

## Module # 14: Cultural Competency

# **Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum**

## **Module # 14: Cultural Competency**

**James J. Peters VA Bronx Medical Center  
Geriatric Research, Education & Clinical Center**

**Mount Sinai School of Medicine  
Brookdale Department of Geriatrics and Adult Development**

*This interdisciplinary curriculum is geared to allied health students and may be reproduced and used with attribution.*

# Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

## Module # 14: Cultural Competency

### Table of Contents

	Page(s)
I. Overview	1
II. Learning Objectives	1
III. Definitions	1
IV. Demographics	2
V. The Acculturation Continuum	3
VI. Cohort Components To Consider Within Cultures	3
VII. Varying Factors Among Different Cultures	4
VIII. Components Of Cultural Assessment	4
IX. Major Cultural Differences	5
X. Individual Culture And The Patient-Practitioner Relationship	7
XI. Values Clarification	11
XII. References	12
XIII. Learning Resources A. Cohort Experiences B. Major Systems Of Culturally Based Health Beliefs C. Multicultural Outcomes D. Cultural Self-Assessment	14-21

## Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

### Module # 14: Cultural Competency

#### I. Overview

A “culturally competent” approach to health care emphasizes an awareness and understanding of how professionals can most effectively interact with people from other cultures. For health care providers, this means considering a client’s cultural context including age, gender, sexual orientation, ethnicity, religion, race, language, beliefs, and values. This module will define “cultural competence” and address the historical events that have led to its heightened awareness in the field of health care. In addition, this module will focus on the importance of maintaining a culturally competent approach when working with patients, as well as discuss ways in which health care professionals may incorporate and strengthen their own cultural competencies to best meet the needs of their clients, patients, and co-workers.

#### II. Learning Objectives

1. Define “cultural competence” and the principles of cultural competence.
2. Provide an overview of the older population with respect to minority representation.
3. Describe why it is important to consider the historical experiences of older ethnic populations when working with them.
4. Describe the different factors which health care providers must be aware of when working with different cultural groups.
5. Delineate the main components of a cultural assessment.
6. Identify communication considerations when providing care to members of different ethnic groups.
7. Describe the effect of culture on end-of-life decision making.
8. Describe the importance of practitioner self-assessment in terms of values.

#### III. Definitions

- A. What is culture? Culture is “the shared values, traditions, norms, customs, arts, history, folklore, and institutions of a group of people.”<sup>1</sup>

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency**

- B. What is “cultural competence”?
1. “Cultural competence is a set of cultural behaviors and attitudes integrated into the practice methods of a system agency, or its professionals, that enables them to work effectively in a cross-cultural situation.”<sup>2</sup>
  2. “Cultural competence in geriatrics is the ability to give health care in ways that are acceptable and useful to elders because it is congruent with their cultural background and expectations.”
  3. “Culturally sensitive health care is a phrase used to describe a health care system that is accessible and respects the beliefs, attitudes, and cultural lifestyles of professional and of patients.”<sup>3</sup>
- C. *Cultural Diversity* refers to differences between people based on treasured beliefs, shared teachings, norms, customs, language and meaning that influence the individuals’ and families’ responses to illness, treatment, death and bereavement.<sup>4</sup>
- D. *Situational Ethnicity* refers to the fact that patients may reveal more of their traditional culture and beliefs depending on the social setting.
- E. *Intraethnic Variation* points out that a person’s life never encompasses all aspects of one culture but is an approximation- a conglomeration of pieces of that ethnic culture. Practitioners must be especially responsive to subtleties within ethnic classes, for example Puerto Rican vs. Dominican.

**IV. Demographics<sup>5</sup>**

- A. In 1970, 16% of the population in the U.S. was a member of a minority group. In 1998, the proportion grew to 27%, and it is projected that it will be 50% by the year 2050.
- B. The United States Census Bureau projects the following redistribution of the 65 and over population between 2000 and 2050.

<b>TOTAL</b>	<b>2000</b>	<b>2050</b>
Non-Hispanic White	83.5%	64.2%
Non-Hispanic Black	8.1%	12.2%
Non-Hispanic American Indian and Alaska Native	0.4%	0.6%

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

TOTAL	2000	2050
Non-Hispanic Asian and Pacific Islander	2.4%	6.5%
Hispanic	5.6%	16.4%

- C. On the average, elders from most ethnic groups use formal health care services and long-term care services to a lesser extent than their white counterparts, with the exception of emergency room visits and acute care.

**V. The Acculturation Continuum** <sup>6</sup>

- A. The Acculturation Continuum is the degree to which an older person is acclimated to American culture.
- B. Providers should be aware of the vast range in acculturation found among elders within each ethnic population. There are many different domains of culture and a person may differ in degree to which he or she is acculturated to the different domains affecting health care.
- C. Indicators of acculturation include use of the English language, length of time in the United States, and the process of adaptation; however, it is important to note that how long ago the patient emigrated may have no bearing on how “traditional” or “American” the patient is.

**VI. Cohort Components To Consider Within Cultures**

- A. It is important to consider the historical experiences of older ethnic populations.
1. Cohort analysis helps us to understand the impact of these experiences on elders of varying ethnic groups.
  2. It also helps us to take appropriate social histories and to understand the influences on the older client’s trust and attitudes about health care. <sup>7</sup>
- B. The following domains should be considered:
- Ethnic Identity
  - Gender

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

- Age
- Differing abilities
- Sexual orientation
- Religion and spirituality
- Financial status
- Place of residency
- Employment
- Education level

### VII. Varying Factors Among Different Cultures

- A. In order to provide the most effective health care, providers must be aware of a number of varying factors that exist across the different cultural groups. Such disparities may be a result of genetic variation, environmental factors, specific health behaviors, or factors of service delivery.
1. For instance, for men 65 years and older 73.5% of non-Hispanic Whites reported good to excellent health, whereas 59.3% of non-Hispanic Black and 65.4% of Hispanic men in this age group reported similar health. <sup>8</sup>
  2. Similarly, for Medicare beneficiaries 65 and older, 4.4% of non-Hispanic White elders reported delays in accessing care due to cost, with the percentage being 9.5% for non-Hispanic Blacks. <sup>9</sup>

### VIII. Components Of Cultural Assessment <sup>1</sup>

- A. Patient/Family/Community
- Birthplace
  - Ethnic identity, community
  - Decision making
  - Language and communication

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

- Religion
- Food preferences/prohibitions
- Economic situation
- Health beliefs re: death, grief, pain
- Gender and power issues
- Views of patient and family about location of death
- Degree of fatalism or activism in accepting or controlling care and death
- How hope is maintained
- Sources of support within the community

**IX. Major Cultural Differences** <sup>10</sup>

- A. Different cultures have different perceptions. It may be helpful to discuss these perceptions with the patient early on in the provider-client relationship.
1. Respect
    - Role of the elder, child, caregiver, provider, etc.
    - Trust/Mistrust and deference towards the healthcare provider
    - Relationships among family members
  2. Death and Dying
    - What constitutes a good death?
    - What happens after death?
    - Attitudes towards life-sustaining treatment, advance directives
  3. Pain
    - Reason for pain (biological vs. punishment)
    - Behaviors concerning pain

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

- Medication issues
- Surgery
- 4. Independence
  - Value of independence with old age
  - Medical decisions made independently or within a family context
  - Preferred caregiving setting and other issues in caregiving
  - What older people should be told about their illnesses: some cultures prefer that medical information, particularly that of a life-threatening prognosis, be given to the family and not to the patient.
  - Informed consent
  - Issues in dementia
  - Long-term care
- 5. Traditions and Rituals
  - Transitions (e.g., birthdays, settings of care)
  - Holidays (e.g., food, decorations, songs, prayers)
  - Death (e.g., funeral preparations, shiva, burial, cremation)
- 6. Effect of Culture on End of Life Decision Making <sup>11</sup>
  - There is no single description of end-of-life preferences for any specific cultural group, but rather considerable variations.
  - Three primary issues where there is ethnic variation is:
    1. Communication of bad news
    2. Locus of decision making
    3. Advance planning for terminal illness

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

7. In a qualitative study by Bullock based on a sample of African-Americans (n =102), nearly three quarters of participants refused to complete an advance directive. The themes identified were:
- Faith and spirituality-belief that what happens is God's plan
  - Perceptions of suffering-prolongation of life does not necessarily indicate suffering
  - Death and dying-are not to be discussed in terms of planning and anticipating
  - Social support network (friends and family) will provide care
  - Barriers- lack of knowledge about advance care planning, feeling of being pushed by health professionals
  - Mistrust of the health care system-lack of trust that health professionals will respect the patient's and families' wishes. <sup>12</sup>

**X. Individual Culture And The Patient-Practitioner Relationship** <sup>13</sup>

- A. Aspects in which cultural differences can affect the patient-provider relationship:
- Language and cultural barriers between providers, patients, and patients' families
  - Explanatory models of illness
  - Dietary habits
  - Medication compliance
  - Alternative (non-Western) practices (e.g. herbal medicines)/belief in existence of non-biomedical illnesses or in the efficacy of scientific treatments
  - Role of religion, with ethical dilemmas of life-sustaining interventions conflicting with religious beliefs

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency**

- Cultural attitude of some communities and families concerning expectations that patients should be cared for at home
- Western emphasis on “independence” as a goal of therapy
- Unrealistic expectations
- Different expectations as to entitlement to good medical care
- Difficulty establishing trusting relationships
- Ignorance of how the American medical system works and lack of skills in navigating it
- Patient unable to verbalize his or her symptoms in detail

**B. Communication Considerations**

1. Be creative in finding ways to communicate with population groups that have limited English-speaking proficiency.
2. Spend time listening to needs, views, and concerns of the community.
3. Ask the older patient for his or her preference for decision making early on in care.
4. Use the language and dialect of the people you serve.
5. Use communication vehicles that have value and use by your target audience.
6. Use a cultural broker or cultural guide from the elder’s ethnic or religious. background.

**C. Recognize cultural differences related to:**

1. Conversation style
2. Personal space
3. Eye contact
4. Touch

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

5. Time orientation
  6. View of healthcare professionals
  7. Learning styles
- D. Appoint a spokesperson
1. Ask the older patient to identify a family spokesperson.
  2. In emergencies, ask the family to appoint a spokesperson.
  3. Respect the appointment, even if the person is not a family member or does not live nearby.
- E. Role of Family
1. Who makes the decisions?
  2. Who is included in discussions?
  3. Is full disclosure acceptable?
- F. Physical Environment
1. Create culturally, linguistically friendly interior design, pictures, posters, and artwork to make facilities more welcoming.
  2. Display material and information with recognizable props that hold significance, value, and interest for your target audience.
  3. Put props in the hands of people that will maximize their distribution, circulation.
- G. Policies and Procedures
1. Mission statement must articulate principles and rationale for culturally competent service delivery.
  2. Develop structures to assure community participation in planning, delivery, and evaluation of services.
  3. Institute procedures to recruit, retain, and train a diverse and culturally competent workforce.

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency**

4. Familiarize the interdisciplinary health care team with cultural explanatory models of the elder's conditions.

H. Population-Based Service Delivery

1. Appreciate the importance of culture while avoiding stereotypes.
2. Understand the socio-political influences that shaped your consumers' attitudes, beliefs and values.

I. Training and Professional Development

1. Provide informal opportunities for staff to explore their attitudes, beliefs, and values.
2. Recognize that cultural sensitivity occurs on a continuum.
3. Provide specialized training for interpreters.

J. Physical Examination/Assessment

1. Cross-gender physical examinations are unacceptable in many cultures.
2. Consider preference of presence of family member.
3. Ask permission to examine various areas of the body.
4. Preferred amount of information provided to the patient and family oftentimes varies.
5. Symptom recognition, report, and meaning may vary.

K. Proactive Attitudes and Activities Toward Cultural Sensitivity (14)

1. Seek information to enhance cultural awareness.
2. Consider own attitudes and behaviors that enhance or hinder relationships.
3. Evaluate use of terms or phrases that may be interpreted as degrading or hurtful.
4. Attended workshops on cultural diversity.
5. Openly disagree with racial, cultural or religious jokes, comments or slurs.

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

6. Create a culturally supportive environment with colleagues and patient/families.

### **XI. Values Clarification**

1. Culturally competent practice begins with values clarification on the part of the practitioner.
  - It is important that the healthcare provider be aware of his or her own feelings toward other cultures, ethnicities and races.
  - One cannot make assumptions based on our own cultural norms and expectations.
  - Whereas elimination of cultural bias is very difficult, recognition of individual biases and expectations.
2. Health Professional's Self-Assessment <sup>15</sup>
  - What are your own beliefs about illness and death and how do they influence your attitudes?
  - How significant is religion in your attitudes toward illness and death?
  - What kind of death would you prefer?
  - If diagnosed with a terminal illness, whom would you want to tell?
  - What efforts should be made to keep a seriously ill person alive?
3. Values and Attitudes Underpinning Culturally Competent Practice <sup>16</sup>
  - Avoid stereotyping and misapplication of scientific knowledge.
  - Be knowledgeable about cultural differences and their impact on attitudes and behaviors.
  - Be sensitive, understanding, non-judgmental and respectful in dealing with people whose culture is different from your own.
  - Be flexible and skillful in responding and adapting to different cultural contexts and circumstances.

### **XII. References**

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)**  
**Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum**  
**Module # 14: Cultural Competency**

1. American Association of Colleges of Nursing & City of Hope National Medical Center. (2000). *End-of-life Nursing Education Consortium (ELNEC) Training Program* (Module 5: Cultural Considerations). Available from the American Association of Colleges of Nursing: [www.aacn.nche.edu/elneec](http://www.aacn.nche.edu/elneec)
2. *Cultural Diversity & Aging: Differences Do Make a Difference*. Seminar conducted by The Consortium of New York Geriatric Education Centers. April 2001, New York, NY.
3. Long, D. M., Wilson, N. L., & Henley, B. (Eds.). (2001). Cultural Competency. In *Geriatric Interdisciplinary Team Training: A Curriculum from the Huffington Center on Aging*. New York, NY: John A. Hartford Foundation, Inc.
4. Showalter, S. (1998). Looking through different eyes: Beyond cultural diversity. In K. Doka & J. Davis (Eds.) *Living with grief* (pp. 71-82). Washington, DC Hospice Foundation of America.
5. United States Department of Health and Human Services, Administration on Aging. (2000). A Profile of Older Americans 2000. Washington, D. C: Author. Available from: [www.aoa.org](http://www.aoa.org).
6. Yeo, G. et al. (2000). *Core curriculum in ethnogeriatrics* (2<sup>nd</sup> Ed.). (Module 3). CA: Stanford University.
7. Ibid.
8. Administration on Aging. (2001). *Achieving cultural competence: A guidebook for provider services to older Americans and their families*. Available from: [www.aia.gov/minorityaccess/guidebook2001/default.htm](http://www.aia.gov/minorityaccess/guidebook2001/default.htm)
9. Ibid.
10. American Association of Colleges of Nursing & City of Hope National Medical Center. (2000). *End-of-life Nursing Education Consortium (ELNEC) Training Program* (Module 5: Cultural Considerations). Available from the American Association of Colleges of Nursing: [www.aacn.nche.edu/elneec](http://www.aacn.nche.edu/elneec)
11. Searight, H. & Gafford, J. (2005). Effect of culture on end of life decision making. *AAHPM Bulletin*, 6(4), 1-4.
12. Bullock, K. (2006). Promoting Advance Directives among African Americans: A faith based model. *Journal of Palliative Medicine*, 9(1), 183-194.
13. Sherman, D. W. (2001). Spiritually and culturally competent palliative care. In M. Matzo & D. W. Sherman (Eds.), *Palliative care nursing: Quality care to the end of life*. New

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency

York, NY: Springer Publishing.

14. Irish, D., Lundquist, K., & Nelsen, V. (1993). *Ethnic variations in dying, death, and grief*. Philadelphia, PA: Taylor & Francis.

15. American Association of Colleges of Nursing & City of Hope National Medical Center. (2000). *End-of-life Nursing Education Consortium (ELNEC) Training Program* (Module 5: Cultural Considerations). Available from the American Association of Colleges of Nursing: [www.aacn.nche.edu/elneec](http://www.aacn.nche.edu/elneec)

16. Sherman, D. W. (2001). Spiritually and culturally competent palliative care. In M. Matzo & D. W. Sherman (Eds.), *Palliative care nursing: Quality care to the end of life*. New York, NY: Springer Publishing.

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
 Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
 Module # 14: Cultural Competency

Learning Resource A

Cohort Experiences: African American, Indian American, Chinese American, and Mexican American Elders

COHORT EXPERIENCES - AFRICAN AMERICAN ELDERS

1900-1920	1920-1940	1940-1960	1960-1980	1980-Present
Urban Migration	Harlem Renaissance	WWII: Segregated Troops; factory work in North and West	Civil Rights Movement and Law	Jesse Jackson ran for President
NAACP and Urban League Founded	Marcus Garvey's back to Africa Movement	Desegregation in plants, schools and military.	Dr. Martin L. King, Jr. led non-violence and then was assassinated	Black Muslims
Ku Klux Klan Active	Klan marched on Washington	Montgomery Bus Boycott	Affirmative Action	Rodney King trial
WWI and the "Red Summer"	Depression	Jackie Robinson	Political Activism	Million Man & Woman Marches
	Jesse Owens and Joe Lewis		Kennedy assassinated	Declining Affirmative Action
			The Black Panthers	

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency**

COHORT EXPERIENCES - AMERICAN INDIAN ELDERS

<u>1900-1920</u>	<u>1920-1940</u>	<u>1940-1960</u>	<u>1960-1980</u>	<u>1980-Present</u>
Reservations	Citizenship	World War II Service	Vietnam War	Education of Professionals
"Vanishing American"	Adoption of Indian Children by Whites	Relocation by BIA to Urban Areas	Indian Activism	Litigation
Forced Boarding Schools	Loss of Land by Allotment System	Termination of 100 Tribes	Youths Return to Traditional Practices	Self-Determination of Tribes
Traditional Culture "Bad"	Forced Assimilation	Forced Assimilation	Urbanization for Education & Jobs	Urban Pan-Indianism
Law Banned Spiritual Practices	Boarding Schools			Reservation Gaming

COHORT EXPERIENCES - CHINESE AMERICAN ELDERS

<u>1900-1920</u>	<u>1920-1940</u>	<u>1940-1960</u>	<u>1960-1980</u>	<u>1980-Present</u>
Chinese exclusion act in effect	1924 Immigration Act Excludes all Asians	Repeal of Exclusion Act	New immigration act favors family members	Continued heavy immigration, from Taiwan, Hong Kong and Vietnam
Urbanization	Families emerge in	Chinese Americans in	Increased educational	Seen as "Model

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency**

	Chinatowns	WWII	opportunities	Minority"
Immigration of "Paper Sons"	Family Associations	Immigration of wives	Continued discrimination in union employment	"Followers of Children"
Predominantly male	Pearl Buck novels	Fear of Chinese Communists		Anti-immigrant bias

**COHORT EXPERIENCES - MEXICAN AMERICAN ELDERS**

<u>1900-1920</u>	<u>1920-1940</u>	<u>1940-1960</u>	<u>1960-1980</u>	<u>1980-Present</u>
Heritage of Loss of Land	Massive Immigration	WWII Participation	Chicano Movement	Increasing Political Power
Mexican Revolution	Depression	Immigration	Bilingual Education	Anti-Immigrant Bias
	Repatriation	Urbanization	Latino Arts and Media	Welfare Reform Movement
		GI Forum	Deportation and Amnesty	Anti-Bilingual Education Trend

Source:

Yeo, G. et al. (2000). Core curriculum in ethnogeriatrics (2<sup>nd</sup> Ed.). Stanford University, California: Module 3.

## Learning Resource B

### Major Systems Of Culturally Based Health Beliefs

<p>Biomedical Model (Western, Allopathic)</p>	<p>Biomedical model of medicine and nursing, the primary healing system of the dominant culture/group in the United States. Based on scientific reductionism and characterized by mechanistic model of the human body; separation of mind and body, and discounting of spirit or soul.</p>
<p>Traditions from American Indian Nations</p>	<p>Health beliefs and views of death predate European immigration and vary by tribe. Many are characterized by mind-body-spirit integration, spiritual healing, and use of herbs from native plants. Harmony with natural environment (e.g., animals, plants, sky, and earth) was important for health. Illness is sometimes seen as a result of an individual's offenses, to be treated by a ritual purification ceremony or a ceremony by a medicine person. In many tribes, life and death are viewed in a circular pattern rather than linear as in European traditions.</p>
<p>Traditions from Africa and Early African American Heritage</p>	<p>Various African traditions frequently integrated with American Indian, Christian, and other European traditions. In the variety of systems, most illness could be seen as:</p> <ul style="list-style-type: none"> <li>• a natural illness, which is a result of a physical cause, such as infection, weather, and other environmental factors;</li> <li>• a occult illness, which is resulted from supernatural forces, such as evil spirits and their agents (e.g., conjurers); or</li> <li>• a spiritual illness is a result of willful violation of sacred beliefs or of sin, such as adultery, theft, or murder</li> </ul> <p>Common characteristics of healing include:</p> <ul style="list-style-type: none"> <li>• healing power of religion, Christian in some cases; and</li> <li>• use of herbs, or " root working".</li> </ul> <p>In some Caribbean Islands, African traditions evolved into strong beliefs in power of spirits and use of healers to maintain health and treat illnesses. However, those beliefs probably have a weak influence on most urban African Americans today.</p> <p>Many current African American elders, particularly those from the rural South, grew up using alternative practices of self-treatment, partly in response to lack of access to mainstream care. Experiences of segregation and memories of the Tuskegee experiment may make the current cohort of older African Americans skeptical and distrustful of mainstream medicine, especially when making</p>

VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
 Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
 Module # 14: Cultural Competency

	<p>decisions about care at the end-of-life.</p>
<p>Traditions from Asia</p>	<p>Classical Chinese medicine influenced traditions in Japan (Kampo), Korea (Hanbang), and Southeast Asia. It is characterized by</p> <ul style="list-style-type: none"> <li>• need for balance between <i>yin</i> and <i>yang</i> to preserve health, especially through the use of herbs and diet;</li> <li>• unblocking the free flow of <i>qi</i>, (chi) or vital energy, through meridians in the body by acupuncture, <i>tai chi</i>, moxibustion, and cupping; and</li> <li>• interaction of basic elements of the environment (e.g. water, fire, earth, metal, and wood).</li> </ul> <p>In parts of Asia, Taoism and Buddhism have influenced the healing traditions.</p> <ul style="list-style-type: none"> <li>• Taoism emphasizes the need to adapt to the order of nature, and</li> <li>• Buddhism emphasizes meditation for spiritual and physical health.</li> </ul> <p>Ayurvedic medicine practiced in India:</p> <ul style="list-style-type: none"> <li>• is shaped by Hinduism and traditional Indian culture.</li> <li>• includes basic elements of the environment (e.g., air, water, and wind) which have analogues in the body.</li> <li>• is characterized by the use of yoga, meditation, herbs, and by integration of mind-body-spirit.</li> </ul> <p>Traditional Hmong health beliefs are characterized by:</p> <ul style="list-style-type: none"> <li>• interventions of a wide variety of spirits that promote health or cause illness; and</li> <li>• risk of loss of soul that brings illness.</li> </ul> <p>For many Asian American elders, traditional healers' offices serve as meeting places to socialize with other elders. The socialization function of traditional healing parallels the traditional Chinese medical view that illness should be addressed not only through medicine, but also through social and psychological aspects of life. End-of-life decisions about care may be characterized by:</p> <ul style="list-style-type: none"> <li>• family vs. individual decision making—even if the elder is competent to make decisions, family members might feel that it is their filial duty to take the decision-making role;</li> <li>• non-disclosure of terminal illness to protect the elder; and</li> <li>• placement of the dying person or the body—wanting to "go home to die" and the practice of not disturbing the body reflecting reluctance of organ donation or autopsy.</li> </ul>

**VISN 3 Geriatric Research, Education & Clinical Center (GRECC)  
Geriatrics, Palliative Care & Interprofessional Teamwork Curriculum  
Module # 14: Cultural Competency**

<p>Traditions from Latin America</p>	<p>Most Latino Americans practice the biomedical model, but among some elders there may be reminiscences of other beliefs.</p> <ul style="list-style-type: none"> <li>• Beliefs rooted in models developed from Native American, European, and African practices form an intricate cultural blend. Examples are <i>Santeria</i>, <i>Espiritismo</i>, and <i>Curanderismo</i>, in which religion is an important component of the system.</li> <li>• CAM practices are seen as exogenous, and in opposition, to the biomedical model. There is an integration of elements from both practices forming a complex cultural product.</li> </ul> <p>Latino Americans are less likely than European Americans to:</p> <ul style="list-style-type: none"> <li>• make individual decisions on end-of-life issues or complete advance directives,</li> <li>• endorse the withholding or withdrawal of life prolonging treatment,</li> <li>• use hospice services,</li> <li>• support physician-assisted death, and organ donation.</li> </ul> <p>Cultural themes that can influence beliefs and practices concerning end-of-life decisions may include the emphasis on the well-being of the family over the individual; respect for hierarchy; and the emphasis on the present as opposed to past or future.</p>
<p>Other European American Systems</p>	<p>Folk healing systems from European countries predating biomedicine, many of which include religious healing and use of herbs, may still be practiced in some areas of the U.S.</p> <p>Variations on the belief systems of allopathic medicine, or competing health philosophies have emerged in the U.S. in the past century. Two of the major ones are:</p> <ul style="list-style-type: none"> <li>• Osteopathy, similar to allopathic medicine, but deals with the "whole person" and emphasizes the interrelationship of the muscles and bones to all other body systems;</li> <li>• Homeopathy emphasizes the healing power of the body, and relies on the "law of similars" to choose drug therapy.</li> </ul>

\*SOURCE: Yeo, G. etal. Core Curriculum in Ethnogeriatrics, Second Edition. Stanford University, California. 2000.

## Learning Resource C

### Multicultural Outcomes: Guidelines For Cultural Competence

*Summary of the Domains of Culture*

Domain	Description
Ethnic Identity	Country of origin, ethnicity/culture with which the group identifies, current residence, reasons for migration, degree of acculturation/assimilation, and level of cultural pride.
Communication	Dominant language and any dialects, usual volume/ tone of speech, willingness to share thoughts/feelings/ideas, meaning of touch, use of eye contact, control of expressions and emotions, spokesperson/decision maker in family.
Time and space	Past, present, or future orientation; preference for personal space and distance.
Social organization	Family structure; head of household, gender roles, status/role of elderly; roles of child, adolescents, husband/wife, mother/father, extended family; influences on the decision-making process; importance of social organization and network..
Workforce issues	Primary wage earner, impact of illness on work, transportation to clinic visits, health insurance, financial impact, importance of work.
Health beliefs, practices, and practitioners	Meaning/cause of cancer and illness/health, living with life-threatening illness, expectations and use of Western treatment and healthcare team, religious/spiritual beliefs and practices, use of traditional healers/practitioners, expectations of practitioners, loss of body part/body image, acceptance of blood transfusions/organ donations, sick role and health-seeking behaviors.
Nutrition	Meaning of food and mealtimes, preferences and preparation of food, taboos/rituals, religious influences on food preferences and preparation.
Biological variations	Skin, mucous membrane color, physical variations, drug metabolism, laboratory data, and genetic variations-specific risk factors and differences in incidence/survival/mortality of specific cancers.
Sexuality and reproductive fears	Beliefs about sexuality and reproductive/childbearing activities, taboos, privacy issues, interaction of cancer diagnosis/treatments with beliefs about sexuality.
Religion and spirituality	Dominant religion; religious beliefs, rituals, and ceremonies; use of prayer, meditation or other symbolic activities; meaning of life; source of strength.
Death and dying	Meaning of dying, death and the afterlife; belief in fatalism; rituals, expectations, and mourning/bereavement practices.

## Learning Resource D

### Cultural Self-Assessment

Adapted from: Zoucha, R (2000). The keys to culturally sensitive care. American Journal of Nursing, 2000:24GG-2411.

1. Where were you born?  
  
If an immigrant, how long have you lived in this country?  
How old were you when you came to this country?  
Where were your grandparents born?
2. What is your ethnic affiliation and how strong is your ethnic identity?
3. Who are your major support people: family members, friends?  
Do you live in an ethnic community?
4. How does your culture affect decision regarding their medical treatment?  
  
Who makes decisions - you, your family, or a designated family member?  
What are the gender issues in your culture and in your family structure?
5. What are your primary and secondary languages, speaking and reading ability?
6. How would you characterize your nonverbal communication style?
7. What is your religion, its importance in your daily life, and current practices?  
  
Is religion an important source of support and comfort?
8. What are your food preferences and prohibitions?
9. What is your economic situation, and is the income adequate to meet the needs of you and your family?
10. What are your health and illness beliefs and practices?
11. What are your customs and beliefs around such transitions as birth, illness and death?  
What are your past experiences regarding death and bereavement?  
How much do you and your family wish to know about the disease and prognosis?  
What are your beliefs about the afterlife and miracles? Beliefs about hope?