which constitutes most of our bodily tissues, and which governs our emotions and such traits of compassion, modesty, patience, and forgiveness. *Vata* is seen to be dry, cold, and light. *Pitta* is hot, moist, and light. *Kapha* is cold, moist, and heavy. In Ayurvedic medicine, these elements are seen to be mutable, and meant to be balanced. An imbalance of *Vata, Pitta, or Kapha* leads to disease. In addressing illness, the Ayurvedic system takes into account all aspects of the person – mental, spiritual, physical, emotional, and attitudinal, among others. It considers psychology, diet, exercise, spirituality, history, occupation, life-style, and whether or not a person is living up to his or her inner purpose in life as it explains the development of a physical problem. It offers a system of self-care for the layperson, and a complex knowledge base for the professional practitioner. This ancient practice spread with Vedic and Hindu culture as far east as Indonesia, and to the west, it influenced the ancient Greeks, who developed a similar form of medicine. It was used and developed in Buddhism, and became the foundation for healing systems in Tibet, and influenced Chinese medicine. Frawley (1989)

> ***Vata, Pitta and Kapha,***
> ***the three biological humors,***
> ***in their natural and disturbed states,***
> ***give life to the body and destroy it.***
>
> ***~ Ashtanga Hridaya, I.6.***

By 460 BCE, Hippocrates simplified earlier theories of the humors by focusing on two: hot and cold. As in the ancient tradition, he postulated that good health was based on balance between these two humors, and that lack of balance resulted in disease. From Greece, the focus on hot and cold traveled to Egypt, the Byzantine Empire, Spain, and Africa. It then spread to the Caribbean and South and Central America. As it traveled, the specifics of the system changed somewhat, but the fundamental belief that heat and cold contributed both to health and to illness remained.

In this way of thinking, many things found in the environment are classified as being either hot or cold, including foods, natural substances such as sunshine and water, and disease symptoms themselves. The system of classification may not be intuitive to practitioners of Western medicine. For example, in Tecopsa Mexico several decades ago, researchers found that people believed ice to be hot because its initial sensation on the skin is burning, while they considered boiling water cold because its initial sensation on the skin was cold. Masden, 1955

In current manifestations, the hot-cold system might influence diet, physical activity, and other behaviors. Illnesses might be perceived as being caused by too much heat (for example, anger or overexertion), or too much cold (for example, too little activity). This identification has nothing to do with temperature, but rather with long-standing beliefs about particular substances. Some hot-cold systems believe that a hot disease should be treated with a hot remedy (again, unrelated to temperature), others suggest that a hot disease should be treated with a cold remedy to re-establish balance.

People who believe in hot-cold explanations of health, illness and healing often incorporate new ideas into their belief structure. For example, when one Maya woman in Guatemala was given cortisone cream for a rash and warned to stay out of the sun, she made the assumption that the cortisone was a "hot" remedy, and that being in the sun would make its heat excessive.

Many systems of health today emphasize the idea of balance. Homeopathy, various Native American systems of care, and many other healing systems focus on a lack of balance as the source of discomfort, and restoration of balance as the emphasis of treatment. Contemporary Ayurvedic medicine emphasizes diet, exercise, meditation, compassion, and balanced living as a way of maintaining health. See Novey (2000) for an excellent source of information about a wide array of complementary and alternative healing systems, including reviews of existing evidence for the efficacy of each. Once seen as competitors to Western medicine, these healing traditions are increasingly being incorporated as a part of healing regimens, and often suggest meaningful complementary and supportive therapies.

Some individuals with a very Western scientific bent are tempted to disparage beliefs such as the hot-cold system of classification. If you are tempted to do so, remember that many of our mothers kept us out of drafts to avoid colds. New scientific knowledge emerges regularly in support of more traditional beliefs, and in the case of hot-cold, there is mounting evidence of the importance of balance in life to good health.

JOURNAL PAGE 10 GOES ABOUT HERE.

Some additional information about hot-cold systems can be found at these websites:
A discussion of hot-cold theory as related to beliefs about pregnancy and solar eclipse in Mexico, www.heilpflanzen-welt.de/science/1995/7502155.htm. An article asserting that cultural competence improves care, with hot-cold as an example, www.ccjm.org/pdffiles/Misra-Hebert403.pdf. Links to information about health beliefs of Hispanic/Latino groups, including constructions of hot-cold, www.sunyit.edu/library/html/culturedmed/bib/hispanic/. Discussion of folk medicine, including hot-cold. www.ama-assn.org/ama/pub/article/2036-2524.html (Note that folk medicine appears in quotes throughout this article, conveying an impression that "folk" medicine may be inferior to Western medicine.)

JOURNAL PAGE 11 GOES ABOUT HERE.

How could different explanatory models contribute to health disparities?

If your patient has a particular view of illness and its causes, prevention, and appropriate treatments, and you have another view, there is great potential for misunderstanding. Misunderstanding can lead to poor follow-through with the treatment you recommend. One now widely known example has to do with the use of antibiotics. There are a number of cultures in which illness is perceived only when symptoms are present. Individuals may be unlikely to take prescribed antibiotics once symptoms have disappeared, even though you have explained that it is important to continue the medication for an entire course. For you, who believe in bacteria as the cause of the illness and the potential for emergence of antibiotic resistant strains of the bacteria, the need for completing the course of medication seems obvious. For your patient, it seems an unnecessary waste. If, in addition, the antibiotic has any side-effects, the patient might believe that it is making things worse instead of curing him.

This is one illustration of the kind of mismatch of beliefs that can occur, but examples are legion, and they include mismatched beliefs about foods, the characteristics of blood, the importance of balance with nature, and the merging of spiritual and biological disease etiologies. Unless you can be with your patient every moment and can force her to do as you suggest, effective outcomes depend on the patient's conviction that the treatment is appropriate and likely to be helpful. You, as provider, can enhance the likelihood that the patient holds those convictions through your efforts to communicate effectively, and your willingness to listen and take into account your patient's explanatory model.

How can you do this? You can ask your patient how the trouble started. You can ask what is bothering him the most or is the most important aspect of the problem. These questions are key to understanding a client's way of thinking about difficulties, and crucial when he presents with a complex condition or with comorbid diseases. You can draw from the patient a story about how she sees the development and prognosis of the problem, find points of connection and shared understanding between you, and present a treatment plan that is compatible with your patient's way of thinking about her own physical condition.

JOURNAL PAGE 12 GOES ABOUT HERE.

AN EXERCISE TO PRACTICE YOUR SKILLS

You have been invited to provide preventive health services at a local senior center. The center is located in a part of the city with a large Puerto Rican population.

1. ***Do you think this population will hold explanatory beliefs like your own? What factors might lead them to think differently?***

2. ***Given what you know now, how could you go about learning more about your clients' explanatory models?***

3. ***Do you think everyone in the community would hold similar beliefs? What factors might influence differences among people?***

4. ***What factors would you consider in developing a treatment plan?***

What Did You Learn?

1. The best definition of “explanatory model” is
   a. *each individual’s understanding of what is wrong and what caused it
      (This is the correct answer)
   b. diagnosis based on lab findings.
      (Practitioners have explanatory models just as do patients. For many, though not all practitioners, this model is likely to be biologically based. You could argue that diagnosis based on lab findings is an explanatory model. However, it is only one possible explanation; others may be equally valid.)
   c. synthesis of laboratory and clinical findings regarding patient complaints
      (As with response b, this assumes that there is a “correct” label. For most conditions, there are many possible explanations for the disorder.)
   d. flow-chart for making clinical decisions
      (Decision trees and flow charts can reflect an individual’s view of illness. However, there are many other strategies for conceptualizing both cause and treatment of illness.)

2. Which question is NOT important to ask in assessing an explanatory model?
   a. What do you call the problem?
      (Labels do matter. This is an important question to ask your patient, and to reflect on for yourself. Try again.)
   b. What do you think the illness does?
      (Beyond a label, it is important to consider the consequences of the illness from the perspective of each individual involved. Try again.)
   c. What do you think the natural course of the illness is?
      (Explanatory models certainly describe the course of an illness. Try again.)
   d. *What lab tests would you like to have done?
   e. (Lab tests reflect a particular explanatory model, and may or may not be consistent with the individual’s construction of the illness. This is the correct answer.)

3. According to the hot-cold system, which of the following is most important for good health?
   a. Consumption of hot drinks every morning, and cold food at night.
      (This might or might not be recommended, depending on the particular hot-cold beliefs of a culture. However, it is not a central tenet of hot-cold systems overall. Try again.)
   b. Avoidance of excessive heat or cold.
      (This might or might not be recommended. Some hot-cold systems recommend avoidance of extremes, but not all. Try again.)
   c. Avoiding heat in the winter.
      (This might or might not be recommended. Some hot-cold systems might encourage heat to balance the cold weather. Try again.)
   d. *Appropriate balance of substances attributed to be either hot or cold.
      (Balance is an important consideration in all hot-cold systems, although what constitutes balance varies from culture to culture.)

RESOURCES

Links and Professional Guidelines

Improving the cultural competence of health care providers is one strategy that has been identified to work toward reducing health disparities. The idea is that if providers are better at understanding and communicating with their patients/clients, providers will identify problems more effectively, care plans will be more consistent with client beliefs, and outcomes will be improved as a result of enhanced follow-through.

The issue is of sufficient importance that both governmental agencies and professional organizations have promulgated rules and guidelines to address the concern. Among the governmental regulations, perhaps the earliest can be found in the Civil Rights Act of 1964. Among the provisions of that act is a requirement that patients who do not speak English must be provided with interpreters.

A number of websites provide information about government guidelines regarding translation.

- http://www.usdoj.gov/crt/cor/coord/titlevi.htm, Homepage for the Civil Rights Act of 1964, emphasizing Title VI
- http://www.usdoj.gov/crt/cor/byagency/hhscrranprm.htm, HHS guidelines related to Title VI of the Civil Rights Act
- http://www.usdoj.gov/crt/cor/13166.htm, Title VI of the Civil Rights Act: rules encouraging access for those with limited English.
- http://www.cmwf.org/programs/minority/youdelman_languageinterp_541.pdf, Extensive summary of rules/regulations related to translation services. Some discussion of cultural competency.

Translation/interpretation will be discussed at greater length in units that follow. Some help can be found at http://www.volunteersinhealthcare.org/resource.htm, which provides information about language barriers and links to resources to overcome language barriers

Since 1964, rules regarding cultural competency have increasingly appeared in health care legislation. Such rules have been proposed for Medicare and Medicaid: http://216.239.41.104/search?q=cache:a9WngLqfbb4J:www.healthlaw.org/pubs/BBAregs/BBAcultural.pdf+%22Cultural+Competency%22+%22Health+Care%22+%22regulations%22&hl=en provides proposed Medicaid rules related to cultural competency. An analysis of proposed Medicaid rules for cultural competency can be found at http://www.healthlaw.org/pubs/BBAregs/BBAcultural.html. Guidelines and links can be found at http://www.cms.hhs.gov/healthplans/quality/project03.asp, on Medicare and Medicaid managed care.

In substance abuse, mental health, diabetes care, long-term care and many other areas of care, governmental guidelines and resources focus on cultural competency.

- SAMHSA offers a brief on managed care contractors and cultural competency at http://www.samhsa.gov/mc/content/Managed%20Care%20Contracting/issubr4/Issue_Brief_4-02.htm.
- Links to SAMHSA guidelines and a discussion of need for competence: http://www.samhsa.gov/mc/content/Managed%20Care%20Contracting/Summer/Summer99.htm.

- AHCPR's summary of a workshop focused on State responses to the need for cultural competence in health care: http://www.ahrq.gov/news/ulp/ulpcultr.htm
- Cultural competence in managed long-term care, http://www.chcs.org/usr_doc/cultural_competency0803.pdf.
- Medicare and Medicaid managed care. Links, discussion of guidelines, http://www.cms.hhs.gov/healthplans/quality/project03.asp?
- NIH discussion of cultural competency as it affects diabetes care. Links and recommendations for care and for policy, http://betterdiabetescare.nih.gov/ISSUESculturalcompetencyreferences.htm

Perhaps most recently, cultural issues have been considered in the context of HIPPA. As we will discuss in later units, health care decisions may be made by the family as a whole in some cultural groups; in others, there may be a single family decision maker (for example, the male head-of-household or the oldest female). In these cases privacy must be dealt with differently than in situations where health care information and decisions are considered intensely private. See HIPPA and cultural competency, http://www.phli.org/Year12/HIPPA/

In an effort to assist clinicians, the Office of Minority Health has promulgated guidelines and resource lists. While these do not carry the weight of law, they can be helpful to providers wishing to improve their cultural skills. Office of Minority Health, http://www.omhrc.gov/omh/sidebar/aboutOMH.htm; Guidelines proposed by the Office of Minority Health, http://www.omhrc.gov/cultural/completed.htm; Office of Minority Health newsletter regarding cultural competency rules and minority health, http://www.omhrc.gov/ctg/competence3new.pdf.

As a way to comply with governmental regulations and as a way to help their members improve their skills, a wide array of professional organizations have developed professional guidelines regarding cultural competence.

- American Academy of Family Practitioners discussion of cultural competency and Medicare: http://www.aafp.org/fpr/assembly/saturday/12.html

- American Dental Association online publication on cultural competence and diversity: http://www.ada.org/prof/resources/pubs/epubs/brief/Brief_0401.htm#cultural

- The American Dental Hygienists' Association offers research abstracts that address herbal and alternative medicine issues in dental care, and cultural competencies among professionals: http://www.adha.org/research/as_abstracts.htm

- American Medical Association links to articles about disparities in health care and cultural competency: http://www.ama-assn.org/ama/pub/category/3480.html

- American Nurses Association web references to diversity and cultural issues in nursing: http://nursingworld.org/ojin/topic20/tpc20lnx.htm

- American Physical Therapy Association discussion of cultural competency: http://216.239.41.104/search?q=cache:RqUCZ1gIRXUJ:www.aptaeducation.org/cultural%2520competence%2520in%2520health%2520care%2520-%2520aasig%2520handouts%25202001.ppt+%22Cultural+Competency%22+%22Health+Care%22+%22regulations%22&hl=en

- American Psychological Association Guidelines and Principles for Accreditation of Programs in Professional Psychology: http://www.apa.org/ed/gp2000.html, recognizes cultural and individual diversity in the training of psychologists, and specifies criteria on diversity for accreditation of training programs. See also the APA Council Policy Manual for professionals, on expectations regarding socioeconomic status, sexual orientation, and other cultural elements: http://www.apa.org/about/division/cpmpubint4.html

- American Public Health Association publication that emphasizes the impact of regulations on care for Asian and Pacific Island populations: http://library.fgcu.edu/ddsg/ddsg.asp?id=8928

- American Hospital Association stand on addressing racial and ethnic disparities: http://www.hospitalconnect.com/aha/advocacy-grassroots/advocacy/agenda/publictrust.html

- The Association of Professional Chaplains offers an online statement of a code of ethics: http://www.professionalchaplains.org/professional-chaplain-services-about-code-ethics.htm

- The National Association of Social Workers has one of the clearest statements on diversity and equity: http://www.naswdc.org/diversity/default.asp

- Substance Abuse Prevention Counselors can find guidelines in The U.S. Department of Health and Human Services (1992), *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working with Ethnic/Racial Communities.* Rockville, MD: Office for Substance Abuse and Prevention, Alcohol, Drug Abuse, and Mental Health Administration, DHHS Publication No. (ADM)92-1884.

- Health care journal articles emphasizing issues about regulations and minority health: http://articles.findarticles.com/p/search?tb=art&qt=Minorities+in+medicine+%2F+Laws%2C+regulations+and+rules

GLOSSARY

Bias: 1) A preference or an inclination, especially one that inhibits impartial judgment; 2) An unfair act or policy stemming from prejudice.

Culture: The accumulated store of shared values, ideas (attitudes, beliefs, values and norms), understandings, symbols, material products, and practices of a group of people. A way of talking about collective identities Kuper, 1999, p. 31 Culture is learned, shared, and mediates behavior of individuals in the group.

Culture Emergent: The idea that culture emerges in interaction, through the talk and behavior that reflect shared learning, location, patterns, and values.

Discrimination: Actions carried out by members of dominant groups, or their representatives, that have a differential and harmful impact on members of subordinate racial or ethnic groups.

Disparity: a difference. In this case, it refers to differences in health, health care, and health care outcomes.

Dominant Group: A racial or ethnic group with the greatest power and resources in a society.

Ethnic Group: A group socially distinguished or set apart, by others or by itself, primarily on the basis of cultural or national-origin characteristics.

Ethnicity: Ethnicity is a concept referring to a shared culture and way of life, especially as reflected in language, folkways, religious and other institutional forms, material culture such as clothing and food, and cultural products such as music, literature, and art. The collection of people who share an ethnicity is often called an ethnic group. **Explanatory Model:** A cognitive structure for understanding health/illness, causative agents, and treatments. Explanatory models are based on our education (both formal and informal) and experience.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health Care: Those services provided to individuals or communities by agents of the health services or professions, for the purpose of promoting, maintaining, monitoring, or restoring health. Health care is broader than and not limited to medical care, which implies therapeutic action by or under the supervision of a physician.

Institutionalized Racism: Differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of customs, practice, and law, so there need not be an identifiable perpetrator. It is often evident as inaction in the face of need.

Internalized Racism: Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. It is characterized by their not believing in others who look like them, and not believing in themselves. It involves accepting

limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-determination, and one's range of allowable self-expression. It manifests as an embracing of characteristics of dominant groups (for example, use of hair straighteners and bleaching creams, or hierarchy by skin tone within communities of color); self devaluation (rejection of ancestral culture, fratricide) and resignation, helplessness, and hopelessness (risky behavior, dropping out of school, not voting).

Minority Group: A group that is singled out because of physical or cultural characteristics whose members become objects of discrimination; it typically has less power and resources than the dominant group.

Prejudice: An antipathy, expressed or felt, based upon a faulty generalization and directed toward a group as a whole or toward individual members of a group.

Race: 1) As many physical anthropologists abandon racial taxonomies altogether, race can be more objectively considered a sociocultural concept in which groups of people sharing certain physical characteristics are treated differently based on stereotypical thinking, discriminatory institutions and social structures, a shared worldview, and social myths; 2) A term developed in the 1700s by European analysts to refer to what is also called a racial group (see below).

Racial Group: A social group that persons inside or outside the group have decided is important to single out as inferior or superior, typically on the basis of real or alleged physical characteristics subjectively selected.

Stereotype: An oversimplified belief or image that is applied to both an entire category of people and to individuals within it. Stereotypes are often negative, and often distort the real characteristics of the group.

Worldview: A culturally structured, systematic way of looking at, perceiving, and interpreting various world realities.

* * * * *

Unless otherwise noted, glossary terms are drawn from Institute of Medicine (2003), *Unequal Treatment,* pp. 522–526, where original sources for terms are cited in detail.

REFERENCES

Abu-Lughod L (1999). The interpretation of culture(s) after television (p. 110-135). In SB Ortner (ed), *The fate of "culture": Geertz and beyond*. Berkeley: University of California Press.

Bobo LD (2001), Racial Attitudes and Relations at the Close of the Twentieth Century, in Smelser N.J., Wilson W.J., Mitchell F, eds., *America Becoming: Racial Trends and Their Consequences*, Vol. 1. Washington, D.C.: National Academy Press, pp. 264-301.

Bonder, BR, Martin, L, & Miracle, A (2002). *Culture in clinical care*. Thorofare, NJ: Slack, Inc.

Braun, Pietsch & Blanchette, eds (2000), *Cultural Issues in End-of-Life Decision Making*, Sage: Thousand Oaks, CA.

Butler, R (1969). Ageism: Another form of bigotry. *The Gerontologist,* 9:243-246.

Collins KS, Hall A and Neuhaus C (1999). *U.S. Minority Health: A Chartbook*. New York: The Commonwealth Fund.

Clifford J (1986). Introduction (p. 1-21). In J Clifford & GE Marcus (Eds.), *Writing culture: The poetics and politics of ethnography*. Berkeley: University of California Press.

Culbertson GH and Caporael LR (1983). Complexity and content in baby talk and non-baby talk messages to institutionalized elderly. *Personality and Social Psychology Bulletin*, 9:305-312.

Davis K and Schoen, C (1978). *Health and the War on Poverty*. Washington DC: Brookings Institution Press.

Frawley, David (1989). *Ayurvedic Healing: A Comprehensive Guide*. Salt Lake City UT: Passage Press.

Geertz C (1973). *The interpretation of cultures*. New York: Basic Books 1973.

Gornick, ME (2000). *Vulnerable populations and Medicare services*. New York: Century Foundation Press.

Gornick ME, Eggers PW, Reilly TW, Mentnech RM, Fitterman LK, Kucken LE, Vladeck BC (1996). Effects of race and income on mortality and use of services among Medicare beneficiaries, *New England Journal of Medicine,* 335(11):815-816.

Holland D, Lachicotte W, Skinner D, & Cain C (1998). *Identity and agency in cultural worlds*. Cambridge, MA: Harvard University Press.

Hummert, ML, Wiemann, JM and Nussbaum, JF (Eds.) (1994). *Interpersonal Communication in Older Adulthood.* Thousand Oaks CA: Sage Publications.

Institute of Medicine (1999). The Unequal Burden of Cancer: An Assessment of NIH Programs and Research for Minorities and the Medically Underserved. MA Haynes and BD Smedley, eds. Washington, DC: National Academy Press

Kleinman, A, Eisenberg, L, & Good, B (1978). Culture, illness, and care. Annals of Internal Medicine, 88, 251-258.

Kuper A (1999). *Culture: The anthropologists' account*. Cambridge, MA: Harvard University Press.

Martin L, & Bonder BR (2004). Achieving organizational change within the context of cultural competence. *Journal of Social Work in Long-Term Care*, 2(1/2), 81-94.

Masden, W (1955). Hot and cold in the universe of San Francisco Tecospa, Valley of Mexico. *Journal of American Folklore, 68*, 123-139.

The National Academies of Science Institute of Medicine (2003), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academy Press, http://national-academies.org.

Novey, DW (Ed.) (2000). *Clinician's complete reference to complementary & alternative medicine*. St. Louis: Mosby.

Nussbaum, JF, Pecchiono, LL, Robinson, JD and Thompson, TL (2000). *Communication and Aging.* Mahwah, NJ: Lawrence Erlbaum Associates.

Office of Management and Budget (2001). Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity, Office of Management and Budget.

Palmore, EB (1982). Attitudes toward the aged: What we know and need to know. *Research on Aging,* 4:333-348.

Rosaldo RI (1999). A note on the cultural essayist (p. 30-34). In SB Ortner (Ed.), *The fate of "culture": Geertz and beyond*. Berkeley: University of California Press.

Rose, J. H., O'Toole, E., Skeist, R., Pfeiffer, B., & Carlsen, W. (1998). Complementary therapies for older patients: An exploratory survey of primary care physicians' attitudes. *Clinical Gerontologist, 19,* (1), 3-19.

Rosenbaum, S (2003). Racial and ethnic disparities in healthcare: issues in the design, structure, and administration of federal healthcare financing programs supported through direct public funding, in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, The National Academies of Science Institute of Medicine, National Academy Press, http://national-academies.org.

Sahlins M, & Service ER (eds.) (1960). *Evolution and culture*. Ann Arbor: University of Michigan Press.

Schulman K, et al. (1999). The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization. *New England Journal of Medicine,* 340:618-626.

Tedlock D, & Mannheim B (1995). Introduction (p. 1-32). In D Tedlock & B Mannheim (Eds.), *The dialogic emergence of culture*. Urbana: University of Illinois Press.

INSTRUCTOR'S GUIDE TO INTRODUCTION and UNIT I

This unit is intended to set the stage for what will follow. It focuses on defining culture and explaining how culture affects health care. It also provides a framework for recognizing how the ways in which culture is dealt with in care affects outcomes.

Perhaps one of the greatest challenges to instructors teaching this subject is dealing with preconceived (i.e., cultural) views of students, particularly when those views are not conducive to cultural competency. One notable example is the issue of political correctness. Some individuals and cultures believe their own culture to be superior or to resent being asked to reach out to others. Indeed, this course is asking people to set aside some of their own cultural views and consider alternatives.

One effective way to defuse this issue is to frame cultural competency as a clinical skill, just as drawing blood, doing a range-of-motion test, reading an x-ray, or doing surgery are clinical skills. Fortunately, almost everyone in a health care profession wants to do a good job (a cultural value) and to help their clients (a cultural value). Encouraging recognition that cultural competency is not about judging the “goodness” or “badness” of ideas, but rather a way to get and use accurate information can help students and practitioners feel less challenged or defensive about learning this material and trying the strategies we recommend.

There are a wide array of exercises you can use in the classroom to emphasize these points.

1. First of all, every thought question in this unit can be elaborated in the classroom. Have students share their responses to the questions. Have them compare and contrast ideas. If a dispute or disagreement arises, try asking each student to defend the other student's perception.

2. The item about professional guidelines is particularly ripe for discussion. Students at this point in the course often miss some obvious issues. For example, professional guidelines tend to be vague or general when discussion cultural competency. They make statements like: “consider the impact of adverse social, environmental, and political factors,” without giving guidance about how one would recognize such factors and what one might do about them.

3. Ask students to bring in articles they find in the media. There is an abundance of such articles, and they can provide excellent material for discussion. Students tend to be surprised at how much relevant information appears in the daily newspaper, on news shows, etc.

4. Ask students to reflect on the classroom as a culture. In what ways is this a localized culture? What are its patterns? What is learned about culture (for example, listen to the instructor who is there to impart wisdom, sit quietly unless asked to respond, etc.)? What are its values (for example, getting work in on time, doing well on tests)? How is it consistent (is college like high school like elementary school?)? How does it change (how is college different from high school?)

5. How might being a student be different from being a professional? Ask students to reflect on behaviors they are learning that are important to professionals that are encouraged/discouraged in classroom settings.

6. As a way to think about the differences between culture and biology (something we will come back to in subsequent units) ask students to reflect on one of their own values. Did they learn this? From whom? Or is it something that they ascribe to their innate personality? You might raise some behaviors for consideration, for example, friendliness, studiousness, athletic prowess. The point here is not to resolve the dilemma, but to begin to identify that both biology and culture affect our behavior.

Evaluation

The case study can be useful as a pre- / post- assessment of students. Ask them to keep their reactions (or collect them for examination later) so that these can be looked at later in the course.

Exercises done outside the class, or examples brought in, can be used for assessment purposes. Look for:

1. Thoughtfulness of response, even if you don't agree with it.
2. Openness to change or alternative explanation. Encourage students to think of more than one meaning for something they find, and give credit for their ability to do this regardless of the content of those alternatives.
3. Recognition of the importance of cultural competency as a clinical skill. It is a goal of this course to teach a particular cultural value and an accompanying skill. Therefore, it is reasonable to give credit to students who make progress in that direction.

Using Journals

Having students keep journals can be an excellent mechanism for encouraging reflection and self-evaluation. However, journaling must be done thoughtfully. Several suggestions:

1. Be clear from the start whether the journal will be handed in for you to read. Students will be less likely to be honest if they know that their work will be read by others; however, trust in you and the class can be compromised by surprise readings.
2. If you want to use the journal material in the classroom, an alternative strategy is to let students know in advance that they may be asked to read passages from their journals aloud in class. This gives them the opportunity to edit or select what they are comfortable sharing.
3. Remind students that journals do not have to be written in complete sentences or narrative. Phrases, random thoughts, sketches, other materials can make the journal more immediate and meaningful.
4. You may want to assign specific journal topics as the course moves along, or simply ask students to record their reactions, questions, and ideas as they emerge.
5. For more information about the use of journals, refer to Bonder, et al. (2002)
6. Additional ideas for classroom exercises and evaluation questions can be found in Martin, et al. (2002) *Instructor's Manual for Culture in Clinical Care*, Thorofare, NJ: Slack, Inc. (on-line and free at slackinc.com)