Section C

A Guide to Information in Section C

RESOURCES TO INCREASE AWARENESS OF CULTURAL BACKGROUND AND ITS IMPACT ON HEALTH CARE DELIVERY

Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind.

The following materials are available in this section:

Let's Talk About Sex	A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.
Pain Management Across Cultures	A guide to help you understand the ways people may use to describe pain and approach to treatment options.
Cultural Background: Information on Special Topics	Points of reference to become familiar with diverse cultural backgrounds.
Promoting Cultural and Linguistic Responsiveness: A Self-Assessment Checklist for Personnel Providing Health Care Services	An assessment tool that can be used by managers to determine how well the health care delivery setting is meeting the needs of its diverse patients.

LETS TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues
Surrounding the collection of sexual health histories.

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Gender roles	• Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age). • A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider). • Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person. • Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.	• Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam. • As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times. • Use same sex non-family members as interpreters.
Sexual health and patient cultural background	• If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues – for example, blood pressure and sexual health are related. • In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. *Example: Chinese males may discuss sexual performance problems in terms of a "weak liver."* • Be aware that young adults may not be collecting sexual history information is part of preventive care and is not based on an assumption that sexual behaviors are taking place. • Printed materials on topics of sexual health may be considered inappropriate reading materials.	• Explain to the patient why you are requesting sexually related information at that time. • For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information. • Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same gender as the patient.

LETS TALK ABOUT SEX

Consider the following strategies when navigating the cultural issues
Surrounding the collection of sexual health histories.

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Confidentiality preferences	• Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals or discomfort, or ask directly how they would like to proceed. • A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials. • Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.	• It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity. • Try to offer the patient a culturally acceptable way to have a confidential conversation. For example: *"To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information."* • Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

***NOTE: Avoid** using family members as interpreters. **Minors** are **prohibited** to be used as interpreters. Find an interpreter with a health care background. Make sure the request for or refusal of an interpreter is **documented** in the patient's medical chart.

PAIN MANAGEMENT ACROSS CULTURES

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management.

These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Reaction to pain and expression of pain	• Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain. • Some men may not verbalize or express pain because they believe their masculinity will be questioned.	• Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm. • Because the expression of pain varies, ***ask*** the patient what level, or how much, pain relief they think they need. • Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.
Spiritual and religious beliefs about using pain medication	• Members of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief. • Other religious traditions forbid the use of narcotics. • Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.	• Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices. • Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment. • Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.

PAIN MANAGEMENT ACROSS CULTURES (continued)

AREAS OF CULTURAL VARIATION	POINTS TO CONSIDER	SUGGESTIONS
Beliefs about drug addiction	• Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population. • Past negative experience with pain medication shapes current community beliefs, even if the medications and doses have changed.	• Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact. • Explain how the determination of type and amount of medication is made. Explain changes from past practices. • Assure your patient you are watching their particular case.
Use of alternative pain relief treatment	• Your patient may be using traditional pain relief treatment, such as herbal compresses or teas, massage, acupuncture or breathing exercises.	• Respectfully inquire about all of the ways the patient is treating their pain. • Use indirect questions about community or family traditions for pain management to provide hints about what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is "safe" to talk about them. • Accommodate or integrate your treatments with alternative treatments when possible.
Methods needed to assess pain	• Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.	• Ask the patient specifically how they can best describe their pain. • Use multiple methods of assessing pain - scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results. • Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques. • Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as "like a burn from a stove," "cutting with a knife," or "stepping on a stone," may produce a more accurate description.

* **NOTE: Avoid** using family members as interpreters. **Minors** are **prohibited** from being used as interpreters. Find an interpreter with a health care background. **Document** in the patient's medical chart the request for or refusal of an interpreter.

CULTURAL BACKGROUND
Information on Special Topics

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, non-judgmental way. This information is important for the accuracy of the clinical assessment.

- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.

- Some treatments and "medicines" that are considered "folk" medicine or "herbal" medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are "hard to find" or that are purchased "at special stores" may get you a more accurate understanding of what people are using than asking about "alternative," " traditional," "folk," or "herbal" medicine.

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.

- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.

- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.

- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, "chubby" children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.

- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby's general health.
  - Among traditional Hmong, saying a baby is "pretty" or "cute" may be seen as a threat because of fears that spirits will be attracted to the child and take it away
  - Some traditional Latinos will avoid praise to avoid attracting the "evil eye"
  - Some Vietnamese consider profuse praise as mockery

- It is often better to focus on the quality of the mother's care – "the baby looks like you take care of him well."

- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.

- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.

- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable ***here***, and what may cause physical harm.

- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse *not* because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.

- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.

- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens who may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.

- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.

- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.

- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.

- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.

- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.

- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

Promoting Cultural and Linguistic Competency
A Self-Assessment Checklist for Personnel Providing Primary Health Care Services

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic competence in provider office settings.

Directions: Mark items with **A** = Frequently **B** = Sometimes or occasionally **C** = Rarely or never
"C" responses present opportunities for improvement.

PHYSICAL ENVIRONMENT	COMMUNICATION STYLES
____Our office setting, (including artwork, décor, and magazines), reflects the diversity of our client population.	____I understand that a limitation in English proficiency is not a reflection of level of intellectual capacity or ability to communicate in the patient's primary language.
____Printed information, videos, or other media resources for health education, treatment, or other interventions reflect the culture and ethnic background of those served by our office.	____I keep in mind that verbal ability is not a refection of the patient's ability to read and write in either English or their own language.
____Printed information disseminated by the office takes into account the average literacy of the office patient base.	____ I understand that a heavy accent is not a reflection of a person's education or the ability to speak or read English.
____There are clear, multi-lingual signs about linguistic services available in the office posted in the front desk area.	____ I understand the legal requirements related to use of bilingual staff when providing medical interpretation for treatment, interventions, or other associated meetings.
____ Signs, bulletin boards and other displays are language-appropriate for the clientele and are presented in large print.	____ I attempt to learn and use key words in the most common language(s) spoken by the office patient base to improve communication during assessment, treatment or other interventions.
____ Examination rooms and other service areas are equipped to handle telephonic interpreter services (by cell or standard phone).	____ I know which documents are legally required to be translated for non-English speaking patients.
____Waiting areas, exam rooms, and restrooms are disabled-accessible for the clientele and are present in large print.	____ When possible, I insure that all notices and instructions are written in the most common language(s) read by the office patient base, or that they know how to get the information translated.
____A TDD/TTY machine or posted instructions on accessing the Relay Services for the deaf is available.	____ I am careful to avoid using idioms, acronyms, and jargon in both written and verbal communication.
	____ I am careful in the use of body language and am aware of what is acceptable among the various people I work with.
	____ I understand that for some, oral transmission of information may have a deep tradition and verbal exchange may be preferred as the primary method of communication.

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VALUES AND ATTITUDES

____I understand that perceptions of health and illness vary greatly and I try to understand how different people think about health.	____ I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the communities I work with.
____ I recognize that the meaning or value of medical treatment, screening for prevention and early diagnosis, and health education will vary and are impacted by culture and previous experience	____ I am aware of the socio-economic, major health, and environmental risk factors that contribute to the major health problems of the communities I work with.
____ I recognize and accept that individuals from culturally diverse backgrounds may have, and/or desire, varying degrees of acculturation into the mainstream culture.	____ I screen books, pamphlets, videos, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my office.
____ I try to be aware of when I might be passing judgment or imposing my own values on those who hold different beliefs from my own.	____ I intervene in an appropriate manner when I observe other staff or clients within my office engaging in behaviors that show cultural insensitivity, racial biases or prejudice.
____ I understand and accept that family composition and dynamics are defined differently by various cultures (e.g. the definition and expected roles of extended family members, fictive kin, and godparents).	____ I seek professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups
____ I accept and accommodate the fact that male-female roles may vary significantly among different cultures and ethnic groups (e.g. who makes major decisions for the family).	____ I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
____ I understand and try to accommodate age and life cycle factors that must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectations of children within the family).	____ I understand and try to accommodate some of the ways that grief and bereavement affect people.
____ Even though my professional or moral viewpoints may differ, I accept and accommodate individuals and families as the ultimate decision-makers for services and supports impacting their lives.	____ I seek information from individuals, families or other key community informants that will help me respond appropriately to the needs and preferences of the diverse groups served by my office.
____ I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.	____I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence.

Promoting Cultural and Linguistic Competency
A Self-Assessment Checklist for Personnel
Providing Primary Health Care Services (continued)

Directions: Mark items with **A** = Frequently **B** = Sometimes or occasionally **C** = Rarely or never "C" responses present opportunities for improvement.
MEDICAL ENCOUNTER
____ I do not use the patient's family members to interpret medical information or questions.
____ I ask my patients whether they would like adult family members or other people important to them present when discussing their diagnosis and treatment.
____ I take extra time to ensure that patients, who are not fluent in the language I use, understand the expected effects and side effects of the medication prescribed for them.
____ I ask patients, who are not fluent in the language I use, to paraphrase what I said in order to check the accuracy of their understanding.
____ I use indirect or open-ended questions with people to help those who have difficulty with direct questioning.
____ I understand which language needs, religious affiliations, and other cultural information, need to be entered into the medical chart.
____ I inquire about the patient's use of alternative medical systems or cultural healers (e.g., *curanderos*, *herbalists*) and try to accommodate that treatment, when it is appropriate.
____ I am aware of the underground "pharmacies" and illegal "medical" services that are active in my community and can discuss them with patients as needed.