

L.A. Care
HEALTH PLAN®

For a **Healthy Life**



Section 4:

*Awareness of Cultural Background and
Its Impact on Health Care Delivery*

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Everyone approaches illness as a result of their own experiences, including education, social conditions, economic factors, cultural background, and spiritual traditions, among others. In our increasingly diverse society, patients may experience illness in ways that are different from their health professional's experience. Sensitivity to a patient's view of the world enhances the ability to seek and reach mutually desirable outcomes. If these differences are ignored, unintended outcomes could result, such as misunderstanding instructions and poor compliance.

The following tools are intended to help you review and consider important factors that may have an impact on health care. Always remember that even within a specific tradition, local and personal variations in belief and behavior exist. Unconscious stereotyping and untested generalizations can lead to disparities in access to service and quality of care. The bottom line is: if you don't know your patient well, ask respectful questions. Most people will appreciate your openness and respond in kind. And most patients respect and find comfort in their provider's willingness to learn and show interest in their cultures.

The following materials are available in this section:

Cultural Background: Information on Special Topics

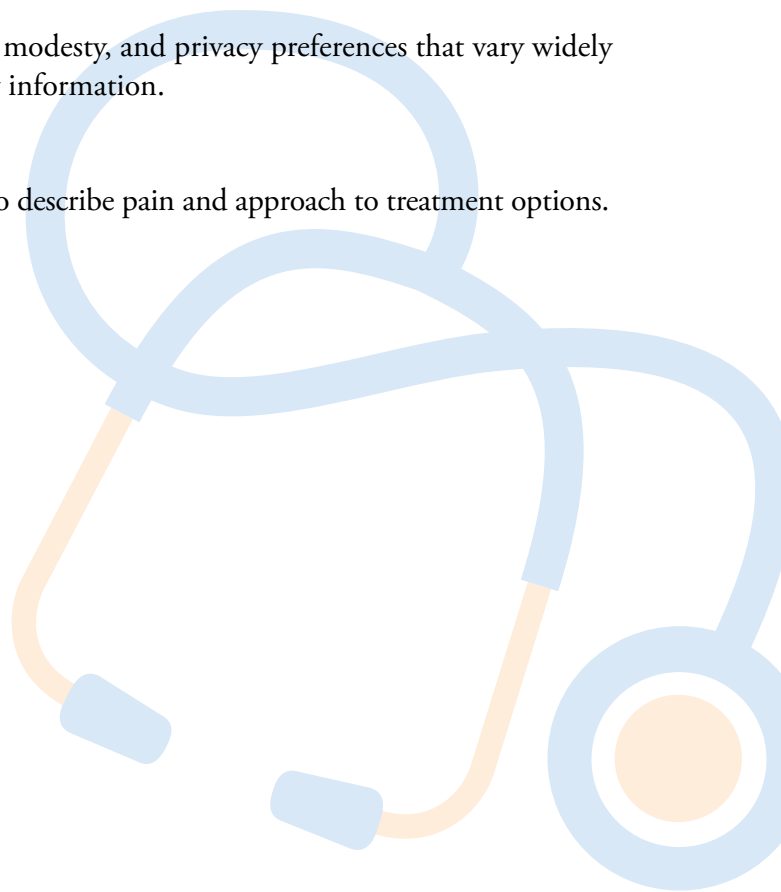
Points of reference to become familiar with diverse cultural backgrounds.

Let's Talk About Sex

A guide to help you understand and discuss gender roles, modesty, and privacy preferences that vary widely among different people when taking sexual health history information.

Pain Management Across Cultures

A guide to help you understand the ways people may use to describe pain and approach to treatment options.



Cultural Background: Information on Special Topics

Use of Alternative or Herbal Medications

- People who have lived in poverty, or come from places where medical treatment is difficult to get, will often come to the doctor only after trying many traditional or home treatments. Usually patients are very willing to share what has been used if asked in an accepting, nonjudgmental way. This information is important for the accuracy of the clinical assessment.
- Many of these treatments are effective for treating the symptoms of illnesses. However, some patients may not be aware of the difference between treating symptoms and treating the disease.
- Some treatments and “medicines” that are considered “folk” medicine or “herbal” medications in the United States are part of standard medical care in other countries. Asking about the use of medicines that are “hard to find” or that are purchased “at special stores” may get you a more accurate understanding of what people are using than asking about “alternative,” “traditional,” “folk,” or “herbal” medicine.

Pregnancy and Breastfeeding

- Preferred and acceptable ages for a first pregnancy vary from culture to culture. Latinos are more accepting of teen pregnancy; in fact it is quite common in many of the countries of origin. Russians tend to prefer to have children when they are older. It is important to understand the cultural context of any particular pregnancy. Determine the level of social support for the pregnant women, which may not be a function of age.
- Acceptance of pregnancy outside of marriage also varies from culture to culture and from family to family. In many Asian cultures there is often a profound stigma associated with pregnancy outside of marriage. However, it is important to avoid making assumptions about how welcome any pregnancy may be.
- Some Vietnamese and Latino women believe that colostrum is not good for a baby. An explanation from the doctor about why the milk changes can be the best tool to counter any negative traditional beliefs.
- The belief that breastfeeding works as a form of birth control is very strongly held by many new immigrants. It is important to explain to them that breastfeeding does not work as well for birth control if the mother gets plenty of good food, as they are more able to do here than in other parts of the world.

Weight

- In many poor countries, and among people who come from them, “chubby” children are viewed as healthy children because historically they have been better able to survive childhood diseases. Remind parents that sanitary conditions and medical treatment here protect children better than extra weight.
- In many of the countries that immigrants come from, weight is seen as a sign of wealth and prosperity. It has the same cultural value as extreme thinness has in our culture – treat it as a cultural as well as a medical issue for better success.

Infant Health

- It is very important to avoid making too many positive comments about a baby’s general health.
 - Among traditional Hmong, saying a baby is “pretty” or “cute” may be seen as a threat because of fears that spirits will be attracted to the child and take it away
 - Some traditional Latinos will avoid praise to avoid attracting the “evil eye”
 - Some Vietnamese consider profuse praise as mockery
- It is often better to focus on the quality of the mother’s care – “the baby looks like you take care of him well.”

- Talking about a new baby is an excellent time to introduce the idea that preventive medicine should be a regular part of the new child's experience. Well-baby visits may be an entirely new concept to some new mothers from other countries. Protective immunizations are often the most accepted form of preventive medicine. It may be helpful to explain well-baby visits and check-ups as a kind of extension of the immunization process.

Substance Abuse

- When asking question regarding issues of substance (or physical) abuse, concerns about family honor and privacy may come into play. For example, in Vietnamese and Chinese cultures family loyalty, hierarchy, and filial piety are of the utmost importance and may therefore have a direct effect on how a patient responds to questioning, especially if family members are in the same room. Separating family members, even if there is some resistance to the idea, may be the only way to accurately assess some of these problems.
- Gender roles are often expressed in the use or avoidance of many substances, especially alcohol and cigarettes. When discussing and treating these issues the social component of the abuse needs to be considered in the context of the patient's culture.
- Alcohol is considered part of the meal in many societies, and should be discussed together with eating and other dietary issues.
- In some Southeast Asian communities, binge drinking at family and friend gathering is considered a bonding ritual. In assessing the issue, avoid judging the practice but rather explore negative consequences that occur after each event.

Physical Abuse

- Ideas about acceptable forms of discipline vary from culture to culture. In particular, various forms of corporal punishment are accepted in many places. Emphasis must be placed on what is acceptable here, and what may cause physical harm.
- Women may have been raised with different standards of personal control and autonomy than we expect in the United States. They may be accepting physical abuse not because of feelings of low self-esteem, but because it is socially accepted among their peers, or because they have nobody they can go to with their concerns. It is important to treat these cases as social rather than psychological problems.
- Immigrants learn quickly that abuse is reported and will lead to intervention by police and social workers. Even victims may not trust doctors, social workers, or police. It may take time and repeated visits to win the trust of patients. Remind patients that they do not have to answer questions (silence may tell you more than misleading answers). Using depersonalized conversational methods will increase success in reaching reluctant patients.
- Families may have members with conflicting values and rules for acceptable behavior that may result in conflicting reports about suspected physical abuse. This does not necessarily mean that anyone is being deceptive, just seeing things differently. This may cause special difficulties for teens that may have adopted new cultural values common to Western society, but must live in families that have different standards and behaviors.
- Behavioral indicators of abuse are different in different cultures. Many people are not very emotionally and physically expressive of physical and mental pain. Learn about the cultural norms of your patient populations to avoid overlooking or misinterpreting unknown signs of trauma.
- Do not confuse physical evidence of traditional treatments with physical abuse. Acceptable traditional treatments, such as coin rubbing (coining) or cupping, may leave marks on the skin, which look like physical abuse. Always consider this possibility if you know the family uses traditional home remedies.

Communicating with the Elderly

- Always address older patients using formal terms of address unless you are directly told that you may use personal names. Also remind staff that they should do the same.
- Stay aware of how the physical setting may be affecting the patient. Background noise, glaring or reflecting light, and small print forms are examples of things that may interfere with communication. The patients may not say anything, or even be aware that something physical is interfering with their understanding.
- Stay aware that many people believe that giving a patient a terminal prognosis is unlucky or will bring death sooner and families may not want the patient to know exactly what is expected to happen. If the family has strong beliefs along these lines the patient probably shares them. Follow ethical and legal requirements, but stay cognizant of the patient's cultural perspective. Offer the opportunity to learn the truth, at whatever level of detail desired by the patient.
- It is important to explain the specific needs for having an advance directive before talking about the treatment choices and instructions. This will help alleviate concerns that an advance directive is for the benefit of the medical staff rather than the patient.
- Elderly, low-literacy patients may be very skilled at disguising their lack of reading skills and may feel stigmatized by their inability to read. If you suspect this is the case you should not draw attention to this issue but seek out other methods of communication.

Serving People with Disabilities

- Use “people first” language. Certain terms, such as “handicapped” or “retarded” may be considered offensive. Certain phrases, such as “He is autistic” or “She is crippled” can also label and stigmatize people. These words and phrases focus on disabilities, not on the person. That is why we want to use “people first language,” such as “She has a disability” or “he has autism.” By using “has” rather than “is,” this avoids labeling the individual and instead makes the disability just another aspect of the person. A more recent acceptable term would be ‘living with’, such as “She is living with a mental illness” rather than “She is mentally ill” or “She is living with an addiction” rather than “She is an addict”, etc. By focusing on the person first and any disabilities or conditions second, this recognizes and respect them as individuals.
- Don't make assumptions. People who have the same disability may not have the same experiences. Get feedback from patients directly on what they are going through. People with disabilities are the best judge of what they can or cannot do and any limitations they might have. Avoid making decisions for them, but instead involve them in the decision making process.
- Ask before you help. Just because someone has a disability, don't assume the person needs help. If the setting is accessible, people with disabilities can usually get around fine. Adults with disabilities want to be treated as independent people.
- Honor people with disabilities' expressed choice for reasonable accommodations. The (Americans with Disabilities Act (ADA) requires the expressed choice of the individual with the disability, who is in the best position to know their needs should be given primary consideration in determining which communication aid to provide. Respect these choices.
- Speak directly to a person with disability. If the patient has brought a caregiver or aid, always speak directly to the person with a disability, unless otherwise instructed by the patient.

Let's Talk About Sex

Consider the following strategies when navigating the cultural issues surrounding the collection of sexual health histories. Some areas of cultural variation points to consider are:

Gender roles

- Gender roles vary and change as the person ages (i.e. women may have much more freedom to openly discuss sexual issues as they age).
- A patient may not be permitted to visit providers of the opposite sex unaccompanied (i.e. a woman's husband or mother-in-law will accompany her to an appointment with a male provider).
- Some cultures prohibit the use of sexual terms in front of someone of the opposite sex or an older person.
- Several family members may accompany an older patient to a medical appointment as a sign of respect and family support.
- Before entering the exam room, tell the patient and their companion exactly what the examination will include and what needs to be discussed. Offer the option of calling the companion(s) back into the exam room immediately following the physical exam.
- As you invite the companion or guardian to leave the exam room, have a health professional of the same gender as the patient standing by and re-assure the companion or guardian that the person will be in the room at all times.
- Use same sex non-family members as interpreters only as the last resort; it is always best to utilize professional interpreters, especially when dealing with sensitive issue in the patient's perspective.

Sexual health and patient cultural background

- If a sexual history is requested during a non-related illness appointment, patients may conclude that the two issues— for example, blood pressure and sexual healthcare are related.
- In many health belief systems there are connections between sexual performance and physical health that are different from the Western tradition. Example: Chinese males may discuss sexual performance problems in terms of a “weak liver.”
- Printed materials on topics of sexual health may be considered inappropriate reading materials.
- Do not ask for their sexual orientation but rather explore their sexual practices/experiences including those with the people of the opposite sex as well as same sex.
- Explain to the patient why you are requesting sexually related information at that time.
- For young adults, clarify the need for collecting sexual history information and consider explaining how you will protect the confidentiality of their information.
- Offer sexual health education verbally. Whenever possible, provide sexual health education by a health care professional who is the same gender as the patient.

Confidentiality preferences

- Patients may not tell you about their preferences and customs surrounding the discussion of sexual issues. You must watch their body language for signals of discomfort, or ask directly how they would like to proceed.
- A patient may be required to bring family members to their appointment as companions or guardians. Printed materials on topics of sexual health may be considered inappropriate reading materials.
- Be attentive to a patient's body language or comments that may indicate that they are uncomfortable discussing sexual health with a companion or guardian in the room.
- It may help to apologize for the need to ask sexual or personal questions. Apologize and explain the necessity.
- Try to offer the patient a culturally acceptable way to have a confidential conversation. Example: “To provide complete care, I prefer one-on-one discussions with my patients. However, if you prefer, you may speak with a female/male nurse to complete the initial information.”
- Inform the patient and the accompanying companion(s) of any applicable legal requirements regarding the collection and protection of personal health information.

Pain Management Across Cultures

Your ability to provide adequate pain management to some patients can be improved with a better understanding of the differences in the way people deal with pain. Here is some important information about the cultural variations you may encounter when you treat patients for pain management. These tips are generalizations only. It is important to remember that each patient should be treated as an individual.

Reaction to pain and expression of pain

- Cultures vary in what is considered acceptable expression of pain. As a result, expression of pain will vary from stoic to extremely expressive for the same level of pain.
- Some men may not verbalize or express pain because they believe their masculinity will be questioned.
- Do not mistake lack of verbal or facial expression for lack of pain. Under-treatment of pain is a problem in populations where stoicism is a cultural norm.
- Because the expression of pain varies, ask the patient what level, or how much, pain relief they think they need.
- Do not be judgmental about the way someone is expressing their pain, even if it seems excessive or inappropriate to you. The way a person in pain behaves is socially learned.

Spiritual and religious beliefs about using pain medication

- Patients of several faiths will not take pain relief medications on religious fast days, such as Yom Kippur or daylight hours of Ramadan. For these patients, religious observance may be more important than pain relief.
- Other religious traditions forbid the use of narcotics.
- Spiritual or religious traditions may affect a patient's preference for the form of medication delivery, oral, IV, or IM.
- Consultation with the family and Spiritual Counselor will help you assess what is appropriate and acceptable. Variation from standard treatment regimens may be necessary to accommodate religious practices.
- Accommodating religious preferences, when possible, will improve the effectiveness of the pain relief treatment.
- Offer a choice of medication delivery. If the choice is less than optimal, ask why the patient has that preference and negotiate treatment for best results.

Beliefs about drug addiction

- Recent research has shown that people from different genetic backgrounds react to pain medication differently. Family history and community tradition may contain evidence about specific medication effects in the population.
- Past negative experience with pain medication shapes current community beliefs, even if the medications and doses have changed.
- Be aware of potential differences in the way medication acts in different populations. A patient's belief that they are more easily addicted may have a basis in fact.
- Explain how the determination of type and amount of medication is made. Explain changes from past practices.
- Assure your patient you are watching their particular case.

Use of alternative pain relief treatment

- Your patient may be using traditional pain relief treatment, such as herbal compresses or teas, massage, acupuncture or breathing exercises.
- Respectfully inquire about all of the ways the patient is treating their pain.
- Use indirect questions about community or family traditions for pain management to provide hints about what the patient may be using. There may be some reluctance to tell you about alternative therapies until they feel it is “safe” to talk about them.
- Accommodate or integrate your treatments with alternative treatments when possible.

Methods needed to assess pain

- Most patients are able to describe their pain using a progressive scale, but others are not comfortable using a numerical scale, and the scale of facial expressions (smile to grimace) may be more useful.
- Ask the patient specifically how they can best describe their pain.
- Use multiple methods of assessing pain—scales and analogies, if you feel the assessment of pain is producing ambiguous or incorrect results.
- Once the severity of the pain can be assessed, explain in detail the expected result of the use of the pain medication in terms of whatever descriptive tools the patient has used. Check comprehension with teach-back techniques.
- Instead of using scales, which might not be known to the patient, asking for comparative analogies, such as “like a burn from a stove,” “cutting with a knife,” or “stepping on a stone,” may produce a more accurate description.