

Cultural Issues in nursing Care*

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SUMMARY

“ This paper is a revised version of a keynote lecture that was presented in several cultural competence conferences in the U.S and Sweden. The current version was presented as an open lecture at the University of Antioquia, Medellín, in August, 2000. It introduces the author's framework to guide culturally competent health care, which is a general approach that includes cultural knowledge, health provider self awareness, and the influence of the sociopolitical context. Cultural influences on health and illness perceptions and communication are described to inform readers about potential variations into which they may want to make inquiries. The remainder of the paper covers practical suggestions on how to improve cross-cultural communication, do a cultural assessment, and plan culturally appropriate interventions”.

Key words.

*Nursing care. Health attention.
Health communication.
Transcultural nursing.*

Introduction

I am pleased to be here today. I'll be talking about a variety of topics in the area of culture and nursing care. We'll begin with the general framework I use in teaching graduate students in nursing how to provide more culturally competent care. My examples will often be from my research and clinical work with Middle Eastern immigrants and Afghan refugees, because I know them well, but my points often pertain to other groups.

¿Why should we be concerned about culturally competent nursing care?

One reason is global migration and every country becoming more diverse. I work in a very diverse city, which reflects some 150 ethnic groups in the U.S. San Francisco is about 27% Asian, mainly Chinese, Filipino, and Japanese, but we have Vietnamese, Koreans, Thais, Cambodians, and Hmong as well. Our choice of restaurants is famous -you can eat from at least 40 different countries. Therefore, nurses in San Francisco have to include cultural variables in our care of individuals, families and in the community.



Columbia also has many different cultural groups. I have learned that there are few immigrants from other countries but many Indians and people of mixed race. Nursing care of people of mixed cultural backgrounds may be more challenging than mono cultural groups.. Since I have little experience with you cultural groups, I will use examples from my own research over the past 15 years. Most of this research has been with immigrants and refugees to California from Iran, the Arab countries, Afghanistan, and more recently, Bosnia and the former Soviet Union. I think that you will recognize these examples in Colombian populations, even through you may have little contact with few immigrants from these countries.

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Even where there is a lot of cultural diversity, some nurses don't deal with it very well. For example, some nurses insist that good care is treating all patients alike. On the surface, treating people "equally" sounds good, like democracy. But despite the good intentions, treating everyone alike usually shows that the nurse doesn't really understand the real differences that culture makes in behavior, values, and even perception of the world. I believe that good patient care requires that we tailor it to the individual patient and family in the context of their culture. We can't expect sick people in crisis to change their beliefs and behavior to suit the culture of the hospital. We often try, however.

¿What is culturally competent care?

The American Academy of Nursing defined culturally competent nursing care as sensitive to issues related to culture, race, gender, sexual orientation, social class and economic situation (Meleis, Isenberg, Koerner, & Stern, 1995). I believe that we need to add disability to this definition. We might also hear words like culture-compatible, culturally appropriate, culturally sensitive, culturally responsive, and culturally informed. Some people think that nurses cannot be culturally "competent" in a second culture unless they grew up in it or at least are fluent in its language. I don't believe it, however. It's a skill that can be developed like other nursing skills.

A Framework for Culturally Competent Care.

I call this framework the cultural perspective. It helps nurses to deal with a very complex area --the cultural, socio-economic, and structural influences on people and their interactions with nurses. It includes three perspectives to help us plan individually and culturally competent care. This model emphasizes how we ourselves influence the care situation.

The cultural perspective consists of a combination of knowledge, attitudes, and behaviors or skills that are interdependent. I believe that culturally competent nursing care requires more than simply knowledge about another ethnic/cultural group. (Lipson, 1984; Campinha-Bacote, 1994). Examples of attitudes are ethnocentrism, bias, respect, and empathy. Skills include flexibility, effective cross-cultural communication and cultural brokerage.

This cultural perspective provides a context for interpreting what we see in our patients to allow us to ask the right questions. It doesn't provide a list of facts about a cultural group, which can lead to stereotyping and communication errors. Specific cultural facts are important but they need to be used with the understanding that every belief and behavior has both a cultural and an individual base.

We improve our cultural perspective both intellectually and through personal experience. You cannot know what it is really like to be a refugee only through reading, although some novels do a pretty good job. The most effective way to understand the magnitude of cultural differences is through experiencing them first-hand, by being a "foreigner," or by having close friends from other cultures. This personal experience makes us confront rather than deny cultural differences.



Picasso. *Ciencia y caridad*,
1897. Óleo sobre lienzo, 197
x 249,5 cm Barcelona

From the perspective of the nurse, the objective component focuses outward on cultural characteristics of the patient and family, and how they influence on health and care. The subjective component focuses inward --the nurse's personal and cultural characteristics and their influence on health communication. The context looks at the influence of the broader situation in which the care encounter occurs. I'll skip over the objective perspective right now because we'll talk about it with cultural influences on perceptions of health and illness.

The subjective perspective emphasizes the nurse's own personal and cultural characteristics. We cannot provide culturally competent nursing care in the absence of self-awareness; we must work to be aware of our own values, beliefs, and communication style because they have a powerful impact on cross-cultural communication. But discovering one's own cultural baggage takes work and motivation.

The context includes the broader cultural, socioeconomic, and political influences on the health care system and their effects on patients and nurses. It is also the immediate environment of a cross-cultural care encounter which influences how people interpret what is going on and what they express about themselves. For example, home or community nursing allows an opportunity to do a good cultural assessment, but there is usually very little time to do this in emergency or critical care settings. In the U.S. right now, the managed care system allows about 10 minutes per patient for a physician or nurse practitioner. Reducing the number of nurses also limits the amount of time nurses have to spend with patients.

Geographical location is also part of the context. For example, San Francisco is a city that respects and enjoys different cultures. My former student, who immigrated to San Francisco from Iran as a teenager, had never experienced any prejudice until she moved to eastern Florida. She found that when people heard her accent, they either started speaking very loudly and slowly or their faces showed confusion or hostility.

Cultural Influences on health and illness perceptions

A. Culture and world view What do you think of when you hear the word culture? (Most people think in terms of language, food practices, mode of dress, religion, family and gender roles, and expectations of other people.) There are numerous definitions of culture, but a simple one is "a system of symbols which is shared, learned, and passed down through generations in a social group."

Culture mediates between human beings and chaos. It is the guide to what people perceive in the world and how they should behave toward each other; It is not static. It changes continuously, sometimes quickly and with large changes, like for a group of refugees, sometimes more subtly, like changes from one decade to another.

B. Disease and Illness

Birth, death, and disease are universal. But, a 1940's medical historian named Edwin Acknerknect said: "Disease and its treatment are purely biological only in the abstract. Whether a person gets sick at all, what kind of disease he acquires, and what kind of treatment he gets depends largely on social factors." How people perceive, experience and cope with sickness are based on how they explain it.

Let me give an example. Chinese culture sees the world in terms of harmony and disharmony. The key to health is maintaining the balance of yin and yang in one's life, family, surroundings, and even the universe. One gets sick because one is out of balance. My son was treated by an acupuncturist for his allergies. The doctor explained that my son has too much yang, and that's why his skin is so dry and his ears become hot. The purpose of acupuncture was to balance his system, to help his energy flow more freely; to decrease the yang and increase the yin. He did not even mention his eczema and stuffy nose. This holistic view of health is quite different from our biomedical model which focuses on discreet physiological systems. An allergist explains my son's symptoms in terms of histamine release in response to allergens and would treat him using anti-histamines.

Illness is the personal, interpersonal and cultural experiences of disease. It's the problems that being sick or disabled pose for the person and his family.

The everyday hassles of living with illness are of much more concern to our patients than the underlying pathological process.

In contrast, disease is what doctors are concerned with -- the malfunctioning of a physiological system, diagnosis and treatment. The biomedical model is not the one reality, it is shaped by culture and a product of history, technology and practice. Both a family's explanation of illness and the biomedical model are explanatory models of sickness. It's quite common for health providers who focus on disease and patients who focus on illness to just talk past each other.

C. Interpretation of illness.

Illness beliefs are part of a cultural group's larger ideas of how it fits into human existence. What is the illness? why does it occur to some people and not others? what are the causes? what can prevent or cure it? how does it relate to how the world works as a whole? For example, if you ask why a person got sick at this particular time, and she tells you that it was God's will, you would realize that the supernatural is an important part of her world view.

In addition to explaining illness, culture shapes the experience and expression of symptoms. In many cultures, mental illness is not separated from physical disorder. It is the person who is sick, not the body or the mind. If mental disorders are talked about, they are often blamed on witchcraft, sorcery, or even soul loss.

An example is belief in the evil eye, which is found in many countries, and is especially prevalent in Latin American countries and Mediterranean countries like Spain and the Middle East. As you know, this is the belief that the eyes are very powerful, and someone can cause illness or harm by looking at another person. People who came from the Middle East often believe that the most powerful "gaze" is from green eyes, impure or ill people. The spell of the evil eye can be unintentional, caused by excessive admiration for someone without remembering to say a preventive phrase. It can be intentional, cast out of jealousy, envy or enmity, and is meant to hurt another person or his property.

Illness caused by the evil eye is distinguished from other illnesses by its sudden onset. The person may feel or act generally sick, or have some more specific symptoms, depending on the culture. Evil eye

may be prevented by saying "In the Name of God," when admiring or giving a compliment, or touching wood. Susceptible people (e.g., children, young beautiful women, brides, rich or fortunate people) are sometimes protected by wearing charms or amulets, such as blue stones or beads. We see Arab patients wearing an amulet in the shape of a hand, with a blue stone in the middle, to protect the person from the evil eye. The Afghans burn wild rue in the fireplace for prevention. One woman explained that "it forces the evil spirits out; the sounds of the seeds popping are like the sounds of eyes popping." There are many curing rituals for the evil eye, which vary by culture, but some use eggs and religious prayers.

This is an example of how patients may be more concerned with the cause of an illness than with its physiology. There are two main kinds of causes of illness: personalistic causes, and naturalistic causes. In the personalistic belief system, a person gets sick because someone or something caused the sickness. This someone can be another human being, a supernatural being like God or the Devil, or a bad spirit or demon. The treatment sought for this kind of illness is very different than for an illness based on a naturalistic cause. The evil eye is an example. A physician cannot treat someone with the evil eye. One way of determining if someone has an unnatural illness is that the more you go to the doctor, the sicker you get --ordinary people, especially physicians, can't cure unnatural illnesses.

Naturalistic causes include weather, viruses, dirt, bad food, and other things, not the intention of someone or something with ill will. Naturalistic illnesses are caused either by not taking care of one's body or by "sinful" behavior, and causes include cold, dirt, or improper diet.

D. Examples of differences in role expectations

1. Compliance: how carefully do people follow instructions? e.g., apparent compliance is particularly characteristic of many Asian groups --courtesy, respect for authority. How many immigrant families have you worked with who say "Yes, Yes" to whatever you say. You can't even find out if they understood you because they consider it to be so important to be courteous to the person of higher status. Sometimes "Yes Yes" means, "no, of course I won't do that." They may outwardly agree with your suggestions but have no intention of following through.

2. ¿How should the patient and family behave in the face of illness or death? For example, expression of pain? Zborowsky's classic study of Italians, Jews and Protestants from northern European origins showed big differences. Asians and Latins provide a more recent example. Who makes the decisions in the family? The patient may not have the authority to make any decisions about his treatment or care. It may be the spouse, the grandmother, or the eldest brother who is expected to make the decisions. Who is responsible for care of the patient? It's almost always the mother's role to care for the sick person. In some countries, the family moves into the hospital to provide all care except medical treatment, including food, bathing, etc.

3. Self-care is culturally inappropriate for people who believe that it is the nurse's or a family member's job to completely care for the patient, including washing his face or brushing his teeth, to say nothing of urine testing or taking

one's own medications. In the U.S. we use a self-care model, and expect the patient to be as independent as possible. We think it helps people heal faster if they take responsibility for their activities of daily living and learning to do some of their own treatment.

4. ¿How should the health provider behave? Many cultural groups regard physicians as complete authorities, such as Middle Eastern and Asian immigrants. Nurses may also be considered authorities, and if you don't act like one you might be seen as incompetent, e.g., asking the family to make choices or to tell you what the problem is. Your age and gender may also play a part in how much respect you are accorded. For example, some immigrant families do not trust or respect young unmarried women. If you are young and single and find a family stand-offish, this might be this issue.

The issue of trust also shows up in asking people to sign consent forms, like we do in the U.S. In many parts of the world, people are not accustomed to signing agreements, they make verbal agreements. If one has to sign a form that spells out the details of a procedure and potential complications, then you must not be very competent. Middle Easterners, for example, also dislike consenting to multiple tests -- which they perceive as potential incompetence as well.

Cross-cultural communication

¿What is communication? It is the exchange of messages and the creation of meaning. You can't exchange meaning, you can only send and receive messages. Good communication is based on mutual understanding -- when the receiver's version of the meaning of the message matches the meaning that the sender intended.

We all communicate in ways that are influenced by our cultural backgrounds. It is important to be conscious of how we communicate so that we can be more flexible. It may be that changing something minor in the way you communicate can really improve the process. It is quite common for an immigrant patient to consider a nurse or doctor insensitive or incompetent simply because of differences in nonverbal communication. If the patient thinks the nurse is inappropriate, he will have trouble trusting her and may avoid subsequent appointments or ignore her suggestions. She may have no idea that she inadvertently offended the person.

A. Language barriers and interpreters.

It is very frustrating when people don't speak a common language.

Using an interpreter is never as good as communicating directly. However, there are problems related to using family members as interpreters. They often don't have medical terminology or adequate English skills, or maybe only a child speaks Swedish. Children or spouses of immigrants are extremely protective of the pride of their family member and try to avoid embarrassment at all costs, including hiding important medical information. One of my Afghan friends described how horrified and embarrassed she was when her gynecologist asked her 12 year old son to interpret about his mother's problem. In male-dominated cultures, it may be a major assault to the father's self-esteem if he must depend on a child or wife for translation on a regular basis.



Picasso. *Ciencia y caridad*.
1897. Óleo sobre lienzo, 197 x
249,5 cm Barcelona, España.

If trained interpreters are not available, it is worthwhile to find a respected community representative to interpret for patients from immigrant groups common to your hospital. A community interpreter can also serve as a culture broker, helping you to understand the cultural meaning of illness and illness behavior as well as traditional ways of treatment or obtaining support.

In the case of something sensitive, like a poor prognosis, it is important to meet with the interpreter beforehand to see if you agree on the major points. Untrained interpreters may provide their own interpretations or advice to the family.

One important guideline for working with an interpreter is speaking directly to patient or family member in the first person, rather than to the interpreter about the family member in the third person, e.g., "tell her that there was nothing she could have done to anticipate this." They may understand some Swedish, they will perceive your desire to help them, and they will be more likely to use your help. Watch their reactions to the interpreter's words and see if they seem to match the message you conveyed.

B. Nonverbal Communication: more subtle

1. Personal space. Edward T. Hall described how people in various cultures relate to their physical space. For example, when interacting with another person, the intimate distance is 0-18 inches. This distance is maintained between intimates and close associates and people experience each other's smell, heat, touch, and rich. Visual detail. Personal distance varies for 1.5 to 4 feet, and allows rich communication. Social distance varies from 4 to 12 feet, and is used for business and general public contact. These distances are culturally patterned.

Before I learned about cultural differences in personal space, I went to Austria after spending 6 weeks in Spain and Italy. My impression of Italians was that they are very warm people; I didn't much like Austria, because it rained a lot, but it also seemed that Austrian people were somewhat cold. I didn't know that I was reacting to a different conception of proper personal space.

I've worked with Middle Eastern immigrants for 15 years and have now adjusted to a more nose-to-nose style of communication. Although before I knew intellectually that there are cultural differences in personal space, I still felt that Middle Easterners were aggressive. I would back up in conversations.

After you leave you, you might try an experiment. Pick a partner and stand at a comfortable distance for a conversation. Now move closer to each other until you are uncomfortable. Could you hold a conversation with an acquaintance at this distance? Now move back until you find the comfortable distance. Move back even further, and imagine you are trying to talk to a very close friend. Notice if you and your partner have different comfort zones.

Later, watch your patients move. Do they move forward or backward when you come close to them. Do you find you want to move in or move back? You can watch the way people move in relation to each other at social events also.

2. Eye contact varies from intense to fleeting. You may feel that Arabs are looking straight through you, which is uncomfortable when you also feel that they are standing on your face. At the other extreme are American Indians who



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almost never meet another's eye during a conversation. Direct eye contact is considered rude and an invasion of privacy. Some Southeast Asian refugees do not look you directly in the eye when you are talking, or maintain eye contact for more than a few seconds. Asian and Middle Eastern women do not look directly into the eyes of men. Subordinates do not look directly into the eyes of superiors. The Arab is not aggressive and the Indigenous person is not evasive; they are behaving normally. These are cultural differences, not personality differences. Direct eye contact has a lot of different meanings. People from my culture keep direct contact when they are paying attention, talking and listening to each other. However, among some African Americans, intense eye-to-eye contact might be seen as a challenge or a way of showing one's power.

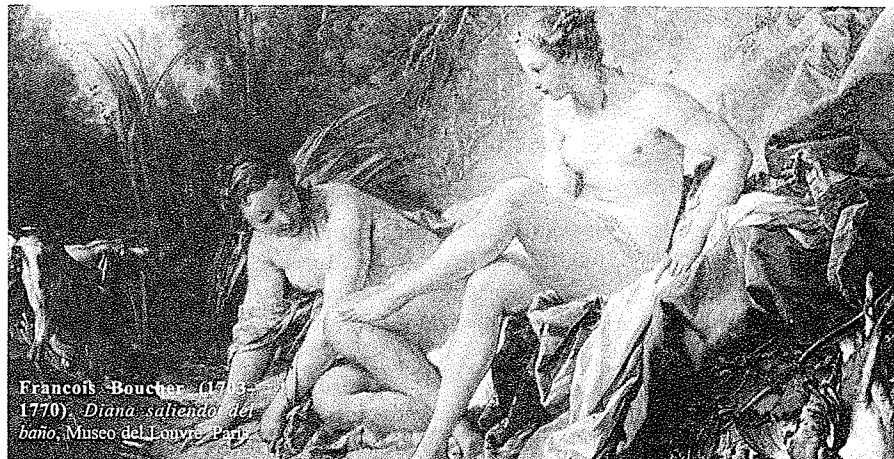
Awareness of cultural patterns helps people adjust to the situation. An American Indian social worker told me that in order to get along with her white colleagues, she knew that she was expected to make direct eye contact. But because eye to eye contact was so uncomfortable, she learned to look at people's noses. Watch where your patient's eyes go when you speak to them, and if they change when they are speaking to you. Try adjusting your eye contact to match theirs and see if they seem more comfortable with you.

Related to eye contact is facial expression. People in some cultures show their emotions not only on their faces, but all over their bodies; in others it is not appropriate to reveal one's feelings non-verbally to anyone outside the family, e.g., the stereotype of the "inscrutable oriental." I attended an Iranian funeral and saw loud and constant crying among both men and women. However, I was surprised to see two women next to me stop crying suddenly, chat and smile with each other, then suddenly start crying loudly again. In other words, this ritual crying was culturally appropriate expression of emotion even though it might not be exactly what the person is feeling inside.

3. Style of conversation and tone of voice are also culturally patterned. Americans tend speak bluntly and to the point. We tend to get irritated with patients who do not answer directly, ramble, or tell stories. We tend to think they are evasive or don't think clearly. However, they are being polite and appropriate, particularly with

a person who they perceive as being in a position of authority. These same Americans are considered rude and insensitive by Asians who are very careful of others' feelings. Middle Easterners will say something loudly when it is important, and may repeat it several times for emphasis. If you don't needle people in the Middle East, nothing gets done. At the other extreme is my Ethiopian colleague, a well-bred woman with a doctorate, who can hardly be heard when giving a presentation, because Ethiopian woman are raised to be quiet and refined.

4. Cultural conceptions of proper touch and modesty Who may touch whom, in what manner, and in which setting? For example, in our recent research on culturally competent care at UCSF, the two most frequent care problems mentioned were language, and having to match women patients with women nurses in male-dominated cultural groups like Middle Easterners. However, some Roman Catholics and Orthodox Jews are very uncomfortable being examined by a nurse of the opposite gender. In more traditional societies, relationships between men and women may be restricted except between family members.



Francois Boucher (1733-1770) *Diana saltando del baño*, Museo del Louvre, Paris

Unrelated men and woman often do not touch each other at all, or in really traditional Muslim societies, like Saudi Arabia or Iran and Afghanistan under the current regimes, men are not even allowed to see uncovered women.

¿How then, do you provide care or greet family members from such traditional societies? Handshakes are pretty much universally accepted while hugs from strangers are not, particularly between men and women. While you may have had difficulty doing physical assessments on women whose cultures require extreme modesty, there are more subtle examples of touch, like cultural practices regarding certain parts of the body. For example, among some Southeast Asians, the head is sacred. Travel books about Thailand state that one should never touch a Thai person on the head or shoulders, and the feet are profane. In several famous temples visited by many tourists, there are signs asking you to remove your shoes and to avoid pointing your feet toward the Buddha. Thus, you might really offend a Southeast Asian by touching something below the waist first. You also should never pat a child's head. It's best to ask first.

5. Orientations to time. Different orientations to time often result in misunderstanding and irritation. Some immigrant patients are late or miss appointments altogether, not because they are irresponsible, but because they have a different approach to time. Some cultures are mainly past oriented, some are mainly present oriented, and some are more future oriented. It's easy to discuss prevention with future oriented people, but it doesn't make sense to those who are present or past oriented.

Northern European cultures pace life to clock time, and clock time is more important than personal or subjective time. In contrast, Africans and Middle Easterners value involvement with people and completion of interpersonal encounters. When I am with Afghan friends, I am very aware of how American I am; I may cut short a visit because of another appointment, while the Afghans will finish the visit naturally and not worry about being late somewhere else. Courtesy is what is important. With regard to time orientation and health care, even knowing how long a particular symptom may have been going on may be a problem when people don't think in terms of chunks of time or calendars.

C. Improving communication through self-awareness

The basis of the subjective perspective is self-awareness --discovering your own cultural baggage. However, unlike regular baggage, you can't check it. No one grows up without culture, because it guides us in how to think, how to feel, and how to behave with others, and actually how to be in the world.

1. Culture as an iceberg. I like the image of culture as an iceberg, with one-tenth above the surface --these are the obvious differences in language, values, and norms.

We don't become aware of the depth of cultural differences, until one iceberg, with 90% of its bulk below the surface, collides with another one. Because so much of each person's culture is out of awareness, we are constantly experiencing collisions that result in misunderstanding and discomfort in interpersonal communication.

The reason that most of one's own culture is out of awareness is because it takes too much work to think about what we do all the time; if we did, we



Pablo Picasso. *El peñal de Góssoli, verano de 1906*. Óleo sobre tela. 151 x 99 cm. Albright-Knox Art Gallery, Buffalo, por cortesía de Scala / Art Resource

wouldn't have the time or energy to get through a day. Those of you who have lived or traveled in other countries remember the cultural exhaustion of trying to make sense of things.

Cultural learning, through these so-called iceberg collisions, brings the magnitude of cultural differences into awareness. Each collision is an opportunity for learning. Such learning can be embarrassing and somewhat painful, but it is highly worthwhile. For example, in my current research, I am constantly reminded of how very American I am. One of the most important Afghan values is hospitality; visitors are treasures, welcomed and treated lavishly, and red enormous amounts of delicious food. My outspoken research assistant tells how that I offend people, because I am "selfish." I refuse a fourth cup of tea because the caffeine keeps me awake at night. I refuse the carefully prepared sweets or a second huge plate of food because I'm trying not to gain more weight and it is very oily. Even when I explain, Afghans are likely to see this as rejecting their hospitality. I insult them even more when I try to help clear the dishes, because I am a guest and guests are to be served.

D. Illustrate flexibility: Let me give an example. I had a confrontation with Mr. x, an Arab father, who was very upset that his 20 year old daughter who had left home because of excessive social restriction. He suspected' that I knew where she was (I did) and he wanted her back. His voice was very loud, his eye contact was intense, and he appeared angry and threatening. After a few minutes, I realized that he was more upset and sad than angry; he was acting like an Arab who had something important to say. I checked myself and found that I was drawing back and becoming quiet, which he would probably interpret as passive disinterest. So I leaned forward, looked him directly in the eye, and said loudly that I'd call him if I heard from his daughter to tell him that she was OK. He said, "OK, thank you."

Problems in cross-cultural communication.

1. *Ethnocentrism* is the conviction that the way one does things in one's own cultural group is the best or only correct way. It is sometimes based on lack of familiarity with the meaning of other practices or in other cultural systems, or may it just may be plain old feelings of superiority. Ethnocentrism can be expressed verbally, or just through a nonverbal attitude of superiority -- a good way to offend our patients!!

2. *Stereotyping* Cultural information by itself can interfere with care if nurse s use it a cookbook manner and attempt to apply cultural "facts" indiscriminately to a patient of a cultural background. Cultural information can lead to stereotyping patients. Stereotyping is making an assumption about a person based on group membership without bothering to learn whether or not the individual in question fits that assumption. It is important to learn whether people consider themselves typical or different from others in their cultural group, because age, education, and individual personality make a difference.

Suggestions for Nursing Care

A. Cultural Assessment

Starting with the objective perspective, let's talk about how to do a cultural assessment. There are a number of cultural assessment tools that range from very brief to very comprehensive; how thorough you can be depends on how much time you have with a patient.



I think at the minimum, we should get the following information

1. General assessment.

a. Immigrant and generation: don't assume anything; Toni Tripp-Reimer in study of Greek Americans found some beliefs and practices were retained in 4th generation --like the evil eye.

Some immigration history is particularly important in populations that came from war-torn countries, e.g., Cambodians, Hmong, Afghans, Palestinians, Central Americans. Some families may have had very traumatic experiences, such as having a family member "disappeared", seeing people, killed.

b. Language: first, second, and whether person reads Swedish or even his first language. What language is spoken at home?

c. Nonverbal: observe where the eyes go and person's movement toward or away from you. Observe posture, other aspects.

d. Religion: ask what, and how observant ¿Are there any religious prohibitions against treatment?

e. Ethnic identity: Ask whether closest friends are mainly of the same group or other groups. If the patient is an immigrant, ¿how strongly does he identify with his own cultural group?

f. Food: ¿What kind of food do you eat at home? If you had your choice of restaurants, what? Allergies, foods prohibited by your religion? There's a lot on food, like biggest meal of day, fasting, etc, how much you find out depends on the presenting problem.

g. Family What are the cultural definitions of family: is it nuclear or extended? Does it contain friends as well? For example, Haitian and other Caribbean families include all kin, in-laws, and close friends from all the generations who are around. Thus, they are loyal to a very large group of people. Some American Indian children consider themselves to have several mothers, because they may freely live with whomever they choose in a clan; if the biological mother is unable to care for the child, a sister or sister-in-law takes over.

Because family members are the main sources of support for most immigrant groups, ask the patient to list who is in the family and their relationship, and questions about available social support. For example, after surgery, who will help you with meals? Who can you ask for help with finances? Also try to determine the firmness of the family boundaries. Are non-family members not trusted with personal information? Are non-family members asked for help? Who makes the family decisions?

h. Illness beliefs Kleinman, Eisenberg and Good's to determine illness beliefs -
-The answers to these questions often give you a good idea of the patient's view of the causes of illness and when it started when it did. For example, punishment from God is very different from bacteria or a weak immune system. However, you may not have the opportunity to include all these questions because of time, or the patient may be embarrassed to tell you what she really thinks caused her illness, because she's afraid

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you'll think that she's superstitious or too old-country. Explaining that you really want to know because it will help you help her better might help a little. Illness beliefs lead into problem specific data.

2. Specific Assessment

Related to presenting problem, or what you pick up on that is behind the presenting problem. e.g., Middle Eastern immigrant maternity patient, who does not appear to be "bonding" with the baby. Ask re: how birth is done in bome country, who takes care of her, who takes care of baby, postpartum customs, special foods for postpartum. An example of problem-specific data is the Cambodian post-partum patient who would not take oral medication following birth. When her nurse asked what postpartum women in her country eat and drink, she said "hot foods, a whole chicken made into a soup, nothing cold." The nurse realized that the patient believe in a hot and cold system. She wasn't avoiding the medication itself but the ice water at the bedside. The nurse gave the pills with warm water, with no further problem.

People will get insulted when you stereotype them or address them inappropriately, like first name for an older woman, but I've rarely encountered anyone who is insulted by sincere interest. If your attitude is that of a learner who respects what the patient can teach you about his culture, people are usually flattered by your interest.

How do you get this data? Ask the patient. Some nurses feel that they are prying by asking patients about their culture, or afraid that we will insult them. People will get insulted when you stereotype them or address them inappropriately, like first name for an older woman, but I've rarely encountered anyone who is insulted by sincere interest. If your attitude is that of a learner who respects what the patient can teach you about his culture, people are usually flattered by your interest. We get hung up on our roles as supposed to know it all health providers.

B. Interventions that incorporate cultural beliefs and practices.

Try to figure out what patient beliefs or practices are detrimental to . health? Which are neutral? Which are positive?

Positive and neutral ones can be incorporated into care: for example, the patient needs fluids, and will drink broths and yerba buena teas that her family brings from borne; or a religious healer can visit and pray with patient.

General rule: reinforce positive or neutral cultural beliefs and health practices because it encourages trust in the health provider. For example, if the family says that God will help the patient heal, by all means, help the patient and family create a better environment for prayer.

What are examples of neutral practices? Wearing an amulet to guard against the evil eye. Examples of harmful practices? Beliefs or practices which seem potentially harmful should be discussed with the family, explaining how and why you think they might be harmful.

Modification diet: soy sauce for hypertensive patient, work with nutritionist to substitute other tasty herbs or spices lower in salt that could be used to flavor traditional foods.

Perhaps the spirit of cultural assessment can be distilled clown to situation-specific models that may emerge in answer to such questions as: what are the needs of this culture, and how does one "show respect" to this cultural group at this point in time? ⑤