Continuing Education

Crossing the Cultural Divide—Cultural Competence is Critical to Safe and Effective Health Care

By Kim Heagy, R.Ph., with an introduction by Nancy Kramer, R.N., B.S.N., CRNI

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An application has been submitted to the Virginia Nurses Association for continuing education approval. Please call the National Home Infusion Association at 703-549-3740, or visit the weblink at the bottom of this page for more information about contact hours.

This continuing education article is intended for pharmacists, nurses, and other alternate-site infusion professionals.

Continuing Education Objectives

After reading this article, the participant should be able to:
1. List common beliefs and cultural practices that relate to health and diet.
2. Identify the ways limited language proficiency can adversely affect health outcomes for patients whose primary language is not English.
3. Describe techniques for enhancing communication with patients from diverse cultural backgrounds.

About the Authors

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Introduction: “Mrs. Lee’s Story”
Let’s imagine it’s the first Monday in April, 1995, and you are a home infusion nurse on your way to visit Mrs. Lee, a 48-year-old woman recovering from heart/lung transplant surgery four weeks prior. Discharged home with 21 days remaining in a four-week IV antibiotic regimen (diagnosed with osteomyelitis of the sternum post-operatively, receiving Vancomycin 750 mg IV every 12 hours), your visit today is to change her tunneled catheter dressing, draw a Vancomycin trough, and assess her response to therapy and overall status. She is part of a research study and is being monitored at home using a sophisticated new telemonitoring program that measures her lung vital capacity every 12 hours, recording the results electronically and transmitting them back to the medical center for evaluation. She is being monitored for early signs of rejection, a concern despite the cyclosporine (anti-rejection drug) she has been taking since surgery.

Mrs. Lee greets you at the door with a smile, and while she seems to be slightly out of breath, she also appears to be in good spirits. You assume her shortness of breath is related to the journey she just took down the stairs, and you move on with the care you came to provide. While preparing for her lab draw, she receives a phone call from her physician, informing her that her lung vital capacity measurements have been declining for the past two days, and while not yet at a “worrisome” level, the medical team is concerned she may be in the early stages of organ rejection, and would like her to come back to the hospital for further tests. Mrs. Lee appears visibly upset and anxious after receiving this news.

In your usual course of care, you ask Mrs. Lee if she is taking any new prescription or over-the-counter medications, to which she responds “no.” She is drinking a cup of very fragrant tea, however, that was prepared by her mother to help with her recovery. She responds “no.” She is drinking a cup of very fragrant tea, however, that was prepared by her mother to help with her recovery. She explains that her mother is an herbalist and just arrived in the U.S. from her home country, which was drinking the tea—herbal remedies, while used for centuries in many parts of the world, were not a widely accepted or an acknowledged part of health care in the United States in 1995. Today, health care providers are more adept at inquiring about herbal remedies as part of the over-the-counter medication questions, but what other culturally motivated health behaviors are we unaware of that could be impacting our patient’s outcomes right now?

Health care providers who are knowledgeable of culturally-inspired health behaviors, can incorporate an assessment for the impact of such behaviors on the patient’s response to therapy and desired clinical outcomes. The goal is for patients and providers to come together and talk about health concerns with cultural differences enhancing, not hindering, the conversation. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

What Is Cultural Competency?
Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual, and as an organization, within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Cultural competence refers to the ability to interact effectively with people of different cultures. Cultural competence is comprised of four components: (a) awareness of one’s own cultural worldview, (b) attitude toward cultural differences, (c) knowledge of different cultural practices, and (d) cross-cultural skills.

Developing cultural competence results in the ability to understand, communicate with, and effectively interact with people across cultures.

Cultural Self-Awareness: A Great Place to Begin Building Your Bridge
Achieving an open, non-judgmental exchange of ideas among culturally diverse people is an evolutionary process, and often the first step along that road is to look internally at your own health care beliefs and values, to understand your own motivations for making specific health care choices. Consider these questions and what your answers tell you about the way your culture has shaped your views of illness and wellness:

1. What is your cultural heritage?
2. What are some of the symbols of your cultural background that you keep or respect (e.g., food, clothing, art, music)?
3. How do you define health and illness?
4. How do you decide the treatment needed for a given health problem?
5. Who do you turn to for help with minor and major health problems?
6. Who makes health care decisions in your family?

Common Beliefs and Cultural Practices

Health care providers can benefit from an increased awareness and understanding of the different health beliefs and treatments of their patients. The first step in this aspect of cultural competence in health care is to be sensitive to the role that folk or traditional medicine may play in a patient’s life. It can be very helpful to ask patients what they think may have caused an illness and what they are already doing to treat it. A health care provider in all settings must show tolerance of and respect for diversity in order to recommend and/or provide appropriate treatment, and to ensure the willingness of the patient and family to achieve treatment goals and comply with the established care plan. The following is a brief discussion of some of the traditional diets and health beliefs of people from different world cultures.

Hispanics/Latinos

- Some Hispanic people believe that disease is caused by an imbalance between hot and cold principles. Health is maintained by avoiding exposure to extreme temperatures and by consuming appropriate foods and beverages. Examples of “hot” diseases or states are pregnancy, hypertension, diabetes, and indigestion. “Cold” disease examples include menstrual cramps, pneumonia, and colic. The goal of treatment is to restore balance. “Cold” diseases are treated with “hot” remedies, and vice versa.

- Traditional medicine in most Hispanic countries has an extensive list of folk remedies. Examples include using garlic to treat hypertension and cough; chamomile to treat nausea, gas, colic, and anxiety; a purgative tea combined with stomach massage to cure lack of appetite, stomach pains, or diarrhea; and peppermint to treat dyspepsia and gas.

- Providers may encounter the concept of a hex, for which the proper diagnosis and treatment require consulting a “santero/santera” (or healer).

Native Americans/American Indians/Alaska Natives

- Some Native Americans/American Indians/Alaska Natives believe that healing will result from sacred ceremonies that rely on having visions and using plants and objects that may be symbolic of the individual, the illness, or the treatment.

- Traditional Navajo medicine includes chanting, prayer, sand painting, dancing, and herbs.

- Many Native American tribes turn to the sweat lodge to cure a variety of physical and emotional ills.

- Native American herbal medicine is widely used by alternative medical practitioners. Examples include the use of Echinacea, goldenseal, and burdock.

Asians

- Chinese medicine is a complex and well-established therapeutic tradition that uses acupuncture, acupressure, and herbs, often in combination with dietary therapy, Western medicine, and supernatural healing. Clients may be reluctant to say that they have been using these approaches to treat their illness, fearing the disapproval of Western health care providers.

- Chinese and Cambodian medicine classifies food, illness, and medications according to the perceived effects on the body, as “hot” or “cold.” Illness is due to excess consumption of “hot” or “cold” foods, wind and other environmental factors, emotional states, and sexual activity, and may be remedied by such treatment as restoring the balance of foods in the diet. Many fruits and vegetables are considered “cold,” while meat is considered “hot.” A woman who gives birth is thought to lose body heat, which must be replaced by eating hot soups for at least six weeks.

- Some Chinese may believe that illness is a result of moral retribution by ancestors or deities due to a person’s misdeeds or negligence. Rituals are performed to appease this anger. Other health beliefs that may be held by patients from this group include cosmic disharmony due to a poor combination of year of birth, month of birth, day of birth, and time of birth, and poor “Feng Shui”—improper placement of objects inside a room or orientation of the room or house itself (north, south, east, or west).

- Some Chinese and Cambodians believe in interference from malevolent spirits. Spiritual healers are sought for illnesses thought to be caused by spirits.

- Some Cambodians may cup, pinch, coin, or rub an ill person’s skin to treat a range of ailments. For cupping, a cup is heated and then placed on the skin, usually on the forehead or abdomen. As it cools, the cup contracts, drawing the skin and what is believed to be the evil energy or “air” into the cup. This causes a skin alteration or scar. Pinching is done by pinching the skin between the thumb and index finger to the point of producing a contusion at the base of the nose, between the eyes, or on the chest, neck, or back. Coining is the rubbing of the skin with the side of a coin, causing striations or ecchymoses. It is important that these techniques not automatically be labeled as abuse without further culturally sensitive investigation.

Eastern Europeans

- Traditional healing approaches include treatments using teas, herbs, grasses, and ointments.

- Coughs and congestion are relieved by the inhalation of the steam from chamomile tea.

- Honey and pollen are consumed to ensure longevity.

- Some Eastern Europeans may treat colds and flu with the use of “bonki.” Similar to the practice of Cambodians described above, glass cups may be pressed on a sick person’s back and shoulders to ease fever and flu symptoms, often leaving behind bruises and welts. It is important that these techniques not automatically be labeled as abuse without further culturally sensitive investigation.

- Coughs and congestion are relieved by the inhalation of the steam from chamomile tea.
While recognizing that there are many similarities among people from the same culture, it is important for healthcare providers to remember that each individual has a unique personal history, belief system, style of communication, and health status. What may be true about some or most individuals from a particular region or country may not be true of all individuals from that region or country.

**How Language Plays a Role in Health Care**
The increasing population growth of racial and ethnic communities and language groups presents a challenge to the health care delivery services within this country. Approximately 50 million people in the United States do not speak English as their primary language, and more than 21 million speak English “less than well.” Persons who have limited English proficiency (LEP) are less likely to have routine preventive care, are less satisfied with the level of care they receive, and are at a greater risk for experiencing medical errors.

A recent study, by the Albert Einstein College of Medicine in New York, of all 161 pharmacies in the Bronx, N.Y. (a borough with a large Spanish-speaking population) revealed that 31 percent could not provide prescription labels in Spanish. All the pharmacists commented that a patient must specifically request a Spanish prescription label in order to receive one. One pharmacy used translation software that could not translate common prescription terms like “dropperful.”

Miscommunications in health care can lead to terrible consequences. A child given a tablespoonful of medication when a “dropperful” was prescribed could wind up in the emergency room or worse. Then there are the simply spoken miscommunications that can be deadly, such as the 13-year-old Phoenix girl whose ruptured appendix was initially mistaken for gastritis because no one could question her Spanish-speaking parents. Her death in 1984 sparked a lawsuit resulting in a $71 million malpractice award against the hospital and physicians involved.

Health care organizations that are making significant strides in translating materials for non-English speakers are not only fulfilling the requirements of Title VI of the Civil Rights Act of 1964 and Executive Order 13166 issued in 2000, they are fulfilling their mission to improve health. It has been shown that when people receive health care information in their own language, the care improves, whether it is under-standing health insurance policies or taking medicine.

**Non-Verbal Communication**
Non-verbal communication is present in everyday conversations but is often overlooked when communication styles are addressed. Behavioral scientists have found that between 55 and 95 percent of messages communicated may be non-verbal. There are many forms of non-verbal communication, including eye contact, body language, touching, hand gestures, use of space, and silence.

The importance of these forms of communication within culture is often ignored and those who are learning a new language and interacting in a new culture often try to use the same non-verbal communication that is common to their own cultures. This can lead to negative consequences. For example, in the United States it is customary for two people who are having a conversation to maintain eye contact. People who are unable to maintain eye contact during a conversation may be viewed as untrustworthy or rude. However, in many Middle Eastern, Asian, and African cultures it is considered disrespectful to look an elder or authority figure in the eyes during a conversation. By avoiding eye contact they are showing their reverence for the other person.

Another important form of non-verbal communication is the
concept of proximity, or comfortable personal space. In general, native English speakers of the U.S. maintain some distance when speaking, and may view touch as unwelcome or uncomfortable. Personal space is very important in the U.S. and most people try to respect the space of others when interacting with them. In other parts of the world, such as Asia and the Middle East, personal space may be dictated by gender, in which a female patient is less comfortable in close proximity to a male who is not her husband or family member. People who tend to stand or sit closer to one another while talking, think nothing of their proximity to each other. Hispanics typically are more comfortable in close contact to each other than non-Hispanic whites may be. When non-Hispanic providers place themselves two feet or more distance away from their Hispanic patients, they may be perceived as not only physically distant but also uninterested and detached. Likewise, health care providers who ignore or fail to ascertain a patient's need for personal space may cause unnecessary stress during their interaction with the patient.

Silence is another form of communication that can make a situation awkward if used improperly. The acceptable length of silence during a conversation varies across cultures. In many cultures, people are more comfortable with longer pauses whereas in the U.S., long pauses can become uncomfortable or may indicate that fact that someone is upset or choosing to ignore what has been said in the conversation.

Tips for Health Care Providers

- Follow the patient’s lead. If the patient moves closer or touches you in a casual manner, you may potentially do the same.
- Use hand and arm gestures with great caution. Gestures can mean very different things in different cultures.
- Be careful in interpreting facial expressions. They may lead you to misinterpret the patient’s feelings or to over- or underestimate the patient’s level of pain. This is also true of the presence or absence of crying and other expressions of pain, which are closely tied to a person’s culture.
- Don’t force a patient to make eye contact with you. He/she may be treating you with greater respect by not making eye contact.

Tips for Cross-Cultural Communication

- Slow down—even when English is the common language in a cross-cultural situation, it does not mean you should speak at normal speed. Speak clearly and ensure your pronunciation is intelligible.

- Separate questions—try not to ask double questions such as “Do you want to carry on or stop here?” Allow your listener to answer one question at a time.
- Avoid negative questions—many cross-cultural communication misunderstandings have been caused by the use of negative questions and answers. In English, we answer “yes” if the answer is affirmative and “no” if it is negative. In other cultures, a “yes” or “no” may only be indicating whether the questioner is right or wrong.
- Take turns—communication is enhanced by taking turns at talking. Make a point and take the time to listen.
- Be supportive—effective cross-cultural communication is, in essence, about being comfortable. Giving encouragement to those with weak English gives them confidence, support and a trust in you.
- Check meanings—when communicating across cultures never assume the other party has understood. Be an active listener. Summarize what has been said in order to verify it. This is a very effective way of ensuring accurate cross-cultural communication has taken place.
- Avoid slang—even the most well educated foreigner will not have a complete knowledge of slang, idioms and sayings. The danger is that the words will be understood but the meaning missed.
- Maintain etiquette—many cultures follow certain rules of etiquette when communicating. It is always a good idea to undertake some cross cultural awareness training, or at least do some research on the target culture, in order to fully understand and follow these unspoken rules.

Conclusion

In addition to exploring some of the concepts introduced here, it’s important for individual health care workers to become aware of their own personal attitudes, beliefs, biases, and behaviors, that may influence—consciously or unconsciously—the care they deliver to patients. It’s also meaningful to consider your own personal interactions with professional colleagues and staff from diverse racial, ethnic, and socioeconomic backgrounds.

There is no “one” way to treat any racial and ethnic group. Cookie cutter approaches about working with patients from diverse backgrounds are not useful and instead risk potentially dangerous stereotyping and overgeneralization. To truly eliminate racial and ethnic “disparity” related to clinical treatment outcomes, health care providers must become more culturally and linguistically competent. The more culturally on-target our care and services are with our patients, the more effective we will be at successfully treating the diverse spectrum of home-based patients.

Editor’s Note

This vital topic will be explored in more detail at the 2011 NHIA Annual Conference & Exposition. Be sure to join us for coverage of this and other topics pertinent to your business.
References


2. Martin M, Vaughn B. Strategic Diversity & Inclusion Management. 2007, pp. 31-36. DTUI Publications Division: San Francisco, CA


