Cultural Competence

OBJECTIVES

- Explain the concepts of cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire in the cultural competence model.
- Describe social and cultural influences in health and illness.
- Describe health disparity and the social determinants that affect it.
- Describe the roles that communication and self-examination play in developing cultural competence.
- Explain the approaches to use in conducting a cultural nursing history and physical assessment.
- Describe how teach-back helps a patient with limited health literacy.
- Explain the principles to apply when using an interpreter.

KEY TERMS

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Assimilation, p. 111
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The term **culture** refers to the learned and shared beliefs, values, norms, and traditions of a particular group, which guide our thinking, decisions, and actions (Giger, 2017; Leininger and McFarland, 2006). Culture also refers to ways of relating to one another, language and manner of speaking, work and lifestyle practice, social relationships, values, religious beliefs and rituals, and expression of thoughts and emotions (Ball et al., 2019; Giddens, 2017). Culture is a learned behavior, yet it is constantly changing in response to environmental, biological, political, and social influences.

Every one of us has some type of bias that is culturally driven. Such biases can be referred to as an **unconscious bias** or an **implicit bias**. Unconscious bias refers to a bias we are unaware of and that happens outside our control, which is influenced by our personal background, cultural environment, and personal experiences. Unconscious bias typically directs one to make quick judgments and assessments of people and situations. An implicit bias is similar; however, we are aware of the bias that is present. We are responsible for implicit bias and must recognize and acknowledge our actions as they impact our behavior, decisions, and patient-centered care provided. One might have a bias toward or against an individual based on his or her culture, such as a bias toward an ethnic group, race, gender, nation, religion, social class, or political party. When you as the nurse hold a bias toward an individual patient or group of patients, it is very difficult to provide patient-centered transcultural care.

Culturally congruent care or transcultural care emphasizes the need to provide care based on an individual's cultural beliefs, practices, and values; therefore, effective communication is a critical skill in culturally competent care and helps you engage a patient and family in respectful, patient-centered dialogue (Hadziabdic et al., 2015). A patient-centered approach to providing transcultural care requires you to address your own implicit bias; be respectful of and responsive to individual patient preferences, needs, and values; and ensure that patient values guide all clinical care decisions (Institute of Medicine [IOM], 2001). This chapter explains the importance of **cultural competence** and its relationship to patient-centered care. Cultural competence means that professional health care must be culturally sensitive, culturally appropriate, and culturally competent to meet the multifaceted health care needs of each person, family, and community (Spector, 2017). Cultural beliefs, values, and practices are learned from birth, first in the home, then in the church or other places where people congregate, and then in educational and other social settings (Purnell, 2013). This cultural learning applies to both you and your patients. The process of cultural competence in delivering health care services is "a culturally conscious model of care in which a healthcare professional

continually strives to achieve the ability and availability to effectively work within the cultural context of a client" (family, individual, or community) (Transcultural C.A.R.E. Associates, 2015). It is a process of becoming culturally competent, not being culturally competent (Transcultural C.A.R.E. Associates, 2015). The goal of delivering cultural care is to utilize research findings to provide culturally specific care that is safe and beneficial to the well-being of the diverse population (McFarland and Wehbe-Alamah, 2015).

The changing demographics of the US population create challenges for the health care system and health care providers. By the year 2060, the percentage of racial and ethnic minority groups in the United States is expected to climb to 32% of the population (US Census Bureau, 2018). The fastest-growing racial ethnic group in the United States is people whose ancestry is from two or more races, and this group is projected to grow by 200% by 2060 (US Census Bureau, 2018). The next fastest–growing is the Asian population, which is projected to double, followed by the Hispanic population (US Census Bureau, 2018). Nearly one in five of the total US population is projected to be foreign born by 2060 (Colby and Ortman, 2015). According to the Administration for Community Living (2017), the population age 60 years and over will increase from 65 million in 2017 to 77 million in 2020 and is projected to reach 94.7 million by the year 2060. The wealth gap between blacks and whites is demonstrated in the fact that blacks lag behind whites in homeownership, household wealth, and median income. These differences remain even when controlling for levels of education (Pew Research Center, 2016). Additionally, the Centers for Disease Control and Prevention (CDC) (2018) reports that studies show adults who self-report the worst health also have the most limited literacy, numeracy, and health literacy skills. A growing body of evidence shows that individuals with the skills and confidence to become actively engaged in their health care have better health outcomes. Although death rates have declined overall in the United States over the past 50 years, people who are poorly educated and people living in poverty still die at a higher rate from the same conditions than people who are better educated and economically advantaged (Ball et al., 2019). These statistics reveal examples of cultural factors that influence the health care system and why issues such as health care resource accessibility, patient adherence to medical therapies, patient satisfaction, and health care outcomes are so difficult to manage.

The Joint Commission (TJC), the National Quality Forum (NQF), and the National Commission on Quality Assurance (NCQA) are a few of the influential organizations that have responded to these complexities in health care by implementing new standards focused on cultural competency, health literacy, and patient-centered and family-centered care. These standards recognize that valuing each patient's unique needs improves the overall safety and quality of a patient's care.

WORLD VIEW

Historical and social realities shape an individual's or group's world view, which determines how people perceive others, how they interact and relate to reality, and how they process information (Walker et al., 2010). World view is a set of assumptions that begins to develop during childhood and guides how one sees, thinks about, experiences, and interprets the world (The Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). It creates a lens through which we view all of life's experiences through our own uniquely tinted view. Our world view evolves during a lifetime process of interacting with family, peers, communities, organizations, media, and institutions (Fig. 9.1). It is important for you to advocate for patients based on their world views. This requires a thorough ongoing assessment, flexibility, and planning in partnership with each patient to ensure that your care is safe, effective, and culturally sensitive.

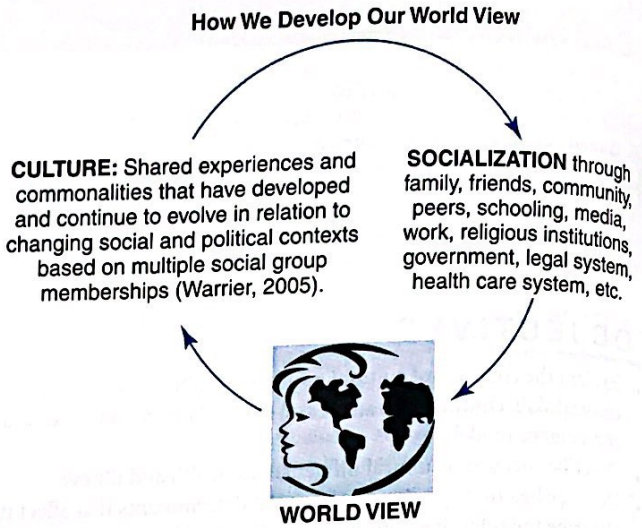

FIG. 9.1 How we develop our world view. (Copyright © 2011 Barnes-Jewish Hospital Center for Diversity and Cultural Competence.)

In any intercultural encounter there is an insider perspective (**emic world view**) and an outsider perspective (**etic world view**). For example, a Korean woman requests seaweed soup for her first meal after giving birth. This request puzzles her nurse. The nurse has an emic world view of professional postpartum care but is an outsider to the Korean culture. As such, the nurse is not aware of the meal's significance to the patient. Conversely, the Korean patient has an etic world view of American professional postpartum care and assumes that the seaweed soup is available in the hospital because, according to her cultural beliefs, the soup cleanses the blood and promotes healing and lactation (Edelstein, 2011). Conflict arises when health care providers interpret the behaviors of patients through their own world view lens instead of trying to uncover the world view that guides the behavior of their patients.

A **stereotype** is an assumed belief regarding a particular group (Ellis-Fletcher, 2015). It is easy to stereotype various cultural groups after reading general information about their ethnic values, practices, and beliefs. Avoid stereotypes or unwarranted generalizations about any particular group that prevents an inaccurate assessment of an individual's unique characteristics, talents, challenges reflected in the places they live, their socioeconomic circumstances, ethnic heritage, religion, language, abilities, characteristics, and world views (Dayer-Berenson, 2014). Instead, approach each person individually and ask questions to gain a better understanding of a patient's perspective and needs.

HEALTH DISPARITIES

More than a decade ago, a report by the IOM (2001) defined quality health care as health care that is safe, effective, patient centered, timely, efficient, and equitable or fair. Although the US health care system has improved in most of those areas since the IOM report was published, the system still does not emphasize equality of care (Mutha et al., 2012). As a result, many health care disparities remain. *Healthy People 2020* defines a **health disparity** as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (Office of Disease Prevention and Health Promotion [ODPHP], 2016) (Box 9.1). Poor health status, disease risk factors, poor health outcomes, and limited access to health care are types of disparities often interrelated and influenced by the conditions and social context in which people live (CDC, 2013).

BOX 9.1 Examples of Health Disparities Identified by the Centers for Disease Control and Prevention

- Among adults aged 25 years and older in 2011, noncompletion of high school was generally more common among adults who were foreign born than adults born in the United States (CDC, 2013).
- In 2011, 30.3% of US census tracts did not have at least one healthier food retailer (supermarkets, large grocery stores, supercenters and warehouse clubs, or fruit and vegetable specialty stores) within the tract or within a mile of tract boundaries. This represents 83.6 million people, representing approximately 27% of the 2010 continental US population (CDC, 2013).
- Non-Hispanic black adults were at least 50% more likely to die of heart disease or stroke prematurely (i.e., before age 75 years) than their non-Hispanic white counterparts (CDC, 2013).
- Colorectal cancer incidence and mortality increased with advancing age. Incidence and death rates were highest among people aged 75 years and older. Non-Hispanic blacks had higher colorectal cancer incidence and death rates than non-Hispanic whites, Asians/Pacific Islanders, and American Indians/Alaska Natives (CDC, 2013).
- The number of individuals who had colorectal cancer screening (any of the test options) was greater among people aged 65 to 75 years compared with people aged 50 to 64 years among non-Hispanics compared with Hispanics, among people with a disability compared with people with no disability, and among people with health insurance compared with people with no health insurance (CDC, 2013).
- American Indian and Alaska Native adults are twice as likely to be diagnosed with type 2 diabetes mellitus than non-Hispanic whites (CDC, 2016).
- Black and Hispanic children are hospitalized with complications of asthma much more often than are white children (CDC, 2016).

Adapted from Centers for Disease Control and Prevention (CDC): CDC health disparities and inequalities report—United States, 2013, MMWR Morb Mortal Wkly Rep 62(Suppl 3):1, 2013, http://www.cdc.gov/mmwr/pdf/other/su6203.pdf; Centers for Disease Control and Prevention (CDC): CDC selected CDC sponsored interventions—United States, 2016, https://www.cdc.gov/minorityhealth/strategies2016/index.html.

Social determinants of health are the conditions in which people are born, grow, live, work, and age (WHO, 2019). This includes conditions within a health care system. According to the World Health Organization (WHO) (2019), social determinants of health are mostly responsible for health disparities seen with and between countries. Social determinants of health include factors such as age, race, ethnicity, socioeconomic status, access to nutritious food, transportation resources, religion, sexual orientation, age, level of education. literacy level, disability (physical and cognitive), and geographical location (e.g., access to health care) (CDC, 2013). It is important that you understand how patients' cultural factors and their social determinants of health influence their health disparities. You also need to understand the implications this has on how you provide patient-centered care. According to the US Department of Health and Human Services (USDHHS) (n.d.), health care disparities can adversely affect communities, thus identifying a public health concern.

The 2016 National Healthcare Quality and Disparities Report by the Agency for Healthcare Research and Quality (AHRQ) (2017) offers some promise regarding health care access and quality. The report noted that access to health care did not demonstrate significant improvement (2000-2014); however, uninsured rates for Americans decreased from 2010 to 2016. Quality of health care improved overall from 2000 through 2014 to 2015, but the pace of improvement varied. Overall, some disparities were getting smaller from 2000 through 2014-2015, but disparities continue to persist, especially for poor and uninsured populations. People in poor households receive worse care than people in high-income households for almost all quality access measures. Black and Hispanic populations experience worse access to care compared with whites; however, improvements are noted in the number of Americans with a usual source of consistent medical care. The quality of health care improved generally through 2016 based on quality of measures such as patient safety, healthy living, effective treatment, and trends in care coordination (AHRQ, 2017).

In addition to disparity among cultural groups, people who are in **marginalized groups** are more likely to have poor health outcomes and die earlier because of a complex interaction among their individual behaviors, environment of the communities in which they live, the policies and practices of health care and governmental systems, and the clinical care they receive (United Health Foundation, 2015). Examples of marginalized groups include people who are gay, lesbian, bisexual, or transgender; people of color; people who are physically or mentally challenged; and people who are not college educated. Marginalization places or keeps someone in a powerless or an unimportant position within a society or group. Limited access to health care is one social determinant of health that contributes to health disparities. Access to primary care is an important indicator of broader access to health care services. A patient who regularly visits a primary care provider is more likely to receive adequate preventive care than a patient who lacks such access. Nursing intersects with a variety of people from different cultures; therefore, the awareness of marginalization is critical (Hall and Carlson, 2016).

Health care systems and health care providers sometimes contribute significantly to the problem of health care disparities. Disparities have been linked to inadequate resources, poor patient-provider communication, a lack of culturally competent care, and inadequate access to language services (National Quality Forum [NQF], 2018). Populations with a culture that differs from the culture of the health care provider tend to encounter decreased access to care, which leads to poor patient health outcomes (Ingram, 2011). To promote equal treatment for all patients who enter the health care system, we must be deliberate about addressing the impact of health care disparities (NQF, 2018).

Consider this example. *Ms. Millman is a 27-year-old African American. She is overweight and was diagnosed with type 2 diabetes 2 years ago and now requires insulin to control her blood sugar. She became homeless after losing her job and health insurance. She currently lives in housing provided through a neighborhood shelter. Ms. Millman was admitted to the hospital with a blood sugar of 322 mg/dL (her normal targeted range is 80 to 130 mg/dL) and a hemoglobin A1c of 11% (target for Ms. Millman is 7% or less). Hannah, a nursing student, is assigned to care for Ms. Millman. After reading her medical record, Hannah notices that Ms. Millman has come to the emergency department three times during the past 6 months for the same reason. Ms. Millman's previous health care providers documented that she verbalized an understanding of how to manage her diabetes but has difficulty following her treatment plan. Hannah teaches Ms. Millman that it is important to take her insulin as prescribed. She also explains how to make healthy food choices. As Hannah provides patient education, Ms. Millman nods. Hannah gives Ms. Millman a chance to ask questions, but Ms. Millman says she has none.*

In the case study, Ms. Millman has a number of social determinants that affect her health status and ability to manage her diabetes: socioeconomic status (no employment or health insurance, no home, limited financial resources if any), no access to primary care (uses the emergency department), being female, and a questionable literacy problem indicated by her neutral reaction to Hannah's instruction. Hannah needs to consider all these factors to provide Ms. Millman a more culturally competent health care plan.

REFLECT NOW

Consider the community in which your nursing program is located. What health disparities are present within the community you serve? How do these disparities impact the health care of the population?

Intersectionality

Intersectionality is a research and policy model used to study the complexities of people's lives and experiences (Lopez and Gadsden, 2016). The model looks at how being marginalized affects people's health and access to care. It serves to describe the forces, factors, and power structures that shape and influence life. Intersectionality is a way of understanding and analyzing our complex world by looking at the human experience (Lopez and Gadsden, 2016). Each of us is at the intersection of two categories: privilege and oppression. **Oppression** is a formal and informal system of advantages and disadvantages tied to membership in social groups, reinforced by societal norms, biases, interactions, and beliefs (Goldbach, 2019). Oppression occurs at individual and group experiences. For example, a patient experiencing oppression has limited access to resources, such as health care, housing, education, employment, and legal services. In contrast, a patient experiencing privilege has no difficulty accessing these resources. Individuals who support the theory of intersectionality believe that we must each determine how privileged and how oppressed we are to understand ourselves, the people around us, and the choices we make. Learning about a culture includes becoming familiar with the heritage of the people and understanding how discrimination, prejudice, and oppression can influence beliefs upheld in everyday life (Purnell, 2013). Then as health care providers, we are better able to identify the nature or source of patient's health care problems and how best to find solutions. Social groups affect our daily lives, shape our world view, control our access to resources, and ultimately determine our health outcomes. Whether we live in a disadvantaged community or in a community with access to social power and resources, we all are affected by the system of oppression. Understanding the different levels of oppression and where you stand helps you develop cultural competence (Fig. 9.2).

To apply the intersectionality model to daily nursing practice, think about the following patients who have been diagnosed with type 2 diabetes: a 25-year-old Hispanic woman who is homeless, an 85-year-old African-American retired nurse from rural Alabama, a 32-year-old Latina lesbian executive in San Francisco who is Catholic, and a woman who is an undocumented immigrant from Eastern Europe and has a 3-year-old child with a developmental disability. How may the experiences of each of these women compare with the experiences of other Americans? How do their experiences with the health care system differ? How does age affect their perspective? How would these answers change if you looked at their lives 15 years ago or 35 years ago? These scenarios are likely to draw a wide range of responses. The idea of intersectionality supports a broad view of culture by allowing consideration of a multitude of experiences within the context of power, privilege, and oppression.

RACIAL, ETHNIC, AND CULTURAL IDENTITY

Cultural competence is "a dynamic, fluid, continuous process whereby an individual, system, or health care agency finds meaningful and useful care strategies based on knowledge of the cultural heritage, beliefs, attitudes, and behaviors of those to whom they render care" (Giger, 2017, p. 7). Cultural competence is challenging to achieve, but it begins with one's ongoing development, while gaining an awareness of your own racial, ethnic, and cultural identity. That awareness prepares you to better understand patients within the context of their own racial, ethnic, and cultural identity.

As a nurse, you will counsel and comfort patients to help them better understand their health issues (e.g., medication adherence, ability to follow diet restrictions, knowledge of risk factors) and improve their willingness to partner with you in making important behavioral changes when necessary. Reflect on your own sense of how you identify with race and ethnicity within the context of your family, community, and cultural history (SAMHSA, 2014). Here are two classic definitions. **Racial identity** is based on one's self-identification with one or more social groups in which a common heritage with a particular racial group is shared (US Census, 2018); **ethnic and cultural identity** is "the frame in which individuals identify consciously or unconsciously with those with whom they feel a common bond because of similar traditions, behaviors, values, and beliefs" (Chavez & Guido-DiBrito, 1999, p. 41). These definitions help us to understand how individuals negotiate their own and other cultures in life (SAMHSA, 2014). It is important for you to examine your own racial, ethnic, and cultural identity

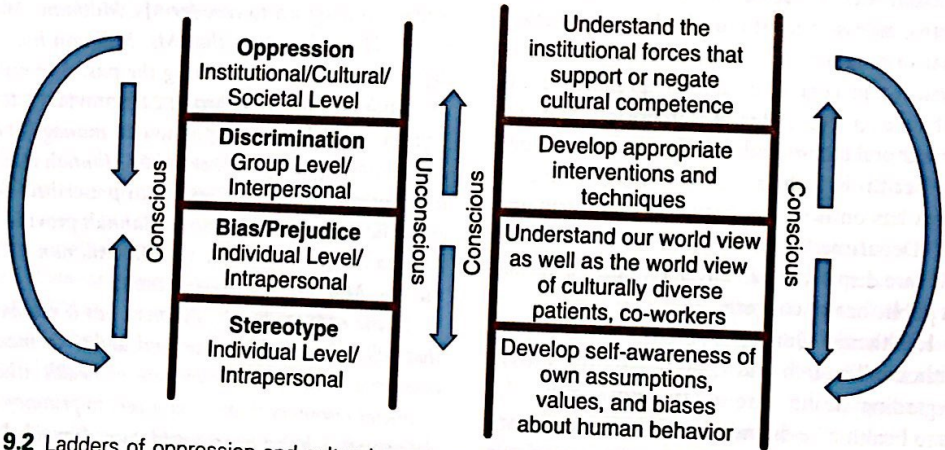

FIG. 9.2 Ladders of oppression and cultural competence. Each level of the ladder of cultural competence offers a response to the ladder of oppression. Because of the extensiveness and complexity of the systems of oppression, individuals and organizations move up and down both ladders simultaneously. (©2011 BJH Center for Diversity and Cultural Competence.)

to better recognize and understand normal and abnormal behavior. If you fail to do this self-examination, you will be more likely to prejudge patients and not accurately assess their health care problems. A self-examination allows you to understand the cultural factors that shape a patient's life experiences, a patient's health care problems, a patient's behavior, and how a patient might perceive those problems, thus supporting the belief that cultural awareness is essential to healing and building trust in the nurse-patient relationship (Conway-Klassen and Maness, 2017; SAMHSA, 2014).

In addition to one's self-examination regarding racial, ethnic, and cultural identities, one must also understand the process of adaptation when transition occurs. The process of **acculturation** occurs when an individual or group transitions from one culture and develops traits of another culture (Purnell, 2013; Spector, 2017). In this transition, there will be adaptation to the new cultures, traditions, customs, and language. This can lead to stress when the values of the transitioning culture differ from the accepted traits of another. **Assimilation** is the process in which the individual adapts to the host's cultural values and no longer prefers the components of the origin culture (Frazer, et al., 2017; Spector, 2017).

The National Institutes of Health (2018) has recently coined the term **cultural respect**, as opposed to cultural competence. Similar to cultural competence, cultural respect is critical to reducing health disparities and improving access to high-quality health care that is respectful and responsive to the needs of the diverse patient. With the growing number of diverse patient populations, the implementation of culturally respectful care is essential and benefits the consumers, stakeholders, and communities, leading to safe and positive health outcomes.

DISEASE AND ILLNESS

People react differently to disease based on their unique cultural perspective. Culture influences our thoughts regarding the way people uniquely define disease and illness. An understanding of the difference between disease and illness allows you to pursue ongoing cultural competence in providing patient care. Illness is the way in which individuals and families react to disease, whereas disease is a malfunctioning of biological or psychological processes. Most health care providers in the United States are primarily educated to treat disease, whereas most individuals seek health care because of their experience with illness. As an example, a patient may have a combination of symptoms that, based on previous experiences with family members and beliefs about illness, the patient believes are untreatable, whereas the patient's physician believes aggressive therapy might offer a cure. Such different perspectives between patients and their health care providers often frustrate patients and providers, fostering a lack of trust, lack of patient adherence to treatment plans, and poor health outcomes. Providing safe, quality care to all patients means taking into consideration both disease and illness (Office of Minority Health [OMH], n.d.).

Culture affects how an individual defines the meaning of illness (see Chapter 6). Some illnesses (e.g., human immunodeficiency virus [HIV], manic depression, cancer, or dementia) are embedded with meaning that is not always based on the physical nature of the condition. Cultural stigma can negatively affect those diagnosed; this can lead to lack of early detection, screening, or diagnosis based on the influence of cultural interpretation and decreased awareness. All illness is socially constructed through the experiences of people—specifically, how individuals come to understand and live with their illnesses (Conrad and Barker, 2010; Shiri et al, 2018). This is particularly true with chronic disease. Patients learn the effects of their diseases and how to adapt to live as normally as possible.

Culture also provides the context in which a person interacts with family members, peers, community members, and institutions (e.g., educational, religious, media, health care, legal). Therefore, culture and life experiences shape a person's world view about health, illness, and health care.

Core Measures

The Centers for Medicare & Medicaid Services (CMS), commercial insurance plans, TJC, Medicare and Medicaid managed-care plans, physician and other care provider organizations, and consumers worked together through the Core Quality Measures Collaborative to identify a set of core measures, which aim to hold health care providers accountable for considering patients' unique cultural perspectives to provide safe quality care (CMS, 2017). The **core measures** are a set of evidence-based, scientifically researched standards of care (CMS, 2017; TJC, 2018). The core measures are key quality indicators that help health care institutions improve performance, increase accountability, and reduce costs. The measures apply to all patients. The core measures need to be meaningful to patients, consumers, and physicians while reducing variability in outcome measure selection, financial collection burden, and cost (CMS, 2017). All the core measures are consistent with national health priorities and are in the following eight sets (CMS, 2017):

- Accountable care organizations (ACOs), patient-centered medical homes (PCMH), and primary care
- Cardiology
- Gastroenterology
- HIV and hepatitis C
- Medical oncology
- Obstetrics and gynecology
- Orthopedics
- Pediatrics

In addition to improving the standard of care, the core measures are intended to reduce health disparities. When hospitals are held accountable to meet the core quality measures, all patients regardless of cultural and socioeconomic status are to be treated equally because the standard of care applies to all. For example, one obstetrics and gynecology core measure is that women are to receive breast cancer screening (CMS, 2017). In another example, patients who present with heart failure are to receive beta blocker therapy for left ventricular systolic dysfunction (CMS, 2017).

A MODEL OF CULTURAL COMPETENCE

Ongoing development of cultural competence will present as your ability to interact effectively with people from different cultures, identifying the need to be respectful and responsive to the health belief practices or linguistic needs of our diverse population (SAMHSA, 2016). Cultural competence is a self-motivated developmental process that evolves over a lifetime as individuals engage with others and learn from their experiences (SAMHSA, 2016). One must look at cultural competency as a journey, not a destination (Montenery et al., 2013). Campinha-Bacote's model of cultural competency has five interrelated constructs (Transcultural C.A.R.E. Associates, 2015): cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. The five constructs provide a framework for you to practice in a culturally competent manner.

- **Cultural awareness** is the process of conducting a self-examination of one's own biases toward other cultures and the in-depth exploration of one's cultural and professional background. It also involves being aware of the existence of documented racism and other "isms" in health care delivery.

- **Cultural knowledge** is the process in which a health care professional seeks and obtains a sound educational base about culturally diverse groups. In acquiring this knowledge, health care professionals must focus on the integration of three specific issues: health-related beliefs and cultural values, care practices, and disease incidence and prevalence.
- **Cultural skill** is the ability to conduct a cultural assessment of a patient to collect relevant cultural data about a patient's presenting problem, as well as accurately conducting a culturally based physical assessment.
- **Cultural encounter** is a process that encourages health care professionals to directly engage in face-to-face cultural interactions and other types of encounters with patients from culturally diverse backgrounds. A cultural encounter aims to modify a health care provider's existing belief about a cultural group and to prevent possible stereotyping.
- **Cultural desire** is the motivation of a health care professional to "want to" (and not "have to") engage in the process of becoming culturally aware, culturally knowledgeable, and culturally skillful in seeking cultural encounters.

When you provide culturally competent care, you bridge cultural gaps to provide meaningful and supportive care for all patients. Transcultural care is culturally congruent when it fits a person's life patterns, values, and system of meaning. These patterns and meaning are generated by people themselves and not from biased, predetermined criteria. For example, during nursing school you are assigned to care for a female patient who observes Muslim beliefs. You notice the woman's discomfort with several of the male health care providers and you wonder if this discomfort is related to your patient's religious beliefs. While preparing for clinical, you learn that Muslims differ in their adherence to tradition but that modesty is an important Islamic ethic that pertains to interaction between the sexes. Thus you say to the patient, "I know that for many of our Muslim patients, modesty is very important. I want to respect your beliefs; is there some way I can make you more comfortable?" You do not assume that the information will automatically apply to this patient. Instead you combine your knowledge about a cultural group with an attitude of helpfulness and flexibility to provide quality, patient-centered, culturally congruent care. There is great diversity within cultural and racial groups themselves, and knowledge provides a general baseline, which is a great starting point in generating a positive patient outcome based on individual health care needs (Giger, 2017).

CULTURAL AWARENESS AND KNOWLEDGE

Cultural awareness requires a self-examination of one's biases toward other cultures and an in-depth exploration of one's own cultural and professional background (Ingram, 2011; Campinha-Bacote, 2002). Self-examination helps you to understand your own world view of how you perceive and engage patients. Before you begin to assess the cultures, races, and ethnicities of your patients and use this information to improve their care, first examine and understand your own cultural history, racial and ethnic heritage, and cultural values and beliefs (SAMHSA, 2014). Every individual is constructed from a unique cultural background, which can influence an individual's opinions, perceptions, beliefs, biases, or thoughts, thus forming a unique individual identity (Giger, 2017). Nurses who understand themselves and their own cultural groups and perceptions are better equipped to respect patients with diverse belief systems. Being open to understanding a patient's beliefs and forming a partnership is more important than knowing everything about a patient's specific culture (Ball et al., 2019). For example, you are giving discharge instruction to your patient. You notice the patient is avoiding eye contact, and you perceive this as disrespectful or showing disinterest when, in fact, the patient's lack of eye contact is a sign of respect, as some cultures believe the lack of eye contact when in presence of an authority is expected. Becoming culturally aware is a first step in one's ability to provide positive patient-centered care.

Campinha-Bacote recommends that you begin to gain cultural awareness by not only asking yourself if you hold any biases but also questioning whether there are any "isms" where you work (Transcultural C.A.R.E. Associates, 2015). For example, are there ageism practices in how older adults have their pain treated (e.g., undertreatment)? Be mindful of such practices so that you can adopt care approaches that minimize biases.

Health care providers gain cultural knowledge by taking time to better understand the populations they serve and obtaining specific cultural knowledge as it relates to help seeking, treatment, and recovery (SAMHSA, 2014). Cultural knowledge is learning or becoming educated about the beliefs and values of other cultures and diverse ethnic groups (Campinha-Bacote, 2002). The health care provider must focus on their specific issues: (1) health-related beliefs and cultural values, (2) disease incidence and prevalence, and (3) treatment efficacy (Campinha-Bacote, 2002). Disease incidence and prevalence differ among ethnic groups. Epidemiological data are needed to guide treatment (Campinha-Bacote, 2002). Treatment efficacy is a critical step for providing care to culturally diverse populations.

One's health-related beliefs and cultural values explain how an illness is interpreted by a patient and will guide health care practices delivered throughout patient care. For example, certain cultures believe in the importance of balance and harmony to stay healthy. Aspects of this concept are evident among the beliefs of many Hispanic, Native American, Asian, and Middle Eastern groups (Ball et al., 2019). Box 9.2 summarizes the naturalistic or holistic balance that many people believe they can achieve by using "hot" and "cold" foods and medicines.

BOX 9.2 Balance of "HOT" and "COLD"

Cold Conditions	Hot Treatments	Hot Conditions	Cold Treatments
Cancer	**Foods**	Constipation	**Foods**
Cold, flu	Beef	Diarrhea	Barley water
Earaches	Cereals	Fever	Chicken
Headaches	Chili peppers	Infection	Dairy products
Joint pain	Chocolate	Kidney problems	Fresh vegetables
Menses	Eggs	Rash	Fruits
Pneumonia	Liquor	Sore throat	Honey
Stomach cramps	Onions		**Medicines and Herbs**
	Medicines and Herbs		Bicarbonate of soda
	Anise		Milk of Magnesia
	Aspirin		Sage
	Castor oil		
	Cinnamon		
	Garlic		
	Ginger root		
	Iron		
	Penicillin		

Adapted from Ball JW, et al: *Seidel's guide to physical examination*, ed 9, St Louis, 2019, Elsevier; and Purnell LD: *Transcultural health care: a culturally competent approach*, ed 4, Philadelphia, 2013, FA Davis.

However, people from different cultures define "hot" and "cold" differently. For example, people who are of Chinese heritage often uphold the philosophical concept of yin (cold) and yang (hot). To restore (treat) a disturbed balance requires the use of opposites (e.g., a "hot" remedy for a "cold" problem and vice versa). If you know about a specific culture's risks for disease, you can focus your nursing history more appropriately during your assessment. If you learn that an individual believes in a "hot" and "cold" balance when choosing certain foods to eat, support your patient's practices, and adapt this information into the patient's dietary plan.

Do not form inappropriate biases or stereotypes when you assess a patient's culture. It is easy to stereotype various cultural groups after reading general information about their ethnic values, practices, and beliefs. Avoid stereotypes or unwarranted generalizations about any particular group that prevents an accurate assessment of an individual's unique characteristics and world view. Instead approach each person individually and ask questions to gain a better understanding of a patient's perspective and needs. Stereotyping occurs in two cognitive phases. In the first phase there is an activation of a stereotype when an individual is categorized into a social group. When this occurs, beliefs and prejudices come to mind about what members of that particular group are like (Ball et al., 2019). Stereotypical views eventually occur without awareness automatically. In the second phase, people use these activated beliefs and feelings when they interact with individuals (Ball et al., 2019). Research shows that health care providers activate these stereotypes or unconscious biases routinely when communicating with and providing care to minority individuals (Dayer-Berenson, 2014). As a result, diagnoses and treatments of patients may be biased even in the absence of the practitioner's intent or awareness.

REFLECT NOW

Consider a patient that you cared for recently. How did the patient's health-related beliefs and cultural values impact the decisions he or she made regarding their health concerns?

Storytelling

One way to begin to understand a patient's cultural perspective is storytelling. Storytelling conveys culture, combining personal experience with the commonalities of all human experiences (Wilson et al., 2015). When you encourage a patient to tell a story or when you tell your own story, you frame important messages in ways that make them memorable for you and your patient. Telling stories engages a nurse and patient in a way that broadens their relational understanding. Use storytelling to explore pertinent health care issues; for example, have patients describe previous surgical experiences, problems with childrearing, or approaches used with self-administration of medications. A story helps identify the real problems affecting a patient's health status and find culturally appropriate ways to intervene (Box 9.3).

World View of Providers and Patients

Health care has its own culture of hierarchies, power, values, beliefs, and practices. Most health care providers educated in Western traditions are immersed in the culture of science and biomedicine through their coursework and professional experience. Consequently, they often have a world view that differs from that of their patients. As a nurse, you need to assume that every patient encounter will be a cross-cultural one.

Patients and all their health care providers bring all their world views into the care process. The iceberg analogy is a tool that helps you visualize the visible and invisible aspects of your own world view (Fig. 9.3). Just as most of an iceberg lies beneath the surface of the water, most aspects of a person's world view lie outside his or her awareness and are invisible to those around the person. For example, a patient who has willingly agreed to be admitted to the hospital for a serious medical condition requiring surgery may refuse the surgery for religious reasons. In the patient's view, she came to the hospital for help to eliminate the pain and infection from her illness. At the same time, she believes that she needs to seek God for a decision that entails removing a body part. The patient's health care provider assumes the patient is in the hospital to receive care for a serious illness and is willing to accept any and all treatments to cure the illness. The patient's deeply held religious beliefs about removing a body part are not obvious by assessing for a religious preference. Thus the nurse needs to conduct a comprehensive **cultural assessment** to understand how the patient's religious values will affect her willingness to receive care (Box 9.4). These deeply held values reside "underneath the iceberg." The

BOX 9.3 EVIDENCE-BASED PRACTICE

Use of Storytelling and Patient Involvement in Health Care.

PICOT Question: Does the use of storytelling compared with standard assessment approaches among adult and pediatric patients affect patient involvement in selecting health care interventions?

Evidence Summary

A patient's ability to understand the complexities of many health issues and to be able to become engaged in decision making requires the ability to discuss and clarify confusing issues. Storytelling allows patients to reflect on their illness experience and create meaning from it (Gucciardi et al., 2016; Hardy and Sumner, 2018). Storytelling enhances self-management of chronic disease (e.g., cancer, diabetes). A recent study involved patients telling stories about their aspirations for the future (Terkildsen and Wittrup, 2015). The shared information allowed clinicians to initiate interventions based on patient experiences of health problems. When patients are able to express their experiences, there is a negotiation with health care providers that leads to a mutual plan of care.

Digital storytelling is also widely used, especially in pediatric patients. Digital storytelling gives children and adolescents with cancer a platform for making sense of and sharing their cancer experience (Wilson et al, 2015). Houston et al. (2011) used DVDs to deliver stories of real patients with hypertension to patients treated for hypertension. Patients with baseline uncontrolled hypertension who watched the storytelling DVDs had a greater reduction in systolic and diastolic blood pressure at 3 months compared with patients watching an attention DVD (a DVD on general health topics unrelated to hypertension). Technology can have a significant impact on providing respect, trust, and justice in patient care (Hardy and Sumner, 2018). The act of telling a story is valuable, allowing a patient to initiate the process of reflection to gain understanding of the self and the disease process (Gucciardi et al., 2016; Hardy & Sumner, 2018).

Application to Nursing Practice

- Create a safe, caring, and nonjudgmental environment when using storytelling (Gucciardi et al., 2016; Hardy and Sumner, 2018).
- Storytelling should be participant-centered; give patients substantial control over when and how to tell a story (Gucciardi et al., 2016).
- Use storytelling to clarify issues when performing a cultural assessment.
- When asking a patient to describe his or her major concerns about a health problem, try to use storytelling to frame the context of those concerns.
- Tell your own stories about patient experiences (respecting confidentiality) to help explain procedures or treatment plans.

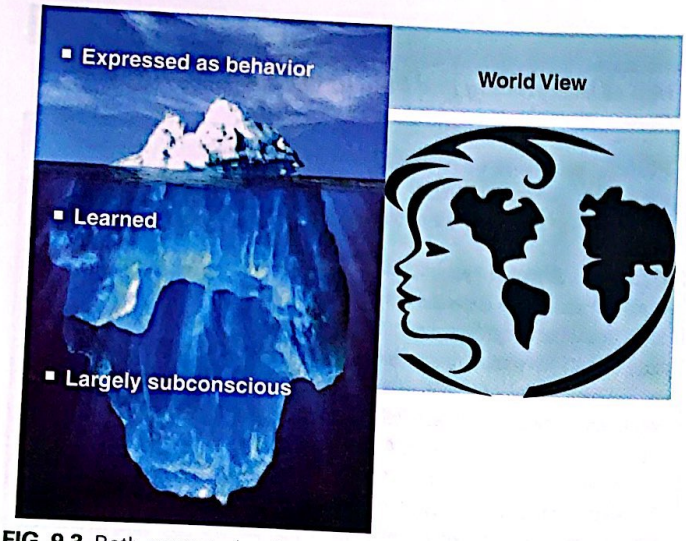

FIG. 9.3 Both nurse and patient act in accordance with their own world views. This model was adapted from Campinha-Bacote et al. (2005) Iceberg Analogy. It incorporates the Kleinman (1980) explanatory model. (Copyright © 2011 Barnes-Jewish Hospital Center for Diversity and Cultural Competence.)

observed behavior (in this case, coming to the hospital) is a visible sign of a person's world view, but the beliefs, attitudes, knowledge, and experiences that guide the behavior are not visible to others. Conflict arises when health care providers interpret the behaviors of patients through their own world view lens instead of trying to uncover the world view that guides the behavior of their patients.

CULTURAL SKILL

Collecting a culturally based nursing history, performing a culturally based physical assessment, and using teach-back with plain language are cultural skills that take practice and require you to apply your cultural awareness and knowledge. The summary of the domains of culture is a framework for the information you might choose to include in a nursing history (Purnell, 2013) (Box 9.5). It takes time to gather a comprehensive culturally based nursing history. If you work in a setting such as home health, school nursing, or a health clinic, you will be able to gather more information with each patient visit. When you are in an acute setting, you must focus your assessment on the domains most relevant to a patient's condition and the impending treatment plan. For example, if you know a patient will require extensive postoperative education, it will be important to assess the patient's and family's language, family roles, and health care practices.

Collecting a Patient History

Begin a patient assessment by being mindful that cultural differences will exist. It is important to grasp exactly what the patient means and know exactly what the patient thinks you mean in words and actions (Ball et al., 2019). Do not make assumptions. Listen carefully, let patients tell their stories, rephrase statements for clarity, and validate any assumptions you make about the patient's condition or health care needs with the patient. As you perform an assessment, the patient may hesitate to offer his or her beliefs and fears, a hesitancy that can be overcome through respectful, nonjudgmental questioning (see Box 9.4). Have a patient help set the agenda for the visit to help you better understand the patient's needs.

A cultural assessment is intrusive and time consuming and requires a trusting relationship between participants. Misunderstandings due to inappropriate communication between a health care provider and the patient are a barrier to accessing health care (Hadziabdic et al., 2015). Misunderstandings occur because of language communication differences between and among participants and differences in interpreting one another's behaviors. **Linguistic competence** is the ability

BOX 9.4 Cultural Assessment Guide: Aspects of Understanding

Health Beliefs and Practices
- How does the patient define health and illness? How are feelings concerning pain, fatigue, and illness in general expressed?
- Are particular methods used for the treatment of illness?
- What is the attitude toward preventive health measures such as immunizations?
- Are there restrictions imposed by modesty that must be respected (e.g., constraints related to exposure of parts of the body, discussion of sexual health)?
- What are attitudes toward mental illness, pain, chronic disease, being handicapped, and death and dying?
- Is there a person in the family responsible for health-related decisions?
- Does the patient prefer a health professional of the same gender, age, and ethnic and racial background?

Faith-Based Influences and Special Rituals
- Is there a religion or faith to which the patient adheres?
- Is there a significant person to whom the patient looks for guidance?
- What events, rituals, and ceremonies are important within the life cycle of birth, puberty, marriage, and death?

Language and Communication
- What language is spoken in the home?
- How well does the patient understand spoken and written English?
- Are there special signs of demonstrating respect or disrespect?
- Is touch an acceptable form of communication?

Parenting Styles and Family Roles
- Who makes the decisions in the family?
- What is the composition of the family? How many generations are considered to be a single family?
- What is the role of and attitude toward children in the family?
- When do children need to be disciplined or punished, and how is this done?
- Do family members show physical affection toward each other and their children?
- What major events are important to the family, and how do they celebrate?

Sources of Support Beyond the Family
- Are there ethnic organizations that may influence the patient's approach to health care?
- Are there individuals in the patient's social network that influence perception of health and illness?
- Is there a particular cultural group with which the patient identifies?

Dietary Practices
- What does the family like to eat? Does everyone in the family have similar tastes in food?
- Who is responsible for food preparation?
- Are any foods forbidden by the culture, or are some foods a cultural requirement in observance of a rite or ceremony?
- How is food prepared and eaten?
- Are there periods of required fasting?

Adapted from Ball JW, et al: *Seidel's guide to physical examination*, ed 9, St Louis, 2019, Elsevier.

BOX 9.5 The Twelve Domains of Culture

- Overview, inhabited localities—country of origin and current residence
- Communication—interrelationship of verbal language skills, including dominant language, dialects, touch, contextual use of language, and willingness to share information
- Family roles and organization—defines relationship of insiders and outsiders; includes concepts related to head of household, gender roles, family goals and priorities, and developmental goals of family members
- Workforce issues—type of employment, location, autonomy, language barriers
- Biocultural ecology—skin color, heredity, genetics, drug metabolism
- High-risk behaviors—tobacco, alcohol, recreational drugs, physical activity, safety
- Nutrition—meaning of foods, common foods, deficiencies, rituals, limitations
- Pregnancy and childbearing practices—fertility practices, views toward pregnancy, birthing, postpartum
- Death rituals—bereavement, ceremonies
- Spirituality—religious practices, use of prayer, meaning of life
- Health care practices—focus of health care, traditional practices, responsibility for health, self-medication, pain, sick role, barriers
- Health care providers—perceptions of providers, folk practitioners, gender, and health care status

Adapted from Purnell LD: *Transcultural health care: a culturally competent approach*, ed 4, Philadelphia, 2013, FA Davis.

to communicate effectively and convey information in a manner that is easily understood by diverse audiences. You use transcultural communication skills to interpret a patient's behavior and to behave in a culturally congruent way.

The National Culturally and Linguistically Appropriate Services (CLAS) Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint to help individuals and health care organizations implement culturally and linguistically appropriate services (Office of Minority Health [OMH], n.d.). The CLAS standards include standards for communication and language assistance. The standards apply when you care for patients who have limited English proficiency and/or other communication needs. All US health care organizations must meet the following requirements:

- Provide language assistance resources (e.g., trained medical interpreters, qualified translators, telecommunication devices for the deaf) for individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language verbally and in writing.
- Ensure the competence of individuals providing language assistance. Do not use untrained individuals and/or minors as interpreters.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

When you begin a cultural assessment there are some basic questions that can help you explore a patient's culture (Ball et al., 2019):

- What do you call your problem?
- What do you think caused it?
- Why do you think it started when it did?
- What does your sickness do to you?
- How long do you think it will last?
- How different is this problem from the one you had a month ago?
- What is the difference between what we are doing and what you think we should be doing for you?
- Why did you come to us for treatment?
- What benefit do you expect from the treatment?
- How do you typically deal with a problem with your health?

Each question requires an open-ended response, enabling you to gain important details about a patient's perceptions, values, and attitudes. A patient's answer to a question may allow you to explore his or her cultural background more thoroughly.

After realizing that Ms. Millman needs help to better understand the types of foods that are appropriate for a diabetic diet, Hannah refocuses her assessment on some basic questions. How do you think the foods that you eat affect your diabetes? What does diabetes do to you if your blood sugar becomes too high? What benefit will you get from eating healthy foods? Tell me what you eat during a typical day.

Culture influences how feelings are expressed verbally and nonverbally. Verbal and nonverbal communication is an important core of all health care encounters (Hadziabdic et al., 2015). Touch, facial expressions, eye contact, movement, and body posture all have varying significance. The questions in Box 9.4 can help provide further insight to particular situations and help avoid misunderstanding and miscommunication (Ball et al., 2019).

Assessing Health Literacy

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and the services needed to make appropriate health decisions (AHRQ, 2015). According to the IOM, 90 million adult Americans have limited health literacy, and 20 million Americans speak poor English and 10 million speak none (NIH, n.d.). Limited health literacy can be a problem for anyone. It is important to understand that even people with good literacy skills find that understanding health care information is a challenge. Patients and family members often do not understand medical vocabulary and the basic concepts in health and medicine, such as how the body works or how to navigate the health care system. During your assessment, be alert for patient behaviors that might reflect a literacy deficit such as having difficulty completing registration forms or health histories, failing to make follow-up appointments, asking few questions during a physical examination, and responding simply "yes" when asked whether explanations are understood. Use health literacy assessment tools to determine the level of a patient's health literacy (AHRQ, 2015). Examples of these tools include:

- The Short Assessment of Health Literacy—Spanish and English (SAHL-S&E) is an instrument consisting of comparable tests in English and Spanish, with good reliability and validity in both languages (Lee et al., 2010).
- The Rapid Estimate of Adult Literacy in Medicine—Short Form (REALM-SF) is a seven-item word recognition test to provide clinicians with a valid quick assessment of patient health literacy (Arozullah et al., 2007). The REALM-SF has been validated and field-tested in diverse research settings.

Assessing a patient's health literacy level is very important in planning appropriate patient education approaches (AHRQ, 2015) (see Chapter 25).

Culturally Based Physical Assessment

When performing a physical assessment, knowledge about a patien directs your physical assessment (see Chapter 30). For example, if yo know a patient has diabetes for many years, you focus on the peripher vascular examination because of the common incidence of circulato

problems in patients with diabetes. If a patient uses an inhaler for asthma, you perform a more detailed assessment of the lungs compared with what you might do for a healthy patient you see during a routine checkup.

Similarly, you learn to anticipate physical findings based on a patient's cultural health practices and distinguish physical characteristics of an ethnic or racial group. There are several ways individuals from one cultural group can differ biologically from members of other cultural groups (Giger, 2017). For example, Mongolian blue spots are a dark pigmented birthmark that may appear shortly after birth on the buttocks, lower back, arms, or legs of dark skin and should not be mistaken for bruising and a signs of abuse. Another example includes the practices of "coining" and "cupping," which are commonly used by some Asian subcultures to release excess force from the body and restore balance (Ball et al., 2019). The practices leave imprints and markings on the skin that can be wrongly interpreted as signs of abuse or disease. Thus it is always important to ask patients about their home remedies and practices. Another example of anticipating findings is to consider sickle cell anemia when blood tests reveal laboratory values that show anemia in a patient of African descent. As you practice and become more knowledgeable of different ethnic groups in your practice, you will more readily recognize physical characteristics of conditions unique to those groups.

Teach-Back and Plain Language

Linguistic competence requires the application of health literacy principles in providing readily available, culturally appropriate oral and written language services to patients and families with limited English proficiency (AHRQ, 2013). The dual challenges of caring for patients with limited health literacy and cultural differences are likely to increase with an expanding, increasingly diverse, and older population. Evidence suggests that health care providers who attend to both issues help reduce medical errors and improve adherence, communication between provider and patient and family, and outcomes of care at both individual and population levels (Lie et al., 2012). Clear communication is essential for effective delivery of quality and safe health care, but most patients experience significant challenges when communicating with their health care providers. Studies show that 40% to 80% of the medical information given to patients during medical office visits is immediately forgotten, and nearly half of the information retained is incorrect (AHRQ, 2018b).

The use of plain language in communicating with patients makes any information you provide easy to read, understand, and use. Plain language is grammatically correct language that includes complete sentence structure and accurate word usage (National Institutes of Health [NIH], n.d.). The Federal Plain Language Guidelines (2011) provide guidance on improving communication through writing. Clear communication is a priority in providing patient care. Written education must be based on specific patient needs. You can find the tips for writing in plain language from the PlainLanguage.gov website: https://www.plainlanguage.gov-/media/FederalPLGuidelines.pdf. Offering patients clear instructions and educational material written in plain language conveys to a learner exactly what to know without using unnecessary words or expressions.

Use the teach-back method following any patient instruction to confirm that you have explained what a patient needs to know in a manner that the patient understands (Fig. 9.4). The teach-back technique is an ongoing process of asking patients for feedback through explanation or demonstration and of presenting information in a new way until you feel confident that you communicated clearly and that your patient fully understands the information presented (Box 9.6). When a family caregiver is the recipient of your instruction, use teach-back to confirm his or her learning. You also use teach-back to identify explanations and communication strategies your patients most commonly understand (AHRQ, 2018a).

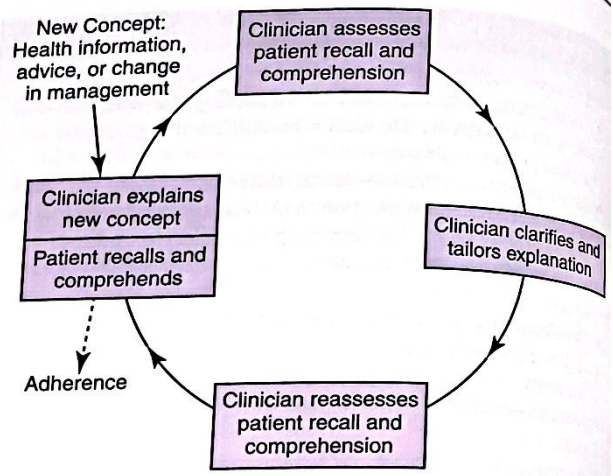

FIG. 9.4 Using the teach-back technique to close the loop. (From the US Health Resources and Services Administration.)

BOX 9.6 PATIENT TEACHING

Medication and Nutritional Adherence

Hannah knows it is important for Ms. Millman to understand her health problems and prescribed treatments. Thus Hannah plans to use teach-back to ensure Ms. Millman understands how to effectively manage her diabetes.

Outcome

At the end of the teaching session, Ms. Millman will be able to:

- Describe how she plans to make healthy food choices at the shelter and neighborhood store.

Teaching Strategies

- Create a shame-free environment by demonstrating a general attitude of helpfulness.
- Use nonmedical language and define in plain language all medical terms.
- Sit instead of stand, and speak slowly.
- Use pictures, models, and written handouts to help Ms. Millman better remember relevant information.
- Have Ms. Millman prepare a meal plan.

Evaluation

Use the principles of teach-back to evaluate patient/family caregiver learning:

- Tell me two strategies that you will use to make healthy food choices when shopping at your neighborhood grocery store.
- We've gone over a lot of information today about changes you plan to make to your diet. In your own words, please review what we talked about. Tell me how you will follow your diet?

When using the teach-back technique, do not ask a patient, "Do you understand?" or "Do you have any questions?" Instead ask open-ended questions to verify a patient's understanding. Some examples include:

- "I've given you a lot of information (e.g., about your insulin) to remember. Please explain it (e.g., how it affects your blood sugar) to me so that I can be sure that I gave you the information you want and need to take good care of yourself."
- "What will you tell your wife (or husband/partner/child) about the changes we made to your medications today?"
- "We've gone over a lot of information today about how you might change your diet, and I want to make sure I explained everything clearly. In your own words, please review what we talked about. How will you follow this diet at home?"

Teach-back is not intended to test a patient but rather to confirm the clarity of your communication (AHRQ, 2018a). Many patients are embarrassed by their inability to sort out health information or instructions. By regarding teach-back as a test of your communication skills, you take responsibility for the success or failure of the interaction and create a shame-free environment for your patients. Following are helpful hints to consider when trying the teach-back method (AHRQ, 2018a).

- Plan your approach. Think about how you will ask your patient to teach back in a shame-free way. Keep in mind that some situations are not appropriate for teach-back.
- Use handouts, pictures, and models to reinforce your teaching.
- "Chunk and check." Do not wait until the end of the visit to initiate teach-back. Chunk out information into small segments and have the patient or family caregiver teach it back. Repeat several times during a visit.
- Clarify and check again. If teach-back uncovers a misunderstanding, explain things again using a different approach. Ask patients to teach-back again until they are able to correctly describe the information in their own words. If they parrot your words back to you, they may not have understood.
- Start slowly and use teach-back consistently. Practice. It will take a little time, but once it is part of your routine, teach-back can be done without awkwardness.
- Use the show-me method. When prescribing new medicines or changing a dose, research shows that even when patients correctly say when and how much medicine they will take, many will make mistakes when asked to demonstrate the dose.
- Clarify. If a patient cannot remember or accurately repeat your instructions, clarify your information, and allow him or her to teach it back again (see Box 9.6).
- Although it takes time to get used to teach-back, studies show that it does not take longer to perform once it becomes a part of your routine (AHRQ, 2018a). *Box 9.6 provides an example of how Hannah used some of these strategies to educate Ms. Millman on how to manage her diet.*

Working With Interpreters

The National CLAS Standards (OMH, n.d.) ensure that qualified translators (written words) and interpreters (verbal words) be provided to patients with limited English proficiency. The CLAS standards require you to notify patients both verbally and in writing of their rights to receive language assistance. If a health care setting does not have timely access to an interpreter, a more feasible option is the use of a telephone service that provides an on-call trained interpreter connected by phone (Juckett and Unger, 2014). Ensure that interpreters are competent in medical terminology and understand issues of confidentiality and impartiality. If available, a cultural broker may be utilized as an interpreter, advocate, or mediator that bridges between the individual or group (Dayer-Berenson, 2014). Do not use a patient's family members to interpret for you or other health care providers. The family member may include his or her own perception or opinion in translation, which can greatly reduce the accuracy of the translated information (Dayer-Berenson, 2014). When you begin a patient interview with an interpreter present, you should speak in the first person ("I" statements), not the third person (e.g., "tell her," "he said"), and speak directly to the patient, as the interpreter functions as an inconspicuous participant for the conversation (Juckett and Unger, 2014). Have the interpreter sit next to or slightly behind the patient. Look at the patient instead of looking at the interpreter and speak in short sentences; then wait for the interpreter to convey them (Juckett and Unger, 2014). Avoid using jargon, acronyms, and jokes; attempts at humor are often lost in interpretation. Ask the patient for feedback and clarification at regular intervals. Be observant of the patient's nonverbal and verbal behaviors. At the end of a conversation thank both the patient and the interpreter.

CULTURAL ENCOUNTER

In every health care setting you will directly interact with patients from culturally diverse backgrounds. This interaction is a cultural encounter, which has two goals (Campinha-Bacote, 2007). One goal is to communicate in a way that generates a wide variety of responses and to send and receive both verbal and nonverbal communication accurately and appropriately in each culturally different context. The second goal is to continuously interact with patients from culturally diverse backgrounds to validate, refine, or modify existing values, beliefs, and practices about a cultural group.

CULTURAL DESIRE

Engaging with people we perceive as "different" from us can be threatening and difficult. It generally takes more effort and patience than engaging with patients who are more similar to us. Cultural desire refers to having the motivation to engage patients so that you understand them from a cultural perspective. It is the pivotal and key construct of cultural competence, for it is a nurse's desire that evokes the entire process of cultural competence (Campinha-Bacote, 2003). Cultural desire involves the concept of caring (see Chapter 7). Establishing a caring relationship with a patient requires you to enter into the patient's world view. Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants (Campinha-Bacote, 2003).

You will care for patients who display behaviors that may be in direct moral conflict with your own values (e.g., abortion, substance abuse, spouse abuse). For example, you are asked to care for a young male gang member whose beliefs about violence and respect for life are in direct contrast to yours. Yet you care for this patient nonjudgmentally and with respect. Acquiring the willingness to practice cultural desire requires a respect and acceptance of all human beings. The LEARN Model (Campinha-Bacote, 2003) can assist with this process. The mnemonic *LEARN* represents the process of listening, explaining, acknowledging, recommending, and negotiating:

- *L*isten to the patient's perception of the problem. Be nonjudgmental and use encouraging comments, such as "Tell me more" or "I understand what you are saying."
- *E*xplain your perception of the problem.
- *A*cknowledge not only the differences between the two perceptions of the problem but also the similarities. Recognize the differences but build on the similarities.
- *R*ecommendations must involve the patient.
- *N*egotiate a treatment plan, considering that it is beneficial to incorporate selected aspects of the patient's culture into the plan.

Applying the LEARN mnemonic will help you to reflect at each patient encounter. You recognize that each patient is unique, but you are responsible for understanding what "unique" truly means so that you can engage patients in a patient-centered approach to care.

QSEN Building Competency in Patient-Centered Care Mrs. Addelman is 28 years old and 39 weeks pregnant. She has been under medical care since the pregnancy was discovered. At this time, Mrs. Addelman is in labor, and an emergency C-section is needed. She refuses to allow the health care team to prepare her for the C-section until her husband arrives. Her family practices the Muslim faith. What are your concerns related to Mrs. Addelman? What are some steps you, as the nurse, can take to assist?

Answers to QSEN Activities can be found on the Evolve website.

KEY POINTS

- Cultural awareness self-examines the dynamics of personal biases, stereotypes, values, and beliefs related to others different from one's own heritage, while cultural encounter is directly interacting with patients of a diverse population other than one's own.
- Cultural desire is the pivotal and key construct of cultural competence. It is your desire to engage with patients who have cultural differences that evokes the entire process of cultural competence.
- A person's culture and life experiences shape his or her world view about health, illness, and health care.
- Poor health, disease risk factors, poor health outcomes, and limited access to health care are types of preventable health care disparities often interrelated and influenced by the conditions and social context in which people live.
- Disparities in access to quality health care, preventive health care, and health education contribute to poor population health.
- Social determinants of health are defined by conditions in which people are born, grow, live, work, and age.
- Health care systems and providers contribute to the problem of health disparities as a result of inadequate resources, poor patient-provider communication, a lack of culturally competent care, system fragmentation, and inadequate access to language services.
- People who are marginalized are more likely to have poor health outcomes and to die at an early age because of a complex interaction among individual behaviors, public and health policy, cultural factors, and access to and quality of health care.
- Gaining cultural knowledge and conducting a self-examination allows a health care provider to understand the cultural factors that shape a patient's life experiences, a patient's health care problems, a patient's behavior, and how a patient might perceive those problems while building a positive nurse-patient relationship.
- Cultural respect is critical to reducing health disparities and improving access to high-quality health care that is respectful and responsive to the needs of a diverse patient.
- Avoid forming inappropriate biases or stereotypes when assessing a patient's needs. Approach each person individually and ask questions to gain a better understanding of a patient's perspective and needs.
- Ongoing cultural competence and cultural skill are necessary for a nurse to complete a cultural assessment and provide culturally appropriate nursing care for each patient, regardless of the patient's cultural background.
- Knowledge about your patient directs your physical assessment, and the health care provider must learn to anticipate physical findings based on the patient's cultural health practices and the physical characteristics of an ethnic or racial group.
- Teach-back is an ongoing process of asking patients open-ended questions to gather feedback through explanation or demonstration until the health care provider feels confident in the patient's ability to understand and safely apply the new educational content.
- Linguistic competence is the ability to communicate effectively and convey information in a manner that is easily understood by diverse audiences.
- Effective communication is a critical skill in culturally competent care and helps you engage a patient and family in a respectful, patient-centered dialogue. Qualified translators (written words), interpreters (verbal words), and/or the use of a cultural broker (mediator) are options to be utilized to assist with linguistic needs related to effective communication.

REFLECTIVE LEARNING

- Consider a patient that you cared for recently on the clinical unit. How did knowledge of your patient's culture impact your nursing care?
- Discuss some of the social determinants of health that you identified while conducting your assessment of the patient. How have these impacted the health of the patient?
- Review your personal approach to patient education when working with a patient who has a different cultural background from your own. Remember, the teach-back method is a valuable tool for all health care providers to use with each patient. As the health care provider, did you do the following?
  - Use a caring tone of voice and attitude?
  - Display comfortable body language, make eye contact, and sit down at the patient's level?
  - Ask open-ended questions?
  - Take responsibility for making sure the instructions were clear and understood?
  - Use print materials that were reader friendly to support learning?
  - Observe the patient's response to teach-back?

REVIEW QUESTIONS

1. Which of the following is an example of a patient with a health disparity? (Select all that apply.)
   1. A patient who has a homosexual sexual preference
   2. A patient unable to access primary care services
   3. A patient living with a chronic disease
   4. A family who relies on public transportation
   5. A patient who has had a history of smoking for 10 years
2. A 35-year-old woman has Medicaid coverage for herself and two young children. She missed an appointment at the local health clinic to get an annual mammogram because she has no transportation. She gets the annual screening because her mother had breast cancer. Which of the following are social determinants of this woman's health? (Select all that apply.)
   1. Medicaid insurance
   2. Annual screening
   3. Mother's history of breast cancer
   4. Lack of transportation
   5. Woman's age
3. During a nursing assessment a patient displayed several behaviors. Which behavior suggests the patient may have a health literacy problem?
   1. Patient has difficulty completing a registration form at a medical office
   2. Patient asks for written information about a health topic
   3. Patient speaks Spanish as primary language
   4. Patient states unfamiliarity with a newly ordered medicine
4. A nurse desires to communicate with a young woman who is Serbian and who has limited experience with being in a hospital. The nurse has 10 years of experience caring for Serbian women. The patient was admitted for a serious pregnancy complication. Apply the LEAP model and match the nurse's behaviors with each step of the model.

1. L _____	a. The nurse notes that she has learned that fathers can visit mothers at any time in both Serbia and the United States.
2. E _____	b. The nurse shares her perception of the woman's experiences as a patient.
3. A _____	c. The nurse asks the patient how she can maintain bed rest when she returns home.