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AMN Healthcare Education Services

Cultural Competence

3 Contact Hours

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Purpose

The purpose of this continuing education course is to provide healthcare professionals with information about cultural competence and how it applies in their practice settings.

The course includes:

- A definition of cultural competence and a cultural competence model
- Dimensions of culture and individual differences among people
- Approaches to providing culturally competent health care across the continuum of care
- Examples of cultural aspects of patient care

The course presents examples of some cultural influences on patient care frequently encountered in the U.S. Clinicians encounter many more cultures, blends of cultures, and individual variations than one course could possibly describe.

The resources section at the end of the course suggests resources for additional information.

Learning Objectives

After successful completion of this course, you will be able to:

1. Define cultural competence
2. Explain components of a Cultural Competence Model
3. Identify dimensions of culture and individual differences among people
4. Explain approaches to providing culturally competent care in phases of the patient's hospitalization experience:
    - Admission
    - Assessment
    - Treatment
    - End-of-Life Care
    - Discharge and Transfer
5. Give examples of cultural aspects in patient care situations

What is Culture?

Culture is defined as:

- The integrated pattern of human behavior that includes thought, speech, action, and artifacts and depends upon the human capacity for learning and transmitting knowledge to succeeding

generations

- The customary beliefs, social norms, and material traits of a racial, religious, or social group

(Merriam-Webster Collegiate Dictionary, 2011)

Often people perceive culture as limited to characteristics of ethnic, racial, or religious groups. Yet, the dictionary definitions above embrace many other ways in which people differ from one another, such as regional identity, sexual orientation, gender identity, educational background, literacy, language, and other differences.

These definitions also extend to differences in personality, learning style, and in functional abilities to hear, see, and move about.

Applying these definitions, most people identify with and participate in more than one culture.

Lesbian, Gay, Bisexual, Transgender (LGBT) Persons

LGBT persons provide one example of persons who identify with more than one cultural group. Persons of many different ethnic backgrounds identify with and participate in the LGBT culture.

An estimated 2%-6% of the US population engaged in same-sex sexual behavior during the last five years and 1%-4% of the US population self-identify as lesbian, gay, bisexual, or transgender (LGBT) (Ambrose & Ladewski, 2005).

Many LGBT persons avoid or delay care or receive inappropriate or inferior care because of perceived or real homophobia, biphobia, transphobia, and discrimination by healthcare providers and institutions (Gay & Lesbian Medical Association, 2006).

Respect transgender patients by using appropriate pronouns for their gender expression, or simply use their preferred name. Ask the patient to clarify terms or behaviors with which you are unfamiliar. When in doubt, ask! (Ambrose & Ladewski, 2005).

Culture and Sensitivity

Healthcare professionals know the term culture and sensitivity to mean a laboratory test that identifies the organism causing an infection and appropriate medications to treat the infection.

This course emphasizes the importance of another shade of meaning for culture and sensitivity. This course encourages healthcare professionals to consider the term “culture” very broadly to include all of the many ways in which people differ from one another.

Certainly ethnic background, race, and religion come to mind right away when culture is mentioned. But other differences affect patient care and interactions with other members of the healthcare team.

“In its simplest terms, culture is the way of life of a people” (Adeniran & Stamm, 2010). People affiliate with one another based upon their similarities, and so groups of people, such as gay, lesbian, bisexual, and transgendered individuals; physicians; Southerners in the U.S.; Mormons, and many other groups of people, share some common values and practices. Yet, most individuals participate in more than one culture, and individuals vary greatly in the extent to which they observe the practices of a culture.

This course encourages healthcare professionals to develop sensitivity to cultural differences. The

course will assist you to develop an awareness of practices of some cultural groups. This knowledge may guide the assessment process, but should never lead to stereotyping or assumptions about any individual patient or colleague. Instead, approach each individual person and hear from that person about the values, beliefs, and practices that affect his care.

Think it Through...

How many cultural groups do you belong to?

- Take a few moments and jot down the different cultural groups that **you** think you belong to. What groups might **others** think you belong to?
- How are you the same and how do you differ from others in those same cultural groups?

What is Cultural Competence?

Cultural Competence is:

- The ability of healthcare providers and healthcare organizations to understand and respond effectively to the cultural and language needs that the patient brings to the healthcare encounter (TJC, 2010).
- An ongoing process in which the nurse continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family, community) (Campinha-Bacote, 2007).

Cultural competence requires an organization and its personnel to:

- Value diversity
- Assess themselves
- Manage the dynamics of difference
- Acquire and institutionalize cultural knowledge
- Adapt to diversity and the cultural contexts of individuals and communities served

(AHRQ, 2010)

On the Journey Toward Cultural Competence

To develop cultural competence, healthcare professionals must enhance their knowledge of the practices of the cultural groups they serve. This course presents a few examples of some of the cultural groups commonly encountered in the U.S. healthcare system. The course includes only a limited number of examples and only a fraction of the possibly relevant information about each cultural group represented in the examples.

Make use of the resources identified at the end of the course and resources that members of your community recommend to increase your knowledge of cultural influences pertinent in your healthcare organization.

Four common Hispanic cultural values influence interactions in the healthcare setting

(Young, 2001):

- **Personalismo** - personal/genuine relationships
- **Respeto** - respect
- **Confianza** - trust/confidence
- **Familiaismo** - familial/group emphasis

A Cultural Competence Model

One model considers cultural competence as an ongoing journey in which healthcare providers strive toward the ability to work within the cultural context of the patient and family (Campinha-Bacote, 2005).

In the model, five interrelated constructs build toward cultural competence.

A Cultural Competence Model

Cultural desire

- The motivation for the healthcare professional to “want to” grow in cultural competence. Cultural desire provides the energy to engage in the journey and requires humility.

Cultural awareness

- The examination and in-depth exploration of one’s own cultural and professional background.

Cultural knowledge

- The process of seeking and obtaining a sound educational foundation regarding beliefs and traditions of cultural groups other than one’s own.

Cultural skill

- The ability to collect accurate information from a patient about the presenting health issues, considering cultural values.

Cultural encounter

- The opportunity to engage in cross-cultural interactions with members of cultural groups different from one’s own.

Cultural Desire

The journey toward cultural competence begins with a sincere motivation to heighten one’s awareness of cultural influences in one’s own life and in the lives of others. The desire is more than a desire to learn. It extends to a desire to respectfully enter the cultural worlds of others, that is, to learn to see things from the perspective of a culture different from one’s own.

Cultural Awareness

Before exploring other cultures, it is important to heighten one’s own cognizance of one’s own culture and beliefs. This enables a person to recognize any biases, prejudices, or assumptions about another person’s or a patient’s cultural health values.

By becoming culturally aware, healthcare professionals can more competently assess patients, negotiate and plan care, and intervene. Awareness of one’s own values helps a healthcare professional to avoid imposing personally held values and knowledge of the Western (biomedical) model.

The demographics of the RN population do not match the demographics of the U.S. population. Non-Hispanic, white females dominate the RN population to a large extent. Therefore, it is unlikely that RNs and their patients will consistently match in cultural background.

This phenomenon is known as lack of concordance. Cultural awareness is an important step to help

RNs and other healthcare professionals avoid imposing their own values on patients or making unfounded assumptions about a patient's values.

Diversity in the RN Workforce

Though greater diversity is developing in the RN workforce, the vast majority of RNs are white, non-Hispanic females.

Demographic Group	% of U.S. Population	% of RN Workforce
White, non-Hispanics	67%	83%
Asian, Native Hawaiian and Pacific Islanders (non-Hispanic)	4.5%	5.8%
African Americans (non-Hispanic)	12.2%	5.4%
Hispanics/Latinos of any race	15.4%	3.6%

The percentage of men in nursing has increased since 1990. In the most recent survey data, female RNs outnumbered male RNs by more than 15 to 1 in the overall number of RNs, but among only those who became RNs after 1990, there is one male RN for every 10 women (U.S.D.H.H.S, H.R.A., 2010).

Cultural Knowledge

Healthcare professionals can gain knowledge about the health-related beliefs and cultural values traditional among the ethnic groups with whom they work. This knowledge includes all beliefs and traditions related to health, illness, treatment, and self-care. This knowledge also includes the incidence and prevalence of disease conditions in those groups, and the efficacy of treatment options.

Cultural knowledge about the health-related beliefs and values of a patient can help healthcare professionals interpret the patient's view of the world and understand the type of treatments and interventions that he or she is likely to follow.

Cultural knowledge also includes:

- What subjects may be particularly sensitive
- What communication patterns exist
- Whether there are gender-related prohibitions
- What days or times of day may carry special significance
- Beliefs about health, illness, birth, and death
- Family relationships

Healthcare professionals gain cultural knowledge in order to become more sensitive to possible concerns of the patient and to improve the effectiveness of communication. Avoid stereotyping and learn from each individual patient what specific cultural traditions apply to that person.

Cultural Skill

Healthcare professionals display cultural skill when they systematically assess the patient and determine the needs and intervention practices within the context of the individual's, family's or community's culture.

Culturally skilled healthcare professionals also understand and act upon any physical, biological or physiological differences that may exist between ethnic groups, such as different responses to specific medications among different cultural groups and differences in skin tones that require different techniques to assess cyanosis, jaundice, pressure ulcers, or other findings related to skin color.

10.4% of Hispanics/Latinos ages 20 years or older have diagnosed diabetes, indicating greater prevalence than in U.S. population (8.3%).

Among Hispanics/Latinos, diabetes prevalence rates are 8.2% for Cubans, 11.9% for Mexican Americans, and 12.6 % for Puerto Ricans.

(National Diabetes Education Program, 2009)

Cultural Encounter

In cultural encounter, healthcare professionals purposefully seek interaction and meaningful communication with persons of cultures other than their own. They make sincere efforts to view the situation from the patient's point of view.

Engage in a dialogue with the patient to understand the patient's explanatory model of illness. Intentional dialogue offers insights useful for choosing appropriate interventions, negotiating care and establishing accurate monitoring of interventions.

During cultural encounters, healthcare professionals can identify the patient's linguistic needs and arrange for certified language interpreters if needed.

Mindful intercultural communications are the opposite of mindless stereotyping.

Explore with the patient his viewpoint of the hospitalization experience and likely follow-up treatment and self-care after discharge. Interpreting recommended treatments within the patient's framework may increase the patient's comfort with the plan of care while in the hospital and after discharge. Overlooking the cultural implications of follow-up care may result in the patient completely rejecting the post-discharge plan of care.

Individualized Cultural Assessment

First and foremost, it is important to remember that a person may adhere strictly to all traditional practices of his background culture and faith, some of them, or even none at all. It is also true that within any religious tradition, there may be a continuum of sects ranging from very conservative to quite liberal in interpreting the tenets of the faith.

In addition, each person most likely represents a blending of ethnic background, religion, generational influences, gender roles, professional roles, and other cultures in which he participates. These other cultural influences may include educational influences and influences related to physical or communication disabilities.

Determine what practices are important to the person, without implying a stereotype or a judgment if the

person does not adhere strictly to traditions or does not choose to during hospitalization. For example, asking “What can we do to facilitate your praying?” implies that the person ought to be praying. Instead, state," Some people pray regularly during the day. Is this something that is important to you?”

In addition to the holidays and holy days observed in certain religious traditions, specific days of the week and hours of the day may have particular significance.

Clinicians can provide culturally competent care more capably when they are knowledgeable of practices and traditions common among the populations they serve. Some patients may defer to authority and decline to express their needs. The clinician’s knowledge of traditions may guide the questions they ask. Individualized assessment is the cornerstone of culturally competent care.

Culture and Communication

A national survey (AHRQ, 2010) defined poor communication by responses to these questions:

- During this hospital stay, how often did doctors/nurses treat you with courtesy and respect?
- During this hospital stay, how often did doctors/nurses listen carefully to you?
- During this hospital stay, how often did doctors/nurses explain things in a way you could understand?

Approximately 5% of adult patients reported poor communication with doctors and nurses.
Persons with less than a high school education reported poor communication with both nurses and doctors.

Members of minority cultural groups reported poor communication with nurses and/or doctors.

Patients ages 45-64 were more likely to report poor communication with doctors.
Patients aged 65 years and older were less likely to report poor communication with nurses.

Many black persons speak African American English (AAE) which includes a number of varied dialects. Healthcare professionals sometimes erroneously associate use of this language with lack of education or lack of intelligence.

Communication with Nurses and Doctors:
AHRQ (2010) Survey Results

- 5.9% of adult hospital patients reported poor communication with nurses during their hospital stay, and 5.3% reported poor communication with doctors.
- Compared with whites, all minority groups were more likely to report poor communication with nurses.
- Blacks, American Indians and Alaska Natives, and patients of more than one race were more likely to report poor communication with doctors.
- Compared with non-Hispanic Whites, Hispanics were more likely to report poor communication with nurses but not with doctors.
- Compared with patients with at least some college education, patients with less than a high school education were more likely to report poor communication with both nurses and doctors.

- Compared with patients who speak English at home, patients who speak Spanish at home were more likely to report poor communication with nurses while patients who speak some language other than English at home were more likely to report poor communication with both nurses and doctors.
- Compared with patients ages 18-44, patients ages 45-64 were more likely to report poor communication with doctors.
- Patients age 65 and over were less likely to report poor communication with nurses.

A Transcultural Assessment Model

Before a nurse can accurately assess a patient's cultural needs, information must be gathered about the patient cultural perspectives. A Basic Cultural Assessment Model containing seven primary elements is presented to help you gather the necessary data.

Biological Variations
- Appearance
- Genetics

Space
- Personal space
- Modesty
- Response to provider touch

Time
- Rigid adherence to "time-by-clock" versus looser time perception

Environmental Control
- Fatalism versus self-determination
- Access to care
- View of health and illness
- Use of traditional treatments or remedies

Food Preferences
- Impacted by spiritual beliefs
- Food as healing

Social Organization
- Fatalistic versus individualistic
- Religion
- Gender power differences
- Who makes the decisions?
- Who makes the healthcare decisions?

Communication
- Verbal
- Direct versus indirect style
- Agreement to show respect?
- Nonverbal: eye contact, gestures, body posture

Think it Through...

Assess yourself using the Davidhizar & Giger model.
Awareness of one's own cultural influences is a key step on the journey to cultural competence.

- How do you describe yourself on these dimensions of culture?
- Return to the previous slide for more specific details associated with each attribute.
- Increase your awareness by writing your responses.

Biological Variations

Space

Time

Environmental Control

Food Preferences

Social Organization

Communication

Joint Commission Recommendations

The Joint Commission (2010) recommends specific practices to improve effectiveness of communication, cultural competence, and patient and family-centered care during phases of the care continuum:

- Admission
- Assessment
- Treatment
- End-of-Life Care
- Discharge and Transfer

Cultural Competence During the Admission Process

The Joint Commission recommends the following actions during the admission process:

- Inform patients of their rights.
  - Each healthcare organization has a patient rights policy. Translate those policy statements into examples that have meaning for the patient population on your unit.
- Identify the patient's preferred language for discussing healthcare.
- Identify whether the patient has a sensory or communication need.
- Determine whether the patient needs assistance completing admission forms.

- Collect patient race and ethnicity data in the medical record.
    - Admitting department staff usually collect this information. Patients may refuse to give the information. The intent is to assist a healthcare organization in describing the demographics of the population it serves so that the organization can develop appropriate services more effectively.
- Identify if the patient uses any assistive devices.
- Ask the patient if there are any additional needs that may affect his or her care.
- Communicate information about unique patient needs to the care team.

TJC, 2010, p. 5

Personalizing Admission to the Unit

How to personalize admission to the unit:

- Introduce yourself with the name you wish the patient to call you and your role in his care.
- Ask the patient for the name she prefers you use when addressing her. Some patients, and particularly those who identify as transgender, may prefer to be addressed by a name other than the legal name on the medical record.
- Ask the patient what cultural, religious, or spiritual beliefs or practices may influence care. Nurses assure patients' privacy and limit exposure of their bodies to the minimum necessary for care. In addition, some cultures and religions interpret touching, personal space/distance, and modesty in specific ways and with specific restrictions depending upon the gender or age of the person with whom one is interacting. Use your knowledge of cultural groups your organization frequently serves to focus more specifically on the patient's possible preferences.
- Identify any specific days of religious observance, times of day, or dietary practices that healthcare providers should respect whenever possible in planning care.
- For optimal safety, the patient needs access to whatever assistive devices he uses: glasses, hearing aid, mobility aids, reaching devices, or other aids.

Many African Americans prefer to be addressed formally as Mrs., Mr., Reverend, or other honorific title with the last name. The family name is a source of pride.

The Patient's Comprehension: Key to Safe Care

Important statistics:

- Nearly 9% of the US population is considered of limited English proficiency (LEP) for healthcare purposes (U.S. Census Bureau, 2007).
- Over 40% of adults have significant literacy challenges and 88% of adults have less than "proficient" health literacy skills (White & Dillow, 2005).

The patient may be reluctant to admit language or literacy limitations. The stress of illness and hospitalization may interfere with the command of English for non-native English speakers and with comprehension of complex medical information regardless of language skills.

- Ask the patient to repeat back to you his understanding of information you communicate.
- Avoid "Do you understand?" Instead ask the patient to explain.

- Use simple terms and when possible models or diagrams to facilitate understanding.
- Ask whether the patient needs assistance with any written information, such as signage, patient-oriented literature, menus, or other written communication.
- Obtain language assistance services if needed. For optimal safety, TJC (2010) and National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001) recommend that consent forms be available in the patient's preferred language rather than sight-translated and that using a certified language interpreter is safer than relying on a member of the patient's family. In some situations, an interpreter of the same gender might be most effective, such as when the genitals or other sensitive subjects need to be discussed.

Health Literacy

Health literacy:

- The degree to which one can understand and make decisions based on health information.

Low health literacy constitutes a significant barrier for many individuals - not only when they enter the healthcare system for care, but also when they attempt to obtain insurance coverage. Many persons who became eligible for coverage under the Patient Protection and Affordable Care Act (ACA) encounter difficulties in understanding their options and selecting the coverage most useful for them.

The Institute of Medicine is focusing attention on opportunities to improve health literacy (IOM, 2011).

Forty percent of African Americans are reported to have low health literacy (Campinha-Bacote, 2009).

Languages in the USA

The main languages by number of speakers older than age five:

Languages in the USA
2000 US Census Data

English - 215 million	**Vietnamese** - 1.01 million	**French Creole** - 450,000 (Mostly Louisiana Creole French - 334,500)
Spanish - 28 million	**Korean** - 890,000	**Greek** - 370,000
Chinese languages - 2.0 million + (Mostly Cantonese speakers, with a growing group of Mandarin speakers)	**Russian** - 710,000	**Hindi** - 320,000
French - 1.6 million	**Polish** - 670,000	**Persian** - 310,000
German - 1.4 million (High German) + German dialects like Hutterite German, Texas German, Pennsylvania German and Plautdietsch	**Arabic** - 610,000	**Urdu** - 260,000
Italian - 1.3 million	**Portuguese** - 560,000	**Gujarati** - 240,000
Tagalog - 1.2 million + (Most Filipinos may also know other Philippine languages, e.g. Ilokano, Pangasinan, Bikol languages, and Visayan languages)	**Japanese** - 480,000	**Armenian** - 200,000

Additionally, some estimates indicate that American Sign Language is spoken by as many as 2 million Americans.

Communication in the Admission Process

When you first meet the patient, establishing an effective means of communication takes priority. Previous slides have identified the important considerations of preferred language, literacy, health literacy, sight, and hearing.

Cultural factors also play a role in establishing effective communication. In some cultures, looking another person directly in the eye indicates disrespect, particularly if the other person is an authority figure.

In some cultures, discussion of bodily functions with a person of the opposite gender is taboo.

When a patient nods in response to communication it may be a sign of respect rather than comprehension or agreement.

Personal space, volume, and emotional expression in communication vary greatly among cultural groups. Some cultural groups rely on nonverbal communication, rather than using words.

Chinese ranks third among languages spoken in the U.S. after English and Spanish. Approximately 50% of Chinese persons in the U.S. speak Chinese at home and speak English less than very well (Barnes & Bennett, 2002).

Social Customs in the Admission Process

During admission to the unit, you and the patient are establishing some ground rules for your relationship and the patient's relationship with other members of the team. During the admission process you have an opportunity to gain insight into family influences that may affect care.

Many cultures de-emphasize the individualistic and autonomous orientation and make decisions as a family. In some cultures, a particular person, such as the eldest son, may assume duties of care and protection for his parents. Although a person other than the patient may be involved in the decision-making process, it is important to gather information from the patient without a family member present, particularly about potentially sensitive topics and culturally prohibited practices.

Family members may wish to protect the patient from disturbing information such as a poor prognosis. This value conflicts with clinicians' value of the patient's right to know pertinent information. Consultation with an ethics committee may be needed to resolve this conflict.

Most cultures greatly revere elderly persons.

Gender Roles: A Hispanic Example

The male role often described as ***machismo*** implies manliness and the expectation that a man be physically strong, unafraid, and the authority figure in the family, with the obligation to protect and provide for his family.

The female role, ***marianismo***, refers to a woman who is self-sacrificing, religious, runs the household

and raises the children.

Motherhood is an important goal for women in Latino culture. A mother is expected to sacrifice for her children, take care of elderly relatives, and care for the sick - even during hospitalization.

Although acculturation and employment opportunities have affected these gender roles, they still persist, especially in low income families.

In a study of strong marriages, men and women shared decision-making in the family and placed their own relationship and nuclear family before the extended family. However, men and women each played a different role in family life.

Couples in the study talked through issues until they came to an agreement. One man stated, “You just talk and talk until you come to a decision.” Of the participants in the study, men and women were likely to have traditional roles, with the man providing the income for the family and the woman providing for the care of the children and the home.

Sensitivity in Introductions

Make no assumptions about a patient’s sexual orientation or gender identification. And if the patient gives you this information, do not assume that the patient is also giving you permission to share this information with others who do not need the information to care for the patient.

Some gay and lesbian people, and particularly older persons, may be very sensitive about the possibility of being “outed,” or making their sexual preference known to others. Though some members of the healthcare team may need the information and the information may be documented in the medical record, the patient may feel strongly that this information be kept from family members or others who may visit.

Introduce yourself with your name and role - not only to the patient, but to visitors. This will invite others to introduce themselves and their roles in relation to the patient. However, if a visitor does not respond, clarify with the patient what role others play and whether the patient wishes specific other persons to receive information about the plan of care.

Never assume that a particular person is the patient’s partner or spouse unless the patient informs you that this is the case.

Religious Practices in the Admission Process

Prayer and religious medals play a role in protecting health and healing in many religious traditions.

Roman Catholic and Pentecostal beliefs and practices are prevalent among Hispanics. Pentecostal practices may include loud prayer and may include miraculous healing, perhaps including large groups of visitors in prayer sessions.

In contrast Muslim prayer requires a quiet environment. Some Sunni Muslims (90% of traditional Muslims) pray 5 times per day. Shiite Muslims (10% of traditional Muslims) pray 3 times per day. There are also a number of smaller Muslim sects. Traditionally they pray on the floor. However, during illness they may pray in bed. Predestination is a part of traditional Muslim beliefs. Exceptions from traditional practices may be permitted during pregnancy, breastfeeding, illness, or travel, but many Muslims observe the practices regardless of permitted exemptions.

Some African Americans practice Muslim traditions, though most are Christians. Many find comfort and support in their spiritual beliefs, view God as responsible for healing, and health professionals as God's instruments. Those with Haitian background may practice Voodoo.

Most Jews observe the autumn holidays of Rosh Hashanah and Yom Kippur. Some may observe particular practices on the Sabbath, extending from sundown on Friday until sundown on Saturday.

Find out from the patient whether any specific religious beliefs and practices have implications during hospitalization.

Eastern Religions

The principles and philosophy of Confucianism, Buddhism, and Taoism influence many traditions of the Chinese and other Asian people.

Confucian principles

- Emphasize respect for the elderly and people in authority. Maintaining harmonious relationships is the key to life. (Andeniran & Stamm, 2010) The 5 most important characteristics are: benevolence, righteousness, loyalty, filial piety, and virtue (Chen, 2001).

Buddhist principles

- Embrace 3 main values: **mercy**, **thriftiness** and **humility**. Fate and cause-and-effect determine health because when people do good, they are peaceful, which in turn helps promote good health through karma. A person receives good fortune for doing right and bad fortune for doing wrong (Lai & Sunrood, 2009).

Taoism

- Emphasizes selflessness and emotional calm - the need for human beings to be in harmony with nature. Because nature provides the elements needed for life, outdoor exercise gives peace of mind and outside air. To achieve good health, a person must adjust to fit in with the natural rhythm of the universe (Lai & Sunrood, 2009).

Islam: the World's Fastest Growing Religion

Islam is the second-largest and fastest-growing religion in the world. A large number of Muslims in the United States are African American and Asian. Of the roughly one-third of Muslim Americans who are native-born, the majority are converts and African American (Pew Forum on Religion and Public Life, 2008).

Muslims in the U.S. responding to a survey identified themselves as:

- 37% white
- 24% black
- 20% Asian
- 15% "other/mixed race"
- 4% Latino

(Pew Research Center for the People and the Press, 2007)

Muslims face Mecca when they pray which is northeast when one is in the U.S. When death is

imminent, a Muslim practice is to turn the patient's face toward Mecca.

The Jewish Culture

Judaism is one of the world's oldest religions, and was the first major one to recognize one god rather than multiple gods. Judaism has been practiced for thousands of years and eventually gave rise to Christianity and then Islam. As an ethnic group Jews originated in the Middle East several thousand years ago, but throughout history have dispersed across Europe, Asia, and Africa due to political upheavals, war, and ethnic cleansing.

Jews are one of the smallest but most active minority populations in the U.S. Those of European origin are called Ashkenazi Jews, while those of Middle Eastern or non-European origin are called Sephardic Jews. Individual Jews vary greatly from one another in the degree to which they practice cultural and religious traditions (University of Northern Iowa, National Institutes of Health. (n.d.)).

Health and Medical Practices in the Admission Process

People in many cultures believe that nature and spiritual forces play a role in health and illness. Home remedies are popular among Asians, Hispanics, African Americans, Native Americans and others. Some may delay seeking healthcare while trying homeopathic approaches.

Members of some cultures may be distrustful and skeptical of the healthcare system - particularly persons who have experienced discrimination or learned of a history of discrimination from their elders. African Americans, Native Americans, and Japanese Americans may be particularly distrustful due to past governmental policies, but any individual may have experiences or attitudes that create suspicion of Western medicine.

Lesbian, gay, bisexual, and transgendered individuals may anticipate discrimination, judgmental attitudes, or being "outed" against their wishes.

Suspicions combined with lack of health insurance may cause individuals to delay care and rely on home remedies.

In some cultures, such as Muslim and Mexican, plumpness may be an ideal body type, so that overweight or obese status may not be viewed as a health problem. Asian Indians however, consider overeating to be a threat to longevity.

Members of some cultures do not consult mental health professionals, but keep such concerns within the family. Some may look down on people who have mental health concerns.

American Indian/Alaskan Native persons have a strong sense of family, extended family, community, and connectedness with history. Native Americans have practiced many healing rituals for centuries.

Skepticism about the Healthcare System

African-American attitudes may be influenced by a history of discrimination and also of the infamous Tuskegee Experiment which recruited African-American men with syphilis. Researchers promised, but never gave, treatment. This history may lead to a distrust of the healthcare system and experimental approaches, particularly when health professionals encountered are other than African American. Elders are likely to be especially sensitive to any indication of disrespect and suspicious of healthcare personnel because of their personal experiences of discrimination (Campinha-Bacote, 2008).

Native Americans have persevered to survive repeated governmental policies of extermination and genocide. The culture greatly reveres history and elders which keep the history of discrimination well within the awareness of recent generations.

Chinese Medicine

Modern Chinese medicine combines traditional Chinese medicine and Western medicine. Based on Taoism, traditional Chinese medicine includes the mind and spirit as well as the physical body. Treatments include the use of medical herbs, acupuncture, diet, animal secretions and organs, massage to stimulate blood flow and skin scraping to re-enforce body force. A practitioner of traditional Chinese medicine makes diagnoses by observing a patient's pulse and tongue (Wade, 2007).

Ch'i is energy that flows freely through the organs via 12 main channels when a person is healthy. Disease results when flow of ch'i is obstructed. For example, a cerebrovascular accident may result from the obstruction of ch'i at a point of vital energy flow in the body (Bowman & Hui, 2000).

The forces of yin and yang work together for harmony. The yin represents the female, cold and negative force. The yang represents the male, hot and positive force. The yin-yang forces are dynamic and complementary. One force cannot exist without the other and an imbalance produces illness. If a patient believes her disease occurred from too much cold, or yin, she may not want to eat food that falls into the cold classification such as cold drinks, fruit, most vegetables and soy products. Generally, foods high in protein, calories and fat are classified as hot. The temperature of food does not determine its classification as hot or cold (Bowman & Hui, 2000).

Wu-hsing associates the five most important organs of the body with five elements of nature. These five elements determine the functions of other parts of the body. Interaction of these five elements represents a productive and conquest cycle. Traditional Chinese medicinal interactions between the body organs and interactions with environmental factors, such as weather and the seasons, affect the human body and emotions (Bowman & Hui, 2000).

Ayruveda Medicine

In Asian Indian culture, Ayruveda medicine is practiced. Ayruveda approaches define causes, remedies, and dietary treatments for a variety of common health problems including fever, headache, common cold, stomachache, diarrhea, constipation, arthritis and joint pains.

Plant products are components of Ayruveda remedies.

Ayruveda medicine espouses beliefs similar to the Chinese medicine concepts of balance and of hot and cold as factors in health in illness, based in Hindu beliefs (Bhungalia, et al, 2000).

Dietary Factors in the Admission Process

During the admission process, inquire about dietary practices and food preferences. Your healthcare organization may not offer a wide variety of choices, or the patient's diet may be restricted as a part of the plan of care. A nutritionist may assist in helping the patient make choices and also assess the potential effects of any foods which family members may bring to the patient.

Many Chinese people and Asian Indian people maintain a vegetarian diet, or consume only small amounts of meat. The hot and cold food classifications associated with yin and yang may also affect food preferences.

During Ramadan, the 9th month of the Islamic calendar, Muslims fast from daybreak until sunset. Observant Muslims may eat only Halal food, food that is humanely slaughtered and blessed, which is similar to Kosher Jewish food.

A given Jewish person may follow all, some, or none of the dietary laws related to kosher foods, separation of dairy products from meat and avoidance of certain foods, such as pork. Assess each individual without making assumptions.

Communicating Findings within the Team

During the admission process, you gather important information that can facilitate patient-centered care. However, ALL members of the healthcare team who participate in the patient's care need ready access to this information.

Healthcare organizations employ various methods in the medical record, in signage, symbols, identification bands, and other means to identify specific needs and risks for patients.

While it is the responsibility of the organization to assure availability of these methods for communicating among staff, staff members must commit to using them.

Patients become frustrated when they find they need to explain the same information to each staff member with whom they interact. And, especially after having given information about cultural practices to a staff member, a patient may feel disrespected if other staff members fail to act on the information which the patient has provided.

Some Vietnamese Practices

Vietnamese cuisine is considered one of the most healthful diets in the world. Vegetables, rice, fish soup, herbs, and tea are staples of the diet.

Vietnamese and some other Asian cultures practice coining, or placement of hot coins on the body to draw out pain and fever. They also practice cupping, or heating the air in a cup and placing it over parts of the body to produce an ecchymotic area. Cupping is believed to enhance the therapeutic effect of heat on selected parts of the body.

Some women drink the urine of 7-year-old boys to maintain youth and ease childbirth.

Often when illness occurs, the ill person first seeks help from Chinese medicine, acupuncture, and herbal remedies (Pickard, 2000).

Cultural Competence During Patient Assessment

Cultural competence during patient assessment involves the following actions:

- Identify and address patient communication needs during assessment
- Begin the patient-provider relationship with an introduction
- Support the patient's ability to understand and act on health information
- Identify and address patient mobility needs during assessment
- Identify patient cultural, religious, or spiritual beliefs or practices that influence care
- Identify patient dietary needs or restrictions that affect care

- Ask the patient to identify a support person
- Communicate information about unique patient needs to the care team

TJC, 2010, p. 5

Assessment

Cultural expressions of pain and attitude toward pain relief vary greatly. Persons of some cultures may suffer stoically and reject the consciousness-altering effects of some analgesic medications. Other cultures have traditions of unrestrained expression of feelings and sensations.

Some patients may resist asking for pain medication out of fear of being disrespectful to those in authority. They may also underestimate pain levels on a scale for fear of receiving too much pain medication as a result.

Behavioral assessments of pain such as elevated pulse and blood pressure may provide a more accurate assessment of pain level rather than asking the patient to rate pain on a scale of 1 to 10.

All patients deserve privacy and exposure of the body only as needed for care. Modesty is a particularly important value in some cultures, such as the Muslim culture. Some Hispanic persons are particularly sensitive about exposing the area between the hips and waste to the knees to a person of the opposite gender.

Although for Muslims, morphine is permitted as a part of medical treatment, mind-altering substances are believed to interfere with a spiritual form of cleanliness and may therefore be rejected. Non-pharmacological pain relief methods may be indicated. Massage may or may not be acceptable to a Muslim person.

Skin Assessment

Assessment often involves skin color, such as for pallor, cyanosis, and assessment related to pressure ulcers.

When assessing dark-skinned persons, the recommended practice is to establish a baseline for an individual's skin color through consultation with family members if possible (Campinha-Bacote, 2009).

Recommendations for assessing skin variations (Purnell and Paulanka, 2003) include:

- Establish a baseline color (ask a family member)
- Use direct sunlight, if possible
- Observe areas with the least amount of pigment
- Palpate for rashes
- Compare skin in corresponding areas

The normal color for the lips of some black persons has a bluish-tinge. For dark-skinned persons, pallor may have an ashen coloration; for lighter-skinned black persons, it may appear as a yellowish color.

Cultural Competence During Treatment of the Patient

Cultural competence during treatment of the patient involves the following actions:

- Address patient communication needs during treatment
- Monitor changes in the patient's communication status
- Involve patients and families in the care process
- Tailor the informed consent process to meet patient needs
- Provide patient education that meets patient needs
- Address patient mobility needs during treatment
- Accommodate patient cultural, religious, or spiritual beliefs and practices
- Monitor changes in dietary needs or restrictions that may impact the patient's care
- Ask the patient to choose a support person if one is not already identified
- Communicate information about unique patient needs to the care team

TJC, 2010, p. 5

Think it Through...

Did one of your patients ever use terms unfamiliar to you to describe health-related practices, such as home remedies, bowel habits, or dietary habits?

- If so, how did you clarify the meaning for yourself?
  - How did your approach affect your relationship with your patient?
  - Were any of the practices threatening the patient's health? If so, how did you raise concerns?

- If not, what questions might you ask to respectfully find out what the patient is talking about?

Respecting Cultural Factors in Treatment Plan

In some cultures, family members, and particularly a man's wife in Hispanic culture, may find it important to show concern by pampering and caring for the patient (Fernandez & Fernandez, 2005). At times, care by family members may interfere with the plan of care if they intervene to discourage prescribed activities which may be difficult or painful for the patient, such as ambulation, or deep breathing and coughing.

Speak with your patient and family members together to explain the critical nature of certain activities to recovery. If you perceive that a language barrier is interfering with communication, secure the services of a certified interpreter. Reinforce the explanation throughout the hospital stay and affirm progress toward engaging in the activities that prevent complications and promote recovery. Gain cooperation from other involved team members, such as a Physical Therapist, in reinforcing the message.

Help the patient's family members to identify ways in which they might "pamper" the patient without impeding his recovery. Family members might walk with the patient in the corridor, or hold a supportive pillow over an incision during deep breathing and coughing.

Ethnopharmacology

Ethnopharmacology

- Studies the way in which members of different ethnic backgrounds may respond differently to

specific medications.

Studies in ethnopharmacology have found that African Americans metabolize many medications differently from other ethnic groups.

These medications include antihypertensives, antipsychotics, and other medications. Overmedication often results (Campina-Bacote, 2009).

Culturally-sensitive Treatment in the Childbirth Experience

In some cultures, new mothers remain at home for a period of time, for a month or slightly longer. This practice is common among the Chinese, Muslims, Hispanics, and others.

During the period of confinement, Chinese women may avoid cold foods and drinks, wind and water, and any other cold substance. They also may avoid physical work and abstain from certain pleasurable activities, such as sex. Some Chinese women are also prohibited from bathing or washing their hair for a defined period after childbirth (Fok, 1996).

In the Muslim culture, breastfeeding and circumcision are traditional practices, though circumcision may be delayed. In the event of stillbirth or neonatal death taking mementos such as a footprint or lock of hair may be considered desecration.

During the intrapartum period, a Hispanic woman's mother often attends her. The father may decline presence at delivery and see the mother and baby only after both are clean and dressed. Hispanics may believe that babies are weak and susceptible to an envious glance ("the evil eye"), such as an admiring glance or a compliment. Touching the person while giving the compliment neutralizes the power of the evil eye. The evil eye causes misfortune. Staring at a person may also invoke the evil eye.

For Roman Catholics, the rhythm method may be the only acceptable approach to birth control.

Pregnancy and Childbirth in the Asian Indian Culture

In traditional Asian Indian culture, rituals at specific times during pregnancy are conducted to protect mother and baby from evil spirits.

After birth, the mother is not told the gender of the child until the placenta is delivered. Males are preferred and the belief is that the mother may be so upset by the birth of a girl, that uterine contractions may be inhibited, delaying delivery of the placenta. After delivery of the placenta, the mother sees the baby first, then the father and other family members.

Cultural Sensitivity in Patient Care

Modesty and respect, important values for all patients, are specially emphasized in some cultures. To show sensitivity to the value of modesty always ask permission, explain the need to uncover, and limit exposure to the greatest extent possible.

Many cultures place high value upon visiting the sick. Family members may visit in large groups at one time.

Cleanliness is a very important value for Muslims. Many Muslim patients, both male and female, use a squeeze bottle for perineal cleansing after urination or bowel movements (Pavlovich-Danis & Kahn, 2009).

Cultural Competence During End-of-Life Care

Cultural competence during end-of-life care involves the following actions:

- Address patient communication needs during end-of-life care
- Monitor changes in the patient's communication status during end-of-life care
- Involve the patient's surrogate decision-maker and family in end-of-life care
- Address patient mobility needs during end-of-life care
- Identify patient cultural, religious, or spiritual beliefs and practices at the end-of-life
- Make sure the patient has access to his or her chosen support person

TJC, 2010, p. 5

A Sampling of Cultural Traditions at End-of-Life

Chinese culture

- In Chinese culture, death and dying are taboo subjects, causing bad luck. Many Chinese people wish to die at home in the main hall of the house, symbolically enabling the deceased to join ancestors (Hsu, et al, 2009). Families may also believe that patients who die with a full stomach die a good death. The full stomach supports the long journey to reincarnation. Those who starve to death are considered cursed as a result of wickedness that occurred in a previous life (Hsiung & Ferrans, 2007).

Muslim culture

- In traditional Muslim culture, when death is imminent, the dying person's head is turned to face Mecca, a northeast direction in the U.S. A same-gender family member performs post mortem care which includes washing the body with running water and covering it in a white shroud. Make gloves available for the family member and encourage use of gloves if infectious material or blood is present. The family may arrange for the post mortem ritual to be performed at a funeral home. Burial occurs within 24 hours after death.

African American culture

- In general, African American patients and healthcare providers favor more aggressive life sustaining treatments in life-threatening situations and at end-of-life (Gordon, et al, n.d.).

Asian Indian culture

- In Asian Indian traditions, only family members touch the body after death. If the family observes this practice, healthcare staff should touch the body as little as possible. As in traditional Muslim culture, a family member of the same gender as the deceased cleans the body after death. After washing the body, the family member wraps the body in a red cloth.

Cultural Competence During Discharge and Transfer

Cultural competence during discharge and transfer involves the following actions:

- Address patient communication needs during discharge and transfer
- Engage patients and families in discharge and transfer planning and instruction
- Provide discharge instruction that meets patient needs

- Identify follow-up providers who can meet unique patient needs

TJC, 2010, p. 5

Culturally-sensitive Discharge Plans

With shortened hospital stays, compliance with the follow-up plan of care becomes very important. Members of some cultures do not place a high value on timeliness. Many aspects of care after discharge involve a time element, such as medication administration.

African American and Hispanic cultures are particularly associated with a relaxed sense of time and lack of punctuality. However, any individual, regardless of cultural background, may have a history of habitually rejecting time requirements or arriving late for appointments.

Tactfully encourage the patient to maintain prescribed times for medications or other treatments and to keep follow-up appointments in a timely manner, especially for those appointments that will require rescheduling if the patient does not appear on time. Stress the importance of the specifics of follow-up care and how compliance will support full recovery and prevent complications.

Researchers have documented the ***Strong Black Woman*** (SBW) script as linked to women's daily life management and health experiences. (Black & Peacock, 2011).

Researchers identified the themes:

- Self-sacrificial role management (''please the masses'')
- Emotional suppression (''game face'')
- Postponement of self-care (''last on the list'')

The SBW script may create a barrier to self-care, preventive care, and compliance with a plan of care. An African American woman healthcare professional may be effective in facilitating compliance and adherence.

Screening and preventive measures are not necessarily sought or valued in all cultures. Identify specific benefits for the individual to encourage compliance.

Home remedies play an important role in many cultures. In non-judgmental fashion, encourage the patient and family to tell you about remedies that they rely on or plan to use.

Assure that none of these plans create a risk for interaction with medication or interfere with other aspects of care. Once these plans have been investigated, there is no reason to advise against use of any practice if it does not interfere with care or create risk. However, if home remedies create risks, it is critical that the patient understands what specific problems may arise if contraindicated home remedies are used.

Culture and Discharge Teaching

In some cultures, the male plays a dominant role in all matters outside of running the household and caring for children (Skoarand, et al, 2005). For some female patients, a male relative's commitment to the plan of care may be important in assuring adherence. Ask the patient who else should receive

discharge information in order to assist the patient to follow through with post-hospital care.

Some cultures, such as the Asian Indian and Jewish cultures, place great value upon education. Regardless of cultural background, some individuals are more interested than others in the plan of care and the evidence that supports it. Because of the availability of healthcare information on the internet, patients may have considerable information and misinformation related to aspects of their healthcare.

Prepare to engage in a dialogue with patients about the plan of care post-discharge. Rather than a one-way communication to the patient, elicit the patient's views, questions, sources of information, and perspectives that may influence that patient's adherence to the plan of care.

Cultural Sensitivity and Adherence

Healthcare professionals may present one-size-fits-all discharge plans to patients. But regardless of how agreeable the patient may appear when receiving the plan, the patient will not make a commitment to initial compliance to ongoing adherence if the plan conflicts with strongly held beliefs or with economic priorities (Brown-Riggs, 2011).

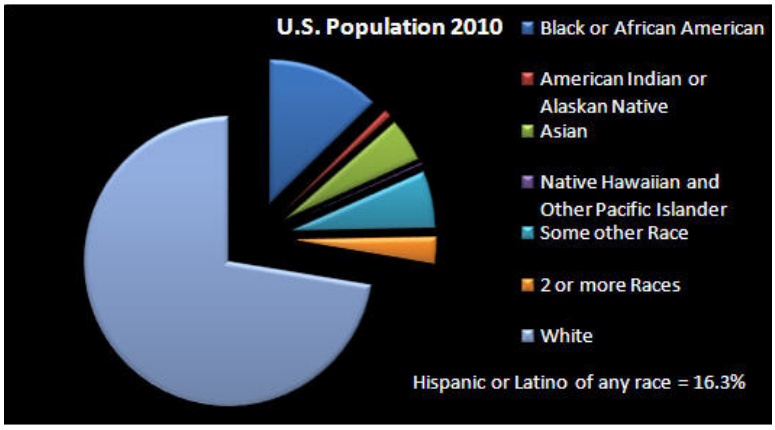
Ideally, a culturally-sensitive care process during hospitalization will have resulted in a plan for care after discharge that has considered cultural and economic factors, leading to a plan which the patient accepts and follows. Unfortunately, this is often not what happens.

Explore the discharge plan with the patient to identify cultural and economic implications. If cultural and economic factors interfere, the patient may reject the plan altogether. But some modifying and priority setting may permit the patient to comply and adhere to the most significant aspects of the plan for his own situation.

"Adherence to a medication or a treatment regimen is usually less than 50 percent. But that figure is further exacerbated when there are cultural variations" (Kagawa-Singer in Chen, 2009).

A social worker may assist in identifying resources to meet economic healthcare needs.

2010 U.S. Census Data



Think it Through...

The 2010 U.S. Census Data is available at the U.S. Census website. The website below will take you to a page from which you can select any state in the U.S. and view selected census data about the state,

including racial composition, age, and gender of the population.

www.census.gov
http://2010.census.gov/2010census/popmap/ipmtext.php

Go to the website and click the link for your state.

- What do the demographic data for your state imply for patient care in your healthcare organization?
- Do you believe you are well informed about cultural practices and healthcare challenges of the ethnic and age groups in your region?
- What sources can you identify to enhance your knowledge of the cultural groups which your healthcare organization serves?

Some Specific Culturally-related Health Risks

Low Socio-economic Status: Regardless of ethnic background, persons who live in poverty or have limited financial resources experience poorer health outcomes. Factors that increase their risk include low income, stressful life conditions, lack of access to care, and negating health behaviors.

African Americans experience poorer health outcomes as compared with other ethnic groups. Blacks suffer disproportionately from decreased life expectancy, and increased rates of: heart disease, hypertension, infant mortality and morbidity; cancer; HIV/AIDS; violence; type 2 diabetes mellitus, and asthma.

American Indian and Alaskan Native (AIAN) adults are more likely to have poorer health, unmet medical needs due to cost, diabetes, trouble hearing, activity limitations, and to have experienced feelings of psychological distress in the past 30 days. The AIAN adults are more likely to be current smokers and current drinkers compared with other adults (Barnes, et al, 2010). The infant death rate is almost double that of whites (Office of Minority Health & Health Disparities, 2006).

Asian persons have a higher incidence of hepatitis B infection, liver cancer and cirrhosis than other ethnic groups. In general, Asians living in the U.S. are among the healthiest populations.

Hispanics living in the U.S. are almost twice as likely to die from diabetes as are non-Hispanic whites. Hispanics also have higher rates of tuberculosis, high blood pressure, and obesity than non-Hispanic whites. There are differences among Hispanic populations as well. For example, whereas the rate of low birth weight infants is lower for the total Hispanic population compared with that of whites, Puerto Ricans have a low birth weight rate that is 50 percent higher than the rate for whites (Office of Minority Health & Health Disparities, 2006).

Diabetes in the AI/AN Population

American Indians and Alaska Natives have the highest age-adjusted prevalence of diabetes among all U.S. racial and ethnic groups, where diabetes is four to eight times more common than in the general population.

Studies have demonstrated that prevention and treatment efforts of the federally-funded Special Diabetes Program for Indians (SPDI) have contributed to significant reductions in diabetes complications in these targeted populations (ADA, 2010).

Visit the websites of the American Diabetes Association and the Indian Health Service for further information and

resources.

Some Specific Culturally-related Health Risks

In India, prevalent problems include malaria, respiratory infections such as tuberculosis and pneumonia, and a host of communicable diseases. Hypertension and cardiovascular disease, rheumatic heart disease, nutritional deficits, and high risk behavior such as alcoholism and cigarette smoking are also common. Poor dental health is also a problem. Sickle-cell disease is prevalent. Prostitution is common and HIV infection is a growing problem. Although Asian Indians who have immigrated to the U.S. may experience better health, they also may travel regularly to India, resulting in exposure to infection.

Jewish people have an increased incidence of cancer (Lynch, et al, 2004), especially breast, ovarian, colorectal, and pancreatic cancer. Genetic diseases also affect Jewish people, including Bloom's Syndrome characterized by photosensitivity and elevated dark red blotches on the skin, growth deficiency, reduced resistance to infectious diseases, and increased susceptibility to tumors; Canavan's Disease (CD) an inherited, degenerative brain disorder; Crohn's disease; Gaucher disease Type 1, the most prevalent Jewish genetic disease, in which the body cannot break down a lipid called glucocerebroside. Symptoms may include anemia, fatigue, easy bruising and a tendency to bleed, enlarged spleen and liver, bone pain, degeneration and fractures, and neurologic problems such as compression of the spinal cord; Niemann-Pick Type A disease a severe neurodegenerative disorder of infancy (About.com, 2011).

Lesbian, Gay, Bisexual, and Transgender (LGBT) persons may be subject to discrimination, harassment, and isolation leading to depression, stress, and anxiety. Many increase use of tobacco and other substances to cope. GBT men smoke 50% more than other men and LBT women smoke 200% more than other women (Gay and Lesbian Medical Association, 2006).

ASKED

Campinha-Bacote, (2002, p. 187) formulated questions healthcare personnel might ask of themselves using her model on the journey toward cultural competence. She summarized the questions in the acronym ***ASKED***.

Awareness:
Am I **aware** of my own biases and prejudices, as well as the existence of racism in healthcare?

Skill:
Do I have the **skill** of conducting a cultural assessment with patients of a culture different from my own?

Knowledge:
Am I **knowledgeable** about health-related beliefs, practices, and cultural values; disease incidence and prevalence; and treatment efficacy among patients whose cultural background is different from my own?

Encounters:
Do I seek out face-to-face **encounters** with persons whose cultural background is different from my own?

Desire:

Do I really "**want to**" become culturally competent with patients and other persons whose cultural backgrounds are different from my own?

EAR

The acronym ***EAR*** serves as a reminder for healthcare professionals in building skill in cultural competence.

- **E**xpect differences
- **A**ccept differences
- **R**espect differences

Conclusion

In this course, you learned:

- A definition of cultural competence
- Components of a cultural competence model
- Dimensions of culture and individual differences among people
- Approaches to providing culturally competent care in phases of the patient's hospitalization experience
- Cultural aspects of example patient care situations

Two acronyms summarize important concepts of cultural competence:

- ASKED
- EAR

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Recommended Resources

General Cultural Competence Resources

The Joint Commission website posts cultural competence resources as a part of its patient safety initiative
http://www.jointcommission.org

The Manager's Electronic Resource Center (ERC), produced by Management Sciences for Health, Inc. posts The Provider's Guide to Quality and Culture which contains information about health disparities, cultural groups, and extensive additional resources.
http://erc.msh.org/mainpage.cfm?file=9.1.htm&module=provider&language=English

National Council on Interpreting in Healthcare provides information about healthcare interpreters.
http://www.ncihc.org

The website of Transcultural Nursing offers a variety of resources including links to other resources.
http://www.culturediversity.org/index.html

USDHHS Office of Minority Health website provides information about health disparities and U.S. government resources and programs to support minority health.
http://raceandhealth.hhs.gov/

Resources Pertinent to Specific Cultural Groups

Curriculum in Ethnogeriatrics offered by Stanford University contains modules specific to the aged population in several different cultures
http://www.stanford.edu/group/ethnoger/

EthnoMed, a website sponsored by the University of Washington, contains information about cultural beliefs, medical issues and related topics pertinent to the health care of immigrants to Seattle or the US. Multilanguage patient education materials are also available.
http://ethnomed.org/

The Gay and Lesbian Medical Association posts information and resources concerning gay, lesbian, bisexual, and transgender health and health-related issues.
http://www.glma.org/

The Indian Health Service, an agency of USDHHS contains information related to American Indian Health Services and has a section related specifically to diabetes in the American Indian population.

www.ihs.gov

Medline Plus, a National Library of Medicine, resource offers information about health specific to gay, lesbian, bisexual, and transgender persons.
http://www.nlm.nih.gov/medlineplus/gaylesbianandtransgenderhealth.html

National Library of Medicine resource re: American Indian Health.
http://americanindianhealth.nlm.nih.gov/people.html

Please Read

IMPORTANT INFORMATION: