14 Cross Cultural Communication: Verbal and Non-Verbal Communication, Interpretation and Translation

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Guideline: *Nurses shall use culturally competent verbal and nonverbal communication skills to identify clients' values, beliefs, practices, perceptions, and unique healthcare needs.*

Douglas et al. (2014: 112)

14.1 Introduction

Despite decades of attention and awareness, healthcare disparities persist across the United States and other countries throughout the world. Racial and ethnic minorities, people with limited English proficiency (LEP) and low health literacy, sexual and gender minorities, and people with disabilities experience worse health outcomes, decreased access to healthcare services, and lower-quality care than the general population (Building an Organizational Response to Health Disparities 2016). Vast demographic changes are occurring around the world; inherent in these demographics are cross-cultural communication issues between patients and healthcare providers. Communication is culture bound: what works in one culture may not work in another culture. Thus, the onus on effective cultural communication is on healthcare providers. Cross-cultural communication combines anthropology, cultural studies, psychology, and communication theory. The goal of cross-cultural communication is to understand how people from different cultures communicate among insiders such as family and friends and with outsiders. Healthcare providers are considered outsiders.

Effective cross-cultural communication can be challenging because it provides people with ways of thinking and interpreting the world. Cross-cultural communication includes verbal and nonverbal components as well as the health literacy of patients.

14.2 Verbal Communication

The components of verbal communication consist of a number of elements: a dominant language and its dialects; contextual use of the language; paralanguage variations, such as voice volume, tone, and intonations; the willingness to share thoughts and feelings; degree of formality; and name format (Galanti 1991; Papadopoulos 2006; Purnell 2013). In addition, the healthcare provider needs to pay attention to the nonverbal communication such as a grimace or lack of eye contact during verbal communication. Dialects, regional variations of a language, can be troublesome

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because specific words may have a different meaning or the provider has difficulty understanding an accent as is the case in some parts of Appalachia in the United States where Elizabethan English is still spoken. In addition, sometimes the word does not exist in another language. In Mexico, while Spanish is the most widely spoken language, the government also recognizes 68 Mexican indigenous languages as official national languages (Mexican Languages 2017). India has 18 major languages and over 1600 regional dialects. Even though Hindi is the official language, many people in India do not speak it at all. Hindi is spoken by about half the population, mostly in North India (How many Languages do Indian People Speak? 2017). The current estimate of languages spoken in Nigeria is 521 with English being the official language, although only 75% of the people speak it. Yoruba, Hausa, Igbo, Fulfulde, Kanuri, and Ibibio are also popular (Languages of Nigeria n.d.). When a patient speaks a dialect for which there is no interpreter, use an interpreter using the language of popular radio stations because most people will understand this language.

The same words can mean different things to people from different cultures, even when they speak the same language. The use of idioms, slang, colloquialisms, and technical jargon should be avoided because they may not be understood by everyone, even by those who have good language proficiency. In addition, they do not translate well into other languages. Even though a patient might be somewhat bilingual, it can be difficult to fully understand the nuances of a language, especially with words that sound alike but spelled differently (homonyms) and must be viewed in context. For example, a "case" can be something that contains papers or other paraphernalia, a "case" as in a lawsuit, or as an adjective as in a "case" study. Another example is "glass," something to hold liquid for drinking, or "glass" as in a window. "Iron" could be an element or something used to iron clothing.

Slang and colloquial expressions can be particularly difficult and cause communication concerns. Some slang expression are the buck (versus as male deer) stops here and sweet to describe a person (versus the sweet taste in a drink). Colloquialisms, using informal words or phrases, can be troublesome, especially for whom the host language is not the patient's primary language. Some examples of colloquialisms are "go bananas" for going insane or angry, "feel blue" for feeling sad, and "y'all" (yawl) for you all. Health providers must make a concerted effort and avoid slang and colloquialisms. When the patient uses colloquialisms or slang, ask the patient to explain the terms.

In some cultures, people disclose very personal information about themselves, such as information about sex, recreational drug use, sexual orientation, and family problems to friends (and even casual acquaintances) and healthcare providers. However, in other cultures, it is taboo to disclose this information to others, even among healthcare providers. Even though some cultures willingly share their thoughts and feelings among family members and close friends, they may not easily share them with "outsiders" until they get to know them. Outsiders may include healthcare providers. By engaging in small talk and inquiring about family before addressing the patient's health concerns, healthcare providers can help establish trust and, in turn, encourage more open communication and sharing important health information (see Chap. 2 for more on collectivistic and individualistic cultures).

In some cultures, having well-developed verbal skills is seen as important, whereas in other cultures, such as among some Appalachians, the person who has very highly developed verbal skills is seen as having suspicious intentions (Huttlinger 2013). In addition, health literacy and limited language proficiency can compromise cross-cultural communication and lead to incomplete or inaccurate diagnoses. Such miscommunication can affect the ability to follow healthcare recommendations and prescriptions, even when the patient is in agreement with them (Andrews and Boyle 2016; Helman 2000; Purnell 2011; Sagar 2014).

Paralanguage is an area that combines verbal and nonverbal communication using nuances such voice volume, tone, and posturing as means of expressing thoughts and feelings. People normally use paralanguage multiple times per day and are sometimes not even aware they are doing so; this can include healthcare providers during assessments and at other times communicating with patients. The ability to interpret this kind of human communication correctly is considered an important competency in both personal and professional settings. Good communicators also

have the ability to gauge how their own paralanguage affects others and to alter it so as to gain patients' trust and to project confidence.

In collectivistic cultures, such as Amish, Chinese, Filipino, Indigenous Indian, Vietnamese, Korean, and Panamanian cultures to name a few, implicit indirect communication is common. People are more likely to tell the healthcare providers what they think they want to hear (Bui and Turnbull 2003).

In collectivistic cultures a formal greeting is usually required by using the surname of the patient or family member with a title. This can be a first step in gaining trust. 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., or Miss 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**,** such as many in Asia, 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, but not always, keep their maiden name. Diversity in naming formats can create a challenge for healthcare workers keeping a medical record; it is important to ask for the family name and then for their given names. The healthcare provider should always ask what is the legal name for medical record keeping and by which name the patient wishes to be addressed.

In some cultures, the concept of "saving face" is highly valued and is reflected in communication patterns (Baron 2003). Sharing intimate life details of self or family is discouraged because it could stigmatize the person and the family. "Yes" may mean I hear you or I understand. "Yes" does not necessarily mean agreement with what is being asked or being explained but rather I hear you. Therefore healthcare providers need to exercise caution in framing questions and interpreting responses to Yes/No questions. Instead of asking a patient if he/she took a medicine today, ask what time did you take your medicine today?

For the healthcare provider, deciding to whom to direct the conversation can also be complicated. In some cultures, decision-making is a responsibility of the male or most respected family member. And in some cases, the male may be the spokesperson for the family, even though he may not be the decision-maker.

In individualistic cultures, such as those of Western Europe, European American, and Canadian to name a few, explicit, direct, straight forward communication is the expected norm (Rothstein-Fisch et al. 2001). More informal greetings using the given name early in an encounter are common, especially among the younger generation. Healthcare providers should introduce themselves by the name they preferred to be addressed. Again, asking the individual by what name they wish to be addressed is the better plan of action.

In individualistic cultures individuals will usually respond to the healthcare provider with straightforward answers or evade the question completely if they do not want to answer it. Questions requiring "yes" or "no" are answered frankly. Sharing intimate life details is encouraged, even with non-intimates, and does not carry a stigma for patients or their families. Egalitarian decision-making is the norm, that is, patients/clients are empowered to make health-related decisions for themselves, although there are variations. When in doubt, ask who the primary decision-maker is for health-related concerns.

14.3 Nonverbal Communication

Nonverbal communication includes touch; eye contact; facial expressions; body language; temporality in terms of past, present, and future orientation; clock versus social time; and dress and adornment. Touch has substantial variations in meaning among cultures. For the most part, individualistic cultures (see Chap. 2 for individualistic and collectivistic cultural values) are low-touch cultures, which have been reinforced by sexual harassment guidelines and policies in the United States and many other countries. For many, even casual touching may be seen as a sexual overture

or taboo and should be avoided whenever possible as is the case with traditional Muslims and Orthodox Jews as examples. In many cultures, people of the same sex (especially men) or opposite sex do not generally touch each other unless they are close friends (Purnell 2013; Purnell and Finkl 2018). However, among most collectivist cultures, two people of the same sex can touch each other without it having a sexual connotation, although modesty remains important (Black-Lattanzi and Purnell 2006; Hall 1990a). Being aware of individual practices regarding touch is essential for effective health assessments. Always explain the necessity and ask permission before touching a patient.

Under Islamic law, it is *haram* (forbidden) for a man to expose himself to any woman other than his wife. Likewise, for a woman to expose herself to a man who is not her husband is also forbidden. Therefore, except for an emergency, a full physical examination generally must be carried out by a healthcare professional of the same sex as the patient unless it is an emergency situation (Kulwicki and Ballout 2014), and even then the patient may be reluctant or refuse touching. When a same-sex healthcare professional is not available, some patients may give permission to touch using gloves, having the healthcare provider's hand over the patient's hand for palpation or through a layer of clothing. When examining women, especially young unmarried girls, a female chaperone must be present. The chaperone could be a member of the family, allowing the patient to feel more at ease. Married women may wish their husbands to be present. Moreover, the patient should also be examined in an area where the sudden intrusion of other people is not possible.

In general, the physical health assessment progresses from head to toe, touching less intimidate areas of the body first such as the head, arms, and hands. However, traditional Vietnamese never touch another's head because it is deemed disrespectful, especially that of a child, and is something that only an elder may do (Mattson 2013).

Personal space needs to be respected when working with multicultural patients and staff. Among more individualistic cultures, conversants tend to place at least 18 in. of space between themselves and the person with whom they are talking. Most collectivist cultures require less personal space when talking with each other (Hall 1990a). 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 (Hall 1990a). However, patients who stand very close and stare during a conversation may offend some healthcare providers. Thus, an understanding of personal space and distancing characteristics can enhance the quality of communication among individuals (Gardenswartz and Rowe 1998; Hall 1990b; Ritter and Hoffman 2010).

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 (Hall 1990b). Among some traditional or collectivist cultures, sustained eye contact can be seen as offensive. Furthermore, a person of lower social class or status is expected to avoid eye contact with superiors or those with a higher educational status (Purnell 2010). Thus, eye contact must be interpreted within its cultural context to optimize relationships and improve health assessments and recommendations.

Although many people in individualistic cultures 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 (Purnell 2013).

Temporal relationships—people's worldview in terms of past, present, and future orientation—vary among individuals and among cultural groups. Highly individualistic cultures are primarily 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 (Gudykunst and Matsumoto 1996).

In terms of healthcare, more future-oriented cultures are more likely to have at least yearly preventive health checkups and prenatal visits, adhere to immunizations, take advantage of flu vaccines, engage in healthy physical activities, and strive to consume a healthy diet. Present-oriented patients may have difficulty incorporating the future into long-term plans. For example, present-oriented patients might not take their antihypertensive medications if they are asymptomatic, although this occurs among some from individualistic cultures as well. Patients with diabetes might be reluctant to perform glucose monitoring unless they are symptomatic. Stress, poverty, and other social issues may exacerbate present-oriented beliefs on healthcare.

In past-oriented cultures, laying a proper foundation by providing historical background information can enhance communication. Past-oriented societies are concerned with traditional values and ways of doing things. They tend to be conservative in healthcare management and slow to change those things that are tied to the past. Past-oriented patients strive to maintain harmony with nature and look to the land to provide treatment for disease and illness. Herbal remedies are important and patients usually prefer traditional approaches to healing rather than accepting each new procedure, treatment, or medication that comes out. 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 (Hall 1990a, c).

Most people from individualistic cultures see time as a highly valued resource and do not like to be delayed because it "wastes time" (Hall 1990d). 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 healthcare setting, if an appointment is made for 1300 hour (1:00 *PM*), the person is expected to be there 15 min early to be ready for the appointment and not delay the healthcare provider. For collectivistic cultures, the concept of time may be more fluid. Expectations for punctuality can cause conflicts between healthcare 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 (Hall 1990d; Purnell and Pontious 2014).

14.4 Sign Language

Sign language is a combination of verbal and nonverbal communication. Although signing is primarily nonverbal, it also includes multiple facial expressions and may have guttural sounds to accompany the signed words. It is important to note that signing is not a direct word-for-word interpretation, but rather the interpreter must extract the meaning from a message and then convey that meaning. No one form of sign language is universal. Different sign languages are used in different countries or regions. For example, British Sign Language (BSL) is a different from American Sign Language (ASL), and Americans who know ASL may not understand BSL (Lingua translations 2016). Belgium and India have more than one sign language. More diversity in sign languages can be found with Japanese Sign Language (or Nihon Shuwa, JSL), Spanish Sign Language (Lengua de signos o señas española, or LSE), and Turkish Sign Language (or Türk İşaret Dili, TID) (World Federation of the Deaf 2016). In addition, there are numerous country-/language-specific sign languages such as Filipino and Hebrew (Abdel-Fattah 2004).

Only recently has sign language in the Arab world been recognized and documented. Many efforts have been made to establish the sign languages used in individual countries, including Jordan, Egypt, Libya, and the Gulf States by trying to standardize the language. Such efforts produced many sign languages, almost as many as Arabic-speaking countries. Levantine Arabic Sign Language, also known as Syro-Palestinian Sign Language, is the deaf sign language of Jordan, Palestine, Syria, and Lebanon (Abdel-

Fattah 2004). Some hospitals in the United States and Great Britain have used Skype to connect with Arab countries in order to communicate with deaf and hearing impaired patients.

14.5 Communicating with Communities

Communicating with community populations can be critical for culturally competent care to better understand issues that affect the lives of the vulnerable and to assist them to make informed decisions for themselves and their community (Public Health Assessment Guidance Manual (2005: Update) 2011). At all times, the message should be in the language(s)/dialect(s) of the populations served.

Strategies to communicate with the community include announcements on public radio and television stations, local newspapers and media outlets, partnering with community organizations and associations, newsletters, neighborhood grocery stores, local libraries, town hall meetings, focus group discussions, and distributing brochures at public venues such as the Post Office, utility companies, restaurants, houses of worship, barber shops and beauty salons, and on public transportation systems if available. Even partnering with local gangs and cults can help gather and disseminate information.

14.6 Health Literacy

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and healthcare services required to make health decisions and follow treatment recommendations (Egbert and Nanna 2009). Studies have shown that people from all ages, races, income, and educational levels are challenged by this problem. Individuals with limited health literacy incur medical expenses that are up to four times greater than patients with adequate literacy skills, resulting in higher costs to the healthcare system, unnecessary visits to healthcare providers, and increased hospital stays (National Academy on an Aging Society 1999). Seeking medical care, taking medications correctly, and following prescribed treatments require that people understand how to access and apply health information (US Department of Health and Human Services 2015). People with limited literacy are less likely to (a) ask questions during the medical encounter, (b) seek health information from print resources, and (c) understand medical terminology and jargon (National Association of the Deaf (n.d.), US Department of Health and Human Services 2015).

Many health-related documents are written at a college level and contain a large amount of text in small print and complex terminology (Neilsen-Bohlman et al. 2004). However, the recommendation is that patient education materials should be written at the sixth grade reading level, although this level varies somewhat by the language (Cotunga et al. 2005). Those with limited language proficiency have difficulty understanding written information, including medication dosage instructions and warning labels, discharge instructions, consent forms for treatment, participation in research studies, and basic health information about diseases, nutrition, prevention, and health services. The inability to read and comprehend such materials also impacts patients' ability to understand medical advice, engage in self-care behaviors, and make informed decisions about their healthcare (US Department of Health and Human Services 2015).

One of the recommendations found in the literature for patients taking medicines is to instruct them to take the "green," "blue," "yellow," etc. pill. This practice **is not recommended** for a number of reasons. Some patients may not be able to distinguish colors, or the color of a pill may change given the numerous generic medications. Moreover, the word for green and blue are the same in some languages (World Heritage Encyclopedia 2017).

14.7 Interpretation Versus Translation

The key difference between interpretation and translation is the choice of communication channels. Translation deals with written communication, while interpretation deals with the spoken word (Bureau of Labor Statistics, Department of Labor; Occupational Outlook Handbook 2006; Lionbridge 2012). Both channels require linguistic and cultural knowledge of the working languages. While translators usually provide word-for-word translation, interpreters must know both the original speech and the target language and transpose one language into another in real-time situations. They also act as facilitators between the speakers and listeners (Translation Central n.d.). Although, in the past, interpretation occurred in real time and only face-to-face, the advent of technology has changed this dramatically. Systems can accommodate (a) headphones used by the patient, healthcare provider, and interpreter, (b) Skyping, (c) television/video service, and (d) other distance methodologies 24 hours a day. Interpreters must capture the tone, inflection, voice quality, and other intangible elements of the spoken word and convey the meaning of the words. Interpretation, unlike translation, is not word-for-word but a paraphrasing of the words (American Translators Association 2015; Federation of Interpreters and Translators 2015; National Council on Healthcare Interpreting n.d.).

14.8 Recommendations for Using Medical Interpreters

1. Use certified interpreters whenever possible. Certified interpreters are trained to be ethical and nonjudgmental. Noncertified interpreters might not report information that he/she perceives as superstitious or not important. Certified interpreters take an oath of confidentiality.
2. Normally, children should never be used as interpreters for their family members. Not only does it have a negative bearing on family dynamics, but sensitive information may not be transmitted. However, the healthcare provider must also be aware that in some cultures, family or other people in the community might be preferred as an interpreter because they are more trusted then outsiders.
3. Avoid the use of relatives if possible because they may distort information or not be objective.
4. If possible, give the interpreter and patient time alone to get acquainted.
5. Use dialect-specific interpreters whenever possible.
6. Use a same-sex interpreter as the patient if desired.
7. Maintain eye contact with both the patient and the interpreter.
8. Direct your question to the patient, not the interpreter.
9. Some patients may want an interpreter who is older. Ask the patients if they have an age preference of the interpreter and accommodate this preference if possible.
10. Social class differences between the interpreter and the patient may affect interpretation.
11. Some patients may desire an interpreter of the same religion.

14.9 Recommendations

Recommendations for clinical practice, administration, education, and research follow.

14.9.1 Recommendations for Clinical Practice

Ascertain the possibility that cultural differences may cause communication problems; pay attention to nonverbal as well as verbal communication. Clinical staff must consider factors that govern diversity within a culture that can affect cross-cultural communication such as age, generation, nationality, race, color, sex, gender roles, religion, military status, political beliefs,

educational status, occupation, socioeconomic status, sexual orientation, urban versus rural residence, limited language proficiency, health literacy, physical characteristics of patients and providers, and reasons for immigration/migration including documentation status. Refugees and asylees may have considerable difficulty trusting healthcare providers based on discrimination in their home country (Purnell and Finkl 2018).

Effective communication is a key to providing culturally competent and congruent care in clinical practice. Therefore, healthcare providers need to understand their own cultural communication practices as well as being knowledgeable of the communication practices of their patients. Concerted efforts must be made for translating educational materials according to the patient's health literacy level and language proficiency. Every attempt should be made to obtain certified interpreters when needed. Recognize that it is not always possible to have an interpreter for every language and dialect. Family members and significant others should only be used as a last resort and for nonconfidential information such as dietary and medication instructions. Moreover, if possible, it is best to refrain from using interpreters known to the patient or family.

Because it is not always possible to know the cultural characteristics and attributes of all diverse patients, using a collectivistic and individualistic communication framework and guide can be helpful when you are not familiar with the culture of the patient (see Chap. 2). The caregiver should always address the patient formally until told to do otherwise and ask how he/she wishes to be identified, along with their legal name for medical record keeping. Likewise, the care providers should introduce themselves by their titles and positions. Patients have a right to know who is providing care to them.

For the hearing impaired, determine whether the patient uses American Sign Language, Signed English, or other specific sign languages. A writing system for communication when a signer is not available should be provided.

Develop pain scales in the patient's preferred language as well as "Faces of Pain" specific to ethnicities. Recognize that some people might not show their amount of pain in facial expressions. Using numerical pain scales might be more helpful.

When providing instructions for medications, the provider should explain them in the correct sequence and one step at a time. For example, (a) at 9:00 every morning, get the medicine bottle, (b) take two tablets out of the bottle, (c) get your hot water, and (d) swallow the pills with the water. Do not use complex and compound sentences or use contractions when giving instructions. Many languages do not use contractions, and they can cause confusion for some patients. The patient should always demonstrate procedures and how medications are prescribed; simply repeating the instructions does not demonstrate understanding. Upon discharge, educational materials should be in the patient's preferred language and at a level that meets the needs of patients with low health literacy and limited language proficiency (Purnell 2008; Purnell and Finkl 2018).

14.9.2 Recommendations for Administration

Administration has a prime responsibility for obtaining resources to ensure that culturally competent clinical practice can occur. Resources include finances as well as recruiting adequate staff from the population the organization serves. In addition, financial resources are needed for interpretation and translation services which are a federal requirement in the United States and highly recommended in many other countries.

Symbols and pictograms should be included in hospitals, clinics, and other healthcare organizations whenever possible. These symbols and pictograms need to be validated with members of the specific ethnic community to assure that they are accurate and not culturally offensive. Intranet websites should be developed and in different languages for diverse patient populations. General health information on illnesses, infections, diseases, and injury protection in languages of the patient population can be developed and distributed in areas where patients, families, and

significant others shop, congregate, and use public transportation. Patients and families should be informed about their existence upon admission. Disease-oriented practice guidelines for culturally diverse populations served in the organization can be developed and shared with all staff. When feasible, consider short video clips in languages spoken by the patient population.

Administration has the responsibility of keeping abreast of assistive technology used with the hearing and visually impaired and perhaps collaborating with communities to develop training for interpreters if certified interpreters are not feasible. In addition, satisfaction surveys should be translated into the languages of the populations served; otherwise only part of the information is gathered. Direct care providers and others who work with patients, families, and significant others from diverse cultures should be surveyed on their most pressing issues. Develop disease-oriented practice guidelines for culturally diverse populations served in the organization.

14.9.2.1 Recommendations for Education and Training

Culturally competent clinical practice begins with formal classes in educational programs of all healthcare professionals. Individual healthcare professionals must continue their education on cultural values, beliefs, and skills because cultures change over time. In addition, culturally congruent care should be included in orientation programs for all staff. Cultural assessment tools need to be included on admission forms. Classes with common foreign phrases could be included, specific to areas of clinical practice for when interpreters are not available.

Ongoing continuing education classes and seminars on the cultures and religions of the patient population served should be conducted on a yearly and on an as-needed basis. Train-the-trainer programs can help assure staff have access to information on a 24/7 basis. Evidence-based printed and electronic resources specific to the diversity of patients and staff in the organization could be in the organization's Intranet so staff can access it on a 24/7 basis. Intranet with articles, book chapters, and books could be included with the organizations' library as well as having them in printed format for staff to take home.

14.9.2.2 Recommendations for Research

Research needs to continue on population-specific health beliefs and values to assure culturally competent clinical practice. Resource-poor organizations may not have the human and material resources to conduct research, but with newer technologies and the Internet, partnering with educational organizations is a viable alternative. At a minimum, staff, educators, and administrators and managers can identify gaps in the literature of patients cared for in the organization, conduct research on those topics, and conduct quality improvement projects. A culture of nursing research can be accomplished by initiating a journal club devoted to evidence-based practice and research studies. Advanced practice nurses with a background in research and evidence-based practice can help staff obtain literature and assist them with quality improvement projects.

Conclusion

The importance of effective verbal and nonverbal cross-cultural communication cannot be overemphasized as it is the basis of establishing trust and obtaining accurate health assessments and providing instructions. Both interpretation and translation have some inherent troublesome concerns. Due to the complexity of languages and multiple dialects of a language, specific words may not exist in the host language and require an explanation of the word or phrase; the exact meaning may still be lost (Van Ness et al. 2010). For example, having knowledge of the cultures to whom care is provided, the variant cultural characteristics, and the complexities of interpretation and translation is a requisite for decreasing/eliminating health and healthcare disparities (International Medical Interpreters Association 2017). A healthcare provider cannot possibly know all worldwide cultures; however, an understanding of the differences between collectivistic and individualistic cultures is a starting point and can be used as a framework

for assessing cross-cultural communication styles and improving health assessments (Keeskes 2016). Intercultural pragmatics, dealing with things sensibly and realistically, can bring some new insight into theories.

Appendix 1: Communication Exercise

Effective communication is essential in the delivery of culturally congruent health and nursing care. For cultural communication to be effective, the healthcare providers need to understand their own communication practices. The following exercise will assist providers to understand their own communication practices.

Instructions

1. Identify your own cultural identity and personal communication practices and how they differ with family, friends, and strangers, including patients.
2. Investigate the scholarly literature on your culture after you have completed the exercises.
3. Identify how your communication patterns differ from what was in the scholarly literature.
4. Posit why these personal practices differ.

Note: Variant characteristics within a culture can be used as a guide to addressing the statements below. These variant cultural characteristics include:

Nationality	Age	Skin color
Race	SES	Physical characteristics
Ethnicity	Occupation	Parental status
Gender	Marital status	Political beliefs
Sexual orientation	Educational status	Religious affiliation
Gender issues	Health literacy	Military experience
Enclave identity	Urban vs. rural residence	

Length of time away from country of origin

Reason for migration: sojourner, immigrant, undocumented status

Once this exercise is completed, it should be shared with others for a discussion. This exercise can be used in academic classes, continuing education classes, and in-services.

- Identify your cultural ancestry. If you have more than one cultural ancestry, choose one for the sake of this exercise.
- Explore the willingness of individuals in your culture to share thoughts, feelings, and ideas. Can you identify any area of discussion that would be considered taboo?
- Explore the practice and meaning of touch in your culture. Include information regarding touch between family members, friends, members of the opposite sex, and healthcare providers.
- Identify personal spatial and distancing strategies used when communicating with others in your culture. Discuss differences between friends and families versus strangers.
- Discuss your culture's use of eye contact. Include information regarding practices between family members, friends, strangers, and persons of different age groups.
- Explore the meaning of gestures and facial expressions in your culture. Do specific gestures or facial expressions have special meanings? How are emotions displayed?
- Are there acceptable ways of standing and greeting people in your culture?
- Discuss the prevailing temporal relation of your culture. Is the culture's worldview past, present, or future oriented?
- Discuss the impact of your culture on your nursing and/or healthcare. Be specific, that is, not something that is very general.

Appendix 2: Reflective Exercises

The following reflective exercises can be used in formal courses at any level and discipline or interdisciplinary. They can also be used in staff development.

1. What changes in ethnic and cultural diversity have you seen in your community over the

last 5 years? Over the last 10 years? Have you had the opportunity to interact with newer groups?
2. What health disparities have you observed in your community? To what do you attribute these disparities? What can you do as a professional to help decrease these disparities?
3. Who in your family had the most influence in teaching you cultural values and practices? Mother, father, or grandparent?
4. How do you want to be addressed? First name or last name with a title?
5. How do you address older people in your culture? First name or last name with a title?
6. What activities have you done to increase your cultural competence?
7. Given that everyone is ethnocentric to some degree, what do you do to become less ethnocentric?
8. How do you distinguish a stereotype from a generalization?
9. How have your variant characteristics of culture changed over time?
10. What ethnic and racial groups do you encounter on a regular basis? Do you see any racism or discrimination among these groups?
11. What does your organization do to increase diversity and cultural competence?
12. What barriers do you see to culturally competent care in your organization? School, work, etc.
13. How many languages are spoken in your community?
14. Do different languages pose barriers to healthcare, including health literacy? What affordability concerns for healthcare do you see in your community?
15. What complementary/alternative healthcare practices do you use?
16. What complementary/alternative healthcare practices are available in your community?
17. Is public transportation readily available to healthcare services in your community? What might be done to improve them?
18. What do **you** do when you cannot understand the language of your patient?
19. In what languages are healthcare instructions provided in your organization?
20. Does your organization offer both interpreter and translation services?
21. Given the heritage and diversity of the population in your community, what cultural, social, and material issues do you consider important?

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