Applying Cultural Competence to Perianesthesia Nursing

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The paper stresses the importance of cultural competence in perianesthesia nursing, both in terms of caring for the patient and in dealing with the patient's family. Cultural variations in gender, decision-making, family, communication, and time orientation are presented. A distinction is made between generalizations (potentially useful) and stereotypes (potentially harmful). Several suggestions for specific ways to provide more culturally appropriate care are presented, and resources for further study are provided.

CULTURAL competence has become a hot new buzz phrase in health care. For many nurses already overwhelmed with high patient loads and mounds of paperwork, mandates that they become culturally competent as well may seem like an overwhelming burden. In reality, however, learning about culture can be both interesting and ease some of the burdens of caring for patients from different cultures. It can make the work environment more pleasant and efficient, given the increasing diversity of staff in US hospitals.

Even in the field of perianesthesia nursing, where patients are unconscious for much of the time, culture can play an important role. Cultural sensitivity—recognizing and understanding cultural differences without judging them—is often needed in encounters with patients' families. In terms of patient care, including the patient and the patient's family, relevant aspects of culture include variation in gender issues, decision making, family and visitors, communication, and time orientation.

Stereotype vs. Generalization

Before beginning a discussion of culture, however, it is essential to distinguish between a stereotype and a generalization. The difference between a stereotype and a generalization lies not in the content, but in the usage of the information.[1] An example is the assumption that Mexicans have large families. If Rosa Gonzales, a Mexican patient, is admitted to the floor, and the admitting nurse warns the others to watch out for lots of visitors, she is stereotyping her. If, instead, she thinks "Mexicans often have large families," and then asks Mrs Gonzales how many people will be visiting, she is making a generalization.

A stereotype is an ending point. No attempt is made to learn whether the individual in question fits the statement. A generalization is a beginning point. Stereotyping patients can have negative results, whereas generalizations can help the healthcare providers avoid potential problems, as can be seen in the following case.

An Irish woman in her early sixties was hospitalized and scheduled for surgery at the end of the week. A generalization about the Irish is that they are typically stoic with regard to pain. Unfortunately, the patient's physician knew nothing about Irish culture, but stereotyped women as being very vocal with regard to pain. As a result, he did not take her complaints of pain as seriously as he should have. When he

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finally did operate, he discovered that the patient's condition had worsened to the point that she could not be saved and she died on the table.[2]

The patient's daughter-in-law, a nurse, firmly believed that had the physician not stereotyped her mother-in-law as a "loud woman," but rather verified with the family that the loud cries of pain were indeed unusual for this typical Irish woman and then moved up the surgery accordingly, he might have been able to save her. Although ultimately it may not have made a difference in the outcome, and complaints of pain should always be taken seriously, this is a case where an inaccurate stereotype might have contributed to a woman's death, whereas an accurate generalization might have saved her life.

One way to think of it is that culture exists separately from the people who are members of that group. It can be helpful to know what the cultural patterns are, but it is important to recognize that any specific individual will adhere to only some of these patterns. They may or may not be accurate when applied to specific individuals. This is why it is essential to observe and question patients to know whether they adhere to the patterns typical of their cultural group. Assuming they do is stereotyping.

Gender Issues

Gender equality has been a goal in this country since the Women's Movement in the early 1970s. However, in many countries, men are still considered the head of the family and responsible for making the major decisions.[3] This can conflict directly with the American expectation that individuals, including women, will make decisions about their own health or feel empowered to do so for their children. This will be discussed further in the section on "Decision Making."

Modesty is a very important value in many Hispanic cultures, including Mexican Americans.[4] For a traditional woman, keeping her body covered is essential. Although most healthcare professionals may be too busy to worry about something as seemingly inconsequential as modesty, for the patient it can make a huge difference.[5] Issues of modesty are taken an additional step when it comes to Muslim women. Their religion requires strict sexual segregation, although according to Dhami and Sheikh,[6] the rules may sometimes be relaxed for medical treatment. A nurse caring for an Arab-Muslim woman being prepped for a colonoscopy reported that it was very important to the patient that everyone involved in her care be female. Accommodating the patient required shifting the entire staff. The patient also requested that she be covered at all times, so they provided a towel for her head and additional draping. It required extra work to accommodate the patient's needs, but as a result, everything went far more smoothly than it might have.

In those instances when an all-female staff cannot be provided, it may be necessary to cover the patient from head to toe. When placing an epidural, if the anesthesia provider or physician is a man, the nurse can accommodate the patient by covering her head and body and literally taping open the space for the male healthcare provider to work. Again, although this means extra work for the nurses and more difficult working conditions for the healthcare provider, it makes the experience much better for the patient.

Decision Making

In this dominant American culture, the individual is the primary unit. Core American values include independence and autonomy.[2] Although many Americans may consult with family members before making important health decisions for themselves, it is expected that they will be the final decision maker. Similarly, given the ideal (if not always the reality) of gender equality, it is assumed that a mother is as equally empowered as a father to sign consent for a child.[7]

In many other cultures, including those in Latin America, Asia, Africa, and the Middle East, the family and not the individual is the primary unit.[8] Therefore, important decisions are often made by the group, rather than the individual, as in the Chinese,[9] Iranian,[10] Puerto Rican,[11] and Nigerian[12] cultures, for example. These cultures are generally male dominant, and women will often defer to their husbands to make decisions for themselves or their children. One nurse* reported that when caring for laboring Hispanic patients, she discusses with the family beforehand the possibility of a cesarean delivery so the family can make the decision should an emergency cesarean delivery become necessary. She finds this a far more effective approach than waiting until it becomes necessary, and then having to delay while family members discuss it or call someone else for consent. Alternatively, in cases where the husband cannot be contacted in time, an effective approach is to have an older (eg, in his seventies) male physician talk to the mother about signing consent for the child because his age, gender, and profession will command respect.

Visitors

One of the most common problems faced by nurses is that patients sometimes have too many visitors at once.[2] Nurses have a difficult job and frequently care for many patients at one time. Having several family members underfoot *and* asking questions can be overwhelming. However, nurses who want to be culturally competent need to consider the needs of their patients. For many people, particularly those from cultures in which the family is the primary unit, when someone is ill, it can be devastating. Within most Hispanic cultures, for example, it is important to show love for family members by being there with them during such times.[5] For many Asians, not only is attending family members the way to show love, but it may also be considered a duty. The Confucian value of filial piety requires that children care for their aging parents.[13] Unfortunately for such immigrants, most American hospitals were built by Americans, for Americans, and as such are ruled by dominant American values which include money and privacy.[2] Rather than provide sleeping facilities for family members, extra beds are used for paying patients. Rather than encourage visitors, visiting hours and number of visitors are limited (assuming that patients want privacy), not to mention that it is easier for nurses if visitors are not underfoot.

Problems stemming from a clash of culture are not restricted to American hospitals, as an American student working abroad for a year in Spain learned.[2] She broke her leg quite severely and was hospitalized and in traction. Because she had no family in Spain, her friends made arrangements to take time off from work so that someone could be there with her 24 hours a day. They could sleep over on the couch provided in her room. They would not believe her when she told them truthfully that she would prefer to be alone. They knew that if they were ill, they would want their family with them at all times; the hospital was set up to accommodate this. How could she not want the same thing? Most people assume that everyone wants what they want, but that is not the case. It is a source of conflict in hospitals that serve a diverse patient population, no matter what the country.

It should also be remembered that some patients might not want family members with them, whereas others do. It is often best to ask patients before going into surgery whom they would like with them when they come out of surgery. Obviously, there should be no relatives in the room when this question is asked. The patient's wishes should be accommodated as best as possible. Although it may seem an inconvenience, if the patient is happier, he or she is more likely to recover more quickly and disturb the nurses less.

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Communication

Another source of problems is communication, or rather, miscommunication. This occurs most frequently at two points. The first is in giving the patient preoperative instructions. The second involves communicating the patient's condition to family members. It is essential that professional interpreters be used with individuals who have limited English proficiency, otherwise patient outcomes are worse, quality of care is reduced, and costs are higher.[14] One study found that a significant portion of respondents who needed, but did not get an interpreter, often delayed seeking medical care and did not buy necessary medications because they didn't understand how to take them.[15]

Some hospitals are now conducting preoperative interviews over the telephone. If the patient speaks minimal English, they may not understand all the instructions given, yet feel uncomfortable mentioning that fact. They often will not ask for an interpreter, even if they need one. Just as it is best to use a professional interpreter in the hospital when the patient is not fluent in English, the same is true over the telephone. There are several telephonic interpretation services* available. It is also important to explain the reasoning for any instructions given to patients. One nurse† commented that even though patients are told over the telephone not to eat or drink anything after midnight, they will sometimes stop and have coffee at the cart in the lobby before registering. This often delays the surgery 6 to 8 hours. If the reasons for the instructions were made clear, this would be far less likely to happen. Nurses should always make sure that patients can repeat back their instructions and the reasons for them. If patients cannot do this, it is essential to use a telephone interpreter.

For example, Language Line Services at 800-628-8486, Pacific Interpreters at 877-472-2434, and Language Services Associates at 800-305-9673

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Time Orientation

Not everyone views time in the same way. Those who come from agricultural communities such as one might find in Latin America, Asia, and Africa, may focus on "activity" time rather than "clock" time.[2,16] The focus is on the present, and doing an activity until it is finished. At that point, one moves on to the next task. Surgical centers, on the other hand, operate on clock time, which essentially means that activities are scheduled according to the clock.

A nurse‡ who worked at a surgical center said that time was a major issue with many of her Hispanic patients. Rather than showing up at their scheduled time, the patients would arrive once they had completed their other responsibilities. Family is one of the most important values in the Hispanic community[17] and thus taking care of the needs of the family takes priority over taking care of oneself. The center dealt with the problem in two ways. They presented a brief workshop on cultural competency, which included the notion of time orientation. This resulted in lower frustration for the staff because they began to understand why patients would not show up until after work or after the children were taken to school. In addition, the staff took the extra step of explaining that their appointment time was time specifically set aside for them. This resulted in more "on-time" arrivals because patients had a better understanding of the meaning of their appointment time.

Conclusion

There are a few simple things that perianesthesia nurses can do to make the medical experience far less stressful for their patients, while at the same time making their own job easier. While it is important to recognize the enormous degree of variation within cultures, and thus avoid stereotyping, the suggestions outlined in this article can—and should—be applied to all

‡*Amy Laboda*

patients, regardless of their culture; it is just good nursing.

- Use same-sex providers when possible or requested.
- Keep women modestly covered whenever possible.
- Ask patients whether they prefer to make decisions on their own or to consult with family members.
- If family members are preferred, discuss possible decisions in advance of need.
- Recognize the importance of family visitors in many cultures, and try to accommodate them when desired by the patient.
- Make sure patients understand the reasoning behind your instructions.
- Unless the patient is fluent in English, use an interpreter (or a telephone language service, even for telephone calls).
- Understand cultural differences in time orientation, and clearly explain to patients the importance of appointment time.

Hospitals can also show their commitment to cultural competence by doing the following:

- Provide staff education.
- Have resources easily available for staff to access cultural information.
- Post information at nursing stations on how to contact an interpreter or cultural resource person.
- Modify hospital policies to accommodate different ethnic and religious groups (eg, visiting hours, dietary practices, etc).
- Print signs and forms in the languages of the ethnic groups served.
- Make cultural assessments part of the intake form. This information could be included on the charge sheet to help ensure that the information gets passed on from one shift to the next.
- Require that culture-specific nursing interventions be part of nursing care plans.
- Make cultural issues a regular topic for discussion at staff meetings.
- Create a "Cultural Questions Box" for nurses to post questions that could be discussed at staff meetings.
- Make cultural competence policy part of the job description and, thus, part of yearly evaluation.
- Create a bulletin board in the break room with information about different cultures and health beliefs.
- Organize potlucks where each person brings something from their own culture and describes any associated traditions or significance.
- Survey and interview patients regarding how well their cultural needs were met. A category regarding "culturally competent" care could be added to patient satisfaction surveys.
- Publically recognize nurses who provide culturally competent care. If a nurse's name is specifically mentioned by a patient in the culturally competence category of patient satisfaction surveys, he or she could receive a small reward.

Caring for patients from different cultures can be challenging at times, but it is a job that can be interesting and rewarding. The key is to provide culturally sensitive care.

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Web Sites

Cultural Diversity in Healthcare

http://ggalanti.com

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 workshops on cultural diversity is also included. Note: all the websites listed below can be accessed directly from the "Related Links" page of this web site.

The Provider's Guide to Quality & Culture

http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

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 Home Page

http://ethnomed.org/

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 fleeing war-torn parts of the world.