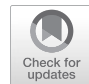

2 The Purnell Model and Theory for Cultural Competence

Larry D. Purnell

2.1 Introduction

Purnell model for cultural competence has been classified as holographic complexity grand theory because it is applicable to all health professionals, has a graphic display of the model, and an extensive assessment framework. The model has been translated into Arabic, Czechoslovakian, Danish, French, German, Korean, Portuguese, Spanish, and Turkish. The assumptions upon which the model is based. The model provides a comprehensive and systematic framework for learning and understanding culture and for use in the clinical practice setting. The empirical framework of the model provides a basis for health-care providers, educators, researchers, managers, and administrators in all health disciplines to provide holistic, culturally competent, therapeutic interventions; health promotion and wellness; illness, disease, and injury prevention; health maintenance and restoration; and health teaching across educational and practice settings. Reflective exercises for the health-care provider are included in each section of the organizing framework.

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2.1.1 The Purposes of This Model Are the Following

- Provide a framework for all health-care providers to learn concepts and characteristics of culture.
- Define circumstances that affect a person's cultural worldview in the context of historical perspectives.
- Provide a model that links the most central relationships of culture.
- Interrelate characteristics of culture to promote congruence and to facilitate the delivery of consciously sensitive and competent health care.
- Provide a framework that reflects human characteristics such as motivation, intentionality, and meaning.
- Provide a structure for assessing and analyzing cultural data.
- View the individual, family, or group within their unique ethnocultural environment.

2.1.2 The Major Explicit Assumptions upon Which the Model Is Based Are as Follows

- All health-care professions need similar information about cultural diversity and culturally congruent care.

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- All health-care professions share the metaparadigm concepts of global society, family, person, and health.
- One culture is not better than another culture; they are just different.
- Core similarities are shared by all cultures.
- Differences exist within, between, and among cultures.
- Cultures change slowly over time.
- The variant cultural characteristics (see Fig. 2.1) determine the degree to which one varies from the dominant culture and should be considered to prevent stereotyping.
- If patients are coparticipants in their care and have a choice in health-related goals, plans, and interventions, their adherence and health outcomes will be improved.
- Culture has a powerful influence on one's interpretation of and responses to health care.
- Individuals and families may belong to several subcultures.
- Each individual has the right to be respected for his or her culture heritage and individuality.
- Caregivers need both culture-general and population specific information in order to provide culturally competent and congruent care.
- Caregivers who can assess, plan, intervene, and evaluate in a culturally congruent manner will improve the care of patients for whom they care.
- Learning culture is an ongoing process that increases by working with diverse encounters.
- Prejudices, biases, and stereotyping can be minimized with cultural understanding.
- To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldviews of diverse populations and individual acculturation patterns.
- Differences in race, ethnicity, and culture often require adaptations to standard interventions.
- Cultural awareness improves the caregiver's self-awareness.
- Professions, organizations, and associations have their own culture, which can be analyzed using a grand theory of culture.
- Every patient contact is a cultural encounter.

2.2 Overview of the Theory, the Model, and the Organizing Framework

The model is a circle: the outer rim represents global society, the second rim represents community, the third rim represents family, and the inner rim represents the person (Fig. 2.1). The interior of the circle is divided into 12 pie-shaped wedges depicting cultural domains and their concepts. The dark center of the circle represents unknown phenomena. Along the bottom of the model, a jagged line represents the nonlinear concept of cultural consciousness. The 12 cultural domains (constructs) provide the organizing framework of the model. Following the discussion of each domain, a table provides statements that can be adapted as a guide for assessing patients in various settings. Accordingly, health-care providers can use these same questions to better understand their own cultural beliefs, attitudes, values, practices, and behaviors.

2.2.1 Macroaspects of the Model

The macro aspects of this interactional model include the metaparadigm concepts of a global society, community, family, person, and conscious competence. The theory and model are conceptualized from biology, anthropology, sociology, economics, geography, history, ecology, physiology, psychology, political science, pharmacology, and nutrition, as well as theories from communication, family development, and social support. The model can be used in clinical practice, education, research, and the administration and management of health-care services or to analyze organizational culture.

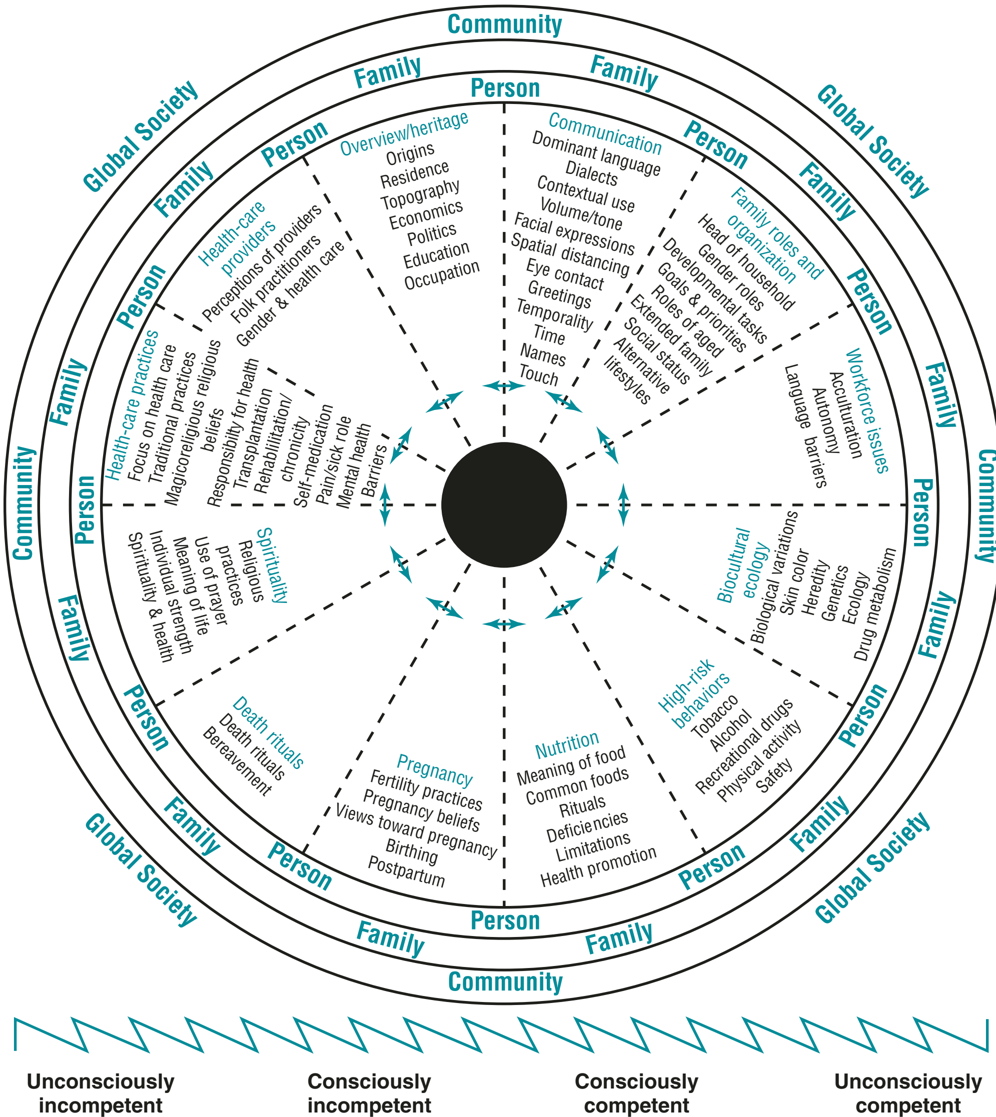

Fig. 2.1 The Purnell model for cultural competence. Variant cultural characteristics: age, generation, nationality, race, color, gender, religion, educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status). Unconsciously incompetent: not being aware that one is lacking knowledge about another culture. Consciously incompetent: being aware that one is lacking knowledge about another culture. Consciously competent: learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions. Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures

Phenomena related to a global society include world communication and politics; conflicts and warfare; natural disasters and famines; international exchanges in education, business, commerce, and information technology; advances in health science; space exploration; and the expanded opportunities for people to travel around the world and interact with diverse societies. Global events that are widely disseminated by television, radio, satellite transmission, newsprint, and information technology affect all societies, either directly or indirectly. Such events

may create chaos while consciously and unconsciously forcing people to alter their lifeways and worldviews.

Reflective Exercise
Think of a recent event that has affected global society, such as a conflict or war, health advances in technology, possible environmental exposure causing health problems, or volcanic eruptions. How did you become aware of this event? How has this event altered your views and other people's views of worldwide cultures?

In the broadest definition, community is a group of people who have a common interest or identity that goes beyond the physical environment. Community includes the physical, social, and symbolic characteristics that cause people to connect. Bodies of water, mountains, rural versus urban living, and even railroad tracks help people define their physical concept of community. Today, however, technology and the Internet allow people to expand their community beyond physical boundaries through social and professional networking sites. Economics, religion, politics, age, generation, and marital status delineate the social concepts of community. Symbolic characteristics of a community include sharing a specific language or dialect, lifestyle, history, dress, art, or musical interest. People actively and passively interact with the community, necessitating adaptation and assimilation for equilibrium and homeostasis in their worldview. Individuals may willingly change their physical, social, and symbolic community when it no longer meets their needs.

Reflective Exercise
1. How do you define your community in terms of objective and subjective cultural characteristics?
2. How has your community changed over the last 5–10 years? The last 15 years? The last 20 years?
3. If you have changed communities, think of the community in which you were raised.

A family is two or more people who are emotionally connected. They may, but do not necessarily, live in close proximity to one another. Family may include physically and emotionally close and distant consanguineous relatives, as well as physically and emotionally connected and distant non–blood-related significant others. Family structure and roles change according to age, generation, marital status, relocation, immigration status, and socioeconomic status, requiring each person to rethink individual beliefs and lifeways.

Reflective Exercise
1. Whom do you consider family?
2. Are they all blood related?
3. How have they influenced your culture and worldview?
4. Who else has helped instill your cultural values?

A person is a biopsychosociocultural being who is constantly adapting to her or his community and environment. Human beings adapt biologically and physiologically with the aging process; psychologically in the context of social relationships, stress, and relaxation; socially as they interact with the changing community; and culturally within the broader global society. In highly individualistic cultures (see Chap. 1), a person is a separate physical and unique psychological being and a singular member of society. The self is separate from others.

However, in highly collectivistic cultures, the individual is defined in relation to the family or other group rather than a basic unit of nature.

Reflective Exercise
In what ways have you adapted (a) biologically and physiologically to the aging process, (b) psychologically in the context of social relationships, (c) socially in your community, and (d) culturally within the broader society and culture?

Health, as used in this book, is a state of wellness as defined by the individual within his

or her cultural group. Health generally includes physical, mental, and spiritual states because group members interact with the family, community, and global society. The concept of health, which permeates all metaparadigm concepts of culture, is defined globally, nationally, regionally, locally, and individually. Thus, people can speak about their personal health status or the health status of the community, state, or nation. Health can also be subjective or objective in nature.

Reflective Exercise

1. How do you define health? Is health the absence of illness, disease, injury, and/or disability?
2. How does your profession define health? How does your community or nation define health?
3. How do these definitions compare with your original cultural heritage?

On a micro level, the model's organizing framework consists of 12 domains and their concepts, which are common to all cultures. These 12 domains are interconnected and have implications for health and well-being. The utility of this organizing framework can be used in any setting and applied to a broad range of empirical experiences and can foster inductive and deductive reasoning in the assessment of cultural domains. Once cultural data are analyzed, the practitioner can fully adopt, modify, or reject health-care interventions and treatment regimens in a manner that respects patients' cultural differences. Such adaptations improve the quality of the patients' health-care experiences and personal existence.

2.2.2 The Twelve Domains of Culture

These are the 12 domains that are essential for assessing the ethnocultural attributes of an individual, family, or group:

1. Overview, inhabited localities, and topography
2. Communication
3. Family roles and organization
4. Workforce issues
5. Biocultural ecology
6. High-risk behaviors
7. Nutrition
8. Pregnancy and childbearing practices
9. Death rituals
10. Spirituality
11. Health-care practices
12. Health-care providers

2.3 Overview, Inhabited Localities and Typography

This domain includes concepts related to the country of origin, the current residence, and the effects of the topography of both the country of origin and the current residence on health, economics, politics, reasons for migration, educational status, and occupations. Learning about a culture includes becoming familiar with the heritage of its people and understanding how discrimination, prejudice, and oppression influence value systems and beliefs used in everyday life.

2.3.1 Heritage and Residence

Heritage and residence include not only the country of origin and ancestry, but other places where the person has lived. For example, one's ancestry might be German as the country of origin but born in the United States and lived or worked in Asia or Central American, where that person might have been exposed to tropical diseases unknown in the United States or Germany. Likewise, the topography and physical environment of one's residence may increase one's chances of being inflicted with and leave with an infection. There is a difference between a disease and an illness and we have both here. Illnesses such as malaria from swampy areas, asthma from polluted inner-city environments, or cancer if exposed to radioactive fallout. Regardless of one's environment and lifestyle, one's heritage may be an increased risk for genetic and heredi-

tary diseases that are common among the Amish and Ashkenazi Jews (see specific chapters on these cultural groups).

One's occupation can also have deleterious effects on health if exposed to asbestos, working in farming with pesticides, or in textile factories with increased risk for respiratory, eye, and ear infections. A complete health history may be required because people might have worked in several occupations over a lifetime.

2.3.2 Reasons for Migration and Associated Economic Factors

The social, economic, religious, and political forces of the country of origin play an important role in the development of the ideologies and the worldview of individuals, families, and groups and are often a major motivating force for emigration. People emigrate for better economic opportunities; because of religious or political oppression, and ethnic cleansing; as a result of environmental disasters, such as earthquakes and hurricanes in their home countries; and by forced relocation, such as with slaves, indentured servants, and human trafficking. Others have emigrated for educational opportunities and personal ideologies or a combination of factors. Most people emigrate in the hope of a better life, but the individual or group personally defines this ideology. A common practice for many immigrants is to relocate to an area that has an established population with similar ideologies that can provide initial support, serve as cultural brokers, and orient them to their new culture and health-care system. When immigrants settle and work exclusively in predominantly ethnic communities, primary social support is enhanced. However, acculturation and assimilation into the wider society may be hindered. Although ethnic enclaves to an extent assist with acculturation, they may need extra help in adjusting to their new homeland's language as well as securing access to health-care services, living accommodations, and employment opportunities. Further, people who move voluntarily are likely to experience less difficulty with acculturation than people who are forced to migrate. Some individuals migrate with the intention of remaining in the selected country only a short time, making money, continuing their education, and returning home. Others migrate with the intention of relocating permanently.

Reflective Exercise

1. What is your cultural heritage?
2. How might you find out more about it?
3. How does your cultural heritage influence your current beliefs and values about health and wellness?
4. What brought you/your ancestors to your current country of residence?
5. Why did you/your ancestors emigrate?

2.3.3 Educational Status and Occupations

The value placed on formal education differs among cultural and ethnic groups and is often related to their socioeconomic status in their homeland and their abilities and reasons for emigrating. Some people place a high value on formal education; however, some do not stress formal education because it is not needed for employment in their homeland. Consequently, they may become engulfed in poverty, isolation, and enclave identity, which may further limit their potential for formal educational opportunities and planning for the future. In regard to learning styles, the Western system places a high value on the ability to categorize information using linear, sequential thought processes (West et al. 2007).

Reflective Exercise

1. How strongly do you believe in the value of education?
2. Who in your life has been responsible for instilling this value?
3. Do you consider yourself to be a more linear/sequential learner or a random-patterned learner?

However, not everyone adheres to this pattern of thinking. Others have spiral and circular thought patterns that move from concept to concept without being linear or sequential; therefore, they may have difficulty placing information in a stepwise methodology, which is common in individualistic cultures. When someone is unaware of the value given to such behaviors, the person may seem disorganized, scattered, and faulty in their cognitive patterns, resulting in increased difficulty with written and verbal communications.

Some educational systems stress application of content over theory. Most European educational programs emphasize theory over practical application, and Arab education emphasizes theory with little attention given to practical application. As a result, Arab students are more proficient at tests requiring rote learning than at those requiring conceptualization and analysis. Being familiar with the individual's personal educational values and learning modes allows health-care providers, educators, and employers to adjust teaching strategies for patients, students, and employees. Educational materials and explanations must be presented at a level consistent with the patient's educational capabilities and within their cultural framework and beliefs.

Immigrants bring job skills from their homelands and traditionally seek employment in the same or similar trades. Sometimes, these job skills are inadequate for the available jobs in the new society; thus, immigrants are forced to take low-paying jobs and join the ranks of the working poor and economically disadvantaged. Immigrants may be employed in a broad variety of occupations and professions; however, limited experiential, educational, and language abilities of more recent immigrants often restrict employment possibilities. More importantly, experiential backgrounds sometimes encourage employment choices that are identified as high risk for chronic diseases, such as exposure to pesticides and chemicals. Others may work in factories that manufacture hepatotoxic chemicals, in industries with pollutants that increase the risk for pulmonary diseases, and in crowded conditions with poor ventilation that increase the risk for tuberculosis or other respiratory diseases.

Understanding patients' current and previous work background is essential for health screening. For example, newer immigrants who worked in malaria-infested areas in their native country, such as Egypt, Italy, Turkey, and Vietnam may need health screening for insect borne diseases. Those who worked in mining, such as in Ireland, Poland, and parts of the United States may need screening for respiratory diseases. Those who lived in overcrowded and unsanitary conditions, such as with refugees and migrant workers, may need to be screened for such infectious diseases as tuberculosis, parasitosis, and respiratory diseases (see Table 2.1 Section on Overview/Heritage).

2.4 Communication

Perhaps no other domain has the complexities as that of communication. Communication is interrelated with all other domains and depends on verbal language skills that include the dominant language, dialects, and contextual use of the language, as well as paralanguage variations such as voice volume, tone, intonations, reflections, and willingness to share thoughts and feelings. Other important communication characteristics include nonverbal communications, such as eye contact, facial expressions, use of touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, or future orientation of worldview; clock versus social time; and the name format and the degree of formality in the use of names. Communication styles may vary among insiders (family and close friends) and outsiders (strangers and unknown health-care providers). Hierarchical relationships, gender, and some religious beliefs affect communication.

2.4.1 Dominant Language and Dialects

The health-care provider must be aware of the dominant language and the difficulties that dialects may cause when communicating in a

Table 2.1 Organizing framework and cultural assessment guide

Cultural assessment tool	Sample rationale/example
Overview, inhabited localities, and topography	
Where do you currently live?	Someone living in a wooded area with deer and other wildlife are at an increased risk for Lyme disease
What is your ancestry?	Ashkenazi Jewish population has a high incidence of genetic and hereditary health conditions
Where were you born?	Immigrants from Eastern Europe near Chernobyl have an increased risk for genetic mutations and hereditary defects related to radioactive contamination
How many years have you lived in the United States (or other country, as appropriate)?	Length of time away from the home country may determine the degree of assimilation and acculturation
Were your parents born in the United States (or other country, as appropriate)?	Generation may determine the degree of assimilation and acculturation
What brought you (your parents/ancestors) to the United States (or other country, as appropriate)?	The reason for migration may determine the degree of assimilation and acculturation
Describe the land or countryside where you live. Is it mountainous, swampy, etc.?	The physical environment has a host of infectious diseases
What was the land or countryside like when you lived there?	People immigrating from or who have recently visited parts of central American may be at increased for and need to be assessed for arthropod-borne diseases
What is your income level?	Income level has implications for affording medications, dressings, and prescriptive devices
Does your income allow you to afford the essentials of life?	Determines the ability to afford healthy diets
Do you have health insurance?	Refer to social services or other source for financial support if no insurance
Are you able to afford health insurance on your salary?	The working poor cannot afford health insurance
What is your educational level (formal/informal/self-taught)?	Educational level may determine ability to understand health prescriptions
What is your current occupation? If retired, ask about previous occupations.	People working in home remodeling may be at risk for asbestosis
Have you worked in other occupations? What were they?	A person may currently be retired or may now work as a salesperson but previously worked as a coal miner, increasing the risk of black lung disease
Are there (were there) any particular health hazards *associated* with your job(s)	Previous employment may have health concerns long-term
Have you been in the military? If so, in what foreign countries were you stationed?	People who served in the military may suffer from post-traumatic stress syndrome or diseases contracted in their military experiences
Communications	
What is your full name?	Part of a standard assessment
What is your legal name?	Part of a standard assessment and medical record keeping
By what name do you wish to be called?	Most people respond better if called by a preferred name
What is your primary language?	Determining the preferred language for consent forms and discharge instructions
Do you speak a specific dialect?	A dialect-specific interpreter is preferred
What other languages do you speak?	Sometimes a second or third language may be helpful for interpretation if a preferred language interpreter is not available
Do you find it difficult to share your thoughts, feelings, and ideas with family? Friends? Health-care providers?	Additional time may be needed to establish trust and get full disclosure, especially with sensitive topics
Do you mind being touched by friends? Strangers? Health-care workers?	Asking permission and explaining the rationale before touching reinforces the trust relationship
How do wish to be greeted? Handshake? Nod of the head, etc.?	Demonstrates respect and helps establish trust

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
Are you usually on time for appointments?	Explain rationale for the expectation of timeliness: Might not be seen and have to reschedule and may still be charged for the appointment
Are you usually on time for social engagements?	Ask only if question is pertinent
Observe the patient's speech pattern. Is the speech pattern high- or low-context? Remember, patients from highly contexted cultures place greater value on silence	Patients from high-context cultures place greater value on silence and implicit communication and may take more time to give a response
Observe the patient when physical contact is made. Does he/she withdraw from the touch or become tense?	Being aware of the patient's level of comfort helps establish trust. Reinforce the necessity and ask permission before touching
How close does the patient stand when talking with family members? With health-care providers?	Spatial distancing is culture bound. Do not take offense if a patient stands closer or farther away than what you are accustomed to
Does the patient maintain eye contact when talking with the nurse/physician/etc.?	Some avoid eye contact with people in hierarchal positions as a sign of respect. The health-care provider is in a hierarchal position
Family roles and organization	
What is your *marital*/partner status?	Part of a standard assessment
How many children do you have?	Part of a standard assessment
Who makes most of the decisions in your family?	If the decision maker is not accessed, no decision will be made and time will be wasted
What types of decisions do(es) the female(s) in your family make?	In many traditional families, the female usually makes decision about the household and child care
What types of decisions do(es) the male(s) in your family make?	In many traditional families, the male usually makes decisions about affairs outside the household, but not always
What are the duties of the women in the family?	Determining the division of labor can become important when illness occurs
What are the duties of the men in the family?	Determining the division of labor can become important when illness occurs
What should children do to make a good impression for themselves and for the family?	A child's behavior in the Appalachian and Greek cultures can bring shame upon the family
What should children not do to make a good impression for themselves and for the family?	Among traditional Koreans, children are expected to do well in school, or shame may come to the family
What are children forbidden to do?	Among traditional Germans, taboo behaviors include talking back to elders and touching another person's possessions
What should adolescents do to make a good impression for themselves and for the family?	Among Somalis, young adults are expected to marry and assist older family members
What should adolescents not do to make a good impression for themselves and for the family?	Among traditional Mexican families, young adults should not dress in a provocative manner; otherwise, shame can come to them or their family
What are adolescents forbidden to do?	A taboo behavior for young female adults in Haiti is engaging in sexual activity before marriage
What are the priorities for your family?	For lower socioeconomic families, the priority may be having adequate food and shelter, with stress on the present
What are the roles of the older people in your family? Are they sought for their advice?	Among traditional Turks, no decision is made until after seeking the advice of older adults
Are there extended family members in your household? Who else lives in your household?	Most traditional Asian cultures live in extended family arrangements in their home country
What are the roles of extended family members in this household? What gives you and your family status?	Extended family members provide significant financial and social support and are important sources for child care

(continued)

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
Is it acceptable to you for people to live together and not be married?	Among traditional Arab families, shame may occur if a pregnancy occurs outside of marriage
Is it acceptable to you for people to admit being gay or lesbian?	Among many Asian cultures, a man and woman living together without being married may cause them to be rejected by their family
What is your sexual preference/orientation? (if appropriate, and then later in the assessment after a modicum of trust has been established)	Not all cultures or individuals are accepting of gay, lesbian, or gender reassignment individuals
Workforce issues	
Do you usually report to work on time?	Not all cultures espouse timeliness in reporting to work. If timeliness is important, this must be explicitly explained along with consequences
Do you usually report to meetings on time?	If timeliness is important for attendance at meetings, this must be explicitly explained
What concerns do you have about working with someone of the opposite gender?	Strict orthodox separation of the sexes may cause disharmony if men and women are expected to work in close proximity
Do you consider yourself a "loyal" employee? How long do you expect to remain in your position?	Among the Japanese, an employer may expect absolute loyalty, and employees remain with the same company their entire lives
What do you do when you do not know how to do something related to your job?	Among many traditional Koreans and Filipinos, when an employee does not know how to do something, rather than admitting it, they may go to a co-worker of the same nationality (if available)
Do you consider yourself to be assertive in your job?	Traditional Asians are sometimes not seen as assertive as some American employers would like. Most professionals are assertive, but in a different way from assertiveness in individualistic cultures
What difficulty does English (or another language) give you in the workforce?	Low verbal and written literacy may have implications for accuracy in fulfilling job requirements
What difficulties do you have working with people older (younger) than you?	Some professionals and some non-professionals are hesitant to follow directions from someone younger than they are
What difficulty do you have in taking directions from someone younger/older than you?	Some professionals and some non-professionals are hesitant to follow directions from someone younger than they are
What difficulty do you have working with people whose religions are different from yours?	Some professionals and some non-professionals prefer to only work with people from their religion
What difficulty do you have working with people whose sexual orientation is different from yours?	Some professionals and some non-professionals do not like to work with people whose sexual orientation is different from theirs
What difficulty do you have working with someone whose race or ethnicity is different from yours?	Some professionals and some non-professionals do not like to work with people whose race or ethnicity is different from theirs
Do you consider yourself to be an independent decision maker?	Independent think is required in many positions
Biocultural ecology	
Are you allergic to any medications?	Part of a standard assessment
What problems did you have when you took over-the-counter medications?	Part of a standard assessment
What problems did you have when you took prescription medications?	Part of a standard assessment
What are the major illnesses and diseases in your family?	Part of a standard assessment

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
Are you aware of any genetic diseases in your family?	Part of a standard assessment
What are the major health problems in the country from which you come (if appropriate)?	Migrants may bring new infections from their home country. Should be part of a standard assessment
With what race do you identify?	Part of a standard assessment
Observe skin coloration and physical characteristics	To assess for rashes on people with dark skin, the health-care provider may need to palpate rather than rely on visual cues
Observe for and document physical handicaps and disabilities	Many people do not disclose handicaps or disabilities upon initial encounter unless specifically asked, especially learning disabilities
High-risk health behaviors	
How many cigarettes a day do you smoke?	Part of a standard assessment
Do you smoke a pipe (or cigars)?	Part of a standard assessment
Do you chew tobacco?	Part of a standard assessment
For how many years have you smoked/chewed tobacco?	Part of a standard assessment
How much do you drink each day? Ask about wine, beer, spirits?	Part of a standard assessment
How many energy drinks do you consume each day?	Part of a standard assessment
What recreational drugs do you use?	Recreational drug use is part of a standard assessment. In order for the patient to disclose this sensitive information, ask in a non-judgmental manner
How often do you use recreational drugs?	Part of a standard assessment
What type of exercise do you do each day?	Part of a standard assessment. Physical activity or lack thereof is part of a standard assessment for health promotion and wellness
Do you use seat belts?	Part of a standard assessment
What precautions do you take to prevent getting a sexually transmitted infections or HIV/AIDS?	Part of a standard assessment
Nutrition	
Are you on a special diet?	Part of a standard assessment
Are you satisfied with your weight?	Not all cultures adhere to or believe in the U.S. weight recommendations
Which foods do you eat to maintain your health?	Food choices are seen as a means for promoting health
Do you avoid certain foods to maintain your health?	Each culture has certain foods people avoid for maintaining their health. E.g.
Why do you avoid these foods?	Kosher Jews do not eat pork or pork products
Which foods do you eat when you are ill?	Common foods eaten when ill among many cultures include toast and tea or ginger ale when ill
Which foods do you avoid when you are ill?	If the health-care provider recommends a food that the person culturally or personally avoids, it may not be followed
Why do you avoid these foods (if appropriate)?	This may be a culturally learned practice
For what illnesses do you eat certain foods?	A common practice is to drink a "hot toddy" for a cold or minor illness. The ingredients vary, but generally include tea, lemon or lime, sugar or honey, and some type of alcohol, such as whiskey or rum
Which foods do you eat to balance your diet?	Many cultures adhere to specific foods for balancing a diet; frequently related to opposite qualities of food such as the hot-and-cold theories
Which foods do you eat every day?	Incorporating these foods into dietary prescriptions will increase compliance with dietary instructions

(continued)

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
Which foods do you eat every week?	Incorporating these foods into dietary prescriptions will increase compliance with dietary instructions
Which foods do you eat that are part of your cultural heritage?	Including culturally preferred foods into nutritional recommendations increases adherence
Which foods are high-status foods in your family/culture?	High-status foods vary according to cost and availability
Which foods are eaten only by men? Women? Children? Teenagers? Older people?	Among some Guatemalan highland indigenous populations, men primarily eat eggs for the added protein value. The belief is that because men do heavy labor, they need more protein. However, they are supposed to share the protein foods on their plates with children
How many meals do you eat each day?	Many Turks eat 4–6 times a day, but in smaller amounts than most European Americans do
What time do you eat each meal?	May have implications for medication administration
Do you snack between meals?	Snacks can be a significant source of added calories
What foods do you eat when you snack?	Many snacks are not considered healthy food choices
What holidays do you celebrate?	Holidays are a time for special meals and a time when many people overconsume calories
Who usually buys the food in your household?	Many times, it is just as important to talk with the person who purchases the food as it is with the person who prepares the meals. In migrant worker camps, the person who prepares the meals is not the person who purchases food for the group. If one member of the group needs a special diet, such as with a diabetic, the purchaser of the food needs to be included in nutritional education
Who does the cooking in your household?	The person who does the cooking should be included in dietary counseling and education for special diets
Do you have a refrigerator?	For the homeless and those in severe poverty, proper food storage must be taken into consideration
How do you cook your food?	Preparation practices with butter, lard, etc., can add significant calories to meals
How do you prepare meat?	Preparation practices can add significant calories
How do you prepare vegetables?	Preparation practices add significant calories to meals, such as adding butter or bacon fat to vegetables
What do you drink with your meals?	Beverages can add significant calories to meals. Be sure to ask if sugar is added to beverages, including natural juices.
Do you drink special teas?	Teas are used by many people for health promotion and wellness and in times of illness
Do you have any food allergies or intolerances?	Many American Indians and Asians have lactose intolerance
Are there certain foods that cause you problems when you eat them?	Looking for allergies or side effects of specific foods to avoid in dietary counseling
How does your diet change with each season?	For those who live in colder climates, fresh fruits and vegetables may be too expensive in the colder months
Are your food habits different on days you work versus when you are not working?	This is a common practice with working adults
Pregnancy and childbearing practices	
How many children do you have?	Part of a standard OB/GYN assessment
What do you use for birth control?	Each cultural and religious group has acceptable and unacceptable methods of birth control
What special foods do you eat when you are pregnant?	Although there are no specifically prescribed foods for a pregnant Polish woman, she is expected to eat for two
What foods do you avoid when you are pregnant?	Chinese women are reluctant to take iron because they believe it will make delivery more difficult

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
What activities do you avoid when you are pregnant?	A belief among many traditional Panamanians is that a pregnant woman should not walk in the moonlight for fear the baby will be born with a cleft lip or palate
Do you do anything special when you are pregnant?	Korean women are expected to work hard during pregnancy to help ensure having a smaller baby
Do you eat non-food substances when you are pregnant?	Eating non-food substances, pica, is common among many cultural groups. One example is clay, which can interfere with iron absorption
Who do you want with you when you deliver your baby?	Some women prefer their mothers or another female family member rather than their husbands
In what position do you want to be when you deliver your baby?	Traditional Indian women in Guatemala prefer to deliver in a squatting position rather than in the supine position. Negotiating for the position during delivery may be necessary in some organizations
What special foods do you eat after delivery?	Hindu women may be restricted to liquids, rice, gruel, and bread
What foods do you avoid after delivery?	Guatemalan women avoid eating spicy foods because the milk will cause irritability in the baby
What activities do you avoid after you deliver?	Russian women should do no strenuous activity after delivery to prevent any complications
Do you do anything special after delivery?	Traditional Japanese women should not wash their hair for several days postpartum
Who will help you with the baby after delivery?	Looking for home support for the mother
What bathing restrictions do you have after you deliver?	Many Egyptian women may be reluctant to bathe postpartum because air may get into the mother and cause illness. However, a sponge bath is acceptable
Do you want to keep the placenta?	Some American Indians bury the placenta outside their home to keep away evil spirits
What do you do to care for the baby's umbilical cord?	A common practice among Mayans is to place a coin or metal object, held on with an abdominal binder, to prevent the umbilicus from protruding when the baby cries
Death rituals	
What special activities need to be performed to prepare for death?	When death is impending, Muslims want the bed to face toward Mecca
Would you want to know about your impending death?	A belief among traditional Somalis is that a person might give up hope if impending death is made known
What is your preferred burial practice? Interment, cremation?	Patient's wishes should be granted
How soon after death does burial occur?	For traditional Jews, burial is before sundown the next day
How do men grieve?	In some cultures, men are expected to be stoical and maintain control of their emotions. Expressions of grief have a wide variation
How do women grieve?	In some cultures, women are expected to be histrionic with their grief to demonstrate their care for the deceased loved one. Expressions of grief have a wide variation
What does death mean to you?	Among Hindus, death means rebirth
Do you believe in an afterlife?	Many Christians believe that there is a better life after death
Are children included in death rituals?	The Amish include children in all aspects of dying and burial
Spirituality	
What is your religion?	Part of a standard assessment

(continued)

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
Do you consider yourself deeply religious?	Religion may have more influence than the culture
How many times a day do you pray?	Islam requires prayer five times a day
What do you need in order to say your prayers?	If possible, Muslims need a prayer rug
Do you meditate?	Meditation can be used for relaxation and for pain control
What gives strength and meaning to your life?	For some, the most important thing in their life is family
In what spiritual practices do you engage for your physical and emotional health?	Prayer, meditation, yoga, and quiet time are some examples
Health-care practices	
In what prevention activities do you engage to maintain your health?	A strong value in the dominant European American culture is to have regularly scheduled health check-ups, including self breast examinations, mammograms, and colonoscopies
Who in your family takes responsibility for your health?	Among Arabs, family, not the individual, has the primary responsibility for a person's health-seeking care
What over-the-counter medicines do you use?	All cultural groups and individuals use over-the-counter medication; some use them to the exclusion of prescription medicines
What herbal teas and folk medicines do you use?	Many Hispanic/Latino and other populations, use a wide variety of herbal teas for many health conditions
For what conditions do you use herbal medicines?	Iranians use a variety of berries, leaves, seeds, and dried flowers steeped in hot or cold water and drunk for digestive problems
What do you usually do when you are in pain?	Some African Americans may see pain and suffering as inevitable and something that is to be endured
How do you express your pain?	Among Mexicans, being able to endure pain is seen as a sign of strength
How are people in your culture viewed or treated when they have a mental illness?	Having a mental illness in many Arab cultures is seen as a stigma; therefore, the person with a mental illness may be well cared for but kept hidden from society
How are people with physical disabilities treated in your culture?	The Amish approach disability as a community responsibility, and those with a disability are incorporated into all family and social activities
What do you do when you are sick? Stay in bed, continue your normal activities, etc.?	For many from the European American culture, a belief is "if you are not dead," take something for relief and continue with your daily routines
What are your beliefs about rehabilitation?	Studies demonstrate that for Germans, if rehabilitation is needed to function at maximum capacity, then all rehab exercises are done
How are people with chronic illnesses viewed or treated in your culture?	For most Arabs, if a chronic illness is debilitating, family members readily assume that person's responsibilities
Are you averse to blood transfusions?	Besides a religious prohibition for a Jehovah's witness to receive blood, many people do not want a blood transfusion for fear of contracting HIV/AIDS
Is organ donation acceptable to you?	Jewish law views organ transplants for four perspectives: The recipient, the living donor, the cadaver donor, and the dying donor. Because life is sacred, if the recipient's life can be prolonged without considerable risk, then the transplant is favorably viewed
Are you an organ donor?	Part of a standard assessment
Would you consider having an organ transplant if needed?	Organ donation and transplantation among Muslims are individual decisions
Are health-care services readily available to you?	The health-care provider needs to be aware of access problems for health care and make attempts to improve access
Do you have transportation problems accessing needed health-care services?	Many organizations have vouchers for public transportation

Table 2.1 (continued)

Cultural assessment tool	Sample rationale/example
What traditional health-care practices do you use? Acupuncture, acupressure, *cai gao*, *moxibustion*, aromatherapy, coining, etc.?	If the health-care provider is familiar with traditional practices within the culture, more specific information can be obtained
Health-care practitioners	
What health-care providers do you see when you are ill? Physicians, nurses?	Not all patients see Western allopathic practitioners for illnesses, at least not as first access. Some use Western providers and traditional providers simultaneously
Do you prefer a same-sex health-care provider for routine health problems? For intimate care?	Among orthodox Jewish and Islamic patients, a same-sex provider should be assigned unless it is an emergency
What healers do you use beside physicians and nurses?	If the health-care provider is familiar with the specific culture, better/more pointed questions can be asked. Among many Hispanics/Latinos, folk practitioners are consulted for the evil eye and other conditions
For what conditions do you use healers?	Many American Indians use a variety of traditional healers. Being able to integrate traditional healers with allopathic professionals will increase compliance with recommendations

An extensive cultural assessment is rarely completed in the clinical setting because of time and other circumstances. A seasoned clinical practitioner will know when further assessment is required. Thus, this tool should be used as a guide. Some i*tems are part of any standard assessment. Other items may also be part of a standard assessment, depending on the organization, setting, and clinical area*

patient's native language. For example, English is a monochromic, low-contextual language in which most of the message is in the verbal mode. Verbal communication is frequently seen as being more important than nonverbal communication. Thus, people for whom English is the dominant language are more likely to miss the more subtle nuances of communication. Accordingly, if a misunderstanding occurs, both the sender and the receiver of the message take responsibility for the miscommunication.

Reflective Exercise

1. What is your dominant language?
2. Do you have difficulty understanding other dialects of your dominant language?
3. Have you traveled abroad where you had difficulty understanding the dialect or accent?
4. What other languages beside your dominant language do you speak?

English differs somewhat in its pronunciation, spelling, and choice of words from English spoken in Great Britain, Australia, and other English-speaking countries. Within each country, several dialects can exist, but generally the differences do not cause a major concern with communications. However, accents and dialects within a country, region, or local area can cause misunderstanding; for example, the "Elizabethan English" that is spoken in parts of the United States and the English spoken in Glasgow, Scotland, are both different from the English spoken in Central London. The Spanish spoken in Spain differs from the versions spoken in Puerto Rico, Argentina, Panama, or Mexico, which has as many as 50 different dialects. In such cases, dialects that vary widely may pose substantial problems for health-care providers and interpreters in obtaining accurate health data and increasing the difficulty of making an accurate diagnosis.

When speaking in a non-native language, health-care providers must select words that have relatively pure meanings, be certain of the voice intonation, and avoid the use of regional slang and jargon to avoid being misunderstood. Minor variations in pronunciation may change the entire meaning of a word or a phrase and result in inappropriate interventions.

Given the difficulty of obtaining the precise meaning of words in a language, it is best for

health-care providers to obtain someone who can interpret the meaning and message, not just translate the individual words. Remember, translation refers to the written word. Interpretation refers to the spoken word. Children should never be used as interpreters for sensitive topics for their family members. Not only can it have a negative bearing on family dynamics, but sensitive information may not be transmitted. However, when discussing dietary concerns, in family centered care family members can be used (see Chap. 3 for guidelines for using interpreters).

Those with limited language ability may have inadequate vocabulary skills to communicate in situations in which strong or abstract levels of verbal skills are required, such as in the psychiatric setting (Purnell 2011). Helpful communication techniques with diverse patients include displaying tact, consideration, and respect; gaining trust by listening attentively; addressing the patient by preferred name; and showing genuine warmth and openness to facilitate full information sharing. When giving directions, be explicit. Give directions in sequential procedural steps (e.g., first, second, third). Do not use complex sentences with conjunctions or contractions because many languages do not use them.

Reflective Exercise

1. Give some examples of problems communicating with patients who did not speak or understand English or the dominant language.
2. What did you do to promote effective communication?

Before trying to engage in more sensitive areas of the health interview, the health-care provider may need to start with social exchanges to establish trust if time permits, use an open-ended format rather than yes or no closed-response questions, elicit opinions and beliefs about health and symptom management, and focus on facts rather than feelings. An awareness of nonverbal behaviors is essential to establishing a mutually satisfying relationship.

The context within which a language is spoken is an important aspect of communication. Some languages are low in context, and most of the message is explicit, requiring many words to express a thought (English and Spanish, and other romance languages). Other languages are highly contextual (Chinese and Korean), with most of the information either in the physical context or internalized, resulting in the use of fewer words with more emphasis on unspoken understandings.

Reflective Exercise

1. On a scale of 1 to 10, with 1 being low and 10 being high, where do you place yourself in the scale of high-contextual versus low-contextual communication?
2. Do you tend to use a lot of words to express a thought?
3. Do you know family members/friends/acquaintances who are your opposite in terms of low-contextual versus high-contextual communication?
4. Does this sometimes cause concerns in communication?
5. Do you think biomedical language is high or low context?

Voice volume and tone are important paralanguage aspects of communication. A loud voice volume may be interpreted as reflecting anger, when in fact a loud voice is merely being used to express their thoughts in a dynamic manner. Thus, health-care providers must be cautious about voice volume and tones when interacting with diverse cultural groups so that their intentions are not misunderstood.

2.4.2 Cultural Communication Patterns

Communication includes the willingness of individuals to share their thoughts and feelings. Some cultures encourage people to disclose very per-

sonal information about themselves, such as information about sex, drugs, and family problems that is more common in individualistic cultures. In some cultures, having well-developed verbal skills is seen as important, whereas in other cultures, the person who has very highly developed verbal skills is seen as having suspicious intentions. Some cultures willingly share their thoughts and feelings among family members and close friends, but they may not easily share thoughts, feelings, and health information with "outsiders" (i.e., health-care providers) until they get to know and trust them that is more common with collectivistic cultures. If the situation permits, engaging in small talk and inquiring about family members before addressing the patient's health concerns, health-care providers can help establish trust and, in turn, encourage more open communication and sharing of important health information.

Touch, a method of nonverbal communication, has substantial variations in meaning among cultures. For the most part, individualistic cultures are low-touch cultures, which are reinforced by sexual harassment guidelines and policies.

Reflective Exercise

1. How willing are you to share personal information about yourself?
2. How does it differ with family, friends, or strangers?
3. Do you tend to speak faster, slower, or about the same rate as the people around you?
4. What happens when you meet someone who speaks much more rapidly or much more slowly than you do?
5. Do you normally speak in a loud or low voice volume?
6. How do you respond when someone speaks louder or softer than you do?

For many, even casual touching may be seen as a sexual overture and should be avoided whenever possible. In individualistic cultures, people of the same sex (especially men) or opposite sex do not generally touch each other unless they are family members of close friends. It is recognized that the low-touch individualistic culture has variations according to age and location. However, among most collectivist cultures, two people of the same gender can touch each other without it having a sexual connotation, although modesty remains important. Always explain the necessity and ask permission before touching a patient for a health examination. Being aware of individual practices regarding touch is essential for effective health assessments.

Reflective Exercise

1. How comfortable are you with being touched on the arm or shoulder by friends? By people who know you well?
2. Do you consider yourself to be a "person who touches frequently" or do you rarely touch friends?
3. Can you think of groups in the clinical setting for whom therapeutic touch is not appropriate?

Personal space needs to be respected when working with multicultural patients and staff. Among more individualistic cultures, conversants tend to place at least 18 inches of space between themselves and the person with whom they are talking. Most collectivist cultures require less personal space when talking with each other (Anasthasia 2015). They are quite comfortable standing closer to each other than are people from individualistic cultures; in fact, they interpret physical proximity as a valued sign of emotional closeness (Anasthasia 2015). Patients who stand very close and stare during a conversation may offend some health-care practitioners. These patients may interpret health-care providers as being cold because they stand so far away, perhaps appearing as being "standoffish". Thus, an understanding of personal space and distancing characteristics can enhance the quality of communication among individuals.

Regardless of the class or social standing of the conversants, people from individualistic cultures are expected to maintain direct eye contact without staring. A person who does not maintain eye contact may be perceived as not listening, not being trustworthy, not caring, or being less than truthful. Among some traditional collectivist cultures, sustained eye contact can be seen as offensive; further, a person of lower social class or status is expected to avoid eye contact with superiors or those with a higher educational status. Thus, eye contact must be interpreted within its cultural context to optimize relationships and health assessments.

Reflective Exercise

1. What are your spatial distancing practices?
2. How close do you stand to family? Friends? Strangers?
3. Does this distancing remain the same with the opposite gender?
4. Do you maintain eye contact when speaking with people?
5. Is it intense?
6. Does it vary with the age or gender of the person with whom you are conversing?
7. What does it mean when someone does not maintain eye contact with you?
8. How do you feel in this situation?

The use of gestures and facial expressions varies among cultures. Most European Americans gesture moderately when conversing and smile easily as a sign of pleasantness or happiness, although one can smile as a sign of sarcasm. A lack of gesturing can mean that the person is too stiff, too formal, or too polite.

Preferred greetings and acceptable body language also vary among cultural groups. An expected practice for many cultures in business is to extend the right hand when greeting someone for the first time. More elaborate greeting rituals occur in Asian, Arab, and Latin American countries and are covered in individual chapters.

Although many people consider it impolite or offensive to point with one's finger, many do so and do not see it as impolite. In other cultures, beckoning is done by waving the fingers with the palm down, whereas extending the thumb, like thumbs-up, is considered a vulgar sign. Among some cultures, signaling for someone to come by using an upturned finger is a provocation, usually done to a dog. Among the Navajo, it is considered rude to point; rather, the Navajo shift their lips toward the desired direction.

Reflective Exercise

1. Do you tend to use your hands a lot when speaking?
2. Can people tell your emotional state by your facial expressions?

2.4.3 Temporal Relationships

Temporal relationships—people's worldview in terms of past, present, and future orientation—vary among individuals and among cultural groups. Some cultures, usually highly individualistic ones, are future-oriented, and people are encouraged to sacrifice for today and work to save and invest in the future. The future is important in that people can influence it. Fatalism, the belief that powers greater than humans are in control, may be seen as negative; however, to many others, it is seen as a fact of life not to be judged. Other cultures are regarded as a past-oriented society, in which laying a proper foundation by providing historical background information can enhance communication. However, for people in many societies, temporality is balanced among past, present, and future in the sense of respecting the past, valuing and enjoying the present, and saving for the future.

Differences in temporal orientation can cause concern or misunderstanding among health-care providers. For example, in a future-oriented culture, a person is expected to delay purchase of nonessential items to afford prescription medications. However, in less future-oriented cultures,

the person may purchase the nonessential item because it is readily available and defers purchasing the prescription medication. The attitude is, why not purchase it now; the prescription medication can be purchased later.

Most people from individualistic cultures see time as a highly valued resource and do not like to be delayed because it "wastes time." When visiting friends or meeting for strictly social engagements, punctuality is less important, but one is still expected to appear within a "reasonable" time frame. In the health-care setting, if an appointment is made for 9 a.m., the person is expected to be there at 8:45 a.m. so she or he is ready for the appointment and does not delay the health-care provider, although the health-care provider may be late. For immigrants from rural settings, time may be even less important. Although it is rare, these individuals may not even own a timepiece or be able to tell time. Expectations for punctuality can cause conflicts between health-care providers and patients, even if one is cognizant of these differences. These details must be carefully explained to individuals when such situations occur. Being late for appointments should not be misconstrued as a sign of irresponsibility or not valuing one's health.

Reflective Exercise

1. How timely are you with professional appointments?
2. With social engagements?
3. What does it mean to you when people are chronically late?
4. Can you give examples indicating that you are past oriented? Present oriented? Future oriented?
5. Do you consider yourself more one than the other?

2.4.4 Format for Names

Names are important to people, and name formats differ among cultures. The most common Western system is to have a first or given name, a middle name, and then the family surname. The person would usually write the name in that order. In formal situations, the person would be addressed with a title of Mr., Mrs., Ms., Miss, or Doctor and the last name. Friends and acquaintances would call the person by the first name or perhaps a nickname. Married women may take their husband's last name, keep their maiden name, or use both their maiden and married names. However, in some cultures, the family or surname name comes first, followed by the given name and then the middle name. The person would usually write and introduce himself or herself in that order. Married women usually keep their maiden name. Other name formats are even more complex and may include a given name, a middle name, the father's family name, and the mother's maiden name. When a woman marries, she may keep all these names plus add the surname of her husband. She may choose any name she wants for legal purposes. When in doubt, the health-care provider needs to ask which name is used for legal purposes. Such extensive naming formats can create a challenge for health-care workers keeping a medical record when they are unaware of differences in ethnic recording of names. See individual chapters for name formats (see Table 2.1: Section on Communication).

Reflective Exercise

1. How do you prefer to be addressed or greeted?
2. Does this change with the situation?
3. How do you normally address and greet people?
4. Do your responses change with the situation?

2.5 Family Roles and Organization

The cultural domain of family roles and organization affects all other domains and defines relationships among insiders and outsiders. This domain

includes concepts related to the head of the household, gender roles, family goals and priorities, developmental tasks of children and adolescents, roles of the aged and extended family members, individual and family social status in the community, and acceptance of alternative lifestyles such as single parenting, non-traditional sexual orientations, childless marriages, and divorce. Family structure in the context of the larger society determines acceptable roles, priorities, and the behavioral norms for its members.

2.5.1 Head of Household and Gender Roles

Reflective Exercise

1. How would you classify the decision-making process in your family—patriarchal, matriarchal, or egalitarian?
2. Does it vary by what decision has to be made?
3. Are gender roles prescribed in your family?
4. Who makes the decisions about health and health care?
5. Who would you want to make health-care decisions if you are unable to do so?

An awareness of family decision-making patterns (i.e., patriarchal, matriarchal, or egalitarian) is important for determining with whom to speak when health-care decisions have to be made. Among many cultures, it is acceptable for women to have a career and for men to assist with child care, household domestic chores, and cooking responsibilities. Both parents work in many families, necessitating placing children in child-care facilities. In some families, fathers are responsible for deciding when to seek health care for family members, but mothers may have significant influence on final decisions.

Among many, the decisions may be egalitarian, but the male's role in the family is to be the spokesperson for the family. The health-care provider, when speaking with parents, should maintain eye contact and direct questions about a child's illness to both parents.

2.5.2 Prescriptive, Restrictive, and Taboo Behaviors for Children and Adolescents

Every society has prescriptive, restrictive, and taboo practices for children and adolescents. Prescriptive beliefs are things that children or teenagers *should do* to have harmony with the family and a good outcome in society. Restrictive practices are things that children and teenagers *should not do* to have a positive outcome. Taboo practices are those things that, if done, are likely to cause significant concern or negative outcomes for the child, teenager, family, or community at large.

For some Western cultures, a child's individual achievement is valued over the family's financial status. This is different from some non-Western cultures in which attachment to family may be *more important* than the need for children to excel individually. At younger ages, rather than having group toys, each child has his or her own toys and is taught to share them with others. Individualistic cultures encourage autonomy in children, and after completing homework assignments (with which parents are expected to help), children are expected to contribute to the family by doing chores, such as taking out the garbage, washing dishes, cleaning their own room, feeding and caring for pets, and helping with cooking. They are not expected to help with heavy labor at home, except in rural farm communities.

In Western cultures, children are allowed and encouraged to make their own choices, including managing their own allowance money and deciding who their friends might be—although parents may gently suggest one friend as a better choice than another. Children and teenagers are permitted and encouraged to have friends of both the same and opposite genders. They are expected to be well behaved, especially in public. They are taught to stand in line—first come, first served—and to wait their turn. As they reach the teenage years, they are

expected to refrain from premarital sex, smoking, using recreational drugs, and drinking alcohol until they leave the home. However, this does not always occur, and teenage pregnancy and the use of recreational alcohol and drugs remain high. When children become teenagers, most are expected to get a job, such as babysitting, delivering newspapers, or doing yard work to make their own spending money, which they manage as a way of learning independence. The teenage years are also seen as a time of natural rebellion.

In Western cultures, when young adults become 18 or complete their education, they usually move out of their parents' home (unless they are in college) and live independently or share living arrangements with nonfamily members. If the young adult chooses to remain in the parents' home, then she or he might be expected to pay rent. However, young adults are generally allowed to return home, as needed, for financial or other purposes. Individuals over the age of 18 are expected to be self-reliant and independent, which are virtues in the Western cultures. This differs from most collectivist cultures in which children are expected to live at home with their parents until they marry because dependence, not independence, is the virtue.

Adolescents have their own subculture with its own values, beliefs, and practices that may not be in harmony with those of their dominant culture. Being in harmony with peers and conforming to the prevalent choice of music, clothing, hairstyles, and adornment may be especially important to adolescents. Thus, role conflicts can become considerable sources of family strain in many more traditional families who may not agree with the values of individuality, independence, self-assertion, and egalitarian relationships. Many teens may experience a cultural dilemma with exposure outside the home and family.

Reflective Exercise

1. Were you taught to be independent and autonomous or dependent in your family?
2. Was there more emphasis on the individual or on the group?

2.6 Family Goals and Priorities

In most cultures, family goals and priorities are centered on raising and educating children. During this stage, young adults make a personal commitment to a spouse or significant other and seek satisfaction through productivity in career, family, and civic interests. In most societies, young adulthood is the time when individuals work on Erikson's developmental tasks of *intimacy versus isolation* and *generativity versus stagnation.*

Western cultures place a high value on children, and many laws have been enacted to protect children who are seen as the "future of the society." In most collectivist cultures, children are desirable and highly valued as a source of family strength; family members are expected to care for one another more so than in Western cultures.

Collectivistic cultures have great reverence for the wisdom of older people; families eagerly make space for them to live with extended families. Children are expected to care for elders when they are unable to care for themselves. A great embarrassment may occur to family members when they cannot take care of their older family members.

The concept of extended family membership varies among societies. The extended family is extremely important, especially in collectivist cultures. Health-care decisions are often postponed until the entire family is consulted. The extended family may include biological relatives and nonbiological members who are considered brothers, sisters, aunts, or uncles. In some cultures, the influence of grandparents in decision making is considered more important than that of the parents.

Individualistic cultures also place a high value on egalitarianism, non-hierarchical relationships, and equal treatment regardless of their race, color, religion, ethnicity, educational or economic status, sexual orientation, or country of origin. However, these beliefs are theoretical and not always seen in practice. For example, throughout the world, women usually have a lower status than men, especially when it comes to prestigious positions and salaries, although

progress is being made. Most top-level politicians and corporate executive officers are White men, although some progress is being made. Subtle classism does exist, as evidenced by comments referring to "working-class men and women." Many Western cultures are known for their informality and for treating everyone the same. They call people by their first names very soon after meeting them, whether in the workplace, in social situations, in classrooms, in restaurants, or in places of business. Some readily talk with waitstaff and store clerks and call them by their first names, considering this respectful behavior.

Formality can be communicated by using the person's last (family) name and title such as Mr., Mrs., Miss, Ms., or Dr. To this end, achieved status is more important than ascribed status. What one has accumulated in material possessions, where one went to school, and one's job position and title are more important than one's family background and lineage. However, in some families ascribed status has equal importance to achieved status. Without a caste or class system, theoretically one can move readily from one socioeconomic position to another. To some, if formality is maintained, it may be seen as pompous or arrogant, and some even deride the person who is very formal. However, formality is a sign of respect in many other cultures, especially collectivistic cultures.

Reflective Exercise

1. Do you consider your family nuclear or extended?
2. How close are you to your extended family?
3. How is status measured in your family?
4. By money or by some other attribute?
5. What are your personal views of two people of the same gender living together in a physical relationship?
6. What about heterosexual couples?
7. Does divorce cause a stigma in your culture? In your family?

Reflective Exercise

1. What were prescriptive behaviors for you as a child? As a teenager? As a young adult?
2. What were restrictive behaviors for you as a child? As a teenager? As a young adult?
3. What were taboo behaviors for you as a child? As a teenager? As a young adult?
4. How are elders regarded in your culture? In your family?

2.6.1 Alternative Lifestyles

The traditional family is nuclear, with a married man and woman living together with one or more unmarried children. This concept of family is becoming a more varied community, including unmarried people, both women and men, living alone; single people of the same or different genders living together with or without children; single parents with children; and blended families consisting of two parents who have remarried, with children from their previous marriages and additional children from their current marriage. However, in some cultures, the traditional family is extended, with parents, unmarried children, married children with their children, and grandparents all sharing the same living space or at least living in very close proximity.

Social attitudes toward homosexual activity vary widely, and homosexual behavior occurs in societies that deny its presence. Homosexual behavior carries a severe stigma in some societies. Discovering that one's son or daughter is gay is akin to a catastrophic event for some, whether it is a collectivistic or individualistic culture. In the last 10 years, sex marriage has become more accepted in both individualistic and collectivistic cultures and they are also able to adopt children.

When the health-care provider needs to provide assistance and make a referral for a person who is gay, lesbian, bisexual, or transgender, a number of options are available. Some referral agencies are local, whereas others are national, with local or regional chapters. Many are ethni-

cally or religiously specific identifies guidelines for assessing the cultural domain (see Table 2.1: Section on Family Roles and Organization.

2.7 Workforce Issues

2.7.1 Culture in the Workplace

A fourth domain of culture is workforce issues. Differences and conflicts that exist in a homogeneous culture may be intensified in a multicultural workforce. Factors that affect these issues include language barriers, degree of assimilation and acculturation, and issues related to autonomy. Moreover, such concepts as gender roles, cultural communication styles, health-care practices of the country of origin, and selected concepts from all other domains affect workforce issues in a multicultural work environment.

Timeliness and punctuality are two culturally based attitudes that can create serious problems in the multicultural workforce. In most Western cultures, people are expected to be punctual on their job, with formal meetings, and with appointments. With social engagements, punctuality is not as important. However, in many cultures, punctuality is not stressed unless one is meeting with officials or it is required for transportation schedules, such as for trains or air travel. Timeliness for social engagements may not be taken seriously and may simply begin when most of the people arrive. The lack of adherence to meeting time demands in other countries is often in direct opposition to the Western concept and the ethic for punctuality.

Reflective Exercise

1. How timely are you in reporting to work?
2. Do you see people in the workforce who do not report to work on time?
3. What problems does it cause if they are not on time?
4. What would you do as a supervisor to encourage people to report to work on time?

Clinical professionals trained in their home countries now occupy a significant share of technical and laboratory positions in health-care facilities in many counties throughout the world. Service employees, such as food preparation workers, nursing assistants, orderlies, housekeepers, and janitors represent the most culturally diverse component of hospitals workforce. These unskilled and semiskilled positions are among the most attainable for new immigrants.

Reflective Exercise

1. How important are technical skills and verbal skills in your work environment?
2. Does your organization encourage more formal or more informal communication? Why?
3. Do you believe that everything needs to be proven scientifically?
4. Do you value a more direct or indirect style of communication?
5. Does your workforce (class) reflect the ethnic and racial diversity of the community? Why? Why not? What might you do to increase this diversity?

2.7.2 Issues Related to Autonomy

Cultural differences related to assertiveness influence how health-care providers view one another. In most Western individualistic cultures, professionals are expected to be assertive with other professionals for the benefit of the patient. However, in some collectivist and patriarchal societies, women, for example, may be unprepared for the level of sophistication and autonomy expected in individualistic cultures. Educational training for health-care providers varies significantly throughout the world.

Language ability in a new country may not meet the standards expected in the workforce, especially in the health-care environment and in positions where highly developed verbal skills are required. Thus, the newer immigrant—for whom the language of the host country is new—may need extra time in translating messages and formulating replies.

Reflective Exercise

1. How many generations are in your work group (class)?
2. Are their beliefs and practices similar to or different from what is reported in the literature?
3. Do the generational differences cause conflict?
4. Which generation takes the lead in resolving conflicts when they arise?

Reflective Exercise

1. Does your profession encourage autonomy in the workforce?
2. Does your current work (class) encourage autonomy and independence?
3. Do you see any cultural or gender differences in autonomy?
4. Do people speak different languages at work?
5. What difficulty does this cause?

When individuals speak in their native language at work, it may become a source of contention for both patients and health-care providers. Some organizations prohibit this, even in social situations at work. Most employees do not want to exclude or offend others, but it is easier to speak in their native language to articulate ideas, feelings, and humor among themselves. Negative interpretations of behaviors can be detrimental to working relationships in the health-care environment. Some foreign graduates, with limited aural language abilities, may need to have care instructions written or procedures demonstrated.

2.7.3 Generational Differences in the Workforce

Not only is the workforce becoming more multicultural in most countries, but over the last decade, increased interest has been found in the professional literature regarding generational differences in the workforce. Most of the literature on generational differences describes the dominant culture of the United States, with little mention as to how these differences might coincide with the multi-ethnic workforce. However, these descriptions do not always "fit" the generalizations as well as they do for the dominant, nonethnic, non-immigrant populations (see Table 2.1: Section Workforce Issues).

2.8 Biocultural Ecology

The domain *biocultural ecology* identifies specific physical, biological, and physiological variations in ethnic and racial origins. These variations include skin color and physical differences in body habitus; genetic, hereditary, endemic, and topographic diseases; psychological makeup of individuals; and differences in the way drugs are metabolized by the body. No attempt is made here to explain or justify any of the numerous, conflicting, and highly controversial views and research about racial variations in drug metabolism and genetics. More research needs to be completed.

2.8.1 Skin Color and Other Biological Variations

Reflective Exercise

1. Do you have difficulty assessing rashes, bruises, and sunburn in people with a skin color different from yours?
2. Do you have difficulty assessing jaundice and oxygenation in people with a skin color different from yours?
3. How does your assessment of skin differ between patients with light versus dark skin?
4. Do you take precautions and protect yourself against the sun? Why? Why not?

Skin coloration is an important consideration for health-care providers because anemia, jaundice, and rashes require different assessment skills in dark-skinned people than in light-skinned people. To assess for oxygenation and cyanosis in dark-skinned patients, the practitioner must examine the sclera, buccal mucosa, tongue, lips, nail beds, palms of the hands, and soles of the feet rather than relying on skin tone alone. Jaundice is more easily determined in Asians by assessing the sclera rather than relying on the overall change in skin color. Health-care providers may need to establish a baseline skin color (by asking a family member or someone known to the individual), use direct sunlight (if possible), observe areas with the least amount of pigmentation, palpate for rashes, and compare skin in corresponding areas. With people who are generally fair-skinned, prolonged exposure to the sun places them at an increased risk for skin cancer.

Reflective Exercise

1. What are the most common illnesses and diseases in your family? In your community?
2. What might you do to decrease the incidence of illness and diseases in your family? In your community?
3. Are you aware of any outbreaks of new illnesses or diseases in your community? In other parts of the world?
4. How might these outbreaks have been prevented?
5. What are the most common illnesses and diseases in your family? In your community?
6. What might you do to decrease the incidence of illness and diseases in your family? In your community?
7. Are you aware of any outbreaks of new illnesses or diseases in your community? In other parts of the world?
8. How might these outbreaks have been prevented?

Variations in body habits occur among ethnic and racially diverse individuals in terms of bone density, length of long bones, and shoulder and hip width, but do not usually cause a concern for health-care providers. However, bone density is greater in Whites than in Asian and Pacific Islanders; osteoporosis is lowest in Black males and highest in White females (Peacock et al. (2009). Given diverse gene pools, this type of information is often difficult to obtain, and much of the research is inconclusive.

2.8.2 Diseases and Health Conditions

Some diseases are more prevalent and some are even endemic in certain racial or ethnic groups, especially with migration. Specific health problems are covered in individual chapters. In general, many adverse health conditions are a result of genetics, lifestyle, and the environment. Genetic conditions occur among families in all races, but some conditions, such as Tay-Sachs disease, hemophilia, and cystic fibrosis are more common among particular ethnic and racial groups. Lifestyle causes include cultural practices and behaviors that can generally be controlled—for example, smoking, diet, and stress. Environmental causes refer to factors (e.g., air and water pollution) and situations over which the individual has little or no control (e.g., presence of malarial or dengue mosquitoes, exposure to chemicals and pesticides, access to care, and associated diseases).

Reflective Exercise

1. Why is it important for health-care providers to be aware of variations in drug metabolism in the body?
2. What conditions besides genetics have an influence on drug metabolism?

Information regarding drug metabolism among racial and ethnic groups has important

implications for health-care providers when prescribing medications. Besides the effects of (a) smoking, which accelerates drug metabolism; (b) malnutrition, which affects drug response; (c) a high-fat diet, which increases absorption of antifungal medication, whereas a low-fat diet renders the drug less effective; (d) cultural attitudes and beliefs about taking medication; and (e) stress, which affects catecholamine and cortisol levels on drug metabolism, studies have identified some specific alterations in drug metabolism among diverse racial and ethnic groups (Burroughs Valentine et al. 2002). Information for specific groups is included in each chapter. Health-care providers need to investigate the literature for ethnic-specific studies regarding variations in drug metabolism, communicate these findings to other colleagues, and educate their patients regarding these side effects.

Medication administration is one area in which health-care providers see the importance of culture, ethnicity, and race (see Table 2.1, section Biocultural Ecology).

2.9 High-Risk Behaviors

High-risk behaviors include use of tobacco, alcohol, or recreational drugs; lack of physical activity; increased calorie consumption; unsafe driving practices (speeding, driving and texting); failure to use seat belts and helmets; failure to take precautions against human immunodeficiency virus (HIV) and sexually transmitted infections (STIs); and high-risk recreational activities. High-risk behaviors occur in all ethnocultural groups, with the degree and types of high-risk behaviors varying.

Alcohol consumption crosses all cultural and socioeconomic groups. Enormous differences exist among ethnic and cultural groups around the use of and response to alcohol. Even in cultures in which alcohol consumption is taboo, it is not ignored. However, alcohol problems are not simply a result of how much people drink. When drinking is culturally approved, it is typically done more by men than women and is more often a social, rather than a solitary, act. The group in which drinking is most frequently practiced is usually composed of same-age social peers (Caetano et al. 1998). Studies on increasing controls on the availability of alcohol to decrease alcohol consumption, with the premise that alcohol-related problems occur in proportion to per capita consumption, have not been supported. Furthermore, countries with temperance movements have greater alcohol-related behavior problems than do countries without temperance movements (Purnell and Foster 2003a, b).

Countries in which drinking alcoholic beverages is integrated into rites and social customs, and in which one is expected to have self-control and sociability, have lower rates of alcohol-related problems than those of countries and cultures in which ambivalent attitudes toward drinking prevail (Purnell and Foster 2003a, b). Hilton's (1987) study demonstrated a clear and distinct difference in the alcohol abuse rate by socioeconomic status. The conclusion of many studies suggests that alcohol-related violence is a learned behavior, not an inevitable result of alcohol consumption (Purnell and Foster 2003a, b).

2.9.1 Health-Care Practices

Obesity and being overweight are a result of an imbalance between food consumed and physical activity. National data have shown an increase in the calorie consumption of adults and no change in physical activity patterns. However, obesity is a complex issue related to lifestyle, environment, and genes. Many underlying factors have been linked to the increase in obesity, such as increased portion sizes; eating out more often; increased consumption of sugar-sweetened drinks; increased television viewing, computer, electronic gaming time; and fear of crime, which prevents outdoor exercise. In some cultures, what is seen as overweight or obese according to actuarial tables, is seen as positive and means that one could afford to lose weight if one is ill, the individual has good socioeconomic status, the person is more desirable to the other gender.

The practice of self-care by using folk and magico-religious practices before seeking professional care may also have a negative impact on the health status for some individuals. Overreliance on these practices may mean that the health problem is in a more advanced stage when a consultation is sought. Such delays make treatment more difficult and prolonged. Selected complementary and alternative health-care practices are addressed in this chapter under the domain *health-care practices* and in each population specific chapter.

Reflective Exercise

1. In which high-risk health behaviors do you engage?
2. What do you do to control or reduce your risk?
3. Which high-risk health behaviors do you see most frequently in your family? In your community?
4. What might you do to help decrease these high-risk behaviors?

The cultural domain of *high-risk behaviors* is one area in which health-care providers can make a significant impact on patients' health status. High-risk health behaviors can be controlled through ethnic-specific interventions aimed at health promotion and health-risk prevention. This can be accomplished through educational programs in schools, business organizations, churches, and recreational and community centers, as well as through one-on-one and family counseling techniques. Taking advantage of public communication technology can enhance participation in these programs if they are geared to the unique needs of the individual, family, or community (see Table 2.1, Section High-risk Behaviors).

2.10 Nutrition

The cultural domain of *nutrition* includes much more than merely having adequate food for satisfying hunger. This domain also comprises the meaning of food to the culture; common foods and rituals; nutritional deficiencies and food limitations; and the use of food for health promotion and wellness, illness and disease prevention, and health maintenance and restoration. Understanding a patient's food choices and preparation practices is essential for providing culturally competent dietary counseling. Health-care providers may be considered professionally negligent when prescribing, for example, an American diet to a Hispanic or an Asian patient whose food choices and mealtimes may be different from American food patterns.

2.10.1 Meaning of Food

Food and the absence of food—hunger—have diverse meanings among cultures and individuals. Cultural beliefs, values, and the types of foods available influence what people eat, avoid, or alter to make food congruent with cultural lifeways. Food offers cultural security and acceptance. Food plays a significant role in socialization and can denote caring or lack of caring or closeness.

Reflective Exercise

1. What are your personal beliefs about weight and health?
2. Do you agree with the dominant American belief that thinness correlates with desirability and beauty?
3. What does food mean in your culture besides satisfying hunger?

2.10.2 Common Foods and Food Rituals

Traditional food habits are basic to satisfactory nutrition to most people. Perhaps a traditional diet does not really exist for some people; rather, they have favorite foods and preparation practices that health-care providers need to assess for effective dietary recommendations for illness and disease

prevention and health promotion and wellness. Most immigrants bring their favorite foods with them when they relocate, including preferred mealtimes. Food choices may vary according to the region of the country, urban versus rural residence, and weekdays versus weekends. In addition, food choices vary by marital status, economic status, climate changes, religion, ancestry, availability, and personal preferences.

Many older people and people living alone, regardless of cultural background, frequently do not eat balanced meals. They state that they do not take the time to prepare a meal, even though most homes have labor-saving devices such as stoves, microwave ovens, refrigerators, and dishwashers. For those who are unable to prepare their own meals because of disability or illness, most communities have a Meals on Wheels program through which community and church organizations deliver, usually once a day, a hot meal along with a cold meal for later and food for the following morning's breakfast. Socioeconomic status may dictate food selections—for example, hamburger instead of steak, canned or frozen vegetables and fruit rather than fresh produce, and fish instead of shrimp or lobster. Special occasions and holidays are frequently associated with ethnic-specific foods. Many religious groups are required to fast during specific holiday seasons. However, health-care providers may need to remind patients that fasting is not required during times of illness or pregnancy.

Reflective Exercise

1. What do you eat to maintain your health?
2. What does a healthy diet mean to you?
3. Do you agree with the U.S. Department of Agriculture Food Pyramid? Why? Why not?
4. What do you eat when you are ill?

Given the intraethnic variations of diet, it is important for health professionals to inquire about the specific diets of their patients. Expecting the patient to eat according to a set mealtime schedule and to select foods from an exchange list may be unrealistic for patients of different cultural backgrounds. Counseling about food-group requirements, intake restrictions, and exercise must respect cultural behaviors and individual lifeways. Culturally congruent dietary counseling, such as changing amounts and preparation practices while including preferred ethnic food choices, can reduce the risk for obesity, cardiovascular disease, and cancer. Whenever possible, determining a patient's dietary practices should be started during the intake interview.

Reflective Exercise

1. In what food rituals does your family engage?
2. Do you have specific foods and rituals for holidays?
3. What would happen if you changed these rituals?
4. Do food patterns change for you by the season?
5. During the week versus the weekend?

2.10.3 Dietary Practices for Health Promotion

The nutritional balance of a diet is recognized by most cultures throughout the world. Most cultures have their own distinct theories of nutritional practices for health promotion and wellness, illness and disease prevention, and health maintenance and restoration. Common folk practices and selected diets are recommended during periods of illness and for prevention of illness or disease. For example, cultures subscribe to the hot-and-cold (opposites) theory of food selection to prevent illness and maintain health. Although each of these cultural groups has its own specific name for the hot-and-cold theory of foods, the overall belief is that the body needs a balance of opposing foods. These practices are covered in culture-specific chapters.

2.10.4 Nutritional Deficiencies and Food Limitations

Because of limited socioeconomic resources or limited availability of their native foods, immigrants may eat foods that were not available in their home country. These dietary changes may result in health problems when they arrive in a new environment. This is more likely to occur when individuals immigrate to a country where they do not have native foods readily available and do not know which new foods contain the necessary and comparable nutritional ingredients. Consequently, they do not know which foods to select for balancing their diet.

Reflective Exercise
1. In what food rituals does your family engage?
2. Do you have specific foods and rituals for holidays?
3. What would happen if you changed these rituals?
4. Do food patterns change for you by the season?
5. During the week versus the weekend?

Enzyme deficiencies exist among some ethnic and racial groups. For example, many people are lactose-intolerant and are unable to drink milk or eat dairy products (unless cooked) to maintain their calcium needs. Thus, the health-care provider may need to assist patients and their families in identifying foods high in calcium when they are unable to purchase their native foods. In general, the wide availability of foods reduces the risks of these disorders as long as people have the means to obtain culturally nutritious foods. Recent emphasis on cultural foods has resulted in larger grocery stores having sections designated for ethnic goods and in small businesses selling ethnic foods and spices to the general public. The health-care provider's task is to determine how to assist the patient and identify alternative foods to supplement the diet when these stores are not financially or geographically accessible (see Table 2.1, Section on Nutrition).

Reflective Exercise
1. What enzyme deficiencies run in your family?
2. Do you have any difficulty getting your preferred foods?
3. What other food limitations do you have?

2.11 Pregnancy and Childbearing Practices

The cultural domain *pregnancy and childbearing practices* includes culturally sanctioned and unsanctioned fertility practices; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and the postpartum period.

Many traditional, folk, and magico-religious beliefs surround fertility control, pregnancy, childbearing, and postpartum practices. The reason may be the mystique that surrounds the processes of conception, pregnancy, and birthing. Ideas about conception, pregnancy, and childbearing practices are handed down from generation to generation and are accepted without validation or being completely understood. For some, the success of modern technology in inducing pregnancy in postmenopausal women and others who desire children through in vitro fertilization and the ability to select a child's gender raises serious ethical questions.

2.11.1 Fertility Practices and Views toward Pregnancy

Commonly used methods of fertility control include natural ovulation methods, birth control pills, foams, Norplant, the morning-after pill, intrauterine devices, tubal ligation or sterilization, vasectomy, prophylactics, and abortion.

Although not all of these methods are acceptable to all people, many women use a combination of fertility control methods. The most extreme examples of fertility control are sterilization and abortion. Sterilization in the United States and most other countries is now strictly voluntary. Abortion remains a controversial issue in many countries and religions. For example, in some countries, women are encouraged to have as many children as possible, and abortion is illegal. However, in other countries, abortion is commonly used as a means of limiting family size for a variety of reasons. The “morning-after pill” also continues to be controversial to some.

Reflective Exercise

1. Does pregnancy have a special meaning in your culture?
2. Is fertility control acceptable in your culture?
3. Do most people adhere to fertility control practices in your culture?
4. What types of fertility control are acceptable? Unacceptable?

Fertility practices and sexual activity, sensitive topics for many, is one area in which “outside” health-care providers may be more effective than health-care providers known to the patient because of the concern about providing intimate information to someone they know. Some of the ways health-care providers can promote a better understanding of practices related to family planning include using videos in the native language and videos and pictures of native ethnic people, using material written at the individual’s level of education, and providing written instructions in both English and the native language. Health-care providers should avoid family planning discussions on the first encounter; such information may be better received on subsequent visits when some trust has developed. Approaching the subject of family planning obliquely may make it possible to discuss these topics more successfully.

2.11.2 Prescriptive, Restrictive, and Taboo Practices in the Childbearing Family

Most societies have prescriptive, restrictive, and taboo beliefs for maternal behaviors and the delivery of a healthy baby. Such beliefs affect sexual and lifestyle behaviors during pregnancy, birthing, and the immediate postpartum period. Prescriptive practices are things that the mother should do to have a good outcome (healthy baby and pregnancy). Restrictive practices are those things that the mother should not do to have a positive outcome (healthy baby and delivery). Taboo practices are those things that, if done, are likely to harm the baby or mother.

One prescriptive belief is that women are expected to seek preventive care, eat a well-balanced diet, and get adequate rest to have a healthy pregnancy and baby. A restrictive belief is that pregnant women should refrain from being around loud noises for prolonged periods of time. Taboo behaviors during pregnancy include smoking, drinking alcohol, drinking large amounts of caffeine, and taking recreational drugs—practices that are sure to cause harm to the mother or baby.

A taboo belief common among many cultures is that a pregnant woman should not reach over her head because the baby may be born with the umbilical cord around its neck. A restrictive belief among others is that permitting the father to be present in the delivery room and seeing the mother or baby before they have been cleaned can cause harm to the baby or mother. If the father is absent from the delivery room or does not want to see the mother or baby during birthing or immediately after birth, it does not mean that he does not care about them. However, in many cultures, the father is often encouraged to take prenatal classes with the expectant mother and provide a supportive role in the delivery process; fathers with opposing beliefs may feel guilty if they do not comply. The woman’s female relatives provide assistance to the new mother until she is able to care for herself and the baby. Additional cul-

tural beliefs carried over from cultural migration and diversity include the following:

- If you wear an opal ring during pregnancy, it will harm the baby.
- Birthmarks are caused by eating strawberries or seeing a snake and being frightened.
- Congenital anomalies can occur if the mother sees or experiences a tragedy during her pregnancy.
- Nursing mothers should eat a bland diet to avoid upsetting the baby.
- The infant should wear a band around the abdomen to prevent the umbilicus from protruding and becoming herniated.
- A coin, key, or other metal object should be put on the umbilicus to flatten it.
- Cutting a baby's hair before baptism can cause blindness.
- Raising your hands over your head while pregnant may cause the cord to wrap around the baby's neck.
- Moving heavy items can cause your "insides" to fall out.
- If the baby is physically or mentally abnormal, God is punishing the parents.

Reflective Exercise

1. What are some prescriptive practices for pregnant women in your culture?
2. What are some restrictive practices for pregnant women in your culture?
3. What are some taboo practices for pregnant women in your culture?
4. What special foods should a woman eat to have a healthy baby in your culture?
5. What foods should be avoided? What foods should a nursing mother eat postpartum?
6. What foods should she avoid?

In some other cultures, the postpartum woman is prescribed a prolonged period of recuperation in the hospital or at home, something that may not be feasible income countries because of the shortened length of confinement in the hospital after delivery. he health-care provider must respect cultural beliefs associated with pregnancy and the birthing process when making decisions related to the health care of pregnant women, especially those practices that do not cause harm to the mother or baby. Most cultural practices can be integrated into preventive teaching in a manner that promotes compliance (see Table 2.1: Section Pregnancy and Childbearing Families).

2.12 Death Rituals

The cultural domain *death rituals* includes how the individual and the society view death, euthanasia, rituals to prepare for death, burial practices, and bereavement practices. Death rituals of ethnic and cultural groups are the least likely to change over time and may cause concerns among health-care personnel. Some staff may not understand the value of customs with which they are not familiar, such as the ritual washing of the body. Death practices, beliefs, and rituals vary significantly among cultural and religious groups. To avoid cultural taboos, health-care providers must become knowledgeable about unique practices related to death, dying, and bereavement.

2.12.1 Death Rituals and Expectations

For many health-care providers educated in a culture of mastery over the environment, death is seen as one more disease to conquer, and when this does not happen, death becomes a personal failure. Thus, for many, death does not take a natural course because it is "managed" or "prolonged," making it difficult for some to die with dignity. Moreover, death and responses to death are not easy topics for many to verbalize. Instead, many euphemisms are used rather than verbalizing that the person died—for example, "passed away," "no longer with us," and "was visited by the Grim Reaper." The individualistic cultural belief in self-determination and autonomy extends to people making their own decisions

about end-of-life care. Mentally competent adults have the right to refuse or decide what medical treatment and interventions they wish to extend life, such as artificial life support, artificial feeding, and hydration.

Reflective Exercise

1. What terms do you use when referring to death?
2. Why do you use these terms?
3. What specific burial practices do you have in your family/culture?

Among most Westerners, the belief is that a dying person should not be left alone, and accommodations are usually made for a family member to be with the dying person at all times. Health-care personnel are expected to care for the family as much as for the patient during this time. Most people are buried or cremated within 3 days of the death, but extenuating circumstances may lengthen this period to accommodate family and friends who must travel a long distance to attend a funeral or memorial service or where frozen land prevents the burial. The family can decide whether to have an open casket—so family and friends can view the deceased—or a closed casket. Cremation is common among many groups. Significant variations in burial practices occur with other ethnocultural groups throughout the world.

2.12.2 Responses to Death and Grief

Reflective Exercise

1. How do men grieve in your culture?
2. How do women grieve in your culture?
3. Do you have a living will or advance directive? Why? Why not?
4. Are you an organ donor? Why? Why not?
5. Is there a specific time frame for bereavement?

Numerous countries have been launching major initiatives to help patients die as comfortably as possible without pain. As a result, more people are choosing to remain at home or to choose palliative care or hospice for end-of-life care where their comfort needs are better met. When death does occur, some people conservatively control their grief, although women are usually more expressive than men. For many, especially men, they are expected to be stoic in their reactions to death, at least in public. Generally, tears are shed, but loud wailing and uncontrollable sobbing rarely occur. The belief is that the person has moved on to a better existence and does not have to undergo the pressures of life on earth. Regardless of the gender or culture, bereavement is a very private issue, and there are no norms; people grieve in their own way.

Variations in the grieving process may cause confusion for health-care providers, who may perceive some patients as overreacting and others as not caring. The behaviors associated with the grieving process must be placed in the context of the specific cultural belief system in order to provide culturally competent care. Caregivers should accept and encourage ethnically specific bereavement practices when providing support to family and friends. Bereavement support strategies include being physically present, encouraging a reality orientation, openly acknowledging the family's right to grieve, accepting varied behavioral responses to grief, acknowledging the patient's pain, assisting them to express their feelings, encouraging interpersonal relationships, promoting interest in a new life, and making referrals to other resources, such as a priest, minister, rabbi, or pastoral care (Table 2.1: Section Death and Dying).

2.13 Spirituality

The domain *spirituality* involves more than formal religious beliefs related to faith and affiliation and the use of prayer. For some people, religion has a strong influence over and shapes nutrition practices, health-care practices, and

other cultural domains. Spirituality includes all behaviors that give meaning to life and provide strength to the individual. Furthermore, it is difficult to distinguish religious beliefs from cultural beliefs because for some, especially the very devout, religion guides the dominant beliefs, values, and practices even more than their culture does.

Spirituality, a component of health related to the essence of life, is a vital human experience that is shared by all humans. Spirituality helps provide balance among the mind, body, and spirit. Trained, lay, and traditional religious leaders may provide comfort to both the patient and the family. Spirituality does not have to be scientifically proven and is patterned unconsciously from a person's worldview. Accordingly, an individual may deviate somewhat from the majority view or position of the formally recognized religion.

Reflective Exercise

1. Do identify with a certain religion?
2. Do you consider yourself devout?
3. Do you need anything special to pray?
4. When do you pray?
5. Do you pray for good health?
6. Do religiosity and spirituality differ for you?
7. What gives meaning to your life?
8. How are spirituality, religiosity, and health connected for you?

2.13.1 Dominant Religion and Use of Prayer

Of the major religions in the world, 31.4% of people are Christians, 23.2% are Muslim; 15% are Hindu; 7.1% are Buddhists; 5% practice folk religions, 0.2% Jewish, 0.8% other, and unaffiliated, 16.4% (CIA World Factbook 2019).

Many people have migrated for religious acceptance or freedom. Furthermore, specific religious groups are concentrated regionally within a country. Unlike in some countries that support a specific church or religion and in which people discuss their religion frequently and openly, religion is not an everyday topic of conversation for many. The health-care provider who is aware of the patient's religious practices and spiritual needs is in a better position to promote culturally congruent health care. The health-care provider must demonstrate an appreciation of and respect for the dignity and spiritual beliefs of patients by avoiding negative comments about religious beliefs and practices. Patients may find considerable comfort in speaking with religious leaders in times of crisis and serious illness.

Prayer takes different forms and different meanings. Some people pray daily and may have altars in their homes. Others may consider themselves devoutly religious and say prayers only on special occasions or in times of crisis or illness. Health-care providers may need to make special arrangements for individuals to say prayers in accordance with their belief systems. A religious leader may be helpful to staff.

2.13.2 Meaning of Life and Individual Sources of Strength

What gives meaning to life varies among and within cultural groups and among individuals. To some people, their formal religion may be the most important facet of fulfilling their spirituality needs, whereas for others, religion may be replaced as a driving force by other life forces and worldviews. For others, family is the most important social entity and is extremely important in helping meet their spiritual needs. For many, what gives meaning to life is good health and well-being. For a few, spirituality may include work or money.

A person's inner strength comes from different sources. For some, inner self is dependent on being in harmony with one's surroundings, whereas for others, a belief in a supreme being may give personal strength. For most people, spirituality includes a combination of these factors. Knowing these beliefs allows health-care

providers to assist individuals and families in their quest for strength and self-fulfilment.

2.13.3 Spiritual Beliefs and Health-Care Practices

Spiritual wellness brings fulfillment from a lifestyle of purposeful and pleasurable living that embraces free choices, meaning in life, satisfaction in life, and self-esteem. For some, ritual dancing and herbal treatments (combined with prayers and songs) are performed for total body healing and the return of spirits to the body. Practices that interfere with a person's spiritual life can hinder physical recovery and promote physical illness.

Health-care providers should inquire whether the person wants to see a member of the clergy even if she or he has not been active in church. Religious emblems should not be removed because they provide solace to the person, and removing them may increase or cause anxiety. A thorough assessment of spiritual life is essential for the identification of solutions and resources that can support other treatments (see Table 2.1: Section Spirituality).

2.14 Health-Care Practices

Another domain of culture is *health-care practices*. The focus of health care includes traditional, magico-religious, and biomedical beliefs; individual responsibility for health; self-medicating practices; and views toward mental illness, chronicity, rehabilitation, and organ donation and transplantation. In addition, responses to pain and the sick role are shaped by specific ethnocultural beliefs. Significant barriers to health care may be shared among cultural and ethnic groups.

2.14.1 Health-Seeking Beliefs and Behaviors

For centuries, people's health has been maintained by a wide variety of healing and medical practices. Currently, most of the world is undergoing a paradigm shift from one that places high value on curative and restorative medical practices with sophisticated technological care to one of health promotion and wellness; illness, disease, and injury prevention; health maintenance and restoration; and increased personal responsibility. Most believe that the individual, the family, and the community have the ability to influence their health. However, among other populations, good health may be seen as a divine gift from a superior being, with individuals having little control over health and illness.

The primacy of patient autonomy is generally accepted as an enlightened perspective in individualistic cultures. To this end, advance directives, such as "durable power of attorney" or a "living will" are an important part of medical care and is common in hospitals and long-term care in the United States. Accordingly, patients can specify their wishes concerning life and death decisions before or upon entering an inpatient facility. The durable power of attorney for health care allows the patient to name a family member or significant other to speak for the patient and make decisions when or if the patient is unable to do so. The patient can also have a living will that outlines the person's wishes in terms of life-sustaining procedures in the event of a terminal illness. Most inpatient facilities have forms that patients may sign, or they can elect to bring their own forms, many of which are available on the Internet. Most countries and cultural groups engage in preventive vaccines for children. Guidelines for vaccines were developed largely as a result of the influence of the World Health Organization. Specific vaccine schedules and the ages at which they are prescribed vary widely among countries and can be obtained from the WHO website (World Health Organization: Immunizations 2019). However, some religious groups, such as Christian Scientists and ultra-conservative Jews, do not believe in vaccinations. Beliefs like this, which restrict optimal child health, have resulted in court battles with various outcomes.

2.14.2 Responsibility for Health Care

The world is moving to a paradigm in which people take increased responsibility for their health. In a society in which individualism is valued, people are expected to be self-reliant. In fact, people are expected to exercise some control over disease, including controlling the amount of stress in their lives. If someone does not maintain a healthy lifestyle and then gets sick, some believe it is the person's own fault. Unless someone is very ill, she or he should not neglect social and work obligations.

Reflective Exercise
1. What do you do to take responsibility for your health?
2. Do you take vaccines to prevent the flu or other illnesses?
3. Do you have adequate health insurance?
4. Do you have regular checkups with your health-care provider?

The health-care delivery system of the country of origin and degree of individualism and collectivism may shape patients' beliefs regarding personal responsibility for health care. Most countries in the world have some kind of basic universal coverage for their citizens, although access and quality may vary significantly from rural and urban settings and for vulnerable populations.

A potential high-risk behavior in the self-care context includes self-medicating practices. Self-medicating behavior in itself may not be harmful, but when combined with or used to the exclusion of prescription medications, it may be detrimental to the person's health. A common practice with prescription medications is for people to take medicine until the symptoms disappear and then discontinue the medicine prematurely. This practice commonly occurs with antihypertensive medications and antibiotics. No culture is immune to self-medicating practices; almost everyone engages in it to some extent.

Each country has some type of control over the purchase and use of medications. The United States is more restrictive than many countries and provides warning labels and directions for the use of over-the-counter medications. In many countries, pharmacists may be consulted before physicians for fever-reducing and pain-reducing medicines. In parts of Central America, a person can purchase antibiotics, intravenous fluids, and a variety of medications over the counter; most stores sell medications and vendors sell drugs in street-corner shops and on public transportation systems. People who are accustomed to purchasing medications over the counter in their native country frequently see no problem in sharing their medications with family and friends. To help prevent contradictory or exacerbated effects of prescription medications and treatment regimens, health-care providers should ask about patients' self-medicating practices. One cannot ignore the ample supply of over-the-counter medications in pharmacies worldwide, the numerous television advertisements for self-medication, and media campaigns for new medications, encouraging viewers to ask their doctor or health-care provider about a particular medication.

Reflective Exercise
1. In what self-medicating practices do you engage?
2. What makes you decide when to see your health-care provider when you have an illness?

2.14.3 Folk and Traditional Practices

Some cultures and individuals favor traditional, folk, or magico-religious health-care practices over biomedical practices and use some or all of them simultaneously. For many, what are considered alternative or complementary health-care practices in one country may be mainstream medicine in another society or culture. In the United States, interest has increased in alternative and complementary health practices (National Center

for Complementary and Integrative Health 2019) to bridge the gap between traditional and non-traditional therapies.

Reflective Exercise

1. In complementary and alternative practices have you practiced?
2. For what conditions have you used them?
3. Were they helpful?
4. How willingly do you accept other people's traditional practices?

As an adjunct to biomedical treatments, many people use acupuncture, acupressure, acumassage, herbal therapies, and other traditional treatments. Some cultural groups and individuals commonly visit traditional healers because modern medicine is viewed as inadequate. Examples of folk medicines include covering a boil with axle grease, wearing copper bracelets for arthritis pain, taking wild turnip root and honey for a sore throat, and drinking herbal teas. The Chinese subscribe to the yin-and-yang theory of treating illnesses, and Hispanic groups believe in the hot-and-cold theory of foods for treating illnesses and disease (see specific population-based chapters. Traditional schools of pharmacy in many countries sell folk remedies. Most people practice folk medicine in some form; they may use family remedies passed down from previous generations.

An awareness of combined practices when treating or providing health education to individuals and families helps ensure that therapies do not contradict one another, intensify the treatment regimen, or cause an overdose. At other times, they may be harmful, conflict with, or potentiate the effects of prescription medications. Many times, these traditional, folk, and magico-religious practices are and should be incorporated into the plans of care for patients resulting in integrative medicine. Inquiring about the full range of therapies being used, such as food items, teas, herbal remedies, non-food substances, over-the-counter medications, and medications prescribed or loaned by others, is essential so that conflicting treatment modalities are not used. If patients perceive that the health-care provider does not accept their beliefs, they may be less compliant with prescriptive treatment and less likely to reveal their use of these practices.

2.14.4 Barriers to Health Care

For people to receive adequate health care, a number of considerations must be addressed. For example, a lack of fluency in language, verbal or written, can be a barrier to receiving adequate health care. Other barriers include the following:

- *Availability:* Is the service available and at a time when needed? For example, no services exist after 6 p.m. for someone who needs suturing of a minor laceration. Clinic hours coincide with patients' work hours, making it difficult to schedule appointments for fear of work reprisals.
- *Accessibility:* Transportation services may not be available or rivers and mountains may make it difficult for people to obtain needed health-care services when no health-care provider is available in their immediate region. For example, it can be difficult for a single parent with four children to make three bus transfers to get one child immunized.
- *Affordability:* The service is available but the patient does not have financial resources.
- *Appropriateness:* Maternal and child services are available but what might be needed are geriatric and psychiatric services.
- *Accountability:* Are health-care providers accountable for their own education and do they learn about the cultures of the people they serve? Are they culturally aware, sensitive, and competent?
- *Adaptability:* A mother brings her child to the clinic for a vaccine. Can she get a mammogram at the same time or must she make another appointment?
- *Acceptability:* Are services and patient education offered in a language preferred by the patient?

- *Awareness:* Is the patient aware that needed services exist in the community? The service may be available but if patients are not aware of it the service will not be used.
- *Attitudes:* Adverse subjective beliefs and attitudes from caregivers mean that the patient will not return for needed services until the condition is more compromised. Do health-care providers have negative attitudes about patients' home-based traditional practices?
- *Approachability:* Do patients feel welcomed? Do health-care providers and receptionists greet patients in the manner in which they prefer? This includes greeting patients with their preferred names.
- *Alternative practices and practitioners:* Do biomedical providers incorporate patients' alternative or complementary practices into treatment plans?
- *Additional services:* Are child- and adult-care services available if a parent must bring children or an aging parent to the appointment with them?
- *Literacy:* Language has been identified as the biggest barrier to health care and not just for those for whom English is a second language.

Reflective Exercise

1. Looking at the list of barriers to health care, which apply to you?
2. How can you decrease these barriers?
3. What are the barriers to health care in your community?
4. Looking at the list of barriers to health care, which apply to you?
5. How can you decrease these barriers?
6. What are the barriers to health care in your community?

Health-care providers can help reduce some of these barriers by calling an area ethnic agency or church for assistance, establishing an advocacy role, involving professionals and laypeople from the same ethnic group as the patient, using cultural brokers, and organizationally providing culturally congruent and linguistically appropriate services. If all of these elements are in place and used appropriately, they have the potential of generating culturally congruent and responsive care.

2.14.5 Cultural Responses to Health and Illness

Significant research has been conducted on patients' responses to pain, which has been called the "fifth vital sign." Most health-care professionals believe that patients should be made comfortable and not have to tolerate high levels of pain. Accrediting bodies survey organizations to ensure that patients' pain levels are assessed and that appropriate interventions are instituted.

A number of studies related to pain and the ethnicity/culture of the patient have been completed. Most of the studies have come from end-of-life care.

- Communication between patient and health-care provider influences pain diagnosis and treatment.
- The brain's pain-processing and pain-killing systems vary by race and ethnicity.
- Few patients are told in advance about possible side effects of pain medicine and how to manage them.
- African American, Hispanic, and other groups with severe pain are less likely than White patients to be able to obtain needed pain medicine because they live in communities that are crime ridden and the pharmacies do not carry the medicines.
- African Americans are less likely to have their pain recorded (see population specific chapters).
- Inadequate education of pain and analgesia expectations may contribute to poor pain relief in the Asian populations.
- Disparities in pain management and quality care at end of life exist among African American women in general and, specifically, those with breast cancer.

- Hispanic patients are more likely to describe pain as "suffering," the emotional component. African Americans are more likely to describe pain as "hurts," the sensory component.
- Socioeconomic factors negatively influence prescribing pain medicine.
- Pain does not have the same debilitating effect for patients from Eastern cultures as it does for patients from Western cultures.
- Stoicism, fatalism, family, and spirituality have a positive impact on Hispanics and pain control.
- Most Chinese, Korean, and Vietnamese patients do not favor taking pain medicine over a long period of time.
- Vietnamese Canadians prefer herbal therapies over prescription pain medicine (Voyer et al. 2005).
- Many Haitians, Haitian Americans, and Haitian Canadians combine herbal therapies with prescription medicine without telling the health-care provider (Voyer et al. 2005).
- Black, Hispanic, and Asian women receive less epidural analgesia than do White women.
- Cultural background, worldview, and variant characteristics of culture influence the pain experience.
- The greater the language differences, the poorer the pain control.
- For Asians, tolerating pain may be a way of atoning for past sins.

Pain scales are in different languages and with faces appropriate to the language and ethnicity of the patient. Additional resources for pain are the American Pain Foundation, The American Pain Society, the Boston Cancer Pain Education Center (in 11 languages), and the OUCHER Pain scale for children (OUCHER!, n.d.), all of which are available on the Internet. Health-care practitioners must investigate the meaning of pain for each person within a cultural explanatory framework to interpret diverse behavioral responses and provide culturally congruent care. The health-care provider may need to offer and encourage pain medication and explain that it can help the healing progress.

Reflective Exercise

1. What is your first line of intervention when you are having pain?
2. When do you decide to see a health-care practitioner when you are in pain?
3. What differences do you see between yourself and others when they are in pain?
4. Where did you learn your response to pain?
5. Do you see any difference in the clinical setting in response to pain among ethnic and cultural groups?
6. Between men and women?

The manner in which mental illness is perceived and expressed by a cultural group has a direct effect on how individuals present themselves and, consequently, on how health-care providers interact with them. In some societies, mental illness may be seen by many as not being as important as physical illness. Mental illness is culture-bound; what may be perceived as a mental illness in one society may not be considered a mental illness in another. For some, mental illness and severe physical handicaps are considered a disgrace and taboo. As a result, the family is likely to keep the mentally ill or handicapped person at home as long as they can. This practice may be reinforced by the belief that all individuals are expected to contribute to the household for the common good of the family, and when a person is unable to contribute, further disgrace occurs. In some cultures, children with a mental disability are stigmatized. The lack of supportive services may cause families to abandon their loved ones because of the cost of long-term care and the family's desire and desperate need for support. Such children may be kept from the public eye in hope of saving the family from stigmatization.

Reflective Exercise

1. What are your perceptions about mental illness?

2. Does mental illness have the same value as physical illness and disease?
3. When you are having emotional difficulties, what is your first line of defense?
4. Have you observed different attitudes/responses from providers regarding physical and mental illnesses?

Rehabilitation and occupational health services focus on returning individuals with handicaps to productive lifestyles in society as soon as possible. The goal of the health-care system is to rehabilitate everyone: convicted individuals, people with alcohol and drug problems, as well as those with physical conditions. To establish rapport, health-care practitioners working with patients suffering from chronic disease must avoid assumptions regarding health beliefs and provide rehabilitative health interventions within the scope of cultural customs and beliefs. Failure to respect and accept patients' values and beliefs can lead to misdiagnosis, lack of cooperation, and alienation of patients from the health-care system.

Reflective Exercise
1. Do you see physically challenged individuals as important as non-physically challenged individuals in terms of their worth to society?
2. What are your beliefs about rehabilitation?
3. Should everyone have the opportunity for rehabilitation?

Sick role behaviors are culturally prescribed and vary among ethnic societies. Traditional individualistic cultural practice calls for fully disclosing the health condition to the patient. However, traditional collectivistic families may prefer to be informed of the bad news first, and then slowly break the news to the sick family member. Given the ethnocultural acceptance of the sick role, health-care providers must assess each patient and family individually and incorporate culturally congruent therapeutic interventions to return the patient to an optimal level of functioning.

Reflective Exercise
1. What do you normally do when you have a minor illness?
2. Do you go to work (class) anyway?
3. What would make you decide not to go to work or class?
4. Does the sick role have a specific meaning in your culture?

2.14.6 Blood Transfusions and Organ Donation

Most religions favor organ donation and transplantation and transfusion of blood or blood products. Jehovah's Witnesses do not believe in blood transfusions. Some individuals and cultures choose not to participate in organ donation or autopsy because of their belief that they will suffer in the afterlife or that the body will not be whole on resurrection. Health-care providers may need to assist patients in obtaining a religious leader to support them in making decisions regarding organ donation or transplantation.

Reflective Exercise
1. Are you averse to receiving blood or blood products? Why? Why not?
2. Are you an organ donor? Why? Why not?

Some people do not sign donor cards because the concept of organ donation and transplantation is not customary in their homelands. Health-care providers should supply information regarding organ donation on an individual basis, be sensitive to individual and family concerns, explain procedures involved with organ donation and procurement, answer questions factually, and

explain involved risks. A key to successful marketing approaches for organ donation is cultural awareness (see Table 2.1: Section Health-care Practices).

2.15 Health-Care Providers

The domain *health-care providers* includes the status, use, and perceptions of traditional, magico-religious, and biomedical health-care providers. This domain is interconnected with communications, family roles and organization, and spirituality. In addition, the gender of the health-care provider may be significant for some people.

2.15.1 Traditional Versus Biomedical Providers

Most people combine the use of biomedical health-care providers with traditional practices, folk healers, and/or magico-religious healers. The health-care system abounds with individual and family folk practices for curing or treating specific illnesses. A significant percentage of all care is delivered outside the perimeter of the formal health-care arena. Many times, herbalist-prescribed therapies are handed down from family members and may have their roots in religious and cultural beliefs. Traditional and folk practices often contain elements of historically rooted beliefs.

Reflective Exercise

1. What alternative health-care providers do you see for your health-care needs besides traditional allopathic-care providers?
2. For what conditions do you use nonallopathic providers?
3. Do you think traditional health-care providers are as valuable as allopathic health-care providers?

The traditional practice in the United States and other countries is to assign staff to patients regardless of gender differences, although often an attempt is made to provide a same-gender health-care provider when intimate care is involved, especially when the patient and caregiver are of the same age. However, health-care providers should recognize and respect differences in gender relationships when providing culturally competent care because not all ethnocultural groups accept care from someone of the opposite gender. Health-care providers need to respect patients' modesty by providing adequate privacy and assigning a same-gender caregiver whenever possible.

Reflective Exercise

1. Do you prefer a same-gender health-care provider for your general health care?
2. Do you mind having an opposite-gender provider for intimate care? Why? Why not?
3. Do you prefer Western-trained health-care providers or does it not make any difference?

2.15.2 Status of Health-Care Providers

Health-care providers are perceived differently among ethnic and cultural groups. Individual perceptions of selected health-care providers may be closely associated with previous contact and experiences with health-care providers. In many Western societies, health-care providers, especially physicians, are viewed with great respect,

Reflective Exercise

1. Does one type of health-care provider have increased status over another type?

2. Should all health-care providers receive equal respect, regardless of educational requirements?
3. Does the ethnicity or race of a provider make any difference to you? Why? Why not?

although recent studies show that this is declining among some groups.

Although many nurses in the United States do not believe they are respected, public opinion polls usually place patients' respect of nurses higher than that of physicians. The advanced practice role of registered nurses is gaining respect as more of them have successful careers and the public sees them as equal or preferable to physicians and physician assistants in many cases.

Depending on the country of origin and experience of working with professional nurses, some physicians may misunderstand the assertive behavior of Western-educated nurses because in their home country, nurses were not expected to be assertive. Some patients perceive older male physicians as being of higher rank and more trustworthy than younger health professionals, especially for patients who come from a collectivist culture where they are taught from a very early age to respect elders and to show deference to nurses and physicians, regardless of gender or age.

Evidence suggests that respect for professionals is correlated with their educational level. In some cultures, the nurse is expected to defer to physicians. In many countries, the nurse is viewed more as a domestic than as a professional person, and only the physician commands respect. Health beliefs are not border bound. People bring their beliefs with them upon migration.

In some cultures, folk and magico-religious health-care providers may be deemed superior to biomedically educated physicians and nurses. It may be that folk, traditional, and magico-religious health-care providers are well known to the family and provide more individualized care. In such cultures, health-care providers take time to get to know patients as individuals and engage in small talk totally unrelated to the health-care problem to accomplish their objectives. Establishing satisfactory interpersonal relationships is essential for improving health care and education in these ethnic groups (see Table 2.1: Section Health-care Practitioners).

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