Current Issues

Culturally Competent Rehabilitation Nursing

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There was a time when the most important skills a rehabilitation nurse needed were technical. In today's increasingly diverse world of health care, it is no longer enough to be technically proficient. In order to do their job effectively, *all* healthcare workers also must be culturally competent. Cultural competence can be defined as "a set of skills, knowledge and attitudes which enhance 1) your understanding of and respect for patients' values, beliefs and expectations, 2) awareness of your own assumptions and value system in addition to those of the U.S. medical system, and 3) your ability to adapt care to fit with the patient's expectations and preference" (Mutha, Allen, & Welch, 2002, p. 25).

To become culturally competent, you must understand your own culture and biases and become sensitive to and appreciate the differences of other cultures. The next step is to acquire knowledge of other cultures and understand those values and beliefs. The final step is to apply that knowledge to your clinical encounters (Mutha et al., 2002). This article will explain why it is important for healthcare providers to know something about the culture of their patients, and discuss in some detail three issues of particular relevance to rehabilitation nurses: touching, pain, and self-care.

Why Culture Is Important

Healthcare providers often say, "I treat each of my patients as an individual, and with respect. Isn't that enough?" The answer is that it is a start, but no, it is not enough.

Treating each patient respectfully would not avoid the problem of inadvertently giving a Mexican child the evil eye by complimenting him. Nor would it avoid insulting a Korean patient by beckoning her over with an index finger. It would not prevent a nurse from misinterpreting a lack of eye contact from a Vietnamese patient as a sign of discomfort. It is only by having a knowledge of cultural norms that these mistakes can be avoided.

Some caveats about the use of cultural information must be understood. Such information is best used retrospectively to understand *why* someone behaved as they did. It is much less effective at predicting behavior because there is more variation within most groups than there is between groups. An understanding of cultural norms can help nurses anticipate the variety of behaviors that might occur as we care for our patients, and help keep us from misinterpreting responses. If a Mexican mother suddenly looks uncomfortable after you have complimented her child, it is helpful to know that it *could* be because compliments are thought by some to reflect envy and thus can result in illness due to *mal ojo* (the evil eye). The perceived damage can be neutralized, however, by touching the child.

If a Vietnamese patient avoids eye contact, consider that in traditional Asian cultures, respect is shown when a subordinate individual avoids direct eye contact with a superior. Asian cultures tend to be hierarchical, and to look someone directly in the eye implies you are equals. This does not mean that all Asians will avoid eye contact, but if your patient was born in an Asian country and does not appear to have acculturated (e.g., speaks English poorly or not at all and/or wears traditional clothing), then you would be wise not to consider their avoidance of eye contact rude or unfriendly. You likely will be considered a superior because you are in a position of medical authority. If you have a Korean patient who appears not to have assimilated into American culture, you should avoid using gestures that are known to be insulting, such as beckoning with an index finger. In Korea and the Philippines, that particular gesture is used to call dogs.

These examples should not lead readers to fear that there is a long list of cultural "facts" that must be memorized in order to provide culturally competent care. That is not the case. Rather, when you are assigned a new patient, ascertain their ethnic background. Because rehabilitation nurses typically spend more time working with each patient than other kinds of nurses do, this information can be invaluable in easing the care process. It is best to ask what their country of origin is, rather than trying to guess; some might find an incorrect guess insulting. Then determine how acculturated they are. The older they were when they moved here, the less likely they are to be acculturated, and the more likely it is that they will adhere to traditional values and behavior patterns. It is helpful to consult information resources about the culture of the patient (see **sidebar**). It will take approximately 5–10 minutes to pick up the kind of information that will help you provide more culturally appropriate care.

Recommended Resources

Books

Fadiman, A. (1997) *The Spirit Catches You and You Fall Down.* New York: Farrar, Straus and Giroux. (Hmong)

Galanti, G. (2004). *Caring for Patients From Different Cultures,* (3rd ed.). Philadelphia: University of Pennsylvania Press.

Galanti, G. (2004). *Cultural sensitivity: A guidebook for physicians & healthcare professionals.* Oak Park, IL: Doctors in Touch.

Gardenswartz, L., & Rowe, A. (1998), *Managing Diversity in Health Care.* San Francisco: Jossey-Bass Publishers.

Lipson, J., & Dibble, S., (Eds.). (2005). *Culture and Clinical Care.* San Francisco: UCSF Nursing Press.

Internet Sites

Cultural Diversity in Healthcare

http://ggalanti.com

This Web site contains basic concepts, cultural profiles, case studies, links to other Web sites, recommended books, articles, and other information relevant to cultural diversity in health care. Information on cultural diversity workshops also is included. *Note:* All the Web sites listed below can be accessed directly from the "Related Links" page of this Web site.

The Provider's Guide to Quality & Culture

http://tinyurl.com/6mkbx

This comprehensive Web site is designed for clinicians to help them provide culturally competent healthcare. It contains an interesting "Quality & Culture Quiz," as well as information on several ethnic groups, along with links and other resources.

EthnoMed

http://ethnomed.org/

This site contains information about cultural beliefs, medical issues, and other related issues pertinent to the health care of recent immigrants to Seattle, many of whom are refugees.

Films

Patient Diversity: Beyond the Vital Signs

This comprehensive training program from CRM Learning features a 20-minute video and a leader's guide with exercises and role-plays for 2–4 hours' worth of training on the topic of cultural diversity in health care. For more information, go to www.crmlearning.com/news

Cultural Issues in the Clinical Setting—Series A and B

Brief, dramatic vignettes raise numerous issues around differing health beliefs and practices, conflicting values, stereotyping, overt and covert prejudices, and language barriers. The video is 70 minutes long and contains 10 vignettes. Each is accompanied by support materials for facilitators and participants that will be sent electronically and are included in the nominal price of the video.

Available from Gus Gaona, Kaiser Permanente Multi-Media Communication, 825 Colorado Blvd., Suite 301, Los Angeles, CA 90041, 323/259-4776. An order form may be downloaded from the Resources section of www.ggalanti.com.

Multicultural Health Series 2 and 3

These are two additional video series from Kaiser Permanente. Series 2 has four vignettes covering Navaho beliefs regarding illness and curing, the Jewish sabbath, foreign physicians, and using an interpreter line. Series 3 has six vignettes discussing a Chinese family at the end-of-life, use of alternative medicine and literacy issues with a Colombian patient, domestic violence, sexually transmitted disease, mistrust and denial in an African American patient, and Afghani refugees confronting the American medical system.

Both series are available from Gus Gaona, Kaiser Permanente MultiMedia Communication, 825 Colorado Blvd., Suite 301, Los Angeles, CA 90041, 323/259-4776. An order form may be downloaded from the Resources section of www.ggalanti.com.

Other Media

CHISPA (Caring for HISpanic PAtients interactively)

A technology-based approach for the acquisition of cultural and linguistic competencies for the multicultural workplace. It is designed to teach allied health professionals how to approach Hispanic patients in a culturally appropriate manner. CHISPA consists of three components: interactive CD, Web site, train-the-trainer and activities manual. For further information, go to http://itdc.lbcc.edu/chispa/

As a rehabilitation nurse, you may be affected by cultural variations in several practice areas, including touch, pain, and self-care. To approach your patients in a culturally competent manner, first examine your own cultural biases. Are you comfortable touching and being touched by others; does the gender of the person involved make a difference? Do you think pain should be expressed verbally, or believe individuals

should remain stoic about their pain? Do you believe that addiction to pain medication should be avoided at all costs, or do you think pain medication is essential to the recovery process? With regard to your own self-care, do you value independence and believe self-care is both necessary and desirable, or do you believe that it is more important to allow family members to care for you? Do you assume that when a patient returns home, she or he will practice self-care primarily, or do you expect that family members will be at home to care for the patient? Note that the culture of nursing as taught in most nursing schools places a high value on both touch and self-care. Rehabilitation nursing's own subculture within nursing also supports these values.

The next step toward cultural competence is to acquire knowledge of other cultures and to understand their values and beliefs. Let's take a closer look at some cultural variations in the areas of touch, pain, and self-care.

Touch

Touch is something that is highly stressed in American nursing, however, not all ethnic groups are equally comfortable with it. Touch is acceptable among most Hispanics; however, it is less so among many Asians. This does not mean that you should avoid touching Asians, but rather that you should pay extra attention to the body language of Asian patients whom you may need to touch, especially those who do not appear to be well acculturated to American society. If they appear uncomfortable—but not in pain—you may be able to surmise that their discomfort is cultural, not personal, and avoid unnecessary touching. Be aware that among Orthodox Jews and devout Muslims, touching between members of the opposite sex is forbidden; therefore, nursing care involving touching is best done by same-sex healthcare providers. The culturally competent nurse will ask patients routinely if they are comfortable being touched and refrain from all but the most necessary touching if the answer is "no."

Pain

Another area in which some understanding of cultural differences can be helpful is in interpreting responses to pain. It also is an area in which it is essential that stereotyping be avoided. In general, people from Northern European, Asian, Native American, and Anglo American cultures tend to be more stoic, while those from Mediterranean, Middle Eastern, and Latin American countries tend to be more expressive. Does this mean you can ignore the cries of pain of a Mexican patient? Absolutely not! That would be a dangerous use of a stereotype. But the culturally competent nurse will realize the need to attend more closely to nonverbal cues given by patients from cultures that value stoicism. Family members also can be quite useful in helping you ascertain the meaning of the patient's verbal or nonverbal expressions. The culturally competent nurse will ask them how the patient usually expresses pain and how the current expression (or lack thereof) should be interpreted.

Be aware that some Asians will not ask for pain medication because of their stoicism and reluctance to "bother" the nurses. Therefore, the culturally competent nurse will offer pain medication several times, if necessary, and insist on it when essential for recovery. For example, a woman from India had stopped using the passive range-of-motion machine following a total knee replacement because she found the exercise too painful. Like many Indians, she had a tremendous fear of addiction, and she had stopped taking pain medication on the advice of her physician son who feared addiction could compromise her recovery. It took several long conversations to explain to her the importance of taking pain medication and the true nature of addiction (Galanti, 2004).

Fear of addiction is common in many cultures, and it is important that rehabilitation nurses discuss such fears with patients, lest their reluctance to take pain medication interfere with their rehabilitation exercises. It also should be noted that if given a variable dosage of pain medication to administer, some Filipino nurses might automatically choose the lowest dosage. A Filipino nurse once confided tearfully and guiltily to me that when her mother was dying, she automatically halved the hospice's recommended dosages of pain medication for her mother to avoid addiction.

Self-care

Another issue of relevance to rehabilitation nursing is self-care. Self-care is important to many Americans in part because we value independence so highly. By contrast, Asian, Hispanic, and almost all cultures other than Anglo American cultures emphasize family interdependence over independence. For them, self-care is not an important goal.

Tome Tanaka, a Japanese man in his sixties, was a patient in a rehabilitation unit (Galanti, 2004). A stroke had left him with significant weakness on his left side. Self-care was an important part of his therapy. He had to relearn to feed himself, dress, shave, use the bathroom, and do other daily activities. Kathy, his nurse, spent a great deal of time discussing self-care with Mr. Tanaka and his family. Nonetheless, later she found Mrs. Tanaka waiting on her husband as though he was an invalid. Mr. Tanaka himself insisted upon this service. Rather than use the toilet, he insisted that his wife hold the bedpan for him. He refused to brush his teeth, shave, or dress himself, demanding that she do everything for him. Although Mr. Tanaka did quite well in his physical therapy and occupational therapy sessions, as soon as his wife or one of his children arrived, he regressed. He was discharged after 4 weeks, almost as dependent as when he first came.

Kathy and the other nurses were frustrated over

Mr. Tanaka's dependency, especially when they saw that he was capable of taking care of himself. They took his "failure" personally, as though they were not doing their jobs properly. How might they have approached his case in a more culturally competent manner?

First, they needed to understand that patients and their families do not always share the same goals as healthcare personnel. Realizing that many Asians value family interdependence over individual independence, they might have asked him whether it was important for him to be able to care for himself on his own, or whether he preferred to have his family take care of him. Second, they might have inquired as to his home situation, and whether he would have to care for himself at home or whether family members would be there to care for him. Asians and Hispanics tend to live in extended-family households, where someone usually is at home to care for the patient. Third, they might have realized that most Asian cultures are hierarchical. Some members of the family are clearly dominant (males and elders), while others are clearly subordinate (females and children). The Tanakas illustrated the proper roles of wives and children in this type of culture. It is their duty to obey and care for the dominant family member—the husband and father.

An additional element when dealing with elderly Asians is the notion that old age is a time for rest, reflection, and being cared for by loved ones after a lifetime of labor. It is seen as inappropriate to insist upon self-care when family members are available to help. This custom raises some health-related issues. Lack of self-care may prolong the period of rehabilitation, and there may be occasions when physical needs outweigh cultural ones. However, it is important that cultural needs at least be considered.

It also may be worthwhile to consider the possibility that control may play a role in a patient's failure to care for himself or herself. A large degree of self-care is not common among men, who are dominant in most cultures. Ordering people around and being waited upon are ways of demonstrating dominance. Although lack of self-care may appear as helplessness, it actually may be a way of maintaining control.

To summarize, a culturally competent nurse will assess his or her own attitudes about self-care, ascertain their patient's values regarding independence and family interdependence, learn what the home situation will be, and selectively encourage self-care only when it is both culturally appropriate and necessary for recovery. The nurse also will incorporate family members into patient care when appropriate.

Conclusions

How will you, as a rehabilitation nurse, know if you are becoming more culturally competent? Remember that cultural competence is a journey that never ends. Diversity experts do not agree regarding how to measure objectively cultural competence. It is possible to be more competent with one patient population than with another. However, you will know that your general competence is improving when you begin to become aware of your own cultural biases and refrain from imposing them, and when you start considering your patient's perspective as well as that of the medical profession. Although most healthcare professionals enter the field with idealistic notions of helping people, these altruistic attitudes often get lost in the realities of providing care in sometimes trying circumstances. When your patient's values and priorities become paramount—even when different from yours—you will know that you are becoming more culturally competent.

There are numerous resources you can use to improve your cultural competence. There are many Web sites, videos, interactive materials, and CD-ROMs you can draw on to learn more about other cultures (see **sidebar**). One easily available, but often overlooked, resource is your colleagues. The nursing and medical professions are filled with members of various ethnic groups. Most people are happy to answer questions about their culture when they are asked in a true spirit of inquiry. Share information about your own culture with your colleagues as well.

The most important step in achieving cultural competence is to change your own attitude. Rather than seeing a patient's culture as an impediment to nursing care, see it as something that makes your job more interesting. Seeing the world through other eyes is a fascinating experience. Doing so will make your job easier and your patients happier. Cultural competence is a win-win situation for everyone involved.

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