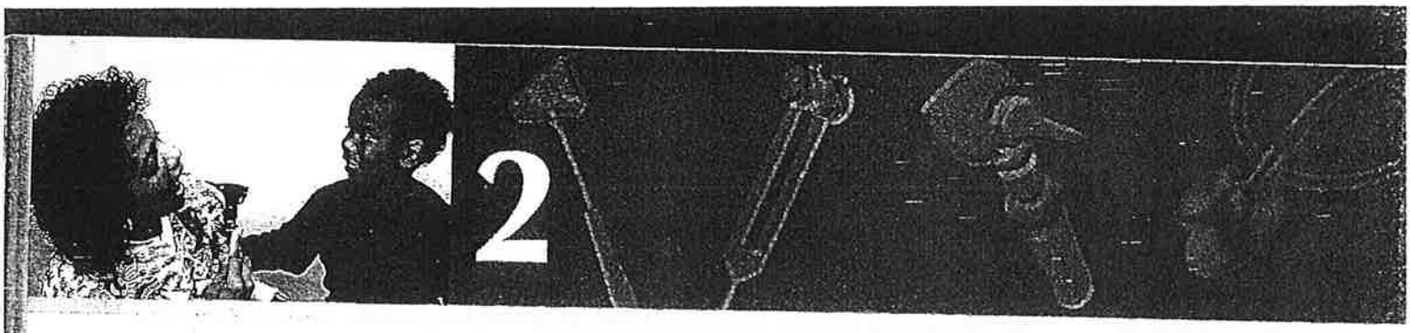


2

Cultural Awareness

To be culturally aware is to understand those aspects of the human condition that differentiate individuals and groups. These differences sometimes have an overpowering effect on the health and medical care of individuals and groups. They cause a variation in the patient's decision as to what may sometimes be a personal responsibility and at other times a signal to seek out a health care professional. Box 2-1 suggests ways of developing cultural competence.

CULTURAL COMPETENCE

It may push the envelope to conclude that we can understand persons from another culture with absolute empathy and without bias. We can, however, validate our efforts to do this by bringing to them a respectful curiosity, imagination, and the best possible insight into the self. Taken with a conscientious understanding of your patient's culture, these can ensure that we offer better care within differing value systems and act with respect and understanding without imposition of our own attitudes and beliefs. The ability to do this is defined by many as culture competence. This compe-

BOX 2-1 Ways of Developing Cultural Competence

Recognize that cultural diversity exists.
Demonstrate respect for people as unique individuals, with culture as one factor that contributes to their uniqueness.
Respect the unfamiliar.
Identify and examine your own cultural beliefs.
Recognize that some cultural groups have definitions of health and illness, and practices that attempt to promote health and cure illness, that may differ from your own.
Be willing to modify health care delivery in keeping with the patient's cultural background.
Do not expect all members of one cultural group to behave in exactly the same way.
Appreciate that each person's cultural values are ingrained and therefore very difficult to change.

Modified from Stulc, 1991.

tence rejects the idea of cultural difference as a problem. It does not demean the "other" but allows a clear vision of differences and their value. There is in it esteem for the "other."

A DEFINITION OF CULTURE

CLINICAL PEARL

Political Correctness

It is important to dispel the notion that cultural awareness implies a need to be politically correct. It is, rather, an integral part of the overall effort to respond well to a person in need.

Culture, in its broadest sense, reflects the whole of human behavior, including ideas and attitudes; ways of relating to one another; manners of speaking; and the material products of physical effort, ingenuity, and imagination. Language is a part of culture. So, too, are the abstract systems of belief, etiquette, law, morals, entertainment, and education. Within the cultural whole, different populations may exist in groups and subgroups. Each is identified in some way by a particular body of shared traits (e.g., a particular art, ethos, or belief; or a particular behavioral pattern).

Any individual may and probably does belong to more than one group or subgroup. These multiple belongings can be the result of—among others—ethnic origin, religion, gender, occupation, and profession. For example, an Episcopalian, British, white male physician bears to some degree the cultural imprint of each of these groups; so, too, an African-American, Catholic, female physician.

DISTINGUISHING PHYSICAL CHARACTERISTICS

The use of physical characteristics (e.g., gender or skin color) to distinguish a cultural group or subgroup can be a trap. There is a sharp difference between distinguishing cultural characteristics and distinguishing physical characteristics. You should neither confuse the physical with the cultural nor allow the physical to symbolize the cultural. To assume homogeneity in the beliefs, attitudes, and behaviors of all men, or all African-Americans, or all health care professionals is to court error and to miss the mark in the effort to understand the individual. The stereotype, a fixed image of any group that rejects the potential of originality or individuality within the group, is itself to be rejected. People can and do respond differently to the same stimuli.

This does not minimize the value of understanding the cultural characteristics of groups; it does deny the use of a physical characteristic, such as gender or race, as a metaphor for the culture of a group. Nor does this deny the interdependence of the physical with the cultural. Genetic imprinting, for example, precedes the development of the intellect, sensitivity, and imagination that allow the creation of a Beethoven sonata or a Miles Davis jazz piece, both of which are genuine cultural achievements. Similarly, skin color precedes most of the experience of life and the subsequent interweaving of color with cultural experience.

THE IMPACT OF CULTURE

Box 2-2 suggests that social and economic conditions can define many of the subgroups in the United States. Poverty and inadequate education have a negative cultural impact that is seriously reflected in health and medical care. Although death rates have declined overall in the United States since 1960, the poorly educated and those in poverty still die at higher rates than those who are better educated and economically advantaged. Morbidity, too, is greater among the poor. Recent studies also suggest that racial and gender differences can have an impact on the care of individuals even in the absence of financial differences. White men, for example, are more apt to be subjected to invasive cardiac procedures and tests than are blacks and white women, suggesting that social, cultural, and clinical factors may be weighed differently in different cultural groups (Schulman et al, 1999). These rather stark facts are

BOX 2-2 A Lexicon of Cultural Considerations

Acculturation: The process by which an individual accommodates to the traits and behaviors of another culture. The degree of acculturation can vary. The past is rarely, if ever, completely rejected.

Culture: A complex, integrated system reflecting the whole of human behavior and experience; a group's adoption of shared values, the attempt to make sense of their world.

Custom: The habitual activity of a group or subgroup; patterned responses to given occasions, generally passed on from one generation to the next.

Enculturation: The process by which an individual assumes the traits and behaviors of a given culture: adapting to it, adopting its values, and taking on that particular cultural identity.

Ethnocentrism: The belief in the superiority of one's own group and culture, combined with disdain for other groups and cultures. Any degree of ethnocentrism impairs effort to understand patients within the context of their individual cultures.

Ethnos (ethnic group): A group of the same race or nationality, with a common culture and distinctive traits.

Minority: A group that is different from the majority of a population, as with regard to religion, race, or ethnic origin. When the difference is deep-seated in historical relationships or is obvious (e.g., because of skin color), the minority group may be treated unjustly, sometimes obviously, sometimes more subtly.

Norm: A prescribed standard of allowable behavior within a group or subgroup. To the extent that individuals adopt the positive values of their group or groups, and to the extent that they measure up to the norms, they are judged favorably or unfavorably by the other members of the group.

Race: A physical, not a cultural, differentiator based on a common heredity, using as identifier characteristics such as skin color, head shape, and stature.

Rite: A prescribed, formal, customary observance (e.g., ceremonial religious acts, graduation ceremonies).

Ritual: A stereotypic behavior regulating religious, social, and professional behaviors (e.g., the expected use of "please" and "thank you") in a variety of circumstances.

Stereotype: A simplified, generally inflexible conception of the members of a group or subgroup.

Subculture: A group or subgroup having values and behavioral patterns or other distinctive traits that differentiate it from other groups or subgroups within a larger culture. Individuals may share the traits of more than one group or subgroup and may, with adaptation, shed some traits and adopt others.

Values: The ideals, customs, institutions, and behaviors within a group or subgroup for which the members of the group have a respectful regard. Values may be positive or negative and desirable or undesirable (e.g., with regard to charitable donation or criminal behavior, consensual sexual relationships or rape).

but the tip of the iceberg; they are, however, sufficient to underscore the need for cultural awareness in health and medical care professionals.

THE BLURRING OF CULTURAL DISTINCTIONS

Cultural differences are malleable in a way that physical characteristics may not be. For example, one nation can be distinguished from another by language. However, change and necessity mandate more and more that we learn one another's languages. We may begin in that way to override political divisions. Modern technology and economics will slowly but inevitably ensure the achievement of universality in language. The changes may be imperceptible, spanning generations, but they are also relentless. However, the resistance to change, driven for better or worse by our culturally derived territorial need to protect individual space, is at the root of social, political, and economic tragedy. This worldwide resistance to develop a true awareness of each other is keenly evident. Still, as health care providers, we must not resist or we will not serve well.

THE PRIMACY OF THE INDIVIDUAL IN HEALTH CARE

The individual patient may be visualized as being at the center of an indefinite number of concentric circles. The outermost circles represent constraining universal experiences (e.g., death). The circles closest to the center represent the various cultural groups or subgroups to which anyone must, of necessity, belong. The constancy of

BOX 2-3 Questions that Explore the Patient's Culture

- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you?
- How does it work?
- How bad is your sickness?
- How long do you think it will last?
- What should be done to get rid of it?
- Why did you come to me for treatment?
- What benefit will you get from the treatment?
- What are the most important problems your sickness has caused for you?
- What worries you and frightens you the most about your sickness?
- Who else or what else might help you get better?
- Has anyone else helped you with this problem?

Modified from Kleinman, Eisenberg, Good, 1978.

CLINICAL PEARL

The Impact of Gender

If a female internist or family practitioner serves a woman, that patient is more apt to be screened with Pap smears and mammograms.

change forces adaptation and acculturation. The circles are constantly interweaving and overlapping. For example, a common experience in the United States has been the economic gain at the root of the assimilation of many ethnic groups, with greater homogeneity dominating, but not necessarily excluding, earlier ethnic behaviors. However, predicting the individual's character merely on the basis of the common cultural behavior is not appropriate; understanding and taking the common cultural behavior into account are. The stereotype cannot prevail. The individual at the center is unique (Box 2-3).

BOX 2-4 Cultural Assessment Guide: The Many Aspects of Understanding

Health Beliefs and Practices

How does the patient define health and illness? How are feelings concerning pain, illness in general, or death expressed?
Are there particular methods used to help maintain health, such as hygiene and self-care practices?
Are there particular methods being used by the patient for treatment of illness?
What is the attitude toward preventive health measures such as immunizations?
Are there health topics that the patient may be particularly sensitive to or that are considered taboo?
Are there restrictions imposed by modesty that must be respected; for example, are there constraints related to exposure of parts of the body, discussion of sexual matters in male/female relationships, and attitudes towards various procedures such as termination of pregnancy or vasectomy?
What are the attitudes toward mental illness, pain, handicapping conditions, chronic disease, death, and dying? Are there constraints in the way these issues are discussed with the patient or with reference to relatives and friends?
Is there a person in the family responsible for various health-related decisions such as where to go, whom to see, and what advice to follow?
Does the patient prefer a health professional of the same gender, age, ethnic and racial background, or is this not a significant issue?

Religious Influences and Special Rituals

Is there a religion to which the patient adheres?
Is there a significant person to whom the patient looks to for guidance and support?
Are there any special religious practices or beliefs that may affect health care when the patient is ill or dying?
What events, rituals, and ceremonies are considered important within the life cycle of birth, baptism, puberty, marriage, and death? What is the culturally appropriate way to respond to these life events? To what extent is an overt expression of emotion and spirituality inherent in that response?

Language and Communication

What language is spoken in the home?
How well does the patient understand English, both spoken and written?
Are there special signs of demonstrating respect or disrespect?
Is touch involved in communication?
Are there culturally appropriate ways to enter and leave situations (e.g., greetings and farewells) and convenient times to make a home visit?
Is an interpreter needed? Should that person be a relative, friend, or a presumably objective stranger? Certainly, whoever it is should be acceptable to the patient.

Parenting Styles and Role of Family

Who makes the decisions in the family?
What is the composition of the family? How many generations are considered to be a single family, and which relatives compose the family unit?
When the marriage custom is practiced, what is the attitude about separation and divorce?
What is the role of and attitude toward children in the family?
When do children need to be disciplined or punished, and how is this done (if physical means are used, in what way)?
Do the parents demonstrate physical affection toward their children and each other?
What major events are important to the family, and how are they celebrated?
Are there special beliefs and practices surrounding conception, pregnancy, childbirth, lactation, and childrearing? Is co-sleeping practiced?

Sources of Support Beyond the Family

Are there ethnic or cultural organizations that may have an influence on the patient's approach to health care?
Are there individuals in the patient's social network that can influence perception of health and illness?
Is there a particular cultural group with which the patient identifies? Can this be clarified by where the patient was born and has lived?
What is the patient's need for relationships with others?
Is the patient socially gregarious or a loner, and is the preference indicated by behavior before illness?

Dietary Practices

What does the family like to eat? Does everyone in the family have similar tastes in food?
Who is responsible for food preparation?
Are any foods forbidden by the culture, or are some foods a cultural requirement in observance of a rite or ceremony?
How is food prepared and consumed?
Are there specific beliefs or preferences concerning food, such as those believed to cause or to cure an illness?
Are there periods of required fasting? What are they?

Modified from Stulc, 1991.

Nevertheless, ethical issues often arise when the care of an individual comes into conflict with the utilitarian needs of the larger community, particularly with the recognition of limited resources, and in the United States, the imposition of managed care. Cultural attitudes, often vague and poorly understood, may constrain our professional behavior and may confuse the context in which we serve the individual. Box 2-4 offers a guide to the understanding of the patient's beliefs and practices and can aid in the relief of confusion.

PROFESSIONAL CULTURES WITHIN THE HEALTH PROFESSIONS

There is a harmony—a unity—in the care of patients that is not constricted by the cultural and administrative boundaries of the individual health professions. Caring and curing, in a practical and a deeply emotional sense, are not the sole provinces of any of them. To the extent that we stake out territories of care, by allowing individual professional cultures and needs to take precedence over patient needs, we impede the achievement of harmony. The blurring of professional cultural borders works to the advantage of the patient, provided the blurring is motivated by the best interest of the patient. Each of us must understand our professional role and must be adaptable as cultural shifts suggest greater homogeneity in a number of those roles. In addition, Table 2-1 indicates that there are health beliefs and practices that are different from the long-institutionalized Judeo-Christian, Western perspective that dominates health education in the United States. Different clinicians in different parts of the world make different decisions. Your ability to understand and to respect differences, and to allow for the blurring of borders, will be a measure of your ability to form reinforcing relationships with other professionals and to care for a wide range of individuals.

Comparison of Value Orientations Among Cultural Groups

Value Orientation	Cultural Group
Time Orientation	
Present oriented: Accepts each day as it comes; future unpredictable	Black, hispanic, Native American
Past oriented: Maintains traditions that were meaningful in the past; worships ancestors	Eastern Asian
Future oriented: Anticipates bigger and better future; places high value on change	Dominant American
Activity Orientation	
"Doing" orientation: Emphasizes accomplishments that are measurable by external standards	Dominant American
"Being" orientation: Spontaneous expression of self	Black, hispanic, Native American
"Being-in-becoming": Emphasizes self-development of all aspects of self as an integrated whole	Eastern Asian
Human Nature Orientation	
Human being basically imperfect but with perfectible nature; constant self-control and discipline necessary	Black, dominant American, hispanic
Human being as neutral, neither good nor evil	Eastern Asian, Native American
Human-Nature Orientation	
Human being subject to environment with very little control over own destiny	Black, hispanic
Human being in harmony with nature	Eastern Asian, Native American
Human being master over nature	Dominant American
Relational Orientation	
Individualistic: Encourages individualism: interpersonal relationships occur more with outsiders and less with family	Dominant American
Lineal: Group goals dominant over individual goals; ordered positional succession (father to son)	Eastern Asian
Collateral: Group goals dominant over individual goals: more emphasis on relationship with others on one's own level	Black, hispanic, Native American

NOTE: The beliefs of a group may not be those of an individual in the group.
Modified from Kluckhohn, 1976.

THE IMPACT OF CULTURE ON ILLNESS

Disease is shaped by illness, and illness—the full expression of the impact of disease on the patient—is shaped by the totality of the patient's experience. Cancers are diseases. The patient dealing with, reacting to, and trying to live with a cancer is having an illness—is "ill" or, in personal terms, is "sick." The definition of "ill" or "sick" is based on the individual's belief system and is determined in large part by his or her enculturation. This is so for a brief, essentially mild episode or for a chronic, debilitating, life-altering condition. If we do not consider the substance of illness—the biologic, emotional, and cultural aspects—we will too often fail to offer complete care. To make the point, imagine that while taking a shower you have done a self-examination and, still young, still looking ahead to your career, you have discovered an unexpected mass in a breast or a testicle. How will you respond? There are components to your response that you can understand and master.

THE COMPONENTS OF A CULTURAL RESPONSE

You can understand the culture of another and be empathetic with it. When differences exist, you must be sensitive to them. You must also be certain that you grasp exactly what the patient means, and know exactly what the patient thinks you mean in words and actions. Ask if you are not sure; this is far better than making a damaging mistake. Avoid making assumptions about cultural beliefs and behaviors without validation from the patient.

Those cultural beliefs and behaviors that will have an impact on your assessment of the patient include the following:

- Modes of communication: the uses of speech, body language, and space
- Health beliefs and practices that may vary from the Judeo-Christian, Western model
- Diet and nutritional practices
- The nature of relationships within a family

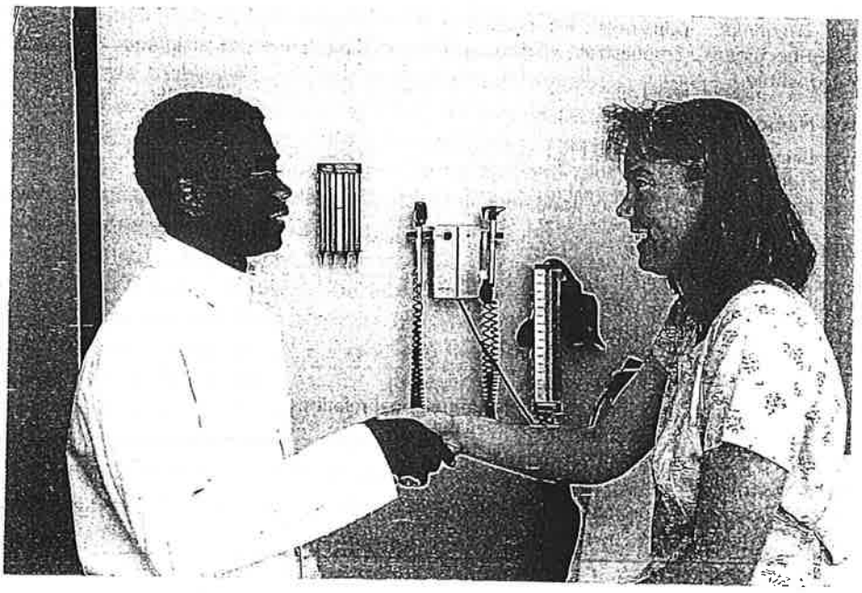


FIGURE 2-1
Being sensitive to cultural differences that may exist between you and the patient can help avoid miscommunication.

In particular, there can be a variety of ethnic attitudes toward autonomy. The patient-centered model, still firmly respected in the United States (although subject now to some critical discussion), is at odds with a more family-centered model that is more likely dominant elsewhere. In Japan, for example, the family is considered the legitimate decision-making authority for competent and incompetent patients (Fetters, 1998). Many cultures, for example, in the Middle East, believe that a patient should not be told of a diagnosis of a metastatic cancer or a terminal prognosis for any reason, attitudes not likely to be shared by Americans with European or African traditions. The desire to avoid discussing such negative information is particularly strong among the Navajo Native Americans. Traditionally, the Navajo culture holds that thought and language have the power to shape reality. Talking about a possible outcome is thought to ensure the outcome. It is important, then, to avoid thinking or speaking in a negative way. It is important to think and talk "in the Beauty Way" (Carrese, Rhodes, 1995). The situation can be dealt with by talking in terms of a third person or an abstract possibility. You might even refer to an experience you have had in your own family. Obviously, the conflicts that may arise from differing views of autonomy, religion, and information sharing require an effort that is dominated by a clear understanding of the patient's goals.

MODES OF COMMUNICATION

Communication and culture are interrelated, particularly in the way feelings are expressed verbally and nonverbally. The same word may have different meanings for different people. For example, in the United States, a "practicing physician" is an experienced, trained person. "Practicing," however, suggests inexperience and the status of a student to an Eskimo or to some Western Europeans. Similarly, touch, facial expressions, eye movement, and body posture all have varying significance.

Americans, for example, tend to talk more loudly and to worry less about being overheard than others do. The English, on the other hand, tend to worry more about being overheard and to speak in modulated voices, at a level that might be considered conspiratorial by Americans. Americans are very direct in conversation and are eager to be logical, preferring to avoid the subjective and to come to the point quickly. The Japanese tend to do the opposite, using indirection, talking around points, and emphasizing attitudes and feelings. Silence, while sometimes uncomfortable for many of us, affords the Native American a time to think; the response should not be forced and the quiet time should be allowed.

Many groups use firm eye contact. The Spanish meet one another's eyes and look for the impact of what is being said. The French, too, have a very firm gaze and often stare openly at others. This, however, might be thought rude or immodest in some Asian or Middle Eastern cultures. Americans are more apt to let the eyes wander and to grunt, nod the head, or say, "I see," or "uh huh," to indicate understanding. Americans also tend to avoid touch and are less apt to pat you on the arm in a reassuring way than are, for example, Italians.

These are but a few examples of cultural variation in communication (Hall, 1969). They do, however, suggest a variety of behaviors within groups. As with any example we might use, they are not to be thought of as rigidly characteristic of the indicated groups. Still, the questions suggested in Box 2-5 can at times provide insight to particular situations and can help avoid misunderstanding and miscommunication.

The cultural and physical characteristics of both patient and practitioner may therefore significantly influence communication. Social class, age, and gender are variables that characterize everyone; they can intrude on successful communication if there is no effort for mutual knowledge and understanding. The young student or practitioner and the elderly patient may have an important bridge to cross if they are to work together successfully. If that practitioner is a young woman and that patient

BOX 2-5 Asking Questions in the Right Order

Communication when you are exploring differences is made easier if you allow time for thoughtful answers and ask your questions in a comfortable order. A suggested sequence is the following:

When Talking About a Patient's Illness:

What do you think is wrong with you?
People have told me that there are sicknesses that doctors and nurses don't know about. Have you heard of them? What are they?
Have you ever known anyone with one of them?
Have you ever had one of them?
Do you think you might have it right now?

When Talking About Treatments:

People have told me that there are ways of treating sickness that doctors and nurses don't know about. Do you know any of them? What are they?
Do they work?
Have you ever tried them?
Do you use them?
Are they helpful?

Modified from Pachter, 1997.

is an old man, the crossing may be even more difficult. Recognizing the possible problem and talking about it, evoking feelings sooner rather than later, makes it easier. It is all right to ask if the patient is uncomfortable with any aspect of your person and to talk about it. Also, when any aspect of the patient's person disturbs you, you must try to understand why.

HEALTH BELIEFS AND PRACTICES

The patient may have a view of health and illness and an approach to cure that are shaped by a particular cultural and/or religious belief or paradigm. If that view is "scientific," in the sense that a cause can be determined for every problem in a very precise way, the patient is more apt to be comfortable with Western approaches to health and medical care.

However, the scientific view is reductionist and looks to a very narrow, specific cause and effect. A more naturalistic or "holistic" approach broadens the context. It views our lives as part of a much greater whole (the entire cosmos) that must be in harmony. If the balance is disturbed, illness can result. The goal, then, is to retrieve balance and harmony. Aspects of this concept are evident among the beliefs of many hispanics, Native Americans, Asians, and Arabs, and they are increasingly evident in people of all ethnic groups in the United States today (Box 2-6). There are also those who believe in the supernatural, or forces of good and evil that determine individual fate. In such a context, illness may be thought of as a punishment for wrongdoing.

Clearly, there can be a confusing ambivalence in many of us, patient and provider alike, because our heartfelt and genuine religious or naturalistic beliefs may conflict with the options available for the treatment of illness. Consider, for example, a child with a broken bone, the result of a careless accident that occurred while the child was under the supervision of a babysitter. The first need is to tend the fracture. That done, there is a need to talk with the mother about the guilt she may feel because she was away working, despite her husband's disapproval. She might think this accident must be God's punishment. It is important to be aware of, to respect, and to discuss without belittlement a belief that may vary from yours, in a manner that may still allow you to offer your point of view. This can apply to the guilt of a parent and to the use of herbs, rituals, and religious artifacts. After all, the pharmacopoeia of Western medicine is replete with plants and herbs that we now call drugs. Our inability to understand the belief of another does not invalidate its substance. Nor does a patient's adherence to a particular belief preclude concurrent reliance on allopathic health practitioners.

CLINICAL PEARL

Chicken Soup

Home-based remedies for common colds are widely used. To some extent, chicken soup complements acetaminophen in European, African-American, Puerto Rican, and West-Indian–Caribbean families.

Pachter et al, 1998

BOX 2-6 The Balance of Life: The "Hot" and the "Cold"

A naturalistic or holistic approach often assumes that there are external factors—some good, some bad—that must be kept in balance if we are to remain well. The balance of "hot" and "cold" is a part of the belief system in many cultural groups (e.g., Arab, Chinese, Filipino, and hispanic). To restore a disturbed balance, that is, to treat, requires the use of opposites (e.g., a "hot" remedy for a "cold" problem). Different cultures may define "hot" and "cold" differently. It is not a matter of temperature, and the words used might vary: for example, the Chinese have named the forces yin (cold) and yang (hot). Western medicine cannot ignore the naturalistic view if many of its patients are to have appropriate treatment for illness as well as disease.

Hot and Cold Conditions and Their Corresponding Treatments

Hot Conditions	Cold Foods	Cold Medicines and Herbs	Cold Conditions	Hot Foods	Hot Medicines and Herbs
Fever	Fresh vegetables	Orange flower water	Cancer	Chocolate	Penicillin
Infection	Tropical fruits	Linden	Pneumonia	Cheese	Tobacco
Diarrhea	Dairy products	Sage	Malaria	Temperate-zone fruit	Ginger root
Kidney problem	Meats such as goat, fish, chicken	Milk of Magnesia	Joint pain	Eggs	Garlic
Rash	Honey	Bicarbonate of soda	Menstrual period	Peas	Cinnamon
Skin ailment	Cod		Teething	Onions	Anise
Sore throat	Raisins		Earache	Aromatic beverages	Vitamins
Liver problem	Bottled milk		Rheumatism	Hard liquor	Iron-preparations
Ulcer	Barley water		Tuberculosis	Oils	Cod liver oil
Constipation			Cold	Meats such as beef, water-fowl, mutton	Castor oil
			Headache	Goat's milk	Aspirin
			Paralysis	Cereal grains	
			Stomach cramps	Chili peppers	

Modified from Wilson, Kneisl, 1988.

DIET AND NUTRITIONAL PRACTICES

CLINICAL PEARL

Beer

The mother-in-law of one of the authors drank beer while breast-feeding her babies in the belief that beer is a galactagogue, a substance that stimulates the flow of human milk. Whether it does or not, *no one* should use alcohol during pregnancy (and, afterwards, always in moderation if at all).

Beliefs and practices related to food, as well as the social significance of food, play an obvious vital role in everyday life. Some of these beliefs of cultural and/or religious significance may have an impact on your care. An Orthodox Jewish patient will not take some medicines, particularly during a holiday period like Passover, because the preparation of a drug does not meet the religious rules for food during that time. The Muslim woman must respect Halal (prescribed diet) even throughout pregnancy. A Chinese person with hypertension and a salt-restricted diet may need to consider a limited use of monosodium glutamate (MSG) and soy sauce. Attitudes toward vitamins vary greatly, with or without scientific proof, in many of the subgroups in the United States. It is still possible to work out a mutually decided care or management plan if the issues are recognized and freely discussed. This is possible, too, with attitudes toward home, herbal, and natural—complementary or alternative—therapies. Many will have benefit; others may be dangerous. For example, dietary supplements containing ephedra alkaloids may increase the risk of stroke (Haller, Benowitz, 2000; Kernan et al, 2000).

FAMILY RELATIONSHIPS

Family structure and the social organizations to which a patient belongs (e.g., religious organizations, clubs, and schools) are among the many imprinting and constraining cultural forces. The expectations of children and how they grow and develop are key in this regard and often culturally distinct. This needs emphasis in America today, with its shift toward dual-income families, single-parent families, and a significant number of teenage pregnancies. The prevalence of divorce (roughly one

for every two marriages) and the increasing involvement of fathers in child care in two-parent families suggest cultural shifts that need to be recognized.

One type of already known behavior may predict another type of behavior. For example, mothers who take advantage of appropriate prenatal care generally take advantage of appropriate infant care, regardless of educational level, marital status, family relationships, or maternal drug use (Butz et al, 1993). Adolescents who are unsupervised after school are more apt to smoke, use alcohol and marijuana, perform poorly in school, be depressed, and take risks than are those who are well supervised (Richardson et al, 1993). Being aware of this sequence of related behaviors is especially important because it often appears unrelated to the integrity of the family structure, gender, or racial or ethnic background. This is particularly true with the American cultural addiction to mass media. Adolescents who spend large amounts of time watching television and listening to heavy metal music are more apt to engage in risky behaviors than are those who do not; this too is regardless of race, gender, or parents' education (Klein et al, 1993). These examples remind us that one individual may belong to many groups and that the behaviors and attitudes of one of those groups, including pregnant women or adolescents, can override or modify the impact of the cultural values of other groups to which that person belongs.

SUMMING UP

As clinicians, we face a compelling need to meet each patient on his or her own terms and to resist forming a sense of the patient based on prior knowledge of the culture or cultures from which that patient comes. That knowledge should not be formative in arriving at conclusions; rather, we must draw upon it to help make the questions we ask more constructively probing. Otherwise, we will see the patient as a stereotype; that is something we must avoid.

You need to understand yourself well. There is no denying that your involvement with any patient gives that interaction a character that is unique, and that the substance you bring to it makes that interaction, to some extent, different from what it might have been with anyone else. If you do not understand this well, your attitudes, which are largely culturally derived, may be so insistent as to overwhelm your better understanding of the patient, and that increases the probability of stereotypic judgment. You must constrain your prejudices and your likes, as well as your tendencies to preach and to be judgmental. Do this and you will be making strides toward cultural competence.

2

Cultural Awareness

LEARNING OBJECTIVES

After studying Chapter 2 in the textbook and completing this section of the workbook, students should be able to:

1. Define *cultural competence*.
2. Distinguish between ethnic and physical characteristics.
3. Discuss the impact of culture on health beliefs and practices.
4. Describe the cultural impact of disease.
5. Identify questions that explore a patient's culture.
6. Compare and contrast value orientations among cultural groups.

TEXTBOOK REVIEW

Chapter 2 Cultural Awareness (pages 38–48)

CONTENT REVIEW QUESTIONS

Multiple Choice

Circle the correct answer for each of the following questions.

1. Developing cultural sensitivity is vital for the examiner in order to be successful in:
   a. performing a physical examination.
   b. recognizing and accepting beliefs about health that differ from his or her own.
   c. identifying patients at high risk for various diseases.
   d. applying statistical trends of various ethnic and cultural groups.

2. The balance of "hot" and "cold" and its relationship to wellness is a concept that:
   a. has been proven to be without validity.
   b. is only characteristic of underdeveloped nations.
   c. has led to poor sanitization practice in many areas of the world.
   d. is held in belief by cultures such as Arab, Chinese, Filipino, and Hispanic.

3. Developing a knowledge base about cultural groups allows the practitioner to:
   a. predict with complete accuracy the behavior and attitude of the patient.
   b. utilize stereotypic judgments to anticipate the patient's need for instruction and support.
   c. understand the behaviors, practices, and problems observed.
   d. change the behavior and/or practices of the patient to conform to health care practice.

4. Which of the following is an example of a cultural characteristic?
   a. skin color
   b. intelligence
   c. skull size
   d. shared belief

5. An integral part of the overall effort to adequately respond to a person in need is:
   a. cultural awareness.
   b. ethnocentric bias.
   c. political correctness.
   d. racial alertness.

6. A young mother brings her infant to the emergency room with a high fever and dehydration. Which of the following questions asked by an examiner demonstrates cultural awareness?
   a. "When did the symptoms begin?"
   b. "What do you think is causing this illness?"
   c. "Has your child been exposed to any sick children recently?"
   d. "What have you already done at home to manage your child's illness?"

7. Which group is most likely to be subjected to invasive cardiac procedures in the United States?
   a. middle-class African-Americans
   b. white males
   c. upper-class females
   d. lower-class Asians

8. A common mistake made by health care professionals is to:
   a. acknowledge the practice of folk or herbal remedies.
   b. adapt health care concepts to meet the needs of individuals of other cultures.
   c. stereotype individuals based on color or ethnic group.
   d. carefully assess the understanding and beliefs of culturally diverse individuals.

9. All of the following are cultural considerations that affect health care except:
   a. eye color, temperature, and visual acuity.
   b. social class, age, and gender.
   c. ethnic traditions, level of education, and family relationships.
   d. religious beliefs, dietary habits, and mode of communication.

10. Which of the following is an example of a physical, as opposed to a cultural, characteristic?
    a. language
    b. hair style
    c. skin color
    d. religious affiliation

11. Despite repeated instruction over a period of 3 years, the mother of three young children has still not had them immunized. Which of the following questions would help the health care provider understand this situation?
    a. "When are you going to get your children immunized?"
    b. "What are your beliefs about immunizations?"
    c. "We have asked you to get your children immunized. Why has this not been done?"
    d. "Don't you understand that your children may get ill without immunizations?"

12. Which of the following beliefs is characteristic of a present-oriented individual?
    a. Understands the connection among past events and behaviors and future outcomes.
    b. Anticipates a brighter future; values change as a coping style.
    c. Maintains behaviors that were meaningful in the past; worships ancestors.
    d. Accepts each day as it comes; sees the future as unpredictable.

13. Which modes of communication may be offensive to a patient with different cultural perspective than the practitioner?
    a. Speaking in modulated tones.
    b. Allowing quiet time for reflection during an interview.
    c. Using reflection to repeat the information to obtain clarification.
    d. Maintaining firm and direct eye contact.

14. Which of the following statements are an accurate interpretation of the balance of "hot" and "cold"?
    a. Treatment to restore "hot" and "cold" balance requires the use of opposites.
    b. The recommended treatment for a "cold" condition is to serve "cold" foods.
    c. The recommended treatment for a "hot" condition is "hot" foods and "cold" medications.
    d. Ailments and treatments considered as "hot" or "cold" are related to the effect of body temperature.

Terminology Review

Fill in the blanks in the following statements, selecting the appropriate terms from the word choice box. Terms may be used more than once.

Word Choice Box

primacy *yin* and *yang* change Doing Orientation cultural competency

15. The ability to conscientiously understand a patient's attitudes and beliefs is often defined as _____.

16. A focus on accomplishments is most typically seen with _____.

17. Resistance to _____ is at the root of social and economic tragedy.

18. The forces of "hot" and "cold" are called _____ in Asian cultures.

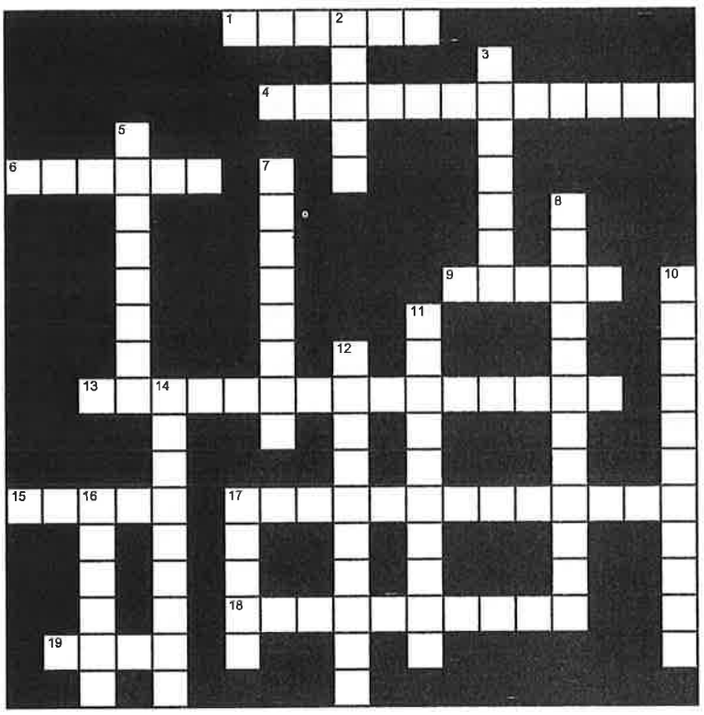
19. The concept of _____ places the individual patient in the center of a series of concentric circles.

Matching

Match each term to its corresponding definition. Use each term once.

	Definition	Term
20. _____	Belief that one's own culture is superior to others	a. Stereotype
21. _____	A physical characteristic not based on culture	b. Ritual
22. _____	A habitual activity passed along by family members	c. Race
23. _____	The act of shedding one culture and assuming another	d. Ethnocentrism
24. _____	Formal, religious, or other ceremonial acts	e. Acculturation
25. _____	Behavior approved by group standards	f. Minority
26. _____	Regulating behavior used in different situations	g. Values
27. _____	Inflexible generalizations about a group	h. Norm
28. _____	The ideas, customs, and behaviors within a group or subgroup	i. Rite
29. _____	A group different than the majority population	j. Custom

Crossword Puzzle



Across

1. The behavioral, cultural, or psychological traits typically associated with one sex
4. Sensitivity or attachment to religious values
6. Legitimate decision-making authority in Asian cultures
9. Orientation that emphasizes self-expression
13. Relational orientation that emphasizes interactions with outsiders
15. Relative worth, utility, or importance
17. Adapting to a culture and taking on its identity
18. A cultural aspect of the socioeconomic profile
19. Orientation that is focused on tradition

Down

2. Orientation that emphasizes accomplishments
3. A group's shared values
5. A "hot" herb that might be used to treat dysmenorrhea
7. View that our lives are a part of a greater whole
8. Typical "hot" condition that might be treated with barley water
10. Decreased diversity within a group
11. Orientation where relationships within one's own level are emphasized
12. Group within a larger culture that has distinctive differentiating traits
14. The phenomenon of various characteristics, values, and behaviors within populations
16. Orientation where group goals dominate over personal goals
17. Group with common culture and distinctive traits

CRITICAL THINKING

1. A young Native American child with severe abdominal pain and fever is brought to the clinic by his mother and grandmother. Upon examination, the nurse notes a foul-smelling cloth wrapped around the child's abdomen, which will interfere with the completion of the examination. What should the examiner do?

2. You have a "minority patient" who has a chronic illness requiring dietary teaching and education about medications. Listed below are areas for cultural assessment. For each area, list at least one question that might be asked as part of a cultural assessment in order to better prepare for this patient's care.

   Health beliefs and practices:

   Religious and ritual influences:

   Dietary practices:

   Family relationships and relational orientation: