

CULTURAL COMPETENCY IN PHARMACY PRACTICE



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Learning Objectives

1. Assess patient or workplace situations using cultural competency terms, concepts, and guidelines.
2. Evaluate potential barriers to and opportunities for cultural competency in pharmacy practice.
3. Adapt a pharmaceutical care plan for a patient based on perceptions of disease and illness.
4. Distinguish common behaviors and values of various cultures found in the United States.
5. Resolve communication challenges that may occur in cross-cultural situations.
6. Determine viable alternatives and resources to implement cultural competency within the workplace.

NOTE: All key people in the cases have been given fictional names to assist in ease of use of the case examples throughout the text. Although fictional, the cases are based on potential cross-cultural and clinical encounters.

Introduction

Case:

Ms. Bekle is a 26-year-old woman from Ethiopia who lives in the Northwest region of the United States. While at a local clinic, the female physician refers the patient to the pharmacist to review the drugs prescribed for her. Ms. Bekle is asked to wait in a patient room. She has come to the clinic carrying a young child and is accompanied by her husband and four other children. She has limited English proficiency.

Dr. Garcia is a 42-year-old pharmacist from Puerto Rico who has been working at the community health center for a week. Before entering the room, he reviews the chart and finds that the patient will receive amoxicillin 250 mg 3 times/day for 5 days for no apparent diagnosis. The physician has placed a note in the chart that the patient was persistent on receiving an antibiotic and that birth control should be discussed in the future. When Dr. Garcia arrives at the room, the patient is breastfeeding her child, and she quickly covers herself.

What are some of the dynamics that exist between the patient and the pharmacist in this case? Ideally, there are no barriers to care if the pharmacist applies pharmaceutical care principles to optimize patient therapeutic outcomes and quality of life. However, experience and understanding of different cultures suggest many factors, including gender, religion, racial/ethnic background, and possibly language, may pose difficulties during the patient-pharmacist relationship in this encounter. Further exploration of the Ethiopian culture reveals the possibility that Ms. Bekle's family moved to the United States as political refugees and that her religious faith is likely Christian or Islam. The man often is the dominant figure in the family and it is common for extended families to live together. Illness often is believed to be a punishment by God, or Waaqa, for sins. Health practices in Ethiopia include using herbs and antibiotics to treat many common ailments, breastfeeding children in public, and avoiding use of oral contraceptives. Patients often anticipate drugs from a clinic visit.

Awareness of this information provides the pharmacist new insight into the case of Ms. Bekle. How can

Ethnomed. Ethnic Medicine Information From Harborview Medical Center. 1995–2003 University of Washington Harborview Medical Center. Available at <http://www.ethnomed.org/>. Accessed November 14, 2003.

pharmacists best ensure patient outcomes in these cross-cultural situations? Health care professionals cannot know about every culture that they encounter. However, pharmacists have a responsibility to respond to their patients in the best manner possible. To achieve this goal, pharmacists must understand that culture can affect the care anticipated by the patient as well as the care that is provided.

Every charted clinical encounter documents basic information about a patient. For example: “J.Y. is a 62-year-old Latin American man with a history of right leg amputation secondary to type 2 diabetes mellitus.” In essence, health care professionals start the clinical encounter with a part of a story, and their job is to uncover the rest of it. By being culturally competent, health care professionals are able to better unravel the patient story and experience in a way that can improve health outcomes and quality of life for the patient and the family. To stay at the forefront of societal changes in pharmacy practice, pharmacists need the skills to understand various cultural beliefs and values and the tools to apply these skills in their interactions with patients and coworkers. This chapter explores values and health care beliefs of various cultures (focusing on racial/ethnic cultures) and provides tools for pharmacists to use in their practice settings.

Nature delights in diversity. Why don't human beings?
—Herself, Southern Comfort (2001)

Definitions

There are many racial/ethnic groups throughout the world. The United States government, through its census data collection process, identifies five primary racial groups in the United States: 1) white or Caucasian, 2) black or African American, 3) Asian, 4) native Hawaiian and other Pacific Islanders, and 5) American Indian and Alaska Natives. The United States government created the term Hispanic to describe people who have an ancestry from Spain and it is now often used to represent an ethnicity. In census data, Hispanic people can be of any race. Census reports often will use the terms non-Hispanic white, Hispanic white, non-Hispanic black, or Hispanic black. Individuals may further delineate their country of origin (e.g., Puerto Rico). It is important to recognize that culture, race, and ethnicity are intertwined (Figure 4-1). However, other cultures exist that are not defined solely by race and ethnicity. These cultures, which may include religion, age, sexual orientation, and disabilities, often have unique health beliefs, values, and needs.

In culturally competent health care environments, the capacity exists for organizations and individuals to work effectively within the context of the cultural beliefs, behaviors, and needs of patients and their communities.

Cultural competency is part of a continuum or ongoing process where diversity is accepted as the norm. Ongoing development and self-reflection occurs to help people better understand how to work in diverse environments. Individuals and organizations strive toward cultural proficiency, often considered the highest level of the cultural competency. Cultural proficiency also has been called fluency—a state where individuals and organizations can easily navigate among a variety of cultures and understand the subtleties of diverse cultural communication styles and beliefs. Culturally proficient individuals and groups provide leadership to better define and study the influences of culture on health outcomes. Just as people can always improve their language fluency, individuals and groups can continue to become more culturally proficient. Linguistic competency occurs when an organization and its personnel are able to communicate information to diverse groups in an effective and easily understood way. These groups may include people with limited English proficiency, low or no literacy skills, or disabilities. People with limited English proficiency do not speak English as their primary language. They also have limited skills to write, read, and/or understand English. When cultural and linguistic competence comes together, the health system and individuals are able to work effectively in cross-cultural situations.

... To consider the welfare of humanity and relief of human suffering my primary concern ... To apply our knowledge, experience, and skills to the best of our abilities to assure optimal drug therapy outcomes for the patients we serve ...
—Oath of a Pharmacist

Defining the Scope of Cultural Competency

*In the book, *The Spirit Catches You and You Fall Down*, Anne Fadiman describes the story of the cultural dissonance that occurred between Lia Lee and her family and the Western medical system. The Lee family is Hmong, an Asian people who have sought refuge in the United States from the country of Laos. Lia Lee is the 14th child born to the Lees and their first child to be born in a modern United States hospital. All of the other children had been born in a house, delivered by the mother, Foua, herself. Lia had epilepsy and experienced her first seizure at 3 months of age. The parents associated this episode with the slamming of the door by Lia's older sister. To the Lees, Lia's soul had taken flight and become lost.*

Cross TL, Bazron BJ, Dennis KW, Isaacs MR. *Toward a Culturally Competent System of Care: Volume I*. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

Huff RM, Kline MV. *Promoting Health in Multicultural Populations: A Handbook for Practitioners*. Thousand Oaks, CA: Sage Publications, Inc., 1999.

Goode TD, Jones W. *A Definition of Linguistic Competence*. National Center for Cultural Competence. Washington, D.C.: Georgetown University Center for Child and Human Development, 2003. Available at http://www.georgetown.edu/research/gucdc/nccc/documents/Definition_of_Linguistic_Competence.rtf. Accessed February 25, 2004.

In the Hmong language, there is not a specific term for epilepsy, rather it is translated to “the spirit catches you and you fall down.” Between the ages of 8 months and 4.5 years, Lia experienced more than 100 outpatient emergency department and pediatric clinic visits and was admitted to the county hospital 17 times. The doctors worked to provide optimal treatment with the best evidence available. However, the family had a difficult time adhering to the prescribed drug treatment and, according to their customs and health beliefs, the treatments were not helpful. To the family, Lia’s illness had a spiritual cause that could not easily be solved with Western therapies. Because of the medical system’s understanding of this case, the family was not capable of taking care of Lia and she was taken out of her family’s custody for a time period. Eventually, she was returned to her family, and in the midst of her frequent use of the health care system, Lia went into a coma. Differences in concepts of illness, language, historical references, geographical displacement, and lack of connection and trust with leaders in the Hmong community were among the factors that influenced the negative outcomes of Lia Lee.

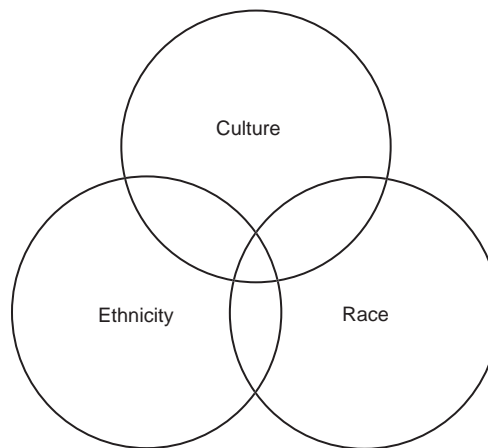


Figure 4-1. Interplay of culture, race, and ethnicity.

Rationale

The examples of the Lee family, Dr. Garcia’s experience with Ms. Bekle, and other documented and personal cases of cultural misunderstandings and errors provide the stories that personally motivate individuals to be culturally competent. Other factors provide rationale for cultural competency in pharmacy practice and health care. By being culturally competent, the health care system will: 1) respond to demographic changes; 2) work to eliminate health care disparities; 3) improve health outcomes and quality of services; 4) meet legislative, regulatory, and accreditation mandates; 5) be competitive in the marketplace; and 6) decrease liability and malpractice claims.

Respond to Demographic Changes in the United States

Demographic changes throughout the United States demonstrate major shifts in race and ethnicity. According to the United States census in 2000, one out of every four Americans (25%) is non-Caucasian. Specific racial/ethnic groups are estimated to be: Caucasian (69.1%), Hispanic (12.5%), African Americans (12.3%), Asian/Pacific Islander (3.7%), and American Indian/Alaska Native (0.9%). Eighteen percent of people in the United States speak a language other than English in the home. An estimated 10% of people in the United States were born in a different country—the largest number in the past 50 years.

However, pharmacists cannot assume that every block looks the same throughout the country. In each corner

pharmacy, health clinic, and hospital, varying concentrations of languages, cultures, and religions exist (Table 4-1). Even in one city, a community pharmacy will serve different patients, depending on what part of town it is located. A “one-size-fits-all” approach can marginalize patients from appropriate health care and pharmaceutical care services. Furthermore, pharmacist and other health care provider shortages may decrease health care access to patients. Pharmacists are faced with the challenge and opportunity to provide patients culturally and linguistically appropriate pharmacy services. To meet this challenge, pharmacists must have the tools to work in diverse communities with diverse staff. Working environments in pharmacies may even need to be adapted.

Eliminate Health Care Disparities Based in Diverse Racial, Ethnic, and Cultural Backgrounds

People from racial/ethnic minority communities in the United States experience grave disparities in health care access and disease burden. Pharmacists, as part of the health care and drug delivery system, have been a part of these growing disparities. According to the United States national initiative, Healthy People 2010, the two goals are: 1) to increase quality and years of healthy life, and 2) to eliminate health disparities in the population. To reach these goals, which embrace health care needs within specific racial/ethnic groups, pharmacists and health care providers must work together.

Among the top leading health indicators of Healthy People 2010, disparities persist. Six areas have been further targeted by the United States Department of Health and Human Services to decrease health disparities among minority racial/ethnic groups: cancer, cardiovascular disease, infant mortality, diabetes, human immunodeficiency virus/acquired immune deficiency

Cohen E, Goode TD. National Center for Cultural Competence. Policy Brief 1: Rationale for Cultural Competence in Primary Care. Washington, D.C.: Georgetown University Center for Child and Human Development, 2003. Available at <http://www.georgetown.edu/research/guccd/nccc/cultural5.html>. Accessed February 25, 2004.

Healthy People 2010. Washington, D.C.: Office of Disease Prevention and Health Promotion. United States Department of Health and Human Services. Available at <http://www.healthypeople.gov>. Accessed October 16, 2003.

Table 4-1. Demographic, Social, and Economic Variations Within a Community

	ZIP Code No. 1	ZIP Code No. 2	ZIP Code No. 3	City	State
Population	0.5%	0.3%	0.3%	0.4%	0.3%
American Indian	2%	0.2%	2%	2.3%	1.8%
Asian/Pacific Islander	29%	61%	11%	26%	14%
Black/African American	18%	27%	8%	19%	17%
Hispanic	~42%	~2%	75%	45%	61%
Caucasian	8.5%	~9.5%	~4%	~7%	~6%
Other					
Education level less than 12th grade (> 25 years old)	24%	47%	9%	23%	20%
Language other than English spoken in home	21%	27%	13%	23%	23%
Families below poverty level	17%	28%	4%	14%	9%
Number of Pharmacies	11	2	6	~175	Unknown

American FactFinder. United States Census Bureau 2000. Available at <http://factfinder.census.gov/>. Accessed September 8, 2004. Based on a real city in the United States.

syndrome, and child and adult immunizations (Table 4-2). Pharmacists and the pharmacy profession must recognize their roles in addressing these disparities. Because pharmacies are located within communities and have high access to diverse patient populations, pharmacists are in an important position to help resolve health disparities.

Differences exist in mortality and disease burden among racial/ethnic minority groups (Table 4-3). Consider the following:

- The top three leading causes of death in the United States across cultures are heart disease, cancer, and stroke.
- Accidents and diabetes are among the top five causes of mortality in minority racial/ethnic groups.
- Human immunodeficiency virus and assault are among top mortalities for African Americans.
- Liver disease and cirrhosis are more common in Hispanics and American Indians.
- American Indians and Asian Americans have higher rates of suicide.

Pharmacists have the opportunity to reduce these health burdens through health promotion, disease prevention, therapeutic management, and being culturally competent.

Improve Health Outcomes and Quality of Services

The roles of pharmacists have been expanded with pharmaceutical care. Many pharmacists have gravitated toward these expanded, advanced practice roles that may include evidenced-based medicine, collaborative practice agreements, disease management, and board certification. To take on these roles, pharmacists must develop and incorporate other skills that shape the care of the patient. Pharmacists and other health care professionals can optimize health and pharmaceutical care outcomes by providing care that incorporates the sociocultural backgrounds of their patients, families, and communities. Opportunities exist to develop models of care that are accessible, effective, and cost-effective while being

culturally competent. Because health care and pharmacy services have become disconnected from their communities, these models can bridge this gap and can incorporate beliefs, values, traditions, and needs of the individuals and communities served (Figure 4-2).

Racial/ethnic minorities are underrepresented in health care professions, including pharmacy. The profession of pharmacy and colleges of pharmacy must become more proactive in recruiting, retaining, and promoting people from diverse backgrounds to serve the diverse public. Studies and evidence suggest that a diverse workforce enhances access, trust, and communication with minority communities. When patients are able to work with health care personnel with similar backgrounds, greater concordance exists. However, achieving a diverse workforce takes time. With more than hundreds of diverse cultures in the United States, it becomes imperative that more health care professionals have the ability to work well in cross-cultural settings. The nursing and medical professions have already taken strides and have begun to incorporate changes in curriculum and practice. Pharmacy, as one of the most accessible health care professions, also must recognize the need to nurture a diverse workforce and a workforce that can serve diverse populations.

Meet Legislative, Regulatory, and Accreditation Mandates

Through Title VI of the Civil Rights Act of 1964, the federal government mandates that no person in the United States be “excluded from participation in, be denied the benefits of, or be subjected to discrimination based on race, color, or national origin” under any program receiving federal funding. Limited English proficiency legislation addresses bridging language gaps that exist in communities. Groups such as the Joint Commission on Accreditation of Healthcare Organizations, which accredits hospitals and other health care institutions, and the National Committee

Smedley BD, Stith AY. *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions*. Washington, D.C.: National Academies Press, 2001.

Table 4-2. Six Focus Areas of Racial/Ethnic Health Disparities and Examples**1. Infant Mortality**

Infant death rate in African-American infants (14.2 per 1000 in 1996) is nearly 2.5 times that of Caucasian infants (6.0 per 1000 in 1996).

2. Cancer Screening and Management

The death rate for cancer for African-American men is about 50% higher than it is for Caucasian men (226.8 vs. 151.8 per 100,000).

The death rate for lung cancer is about 27% higher for African American(s) than for Caucasian(s) (49.9 vs. 39.3 per 100,000).

Vietnamese women in the United States have a cervical cancer incidence rate more than 5 times greater than Caucasian women (47.3 vs. 8.7 per 100,000).

3. Cardiovascular Disease

Racial and ethnic minorities have higher rates of hypertension.

The incidence of stroke is disproportionately high in African Americans, where the mortality rate is nearly 80% higher than in Caucasians.

4. Diabetes

Diabetes prevalence rates among American Indians are 2–5 times those of Caucasians.

Prevalence of diabetes in African Americans is nearly 70% higher than in Caucasians.

5. HIV Infection/AIDS

HIV infection is the leading cause of death for African-American men 25–44 years of age.

The rate of new AIDS cases reported in 1998 per 100,000 population was 81.9 among African Americans, 34.7 among Hispanics, 9.4 among Native Americans and Alaska Natives, 8.4 among Caucasians, and 4.1 among Asians and Pacific Islanders.

6. Immunizations

Influenza and pneumococcal immunization rates are significantly lower for African-American and Hispanic adults than for Caucasian adults.

AIDS = acquired immune deficiency syndrome; HIV = human immunodeficiency virus.

National Institutes of Health. Addressing Health Disparities: The NIH Program of Action. Available at <http://healthdisparities.nih.gov/welcome.html>.

Accessed September 8, 2004.

Table 4-3. Comparison of Top 10 Leading Causes of Death by Racial/Ethnic Group and Sex—Rank (%)

	US	Afr-Am non-Hisp	Am Ind	Asian/PI	Hisp	White non-Hisp	Men	Women
Heart disease	1 (29.6)	1 (27.1)	1 (21.3)	2 (26.1)	1 (24.1)	1 (30.3)	1 (29.3)	1 (29.9)
Cancer	2 (23.0)	2 (21.7)	2 (16.8)	1 (26.4)	2 (19.7)	2 (23.4)	2 (24.3)	2 (21.8)
Cerebrovascular disease	3 (7)	3 (6.7)	5 (5)	3 (9.4)	4 (5.8)	3 (7.1)	3 (5.5)	3 (8.4)
Chronic lower respiratory disease	4 (5.1)	8 (2.7)	7 (3.8)	5 (3.2)	8 (2.5)	4 (5.6)	5 (5.1)	4 (5.1)
Accidents (unintentional)	5 (4.1)	4 (4.3)	3 (11.9)	4 (4.8)	3 (8.2)	5 (3.8)	4 (5.4)	8 (2.8)
Influenza and pneumonia	6 (2.9)	10 (2.1)	9 (2.5)	6 (3.2)	9 (2.4)	6 (2.8)	7 (2.4)	6 (3)
Diabetes mellitus	7 (2.7)	5 (4.2)	4 (5.4)	7 (3.2)	5 (5)	7 (2.6)	6 (2.7)	5 (3.1)
Alzheimer's disease	8 (2.1)	-- (1)	-- (0.8)	-- (0.8)	-- (1.1)	8 (2.3)	-- (1.2)	7 (2.9)
Nephritis, nephrotic syndrome, nephrosis	9 (1.5)	9 (2.4)	10 (1.9)	9 (1.5)	-- (1.5)	9 (1.4)	9 (1.5)	9 (1.6)
Septicemia	10 (1.3)	--*	--	--	--	--	-- (1.1)	10 (1.4)
Assault (homicide)	--*	6 (2.7)	-- (1.8)	-- (1)	7 (2.7)	-- (0.3)	--	--
HIV	--	7 (2.7)	-- (0.5)	-- (0.2)	-- (1.8)	-- (0.2)	--	--
Chronic liver disease/cirrhosis	--	-- (1)	6 (4.7)	-- (0.9)	6 (3)	-- (1)	10 (1.5)	-- (0.8)
Suicide	--	-- (0.7)	8 (2.6)	8 (1.8)	-- (1.7)	10 (1.3)	8 (2)	-- (0.5)
Perinatal-related conditions	--	-- (1.7)	-- (1.1)	10 (1.1)	10 (2)	-- (0.3)	--	--

* (--) not in top 10

Afr-Am = African American; Am Ind = American Indian; Hisp = Hispanic; HIV = human immunodeficiency virus; PI = Pacific Islander; US = United States

Anderson RN. Deaths: leading causes for 2000. National vital statistics reports. Hyattsville, MD: National Center for Health Statistics, 2002;50(16).

Available at http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_16.pdf. Accessed September 8, 2004.

for Quality Assurance, which accredits managed health care organizations, incorporate elements of cultural and linguistic competence as part of their accreditation standards. Culturally and linguistically appropriate services standards provide guidelines for organizations to follow.

Pharmacies that are a part of the Joint Commission on Accreditation of Healthcare Organizations, National Committee for Quality Assurance, and community health center accreditation processes often have greater exposure to cultural competence initiatives. Pharmacists serving in the Public Health Service and Indian Health Service corps also may have had cultural competency initiatives incorporated into much of their training and staff development. However, many community pharmacies and pharmacy schools have not been actively engaged in cultural competency training and implementation. Pharmacies serve diverse constituents and many receive federal funding through Medicaid and Medicare reimbursement. By receiving assignment from these federal programs, pharmacists also are exposed to federal regulations. The Omnibus Budget Reconciliation Act of 1990 influenced changes in pharmacy practice acts regarding drug counseling and drug use review. The Omnibus Budget Reconciliation Act of 1990 set precedence for expanding pharmacy patient care services. Under Title VI, entities that receive federal funds (e.g., Medicaid and Medicare) must take reasonable actions to provide people

with limited English proficiency access to their services. At this time, pharmacy regulations and organizations have developed little infrastructure to support culturally and linguistically competent pharmacy systems.

Some legislation may prove to be antagonistic to some aspects of culturally competent care. Details of patient privacy continue to be delineated by the Health Information Portability and Accountability Act. However, in some cultures, families are accustomed to visiting clinics and pharmacies together. These cultures may value family as important to the overall care of the patient. The Health Information Portability and Accountability Act may conflict with these values. Clinicians will need to evaluate policies and procedures, informed consent, and clinic protocols carefully to assess how to be mutually inclusive of Health Information Portability and Accountability Act regulations and culturally competent practices.

Be Competitive in the Marketplace

Many private organizations are competing for and receiving contracts to provide public health services under federal government assignment (e.g., Medicaid). By being engaged in health care services that receive federal reimbursement, it is inferred that pharmacists provide culturally and linguistically competent services. To meet these government requirements, private and managed health care plans must be able to provide services to diverse patients and develop policies that are consistent with culturally competent care.

Community pharmacies can now work with federally funded community health centers to provide drugs to the patients served in these clinic settings. These special contracts (340B contracts) are secured through the Office of Pharmacy Affairs in the Bureau of Primary Health Care. These contracts are ways for the private sector of pharmacy to expand and provide public health services to underserved populations.

Decrease the Likelihood of Liability and Malpractice Claims

Future liability and malpractice claims may be targeted toward providers and programs that do not evaluate patient belief systems and practices. Drug errors due to cultural misunderstandings have already been identified and could lead to claims against pharmacies and pharmacists. Drug errors may occur due to nonadherence, dosing in patients with varying genetic polymorphisms, pain management, and other drug considerations. To some Hispanic, African-American, and American Indian groups, lack of symptoms may signify that a disease or illness has been cured. Patients may decide to discontinue their drugs prematurely if pharmacists are not aware of the potential for nonadherence or completion of therapy. Genetic polymorphisms affect metabolism of certain drugs. Rate of metabolism can influence drug doses. For example, only 3–5% of Caucasians are poor metabolizers of diazepam and imipramine. However, 15–20% of Chinese and Japanese

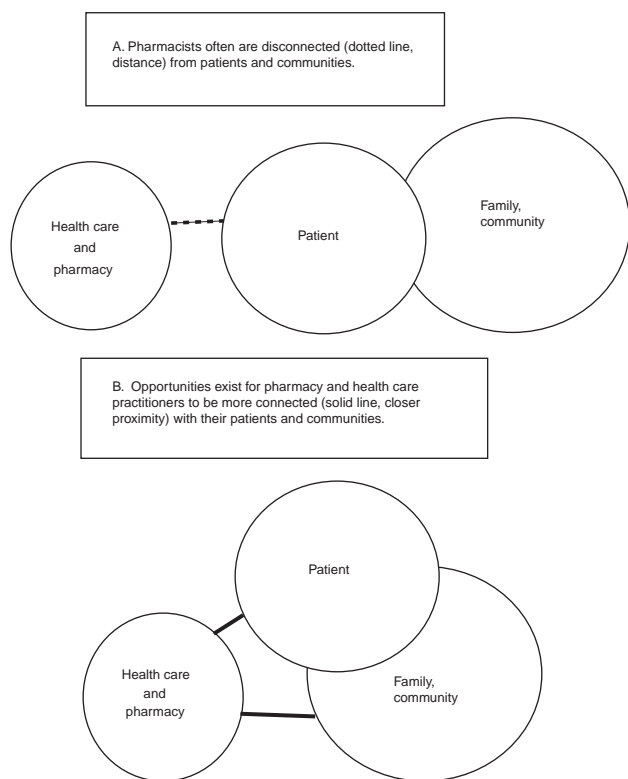


Figure 4-2. Opportunities for evolving relationships among health care and patients and communities.

Let Everyone Participate Web site. Meaningful Access for People who are Limited English Proficient. Available at www.lep.gov. Accessed February 25, 2004.
Medication Safety Alert. Cultural Diversity and Medication Safety. Huntingdon, PA: Institute for Safe Medication Practices. September 4, 2003.

people are poor metabolizers of diazepam and imipramine and may require a decreased dose. Dosing of pain medication may be subtherapeutic in some populations because of fears of addiction by patients and family members. By being able to communicate and facilitate care with patients and families from diverse backgrounds, pharmacists may improve patient outcomes, decrease the risk of liability, and decrease drug errors.

Understanding Cultural Competence

Stereotyping Versus Generalizing

To care for patients, pharmacists often are forced to make quick decisions about patients' abilities to understand their drug or disease processes. Pharmacists should be aware if they are making generalizations about or stereotyping patients and whether these actions may positively or negatively affect patient care. Stereotyping involves imposing preconceived assumptions or observations about behaviors, beliefs, and actions to individuals without evaluating unique values and experiences. Stereotyping involves making assumptions that people in certain groups are the same. A generalization draws on experiences and commonalities of groups or cultures while allowing room for the individual experience. Often, stereotyping results in a negative encounter. Although generalizations can be negative, a generalization helps to shape the encounter so clinicians better understand the unique needs of a patient.

Case:

You provide diabetes management and education in a clinic with a high population of Asian Americans. You are aware that many Asian patients you see include rice in their diets.

Pharmacists would be stereotyping if, in counseling all Asian patients, they give the advice, "You should not eat so much rice." In making a generalization, the pharmacist may use the information that many Asian Americans eat rice to guide counseling. The thought process might be, "Many Asian patients that I see eat rice, so it is possible that the Asian-American patient scheduled for my next appointment does also."

The Platinum Rule: Treat your patients as they would want to be treated.

—Source unknown

Cultural Competency Continuum

Case:

Dr. Park is a 32-year-old Korean-American pharmacist who lives in a West Coast city. He and his parents moved to the United States from Korea when he was 10 years of age, at which time he began to learn English. He is now fluent in

English. A Hispanic woman, Ms. Dominguez, who appears to be in her early 40s, is accompanied by an older woman (possibly her mother) and brings in a prescription for metformin 500 mg to be taken once daily. Ms. Dominguez states she is from Mexico. It quickly becomes apparent that she speaks limited English.

Several definitions describe cultural competency as a process or journey that can be visualized on a continuum. One frequently used model was developed by Terry Cross and colleagues in the late 1980s. Using the continuum for cultural competency, there are various illustrations of how Dr. Park can approach Ms. Dominguez based on the setting where he works (Figure 4-3).

Scenario 1:

Dr. Park, although polite to Ms. Dominguez, is reserved and may think to himself, "I learned to speak English, why can't she?" As the conversation unfolds, Ms. Dominguez reveals that she has been seeing a local herbalist and healer (curandera), and the pharmacist becomes condescending. At this point, Dr. Park tells Ms. Dominguez that she should not go to these healers because they are quacks.

In this situation, the pharmacist is culturally destructive, a phenomenon that occurs when people or systems devalue other cultures or individuals. Culturally destructive behavior may occur through attitudes people exhibit or through policies and practices that are in place in a system (e.g., pharmacy). Trust can be lost by the individual, systems, or groups, which leads to distrust and betrayal. One of the most apparent examples of cultural destructiveness occurred during the Tuskegee trials from 1932 to 72. The United States Public Health Service conducted studies in poor African-American men with syphilis without obtaining informed consent. Even after penicillin was introduced to the market, treatment was withheld from subjects to learn about the long-term effects of syphilis. For many minority populations, this study has served as a gross example of destruction and distrust toward the health care system.

Scenario 2:

Dr. Park could have responded to Ms. Dominguez without any intention of being destructive. His experience may have included working with a large number of Mexican Americans who he realized were using an extensive amount of complementary alternative medicines. However, Dr. Park's interaction with the patient could have resulted in the following abrupt counseling session. "Here are your pills. But I do not think you are going to take them because you probably go to a curandera. Here they are anyway."

In this situation, the pharmacist is exhibiting cultural incapacity. He does not intentionally want to dismiss the patient's beliefs. However, he makes a judgment call and stereotypes based on his experiences with other people he

Galanti GA. Caring for Patients from Different Cultures: Case Studies from American Hospitals, 2nd ed. Philadelphia, PA: University of Pennsylvania Press, 1997.

has encountered from Ms. Dominguez’ culture. He then perpetuates his bias in his conversation with the patient.

Scenario 3:

Dr. Park also could respond by treating Ms. Dominquez as he does all of his other patients. He could provide an extensive explanation of metformin and its effects and provide the information in English while the patient nods attentively. According to the competency continuum by Cross (Figure 4-3), Dr. Park is in a stage of cultural blindness. He is providing services with the belief that culture, race, and language are not different because all people are essentially the same. He feels that his approach has worked for most patients, so it should work for everyone.

Scenario 4:

Dr. Park works in a pharmacy that recognizes the changing demographics and languages in the city. The owner has hired a bilingual community member to serve as an interpreter. However, Dr. Park realizes that the new staff member is not interpreting word for word and becomes frustrated. The pharmacy and its staff believed that hiring an interpreter would solve many of the needs for their growing Spanish-speaking community. The pharmacy did not train any of the staff on how to work with an interpreter and it did not provide appropriate training for the interpreter either.

In this situation, Ms. Dominguez received services in a setting that is culturally precompetent. Dr. Park and staff are committed to serving the community and its changing

demographics. They want to provide high-quality services. However, the pharmacy owner and staff believed that by simply hiring a bilingual staff member, they would be able to “solve” their identified major issue—Spanish language interpretation. In a state of cultural precompetence, there is recognition that cultural differences exist and some adaptation in services should occur. But there may be difficulty in focusing on long-term plans and changes. A danger in precompetence is that organizations and individuals may easily get discouraged if a change occurs to provide culturally competent care and it does not function well. Organization administrators and staff can become frustrated and decide that the change is not effective or worthwhile.

Scenario 5:

In a culturally competent setting, Dr. Park may have access to a trained bilingual staff member and have received appropriate training as well. Pharmacists and staff would accept and respect differences while being able to apply these principles to the populations they serve. In culturally competent systems, health care professionals understand that services are multifaceted and extend from patient care to policies and procedures. Individuals and organizations recognize their own biases and work to evaluate and improve the entire chain of patient care.

Scenario 6:

Culturally proficient care, found at the highest end of the continuum, could be classified as a setting with personnel who hold the diversity of culture in high esteem. At every

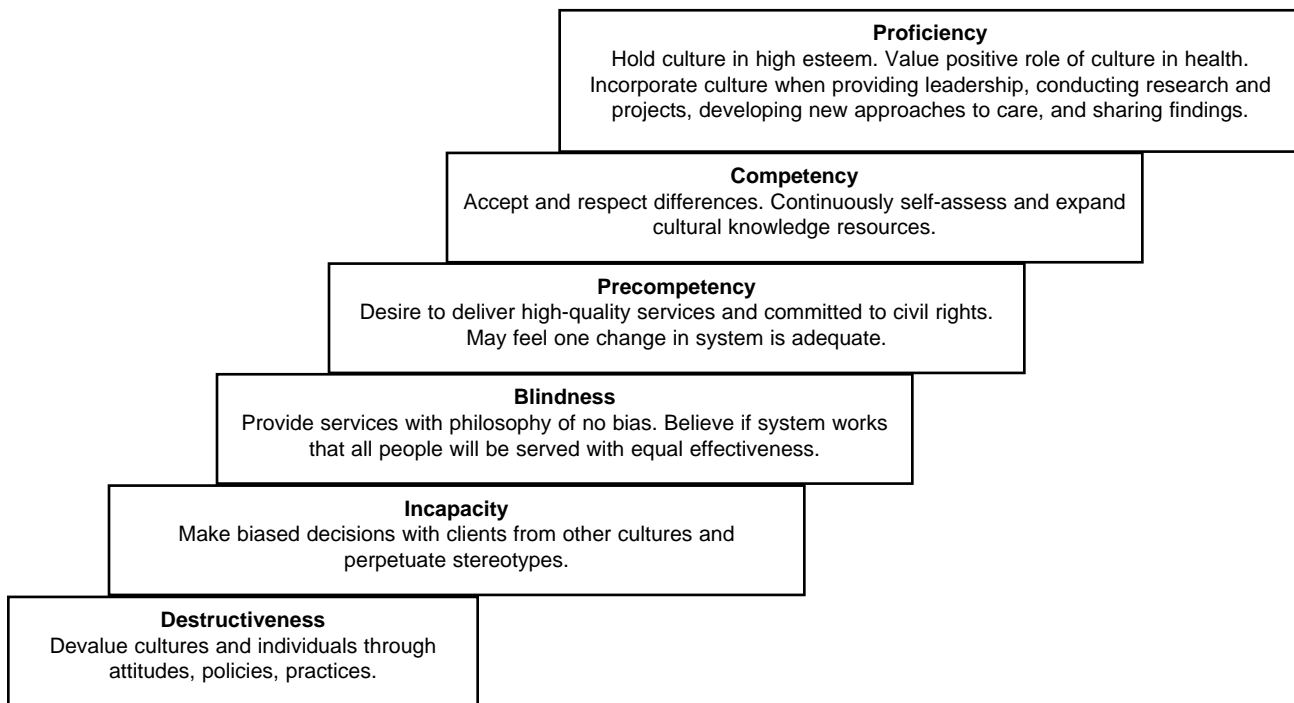


Figure 4-3. Cultural competency continuum. Adapted with permission from the National Indian Child Welfare Association, Inc. and Terry Cross. TL, Bazron BJ, Dennis KW, Issacs MR. Toward a culturally competent system of care: Volume I. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center; 1989.

level of the organization, resources (e.g., time and money) are allotted to improve organizational, structural, clinical, and personal capacity to serve diverse populations. They recognize the value of culture in people's health and well-being. They are able to carry these principles into other settings and provide leadership to other organizations that need assistance. They may have demonstration projects or be engaged in research that evaluates the differences in culture in the health care. They acknowledge that their understanding of cultures is an ongoing process of continuous improvement.

If Dr. Park were in a culturally proficient setting, financial resources and time consistently would be allotted to develop and adapt policies and procedures and to train the staff in culturally competent care. Dr. Park would have had access to a trained translator and would likely have acknowledged the patient and her mother as often is appropriate in the Mexican culture. The pharmacy would be connected with community members and resources. It would dedicate resources to investigate the role of culturally proficient services on health outcomes.

Acculturation

Another challenge that patients and providers face in working with diverse cultures is understanding acculturation (i.e., the degree to which individuals are able to function within a new or host culture). These levels have been described as “integration”, “assimilation”, “marginalization”, and “separation”. In both assimilation and integration, strong ties to the host culture exist. People who can assimilate to a host culture often will lose ties to their home culture or the culture where they were raised. They develop very strong ties to their host culture (the culture where they now live). Individuals who can integrate cultures are able to function well in the new host culture and can relate well to those in their home culture. They have strong ties to both their home and host culture. Marginalized and separated people have weak ties to the new host culture. Specifically, individuals who are marginalized have weak connections to their host and home cultures, and they find it difficult to function fully in either culture. When individuals are separated from their home culture, they find it difficult to function in the host culture. They have a strong connection to their home culture and are weakly connected to their host culture.

Case:

Dr. Park demonstrates an ability to function well in the United States (host culture) after his family moved from Korea (home culture). He has either assimilated or integrated into United States culture. Further information reveals that when Dr. Park was 10 years old, his parents moved to the southeastern United States into a predominantly English-speaking community so that their children could learn English. Because he began to learn English at a young age, he is fluent in reading,

writing, and speaking. Most of the friends he grew up with only spoke English, so he adapted to the culture of the southeast. He has had little interaction with the Korean community except for his extended family. He has lived in the West Coast city for about 3 years. Dr. Park has assimilated to the United States culture, even though there are some changes from the southeast to the West Coast. He is unable to navigate comfortably between his adopted United States culture and the home Korean culture of his birth and early childhood.

Based on the limited information on Ms. Dominguez, it appears that she is best able to function within her home Mexican culture and has a lower degree of acculturation: marginalization or separation. More information regarding Ms. Dominguez reveals that she has been living in the United States for about 2 years. She lives in a primarily Spanish-speaking neighborhood and stays at home to care for her mother and children while her husband works. She has little interaction with this area of the West Coast city except for occasional errands with her mother. It is likely that Ms. Dominguez is separated from her home culture and has had difficulty making ties to the host United States culture. She is not marginalized because she still demonstrates signs of strong ties to her home Mexican culture.

Recognizing Barriers to Cross-cultural Care

In health care and pharmacy systems, barriers to cross-culture care often are due to organizational, structural, economic, and clinical issues. Clinical barriers of health care providers, including pharmacists, often are generated from variations in acculturation, communication styles, knowledge, and personal beliefs and values. Barriers for patients may result from acculturation, access, financial, communication, and personal challenges.

Health Care System Barriers

Case:

The personnel of a family practice clinic in the Midwest serve a population that is about 90% Caucasian and predominantly Protestant. The racial/ethnic background of the clinic staff is about 80% Caucasian and 20% Asian American. The staff members begin to notice that they have an increasing number of patients who are refugees from Bosnia. Refugee resettlement assistance programs have secured housing, work, and health insurance for the community. This new patient group's racial background appears to be Caucasian, so providers approach care in a similar

Berry JW. Acculturation as varieties of adaptation. In: Padilla AM, ed. *Acculturation: Theory, Models, and Some New Findings*. Boulder, CO: Westview Press, 1980.

method to the other Caucasian patients in the community.

The clinic personnel learn that many of the patients will come to the clinic but do not return after one or two appointments. Although the patients make an effort to communicate with limited English, barriers still persist. On occasion, when male providers make contact with female patients for the physical examination, patients demonstrate great discomfort. Differences surface regarding religious background. Most of the staff is Christian or Protestant, whereas many of the patients from Bosnia come from the Islamic faith. On further analysis, the clinic staff realizes that the patient wait time for the Bosnian patients typically has been 30 minutes to 1 hour longer than for other patients at the clinic because of extra time needed to complete forms, process paperwork, and communicate in English.

Organizational Barriers

At first glance, it does not appear that organizational barriers exist in this clinic. Organizational barriers focus on the capacity for health care systems to hire leadership and a workforce to reflect the racial/ethnic demographics of the population they serve. Although there is a paucity of scientific studies, anecdotal evidence suggests that the policies, procedures, and delivery systems of many health care organizations that lack diversity in leadership and workforce are not prepared to serve diverse patient populations. Some patients may not access the health care system because of organizational incapacity to adapt clinic hours to the community's work schedule or out of fear for deportation if undocumented. Furthermore, studies have shown that racial/ethnic minority patients tend to be more satisfied and perceive a higher quality of care when receiving care from providers of the same racial/ethnic background demonstrating concordance. For example, patient satisfaction has been higher in Spanish-speaking patients who have Spanish-speaking providers. African-American patients are more satisfied with providers who include the patient in decision-making. If the health care workforce lacks diversity, then diverse patient populations may not access health care appropriately. However it may be difficult to adapt health care services quickly for populations that have sought political refugee or immigration status. One of the first steps the clinic in the case can take is to consider the need to recruit staff, interpreters, or health workers from the Bosnian population. This clinic may need to identify if there are community leaders in this growing Bosnian population who have health care experience and are willing to assist in the care of patients.

Structural Barriers

Structural barriers prevent patients from accessing health care services because of complicated, bureaucratic, or underfunded systems. In the Midwest clinic case, the new patients may be intimidated by the length of time to receive care and to complete forms. Patients may decide that clinic services are not worth the wait or language frustration.

Limited English proficiency among the patients and lack of interpreter services may lead to misdiagnoses and unnecessary prescriptions.

Economic Barriers

Economic barriers exist in pharmacy and health care systems that view cultural competency as not profitable. To develop education materials specific to different populations, to hire interpreters, to train and educate staff, and to evaluate the work site can take financial resources. However, health systems and pharmacies must look at the bigger picture. Working with patients in a culturally appropriate manner can help reduce health disparities and economic burden to the health care system by decreasing medical errors and improving adherence to treatment regimens.

Clinical Barriers

Although the providers in the Midwest clinic case are making an attempt to understand the new patient population, there are still barriers for the patients and a lack of knowledge about the new culture. The Bosnian patients, because their race appears to be Caucasian, are treated with similar care to other Caucasian patients. Clinical barriers exist in the quality and type of interaction that occur between the patient or family and health care provider. Many of these barriers are related to differences in beliefs, values, and behaviors. In this case regarding the Bosnian population, providers may need to give particular notice to mental health concerns that often occur because of the difficult transitions from a war-afflicted country to another country.

Providers whose origins are from different countries or who have moved from a distinct part of the United States to another can experience difficulties with acculturation. Although many providers have been trained in the concepts of Western medicine, they still bring their cultures of origin with them into the health care environment. In the Midwest clinic case, many of the providers are Caucasian and probably feel integrated into the culture of the clinic and community. However, the provider must evaluate how the patients, who may feel separated, will fit into the new system. Consider a Mexican-American pharmacist who was raised and trained in a predominantly Mexican-American community. If he or she moves to a community that is primarily Asian-American, the pharmacist is now separated from his or her original culture and may need to learn to adapt to new styles of patient care.

Communication barriers exist whenever the provider cannot correctly identify the language needs of the patient. These barriers may occur when the provider uses technical vocabulary to explain information to a patient or when patients have low literacy. Communication barriers also occur when there are differences in language and even when interpreters are used. A recent study evaluated 13 pediatric interventions using professional or ad hoc interpreters. About 66% of the errors made (average of 31 errors per intervention) had potential negative consequences for the patient. Steps must be taken to minimize communication errors that originate from the provider.

Perhaps the most difficult barrier to overcome is the personal biases and viewpoints providers have. Each pharmacist has had biases and stereotypes that they have developed over time. To rethink and relearn how to approach and work with people of various backgrounds often can feel overwhelming to individuals and to organizations.

Patient Barriers

The patients in the Midwest clinic case who have moved from Bosnia experience their own set of barriers to health care. They have been able to access the health care system but face structural barriers of waiting times and communication difficulties. They may have felt that they were not treated with the appropriate cultural mannerisms (e.g., appropriate greetings and treatment of different sexes) to which they were accustomed.

Healthy People 2010 identifies financial, structural, and personal barriers as limiting patient access to health care. People who experience financial barriers do not have health insurance or cannot pay for needed services. Structural barriers include the lack of access to primary care providers, other health care professionals, or health care facilities. Cultural or spiritual differences, language, or concerns about confidentiality or discrimination are among personal barriers faced. Other personal barriers include biases and stereotypes that patients bring with them. A male patient may not accept a female pharmacist or nurse practitioner. Patients may come from cultures where racial/ethnic discrimination is more acceptable. Patients who have resettled from war-torn cultures, such as Bosnia, may have experienced ethnic cleansing where the clash of cultures led to cultural destructiveness. Patients walk into clinics and pharmacies with their own biases. Pharmacists should understand that these biases may affect who patients will accept as providers or how patients perceive the quality of care being provided.

A patient's acculturation level varies according to the amount of time living in the community. This acculturation also may affect the use and acceptance of complementary alternative medicine and Western medicine. The ability for patients to effectively communicate their health care concerns may be halted. If patients are accustomed to always conceding with the providers' viewpoint, their chief complaint may never be uncovered. In some cultures, as in the Bosnian culture, it is common for the provider to give a great deal of attention to symptoms and complaints and for the patient to receive some type of drug for treatment.

Understanding Patient Health Beliefs and Perceptions

Illness and Disease

Patient values and beliefs about health and life span from birth to death, from an upset stomach to pain, from perceived spiritual states to concepts of afterlife. These values shape patient perceptions and how patients will respond in various health care encounters. Pharmacists, often are called on to prevent or treat a disease with drugs. However, patients may not view their health situation as a disease that can be cured with drugs. Rather, they may view their current biological state as a physical, spiritual, emotional, or social imbalance. Medical sociologists and anthropologists refer to this difference in understanding in terms of "illness" vs. "disease".

"Disease" from the Western biomedical model can be viewed as an abnormality that exists at a physical or mental level in the patient's structure or function. This biomedical view focuses on questions of the "Where?", "When?", or "How long?" of a disease process. This line of questioning detaches the patient from the disease.

The concept of "illness" refers to the patient's own experience of health or discomfort. It may be shaped by patient feelings or thoughts. This lifeworld view varies from the biomedical model because it focuses on the social context of a patient and what makes sense to the patient's situation. This patient history will explore "What worries you most?", "How do you think I can help?", and "How does it affect your life?" concepts and states that can adversely affect the patient's health.

The disease model of the biomedical world centers on cause, diagnosis, and treatment. The illness model of the patient's lifeworld encompasses ideas, feelings, expectations, and effect on body function. When a patient is introduced to a health care setting, these two concepts often do not meet. Rather, two parallel experiences occur, and if the patient and provider are lucky, the patient will have a positive outcome (Figure 4-4).

It is much more important to know what sort of patient has a disease, than what sort of disease a patient has.

—Sir William Osler

Patient Explanatory Models

Case:

Mrs. Taylor is a 48-year-old African-American woman who has smoked about a half pack of cigarettes per day for 15 years. She smokes off and on throughout the day. However, when she is busy, she does not "remember" to smoke. She says, "I

Salimbene S. What Language Does Your Patient Hurt In? A Practical Guide To Culturally Competent Care. Amherst, MA: Diversity Resources, 2000.

Spector RE. Cultural Diversity in Health and Illness. Upper Saddle River, NJ: Pearson Education, Inc. 2004.

Brown JB, Weston WW, Stewart M. The first component: exploring both the disease and the illness experience. In: Stewart M, Brown JB, Weston WW, et al, eds. Patient-Centered Medicine: Transforming the Clinical Method. Thousand Oaks, CA: Sage Publications; 1995:31–43.

want to quit smoking. I have cut back on my own to four to five cigarettes each day.” Her past medical history includes type 2 diabetes mellitus for 13 years, dyslipidemia for 5 years, and hypertension for 2 years. Her mother, who died 15 years ago, had type 2 diabetes mellitus. Mrs. Taylor has been married for 28 years, has two children, and does not work. Her husband takes care of family expenses. She speaks English, attended some high school, and does not read well. Mrs. Taylor’s drugs include metformin 500 mg two tablets 2 times/day, rosiglitazone 4 mg one tablet every day, simvastatin 20 mg one tablet every night, and lisinopril 10 mg one tablet every morning.

After several visits from Mrs. Taylor, it becomes apparent that she is focused on trying to quit smoking. She has focused so much on smoking cessation that you notice she is not refilling her diabetes drugs. Mrs. Taylor can explain how to use the drugs appropriately; however, she really seems unwilling to take her medication. At this time, there does not appear to be any financial difficulties in obtaining her medication.

There are times in working with patients that pharmacists come to an impasse. Patients may be cooperative and able to verbalize their drug regimens but are reluctant to take their medicine. Their responses may be connected to their unique perceptions, cultural beliefs, or situational realities. In these situations, as with Mrs. Taylor, it may be helpful to elicit how patients understand their medical condition(s).

Arthur Kleinman is a medical anthropologist who developed a series of questions in the 1970s to elicit patient understanding of their illnesses. The way patients answer may be consistent with other patients of the same culture. For others, the answers will be individualized. On the surface, these questions appear simple and straightforward. However, when asking patients these questions, pharmacists will be able to better understand the explanation of the illness/disease process, which may help in approaching the medication regimen with patients.

The patient explanatory model (developed by Kleinman) questions are listed below and have been adapted to Mrs. Taylor’s situation. Although she has been going to the pharmacy for smoking cessation, the primary reason for asking the questions is because of her reluctance to continue taking her diabetes medication.

1. What do you call diabetes (the problem or illness)? *I call it “sugar”.*
2. What do you think has caused the diabetes [the problem or illness]? *My mother had “sugar” and I know it can run in the family. I also know I have not eaten well, but I had been smoking for a couple of years when it started.*
3. Why do you think the diabetes started when it did? *Well, my mother died from “sugar”. I started smoking right after she died.*
4. What do you think the diabetes (illness) does? How does it work? *My body cannot control the food I eat. I have too much sugar in my body.*

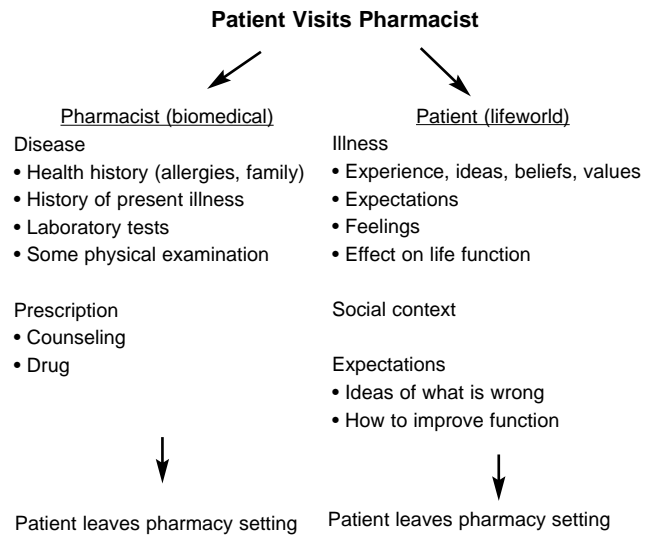


Figure 4-4. Common patient-pharmacist encounter—disease vs. illness. Adapted with permission from Sage Publications. Brown JB, Weston WW, Stewart M, et al. The first component: exploring both the disease and the illness experience. In: Stewart M, Brown JB, Weston WW, eds. Patient-Centered Medicine: Transforming the Clinical Method. Thousand Oaks, CA: Sage Publications, 1995:37.

5. How severe is the illness? Will it have a long or short course? *I do not really know. I just know my eyes get blurry sometimes and I cannot see well.*
6. How do you think the illness should be treated? What are the most important results you hope to get from the treatment? *Well, I know I take some medicine for it and I am supposed to exercise and eat better, but I keep having to take more and more medicine. If I quit smoking, maybe my blood will be thinner. I am hoping it might go away because right after my mother died from diabetes, I started smoking, and then not too much later I started having the “sugar”.*
7. What are the chief problems the illness has caused? *I cannot see as well. The medicine costs too much. My husband and I do not get along well anymore because of the drugs. I feel stressed.*
8. What do you fear most? *I do not want to die.*

Other Considerations

- Who do you turn to for help? *I do not ask people for help. I pray sometimes.*
- Who should be involved in decision-making? *I should be the strong one in the family.*

By asking Mrs. Taylor these questions, the pharmacist is able to gain a better understanding of some of her beliefs about diabetes and why she really wants to quit smoking. With this information, pharmacists can develop responses about the importance of quitting smoking and emphasize the value of taking the medication in terms that incorporate the patient’s explanatory model. This tool may not be necessary in every patient situation. However, it can provide some helpful information in cases where therapy and patient improvement have come to a standstill.

Pharmacists should recognize that patients have different concepts of how diseases originate, which may affect their acceptance of drug use. Disease etiology in Western medicine is typically because of the introduction of a foreign

object (e.g., infection) to the body or because of malfunction or imbalance of an organ system. These etiologies often require medication. Other concepts of illness may not require medication. Some illness concepts are derived from an imbalance in the body. In some Asian cultures, it is the yin and yang. In other cultures, such as Latin-American and African-American cultures, the balance may be viewed in terms of “hot” and “cold”, where certain foods may be eaten in particular conditions. These foods are not consistent from culture to culture. Other illnesses in various cultures may be due to soul loss, where the body is weakened because the soul is lost or not completely present. Spirit possessions are described in different cultures as occurring when a body is taken over by another spirit. A breach of taboo may occur when a person does something forbidden and becomes ill as a form of punishment (e.g., extramarital relationships or talking back to an elder). Atonement may be the treatment that brings full closure to the tabooed illness. Object intrusion occurs when a foreign object (often magical) enters the body. Treatment may occur with the assistance of a traditional healer who removes the object. Regardless of the viewpoint of the etiology of disease and illness, cultures have passed down ways to treat these problems. Respecting the appropriate cultural method to resolve the situation should be considered. Whether killing bacteria, restoring balance, retrieving the soul, or asking for atonement, treatments typically exist that are culturally acceptable and often noninvasive. The pharmacist may be called on to assist patients and primary providers with identifying when the traditional or complementary alternative therapies may be used in combination with the treatment common to the biomedical model.

Complementary and alternative medicine use has steadily increased in the United States. In many occasions, complementary medicines are used together with conventional medicine to achieve positive patient outcomes. Alternative medicine refers to treatments that replace conventional medicine. Often, patients believe that they must choose between systems. If a combination of complementary and alternative medicine and Western drugs have been evaluated to be safe from negative consequences, it is possible at times to use both treatment options.

Western Medicine

The culture of Western medicine has its own unique characteristics that shape pharmacists’ and other health care professionals’ beliefs and values about disease and illness. Western medicine often seeks dominance and control over nature and often is aggressive about curing with the strongest therapy available. This culture emphasizes timeliness where “sooner” is better than “later” and “newer” is better than “older”. There is an orientation and planning for the future which allows for concepts of prevention to exist. A tendency exists to standardize therapy, growth charts, and laboratory requirements based on a certain age, sex, or weight. These similar characteristics may then be treated the same.

Well, what we got here is a failure it communicate.
—Cool Hand Luke

Communicating Across Cultures

Cultural Values and Styles of Communication

What differentiates one culture from another? Even when openness and acceptance of diversity exist, misunderstandings can still occur in cross-cultural interactions. Although race/ethnicity, gender, and language are important to understanding cross-cultural situations, other cultural issues, including values and styles of communication, also can affect the pharmacist-patient encounter. These values may be determined by beliefs regarding decision-making, civic ideals, and social interaction. By examining a few broad concepts, pharmacists can better understand characteristics of different cultures.

Control and Decision-making

Individuals in various cultures have differing beliefs about whom or what has control of their lives. Some people believe that fate or a higher being has ultimate control, whereas others believe that they can determine their own futures. Birthright inheritance may be a hallmark of some families and cultures, whereas others may believe that education can better influence people’s destiny. Religion is a way of life for some cultures and is only a segment of life or nonexistent for others. These beliefs and values inevitably influence who patients trust and turn to in making decisions about their health. A patient who values harmony with nature may not be accepting of statements that suggest that the health care treatment will cure everything. Those who believe in fate may have a more difficult time believing that prevention is important.

Civic Ideals

In cultures that value hierarchy over equality or group welfare over individual welfare, pharmacists may find differences in their approach to care. Societies that are hierarchical in their social structure may have a hierarchy within the health care structure as well. It may be more difficult to accept a pharmacist or person of a different sex as a true health care professional. For cultures that favor group welfare, patients may not value their self-improvement. Care to patients may need to be discussed in terms of what is important to the family. Other civic ideals value competition over cooperation. Some people work to meet the needs of the family, whereas others work for personal advancement and wealth.

Social Interactions

To evaluate social interactions, pharmacists must consider the family structure of individuals and communities that are served. Is the family considered the extended family that lives under one roof or the nuclear family? Is respect in the family given to the elderly or to youth? Are close friends and neighbors considered to be family and called “aunts” and “uncles”? Modesty may be valued over self-attention. Giving and sharing may be more valued than taking and saving. In some cultures, people

believe that excellence is only achieved as a result of group effort. In other cultures, people reward and value the individual and the hero. In pharmacy, younger pharmacists may have difficulty gaining trust with people whose culture values age. A patient counseling session may include other members of the family if the structure is close-knit. Some patients may not respond to motivational discussions on smoking cessation or diabetes management because they draw too much attention to themselves.

Different cultures respond to these classes differently. Patients who are future-oriented may understand concepts of prevention better than patients who are past- or present-oriented. Some patients come from cultures where time is based on “when you arrive” as opposed to “clock time”. On the United States-Mexico border, the word “ahorita” often is used and is translated literally to “right now” or “at this very moment”. However, people in this community understand “ahorita” to mean “in a minute” or “as soon as I can”. Problems can arise if a patient says to the pharmacist, “I’ll be back ahorita.” The patient may return in 15–20 minutes, whereas the pharmacist anticipates that the patient will return immediately. Time with human interaction may be more valued than time conducting business. Some cultures are not ready to deal with business unless they have had time to talk and catch up. These differences in cultural expectations can affect the pharmacist-patient counseling session and the ability to develop rapport with a patient or family member. Other concepts of time may be distorted in counseling patients on timing of taking a medication regimen.

Communication Styles

Communication styles can vary greatly from culture to culture. Trust can be developed or obstructed through various communication styles. It may be appropriate to not look at people from certain cultures directly, whereas others expect that gaining direct eye contact is a sign of trust. In some cultures, people are accustomed to learning and communicating through stories and listening. Others rely heavily on written cues and media. Some patients will view the pharmacist as sterile and cold if the pharmacist does not extend welcoming gestures and physical contact when greeting them and their family members. To develop a rapport with people from certain cultures, fewer words are more meaningful because ideas and feelings are conveyed through action and not through speech.

Pharmacists and other health care providers can become confused as to what values or communication styles each patient or culture responds best. Being aware of some of the common traits can help the pharmacist focus on different cues.

Values of the Predominant Culture

A key for pharmacists to learn about other cultures is to understand their own first. Values often upheld by the white Caucasian and Western culture, which often is the predominant culture in the United States, have been identified (Table 4-4). These values can shape the behaviors and communication styles of many people in the United States.

It takes a whole village to raise a child.
—African Proverb

Table 4-4. Some Common Western Culture Characteristics and Values

1. Decision-making may be shaped by a sense of having personal control over nature and the environment with the ability to help one’s self. Material possessions may be perceived as important.
2. Civic ideals of equality may be shaped by values of competition and being practical. Change and “being busy” may be viewed positively.
3. Values in societal structures may place emphasis on youth and individuals before older age and groups.
4. Time may focus on the benefits of the future. Importance may be given to arriving on time and not wasting time.
5. Being open, honest, and direct may be valued communication styles. Others value being more detached and removed.

Reprinted with permission from Sage Publications. Huff RM, Kline MV. Promoting Health in Multicultural Populations: A Handbook for Practitioners. Thousand Oaks: Sage Publications, Inc., 1999. Spector RE. Cultural Diversity in Health and Illness. Upper Saddle River, NJ: Pearson Education, Inc., 2004.

Exploring the Social Context

Understanding Patients’ Environments

Case:

Mrs. Smith is a 58-year-old Caucasian woman who lives by herself in a rural Appalachian community. She was told a few years ago at the local health clinic that she has asthma. She has been coughing a lot lately, has difficulty breathing, and is losing weight. She does not use any medicine because she can tolerate her difficult breathing spells. Her clothes do not fit her very well anymore. Her daughter and grandchildren live a couple of miles down the road. She has smoked about a half pack of cigarettes every day for 40 years. She has been widowed for 2 years. She has an 8th-grade education and her religion is Southern Baptist. She does not have consistent transportation and occasionally she gets a ride from her daughter. She has not been back to the clinic because it closed a year ago and it is too far and expensive to get to the next clinic. She realizes she cannot wait anymore to seek health care.

The social environment in which patients live is intertwined with patients’ beliefs and can affect the health care of individuals and communities. To better understand the social context, pharmacists can evaluate four major categories: control over environment, change in environment, social stress and support network, and literacy and language.

Some patients feel that they have no control over their surroundings. Mrs. Smith does not have consistent income for transportation. Her weight loss may be due to lack of income for food, increased smoking, disease progression, or a combination of factors. Some patients may find it difficult to plan for their future when, financially, they live on a weekly or daily basis.

Environmental changes can occur because of immigration, movement to another town for work or family, or forced resettlement. Exploring major stressors or difficulties patients face reveals other underlying social conditions. Some patients do not have friends or relatives who live close to provide a support system. Others turn to religious or social groups for support and guidance. Evaluation of literacy levels and language spoken in the home can reveal communication barriers. Mrs. Smith does not face any apparent environmental changes; however, her health is beginning to take its toll. She states a belief in the Christian religion and her daughter lives close by. However, the extent to which she relies on these potential support networks is unknown. Mrs. Smith has a low literacy level which can adversely affect her ability to navigate the health care system and other social support networks.

Pharmacists who are familiar with their communities should have a good sense of individual patient needs as well. Asking patients about their situations will come naturally when the patient has gained trust in the pharmacist. Taking time to learn about the social context of the patient cannot be forgotten in culturally competent care.

The past was never really a thing of the past; we are all products of what went before, our present having been shaped by our history.

—William Faulkner

Exploring Different Cultures

To understand the intricacies of every culture is a monumental goal. However, exploring the history and culture of others is important to learning about them. Characteristics common to the various cultures many times are shaped by a historical framework. These characteristics can serve as generalizations and guides to working in different cultures. Not every patient in a cultural group has the same behaviors or values, and care must be individualized. To approach patients with genuine respect and a degree of curiosity is a must in any patient encounter.

African-American Cultures

The diverse African-American groups in the United States have come to be characterized by black Americans whose cultures originate from Africa, the Caribbean, and some Spanish-speaking Central American countries. Some recent immigrants or foreign-born blacks have a different identity surrounding life in the United States because they may not have experienced the same acculturation process or historical legacy of slavery of many American-born blacks. Health care professionals must recognize that the history of slavery and the experience of the Tuskegee medical study may lead many African Americans in the United States to distrust the health care system.

Urban and rural living experiences also have led to different uses of health care. People in urban communities have more access to health care and urban African Americans are more likely to use prevention. Rural African Americans are more likely to wait until emergencies to receive health care. Although efforts to reform health care have occurred, a collective memory of inhumane treatment

and lack of access may cause African-American patients to avoid health care.

Immigration and refugee resettlement patterns in the United States since 2000 have led to increased populations of Somalians, Ethiopians, Sudanese, and Egyptians. It may be common to see extended family living in the same household. Health care practices in several African cultures do not permit the discussion of serious health care problems directly with the patient. Rather, a family member tries to save the patient from undue worries.

Spirituality often is incorporated into daily life whether the basis of the religion is Christian or Islam, the faith traditions most common to African Americans in the United States. Family structures for American-born blacks are strong and people may have many “aunts” or “uncles”. Child rearing may be shared by the grandparents. Referring to patients as Mr. or Mrs. will demonstrate respect to them. Maintaining a consistent presence in the community and with patients helps to build trust (Table 4-5).

Health beliefs of African-American communities may be linked to the level of acculturation and socioeconomic status. Communities with patients who are more recent immigrants or who are from a lower socioeconomic status are more likely to hold onto health beliefs that differ from the Western medical model. Both groups tend to share health beliefs that include use of traditional healers and folk or complementary alternative medicine which often relies on beliefs and spiritual or magical gifts. Health disparities persist, and variations in cause of mortality exist in the African-American population (Table 4-3).

Health in some African-American communities can be attributed to harmony with nature, whereas illness may be due to natural or unnatural causes: a divine punishment, environment, or a disruption in social order. Natural illnesses may be attributed to God’s plan, eating the wrong foods or changes in the solar system, and could be perceived as difficult to treat with medication. Rather, atonement or vows to be a better person are the primary prescriptions. Unnatural illnesses have evil origins, such as demons, spirits, or the devil, and a “hex” may be cast. Treatment may require the resources of a magician, priest, or voodoo

Table 4-5. Some Common African-American Culture Characteristics and Values

1. Decision-making may be shaped by philosophies of being in harmony with nature, self-determination, and consensus building.
2. Civic ideals often represent equality and cooperation with an emphasis on unity and identity.
3. Social structures often are based in personal relationships with the group welfare, extended family, and church/religion being integral to the value system.
4. Time may be perceived in terms of one generation passing on to the next generation with rites of passage being important.
5. Styles of communication may be more open and emotive with closer contact.

Community Partnership Training (CCPT) Program. Institute for African-American Mobilization Training. Center for Substance Abuse Prevention. Available at: <http://p2001.health.org>. Accessed August 16, 2004. Spector RE. Cultural Diversity in Health and Illness. Upper Saddle River, NJ: Pearson Education, Inc., 2004.

doctor. Worry is another form of unnatural illness that may drive a person crazy as it disrupts cycles of sleeping, eating, and other daily activities.

In traditional medicine, diet may be associated with the amount and thickness of the “blood” circulating. “High blood” is linked to reddish-colored foods (e.g., beets and carrots), red meat, and pork. These foods could cause the clogging of the organs. A patient with high blood may “fall out” or suddenly collapse and experience headache or dizziness. Anemias are caused by “low blood”. Foods that induce low blood include whitish-colored foods (e.g., garlic and vinegar), teas, and laxatives—treatments to thin the blood and open the pores and bowels. “Cold” is linked to mucus and phlegm and the slowing down of bloodflow. During menses and after birth, women may be more susceptible to “cold”. Each spring, as an attempt to clean the internal “dirt” that has collected over the winter and thickened with the cold, some African Americans will use laxatives to cleanse and purify their systems.

American Indian and Alaska Native Cultures

To better understand American Indian populations, the roles of history, citizenship, cultural identity, and sovereignty must be considered. Between 1500 and 1900, an estimated 75–99% of the indigenous populations were destroyed because of disease, war, or “extermination” policies by United States government leaders. More recent history of Native Americans in the United States has been shaped by forced migration to reservations and childhood separation from families to boarding schools. Separation from parents left children vulnerable to being raised in a community void of a natural family structure, passing of tradition, and spirituality. It exposed many children to emotional, physical, and sexual abuse.

Currently, there are more than 500 American Indian and Alaska Native tribes in the United States, each with its own unique history, definition of citizenship, and concept of cultural identity. Tribal nations are now able to determine their own citizenship, often delineated by percentage of blood relation to an American Indian nation. Some North American Indians feel a stronger identification to their tribal

Table 4-6. Common American Indian Culture Characteristics and Values

1. Control of life may have a strong spiritual link that respects a balance between nature and the body.
2. Civic ideals often focus on cooperating with others and equality.
3. Social structures may be heavily dependent on the family with the elders being highly valued. People in this culture treat others with respect while being modest themselves.
4. Time often is oriented in the past and present with little sense of needing to hurry.
5. Being honest and indirect when communicating with others may be important. Silence and giving others space to communicate may be respected. The act of sharing stories may be a key communication tool.

Reprinted with permission from Sage Publications. Huff RM, Kline MV. Promoting Health in Multicultural Populations: A Handbook for Practitioners. Thousand Oaks: Sage Publications, Inc., 1999. Salimbene S. What language does your patient hurt in? A practical guide to culturally competent care. Amherst, MA: Diversity Resources, 2000.

tradition than others. Many who were separated from families have acculturated to mainstream culture. Others have strong cultural identity to a specific tribal nation, band, or clan, and will prefer to be identified with a specific group. Still others will seek a common, more global identification, such as American Indian, Alaska Native, Native American, First Nation, or indigenous people. Sovereignty is the basic principle of American Indian law which upholds equal status of Indian nations to foreign nations. American Indians may receive dual Indian nation and United States citizenship. For some people, sovereignty is connected to identity and self-determination; for others, it is analogous to economic freedom.

Even though there are numerous subcultures, a few common traits exist. Tribal values instill the importance of interdependence. Family and communities often have close connections and pass many traditions by oral history and storytelling. Many generations valued the group over the individual and lived on cooperation, sharing, and balance with nature. The acts of being modest and not drawing attention to oneself often are found. Respect, equality, and kindness to others are values that are upheld (Table 4-6).

Traditional healers and ceremonies may be used by some populations. In some American Indian traditions, out of respect to the elders, it may be more appropriate to avoid looking or speaking directly to older patients. A family member specifically may be sent with an elderly patient to be the interpreter or messenger for communicating health information to the patient. In disease education, incorporating the art of storytelling to convey educational messages has been incorporated in some health settings. Pharmacists will need to keep an open mind and be willing to adapt their communication style to accommodate and not offend the patient. Pharmacists also should work to recognize health care problems common to the American Indian population (Table 4-3).

Asian and Pacific Islander Cultures

Although there are many Asian cultures and languages, common subgroups include East Asian (e.g., Korean, Chinese, and Japanese), Southeast Asian (e.g., Indonesian, Vietnamese, and Cambodian), and South Asian (e.g., Indian and Sri Lankan) cultures. Pacific Islanders (e.g., Polynesia and Micronesia) have unique identities from other Asian cultures but often are grouped with them. The Pacific Islander community has unique morbidity and historical factors that shape it. However, that population is not covered in the scope of this text. Pharmacists should be cautious not to assume that Pacific Islanders and Asian Americans have the same cultural traits.

Asian-American history in the United States is traced largely to the Chinese in the 1800s as the settling of the West and building of the railroad occurred. South Asians (Indians) began immigrating in the late 1800s. Asian Americans met mixed messages of welcome in the United States. The Chinese Exclusion Act of 1882 cited that no Chinese could immigrate to the United States, and the act was not repealed until 1943, more than 60 years later. Japanese-American citizens experienced forced internment in the United States during World War II. The Asian communities have histories of war and conflict within Asia

and with other non-Asian countries that may linger in the memories of older generations. For example, resistance and lack of trust may exist among some Asian cultures, depending on whether communism, democracy, or dictatorship was the prominent political structure. Since the 1970s, many Southeast Asian cultures have been displaced from their home cultures because of war and have relocated to the United States.

Religions in the Asian cultures vary from Buddhism and Hinduism to Muslim and Christian. In Chinese-based cultures, Confucianism and filial piety (family devotion) often are foundations of life structure. The social order in many Asian cultures involves hierarchy, tradition, and respect that can be found throughout the family and social structure. The community often is more important than the individual, and it is common to sacrifice individual needs for the sake of the family. Family structures include the extended family and are closely bound. Often, close friends of the family are referred to as “aunt” and “uncle” out of respect. Emotions often are spared and physical distance may be preferred. It may not be appropriate to console a patient with physical gestures, such as a hug or pat on the hand. Silence, which may be preferred to “small talk”, can be difficult to interpret as it also may signify that the patient is in disagreement or is simply respecting the provider in the clinical encounter. Communication styles often revolve around humility, shame, and respect; therefore, people may avoid direct eye contact, not smile, and apologize for actions repeatedly. Family matters are not typically discussed in front of other people, and mental health problems may be viewed as shameful. Out of respect for the provider, patients from Asian cultures usually will agree or nod in understanding. In Asian Indian cultures, shaking the head to each side may indicate “yes” instead of “no” as is customary in Western cultures (Table 4-7).

Concepts of health include the balance of yin (cold) and yang (hot). Chi describes the energy and flow of blood to maintain harmony. Traditional medicine includes the use of acupuncture, a healing art developed in China more than 2000 years ago. Three Asian treatments leave skin disruptions that have been confused with abuse in the United States. To draw out fever and illness, “coining or pinching” may be used. Metal coins dipped in oil and heated are rubbed over the skin and produce welts. Pinching of the skin also may occur. Both processes leave bruising. During “cupping,” hot cups are applied to the forehead or abdomen releasing negative pressure as the cups cool. They leave a circular reddish mark on the skin. To balance excess yin (cold), “moxibustion,” a treatment of heated incenses or special woods applied to the head, neck, or torso, making superficial burns, is used. Recognizing some of these health interventions and appreciating common health beliefs and problems experienced by Asian Americans will assist pharmacists in providing patient care (Table 4-3).

Hispanic Cultures

The Hispanic population is the fastest growing in the United States. The word “Hispanic” was created by the United States census. Hispanic became more widely used during the 1970s based on subcultures with a common Spanish-language history wanting to join together. Some

Table 4-7. Some Common Asian-American Culture Characteristics and Values

1. Age, wisdom, and the man’s opinion often are valued in making decisions. Being in balance with nature may be highly valued.
2. Civic ideals may be shaped by respect for tradition, ancestors, and a hierarchy of leadership. Conforming with tradition and a simple approach to life may be more valued.
3. Social structures often will value the extended family and the group welfare. Elders typically are shown great respect. Being humble may be highly regarded.
4. Time can be viewed as cyclical in nature with a focus on the past and present.
5. Styles of communication can be more formal, detached, with a lack of close contact. A higher level of comfort with silence may exist.

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groups of individuals prefer to be called Latino (masculine) or Latina (feminine), particularly if they are from Latin America. Still others prefer to be identified by the country of their cultural heritage (i.e., Puerto Rican, Cuban American, and Mexican American) because they do not relate to other terms of racial/ethnic identity.

The history of Hispanic culture in the United States varies according to specific country. The Mexican culture has been present in the Americas for generations. At the end of the United States war with Mexico in 1948, the Treaty of Guadalupe Hidalgo formalized the United States-Mexico boundaries. Because of the shared border, there is a dynamic and constant flow of Americans and Mexicans across the United States-Mexico border. The North American Free Trade Agreement, signed in 1992, provides for shared economic resources among Canada, the United States, and Mexico. Migrant worker patterns of Mexican Americans extend throughout the United States. As a commonwealth of the United States since the 1950s, Puerto Rico also has a fluid relationship because Puerto Ricans also are United States citizens from birth. A large number of Puerto Ricans have settled in major United States cities (e.g., New York City). Many Cuban Americans came to the United States seeking political asylum from Fidel Castro in the 1960s. As a result, a large Cuban population exists in Florida and the southeast United States. Other Latin American cultures also reside throughout the United States.

Characteristics common to the Hispanic culture in the United States include: family (*la familia*), respect (*respeto*), personal relationships (*personalismo*), and trust (*confianza*). In the patient case with Ms. Dominguez, the patient came to the pharmacy with a family member. Because of the close-knit structure of many Hispanic families who maintain a high affiliation to their home culture, the pharmacist or clinician may find that a family member or several family members participate in the health care encounter. Because of the importance of family (*la familia*), the culture often is more interconnected, relying on cooperation. The family may be integral to the success of a patient’s treatment plan. The patient may welcome the family’s participation in

Table 4-8. Some Common Hispanic Culture Characteristics and Values

1. Decisions may be made by consulting with the family and be based in the father's final input. Lives may be controlled by fate as opposed to having personal control.
2. Civic ideals often are based in the community and pride. Hard work and responsibility often are highly valued.
3. Being respectful and hospitable while emphasizing the value of family is often at the center of the social structure. It may be preferable to avoid conflict instead of facing it. Ties to church are common.
4. Orientation to time may be based in the ability to personally interact with others and live life. An emphasis on the present may be a more common value than being preoccupied with the future.
5. Close and personal communication, demonstrated by friendly handshakes or hugs, is common. Being formal to elders demonstrates a sign of respect.

Reprinted with permission from Sage Publications. Huff RM, Kline MV. Promoting Health in Multicultural Populations: A Handbook for Practitioners. Thousand Oaks: Sage Publications, Inc., 1999:18. Spector RE. Cultural Diversity in Health and Illness. Upper Saddle River, NJ: Pearson Education, Inc., 2004.

achieving better health. Respect (el respeto) includes appropriate deference in relation to age, sex, and social status. Respect is even incorporated into the language by distinguishing a difference between a formal “you” (Usted) and an informal “you” (Tú). Younger clinicians should refer to their patients as Mr. (Señor) or Mrs. (Señora) rather than by first name. Although patients may not engage in direct eye contact with an authority figure such as a pharmacist, the pharmacist should still try to look directly at the patient, even if using an interpreter. Pharmacists should be open-minded to listening to the patient regarding use of complementary alternative medicine or religious beliefs (predominantly Catholic and Protestant). Respect given to the patient will be returned to the provider. Developing and maintaining personalismo with patients can occur by greeting patients courteously, asking about other family members, and engaging in brief conversation about patients’ general well-being at the patient-pharmacist encounter. Many patients appreciate any attempt to say common greetings and conversation in Spanish. Often, it is culturally acceptable to be in closer proximity to the patient during counseling or appointments. Too much physical distance may indicate lack of interest in the patient or the problem. By demonstrating some basic understanding of these cultural characteristics, pharmacists will make great strides in developing confianza with patients. Patients who feel rushed and unheard will not automatically give their trust to the provider (Table 4-8).

Folk medicine diagnoses common to the Hispanic culture include empacho, susto, and mal de ojo. Traditional healers who may specialize as herbalists, masseurs, or midwives are called curanderos. They often are trusted members of the family and community. Mal de ojo, or the evil eye, usually occurs when a person looks at a child or another person with admiration and envy. The child often will cry, be listless and

weak, and have a poor appetite. The most common treatments usually are sweepings across the body with a mixture of herbs and prayer. In Mexico, these cleansings are called limpias, and in Puerto Rico, they are called barridas. Susto, or fear/soul loss, is a sudden event or a series of events that causes fear or guilt in the patient. Patients may feel listless and depressed. Patients have claimed that susto occurred before the onset of diabetes, high blood pressure, and other chronic diseases. Treatment of susto can range from teas to limpias, depending on the severity. Empacho is an intestinal disorder suggestive of an intestinal blockage that can cause bloating and stomach distress. It commonly is treated externally with an abdominal massage of olive oil and internally with chamomile tea (té de manzanilla). On occasion, the remedies are used complementary to Western medicine. Pharmacists who work with Hispanic patients should become familiar with some of the common beliefs. Pharmacists also have opportunities to help decrease health disparities and mortalities that are common to the Hispanic population (Table 4-3).

Gay, Lesbian, Bisexual, and Transgender Cultures

Civil liberties apply to most minority groups in the United States. However, gay, lesbian, bisexual, and transgender people often are still vulnerable to discrimination. People in these cultures may be accustomed to mainstream United States culture and will access health care services. Cultural dissonance may occur when pharmacists or other health care providers work with patients from this population or when a patient works with a pharmacist or other health care provider who openly is gay, lesbian, bisexual, or transgender. Pharmacists should be sensitive and recognize their own culture and views regarding homosexuality and bisexuality to best serve this patient population.

Immigrant Cultures

Populations move to the United States from other countries for various reasons. Some people move to the United States because of employment. Others move because of family relations in the United States. Some individuals migrate in and out of the United States with work opportunities. People seek political refugee status because of political instability in their country of origin. For immigrants who have undergone refugee resettlement, an estimated 5–10% seen in urban medical centers has experienced some form of torture. These populations may need additional health care services, including extensive mental health services.

Each of these populations may view health care differently. In other countries, access to drugs or health care may be more readily available. Some immigrants will have little to no exposure to Western medicine processes. Pharmacists should be aware of any stereotypes or personal biases regarding immigration to the United States and be sensitive to the current drug needs of the patient.

National Standards for Culturally and Linguistically Appropriate Services in Health Care. Washington, D.C.: Office of Minority Health. Department of Health and Human Services, 2001. Available at <http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf>. Accessed August 8, 2003.

Loss of Hearing or Sight Cultures

Patients who have loss of hearing or sight experience a culture that may cross age, race/ethnicity, religion, or gender. Many times, the skills and abilities of patients from these cultures are underestimated. Patients may have adapted their own processes for accessing health care. Furthermore, their pharmacy services may require another method of language translation.

About 10% of Americans have hearing loss to some degree. Patients who are deaf or hard-of-hearing may use American Sign Language, written notes, hearing aids, or teletypewriters, depending on the degree of hearing loss and comfort with use. During counseling sessions, patients may rely more on facial cues and body language. Pharmacists should work to keep their faces open toward patients so that patients can follow the facial cues better. If it is necessary to get the attention of a person who has a loss of hearing, a gentle tap on the forearm or shoulder is appropriate.

Patients who are blind, have limited eyesight, or are losing sight due to eye conditions may require the use of Braille, verbal counseling, or tactile cues to distinguish medication. Some patients will feel more comfortable than others conveying their loss of vision. Pharmacists can approach patients by simply offering, “How can I help you?” or “Can I get you that information in another format?” There are an increasing number of talking devices (e.g., blood pressure monitors and scales) that may be of assistance to patients.

Religious Cultures

Hospitals and hospice settings traditionally have been better equipped to work with patients of various religions and backgrounds because of available pastoral and spiritual care services. As pharmacists take on more advanced practice roles, religious and spiritual concerns may surface (e.g., adherence to treatment plans, contraception, diet restrictions, or pain management). Pharmacists may be able to address questions for patients in the following manner: “Are there religious or spiritual concerns that could help you in your health?” or “Is there someone from your (religious or spiritual) background that you would like for me to contact?”

The pharmacist does not need to be of the same faith tradition to identify with patient needs. However, the pharmacist should be able to distinguish if support in the form of spiritual or religious leaders should be requested. If the pharmacist realizes that there are numerous people in the community of a particular faith tradition, it may be helpful to become more familiar with their religious customs and beliefs.

Western United States Culture

Much of the historical basis for the culture of life in the United States is rooted in the formation of a democratic nation that largely stemmed from a Christian Protestant perspective. A host of freedoms and responsibilities shape the country’s constitution and these values are instilled in much of the education system. Individual freedoms and responsibilities often are valued over the group or community. There is a separation of church and state.

Timeliness and preparation for the future often are given high value. All people are responsible for their own destiny.

Traditional medicine and folklore in Western culture include common treatments of chicken soup or orange juice for a cold and drinking plenty of fluids during an illness. Often, a preventive message is conveyed through sayings such as “an apple a day keeps the doctor away” or Benjamin Franklin’s “an ounce of prevention is worth a pound of cure”. Some consider type A personality and bulimia to be culture-bound syndromes. People of the Christian tradition may find comfort with the assistance of a pastor or priest or a prayer circle.

Every head is a world.

—Cuban Proverb

There are numerous other religions, immigrant populations, and cultural traditions that exist. The previous descriptions are points to consider in some of the more common population groups in the United States. When working with any individual or group, one of the most important lessons pharmacists can learn is that they may not be the best person to provide pharmaceutical care to the patient. Sometimes, pharmacists and other health care providers must set aside their own pride and recognize that another pharmacist in the setting may be the more appropriate person to communicate with a patient or family member. These differences can occur because of culture, personality, recognized self-biases, and/or patient preferences.

Negotiating a Treatment Plan

After gaining knowledge about the patient’s understanding of illness and the social context, the pharmacist can work with the patient to negotiate a plan that incorporates both the patient’s beliefs and the pharmaceutical care model. These care plans will balance the evidenced-based model with the patient’s culture and ability to adhere and accept responsibility for self-management. On occasion, the treatment plan may incorporate complementary alternative medicine resources such as traditional healers. Pharmacists should consider employing community health care workers (i.e., laypersons who live in the community or neighborhood being served and are familiar with cultural norms). The more familiar the pharmacist is with community resources and patient beliefs, the better the pharmacist can help negotiate adherence or treatment with the patient. Pharmacists in advanced practice roles should discuss complementary alternative medicine with providers, carefully document its use of complementary alternative medicine, and incorporate these options into collaborative practice agreements as appropriate.

Pharmacists who “RESPECT” their patients in the context of their communities will be well on their way to providing culturally competent care. The RESPECT acronym refers to:

- Developing **rapport** with the patient and not making assumptions;

- Being **empathetic** while acknowledging patient beliefs;
- Being **supportive** by understanding barriers and involving the family as appropriate;
- Developing a **partnership** with the patient (and family as appropriate) to negotiate a patient-centered plan;
- Providing **explanations** to the patient and clarifying patient understanding;
- Being **culturally competent** by recognizing personal biases, respecting differing beliefs, and knowing limitations; and
- Gaining **trust** by taking time and displaying genuine interest in the patient's welfare.

As the integrated patient-pharmacist encounter concludes, the pharmacist should be certain that the plan is practical for the patient and family. Using these strategies in counseling and therapeutic management allows for the concepts of disease and illness to come together for an integrated understanding and plan for the patient (Figure 4-5).

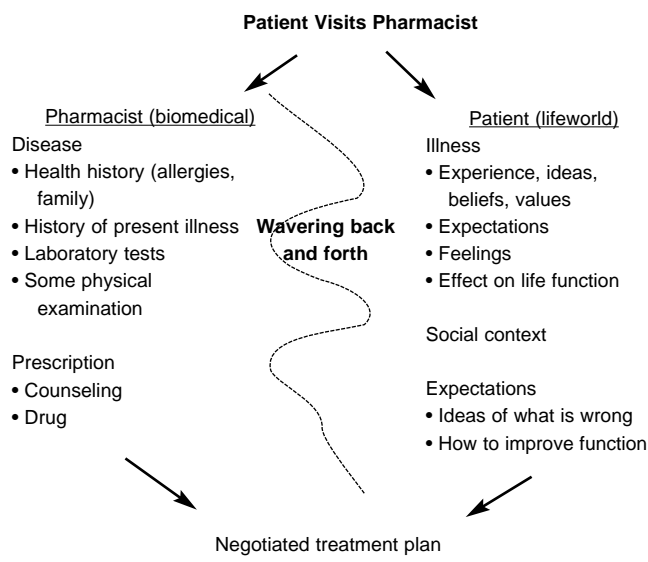


Figure 4-5. Negotiated patient-centered pharmacist encounter—disease and illness.

Adapted with permission from Sage Publications. Brown JB, Weston WW, Stewart M, et al. The first component: exploring both the disease and the illness experience. In: Stewart M, Brown JB, Weston WW, eds. *Patient-centered Medicine: Transforming the Clinical Method*. Thousand Oaks, CA: Sage Publications, 1995:37.

Establishing a Framework for Cross-cultural Care

Guidelines and Accrediting Bodies

Several guidelines are now available for guiding health care entities toward culturally competent systems of care, including the national culturally and linguistically appropriate services standards, limited English proficiency, and certain elements in the Joint Commission on Accreditation of Healthcare Organizations standards.

In the late 1990s, the Office of Minority Health of the United States Department of Health and Human Services developed guidelines for health care systems to provide culturally and linguistically appropriate services to diverse populations. In December 2000, the final revisions were posted in the Federal Register as national standards for “adoption or adaptation” by health care organizations. Although the culturally and linguistically appropriate services standards are not yet mandated, they do provide a context of definitions, common understandings, and a practical framework for organizations. The 14 standards are related to: culturally competent care (standards 1–3), language access services (standards 4–7), and organizational support (standards 8–14) (Table 4-9). Pharmacists and pharmacy system managers can use the culturally and linguistically appropriate services standards as a guide for evaluating their own systems of care for serving diverse populations.

Under Title VI, organizations providing care to people with limited English proficiency must balance four factors when determining necessity of providing federally funded services/programs:

- number or proportion of people with limited English proficiency eligible for services/programs.
- frequency of contact with the services/programs.
- nature and importance of services/programs.
- resources available to provide services/programs.

Because pharmacies often receive funding from Medicaid and Medicare, this legislation can pertain to the

profession. Pharmacists and pharmacy systems must carefully evaluate whether these factors apply to their patient care setting.

Accreditation bodies increasingly are implementing policies and procedures that allow for systemic changes to occur to serve a diverse patient population. In November 2003, the Joint Commission on Accreditation of Healthcare Organizations participated in public hearings to evaluate culturally and linguistically appropriate services standards for language access services. Within the Comprehensive Accreditation Manual for Ambulatory Care 2004, standards exist that pertain specifically to patients’ cultural and language needs and services. These points are emphasized in standards relating to assessment of patients, patient and family education, patient rights and organizational ethics, and leadership.

Some of the standards specifically related to pharmacy and drug use follow:

- **Standard PC.6.10, Element of Performance No. 2:** The assessment of learning needs addresses cultural and religious beliefs, emotional barriers, desires and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate.
- **Standard RI.2.10, Element of Performance No. 2:** Each patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.

Other Joint Commission on Accreditation of Healthcare Organizations standards can be linked to cultural competency. Patient education regarding the safe and effective use of drugs can incorporate patients’ negotiated treatment plans. Pharmacists who educate patients about potential drug-food interactions should understand some of the unique diets of various cultures. Patient education that

Table 4-9. National Standards—Culturally and Linguistically Appropriate Services in Health Care

Standard	To provide culturally and linguistically appropriate services, health care organizations ...
Culturally Competent Care	
1.	Should ensure that patients/consumers receive from all staff members <u>effective, understandable, and respectful care</u> that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2.	Should implement strategies to recruit, retain, and promote at all levels of the organization a <u>diverse staff and leadership</u> that are representative of the demographic characteristics of the service area.
3.	Should ensure that all levels and across all disciplines receive <u>ongoing education and training</u> in culturally and linguistically appropriate service delivery.
Language Access	
4.	Must offer and <u>provide language assistance services</u> , including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5.	Must provide to patients/consumers in their preferred language both <u>verbal offers and written notices informing them of their right to receive language assistance services</u> .
6.	Must <u>ensure the competence of language assistance</u> provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7.	Must make available <u>easily understood patient-related materials and post signage in the languages</u> of the commonly encountered groups and/or groups represented in the service area.
Organizational Support	
8.	Should develop, implement, and promote a <u>written strategic plan</u> that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9.	Should conduct <u>initial and ongoing organizational self-assessments</u> of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10.	Should ensure that <u>data on the individual</u> patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, <u>integrated into the organization's management information system</u> , and periodically updated.
11.	Should maintain a <u>current demographic, cultural, and epidemiological profile of the community</u> as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12.	Should develop <u>participatory, collaborative partnerships with communities</u> and use a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13.	Should ensure that <u>conflict and grievance resolution</u> processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14.	Are encouraged to regularly make available to the <u>public information about their progress and successful innovations</u> in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

CLAS = culturally and linguistically appropriate services.

National Standards for Culturally and Linguistically Appropriate Services in Health Care. Washington, D.C.: Office of Minority Health. Department of Health and Human Services, 2001. Available at <http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf>. Accessed August 16, 2004.

is interactive will provide the pharmacist an opportunity to integrate patient beliefs and social context with the biomedical model and will involve patients in their care. As information is gathered and discussed with the patient, the family may be important participants in the care decisions that are made.

To overcome the organizational barriers in cross-cultural care, pharmacists and pharmacy system managers should assess their current health care structures. A recent review of the literature identified nine critical domains for measuring cultural competency in organizations. As pharmacists create more culturally competent pharmacy systems, these domains can be considered for developing a measurement profile.

- What values and attitudes are held by the pharmacy personnel and pharmacy organization? Is there a commitment of time and resources?

- What level of awareness exists regarding being culturally sensitive?
- What channels best enhance communication among patients, pharmacy personnel, and the system?
- What policies and procedures support providing culturally competent care?
- What training and staff development exist to enhance care?
- How do the facility characteristics, capacity, and infrastructure support culturally competent patient care?
- How do the intervention and treatment model features incorporate culturally specific beliefs and needs?
- How does the system allow for family and community participation?
- How will the system monitor, evaluate, and research activities to assess progress and share new knowledge?

The Lewin Group, Inc. Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings: A Review of the Literature. Rockville, MD: The Health Resources and Services Administration. September 2001. Available at <http://www.hrsa.gov/OMH/cultural/cultural.htm>. Accessed November 15, 2003.

Economic

Every pharmacy practice setting has a responsibility to balance caring for the patients while meeting budget demands. A recent business concept has been used in cultural competency training. The virtue matrix illustrates the factors affecting corporate social responsibility with profit-making (Figure 4-6). At the bottom of the matrix is the civil foundation which governs corporate practice—the norms, customs, and laws. Companies may choose to engage in these practices or may be mandated to comply. This civil foundation, which enhances corporate value, typically meets but does not exceed expectations set by society.

The top of the matrix is the frontier—where innovations such as cultural competency occur. The frontier exists because it is “the right thing to do.” Often, organizations engage in these practices because of good will. Changes may or may not have a direct effect on shareholder values. When companies are strategic in their planning, they will be able to advance corporate dollar and public interest. Companies that are more structural will recognize that their actions may help society but not the corporate shareholders. Resistance to corporate action may follow. Eventually, a strategic or structural innovation may become part of the civil foundation. This process is how companies change and grow.

The relationship the virtue matrix has with cultural competency in pharmacy practice can be explained by focusing on each quadrant and using the concept of “pharmaceutical care” as an example.

Compliance. Title VI of the Civil Rights Act provides foundational basis for culturally competent practices. However, there are few clear mandates for compliance to cultural competency. The Joint Commission on Accreditation of Healthcare Organizations accreditation standards and federal funding guidelines do provide criteria to incorporate cultural competency into health care and pharmacy practice. Pharmaceutical care is now integrated into pharmacy practice acts and through Omnibus Budget Reconciliation Act of 1990 regulations regarding patient counseling for Medicaid recipients. Future legislation may be implemented for pharmacies and health care organizations to use cultural competency guidelines similar to culturally and linguistically appropriate services standards.

Structural. Pharmacy managers and administrators may view cultural competency in the structural quadrant. They may state that providing culturally competent care would be a nice benefit to the patients, but it simply cannot be funded, there is not enough time, and it will not improve the financial bottom line. When cultural competency is delegated as a structural responsibility, pharmacy systems will have a difficult time gaining support from leadership and staff. Some organizations may state that no action can be taken because cultural competency will hurt the bottom dollar. When pharmaceutical care was first introduced, many pharmacists liked the concept but had a difficult time fitting it into the pharmacy system’s organizational plan.

Frontier

<p>Strategic Goodwill and profit making Helps organization and patients</p>	<p>Structural Goodwill Nonprofit organization</p>
<p>Choice Norms and customs of society</p>	<p>Compliance Set by laws and regulations</p>

Civil Foundation

Figure 4-6. Virtue matrix. Reprinted with permission from Harvard Business Review. Martin RL. The virtue matrix: calculating the return on corporate responsibility. HBR OnPoint. Product Number 2438. Copyright 2002 by Harvard Business School Publishing Corporation; all rights reserved.

Strategic. The strategic quadrant can be viewed as the area of greatest growth and creativity. Pharmacists may view cultural competency as a method to market to and recruit patients and providers from diverse backgrounds. There are other strategic and clinical reasons to incorporate cultural competency into pharmacy practice. Providers and pharmacists will better be able to diagnose and determine the appropriate treatment plan for the patient. Medication errors may be decreased. Because patients will have greater trust for the provider, a decrease in no-show appointments can occur. Cost-savings may be realized by avoiding emergency department visits or complicated procedures. Patient satisfaction can improve. The community will perceive the organizations and pharmacies as trusted partners. Pharmaceutical care started out in the strategic quadrant of what can be defined today as exemplary pharmacy practice sites. New, innovative concepts are in the strategic quadrant and require leadership to help advance these concepts into realities.

Choice. Pharmaceutical care has become a fundamental part of pharmacy education and practice; it is an expectation in pharmacy services. Currently, cultural competency is not a universal norm in health care and pharmacy practice throughout the country. As it gains acceptance and model practice sites emerge, pharmacists will view cultural competency as a foundational expectation in pharmacy.

Linguistic Competence

Case:

Mr. Hernandez is a 68-year-old patient recently diagnosed with benign prostatic hyperplasia. He has been given a prescription for doxazosin 4 mg. He brought his daughter with him to get the prescription filled. It is spring and you notice that Mr. Hernandez’ eyes are a bit red as he continues to rub his eyes. When speaking with the patient, you realize that he does not understand English very well. You also notice his daughter is standing nearby talking with the technician about the price

Martin RL. The Virtue Matrix: Calculating the Return on Corporate Responsibility. HBR OnPoint Enhanced Edition. Boston, MA: Harvard Business School Press, 2002. Also available at http://harvardbusinessonline.hbsp.harvard.edu/b01/en/common/item_detail.jhtml?id=2438.

of diphenhydramine. Mr. Hernandez asks his daughter to come over to help explain the drugs.

As you begin, you counsel back and forth between Mr. Hernandez and his daughter. First, you start by explaining what the doxazosin is used for. You pause to wait for the daughter for interpret to the patient. She turns a bit red, takes a breath, and then says something to her father. You continue explaining how the patient should take the doxazosin. The daughter tries to recall everything you say, but you notice she stumbles and you must explain again. Finally, you explain the side effects and recommend that Mr. Hernandez not take antihistamines or decongestants. Her time to translate seems much shorter than your explanations. The daughter is able to verbalize understanding of the use of the drugs. You provide written drug information that is printed in Spanish to Mr. Hernandez' daughter.

In evaluating the case of Mr. Hernandez, numerous questions arise. How can pharmacists best use interpreters in a pharmacy setting? Who can pharmacists use to help interpret and when is it appropriate to use family members? What sensitive dialogue may occur between a man and a woman regarding certain disease states? When using an interpreter, do pharmacists talk to the patient or the interpreter? Determining whether an interpreter is needed can present a challenging situation for the patient and the pharmacist.

Linguistic competence between patients and providers can be achieved through various mechanisms. Literature suggests that having bilingual and bicultural staff or trained medical interpreters is the most effective way to communicate with patients from different cultures. A common problem is that there are not enough bilingual/bicultural health care professionals trained in the United States. One solution is to identify foreign-trained health care professionals and to assist them in recertification or licensure in their profession, as pharmacy technicians, or community health workers. Recruiting young students from diverse communities is another way to help prepare the future pharmacy workforce. Other ways to close the gap is to partner with traditional healers and religious leaders who are trusted in the community.

Pharmacists should be aware that employees who are bilingual may make assumptions about literal translations, knowledge of medical terminology, or vocabulary that may or may not cross cultures. Standardizing linguistic skills and cultural awareness can address this potential problem but is not uniformly reinforced in various clinic settings.

Although community health centers and public health clinics have employed community health workers, pharmacists have not traditionally explored hiring these potential employees. Community health workers are familiar with the beliefs, customs, and language of the

community and can serve as critical connections for outreach and health promotion. For example, if the pharmacy clinician wants to conduct screenings or immunizations in the community, the community health worker can assist in promoting and encouraging participation from the neighborhood. On the United States-Mexico border, these health workers are called *promotores de salud* (health promoters). By hiring these individuals and providing appropriate background training for the community health worker and the pharmacy/clinic staff, these health workers can serve to assist with oral interpretation, written translation, and health promotion activities. Caution should be used to ensure that any health workers employed have received appropriate training in confidentiality of patient information.

Other resources include language banks and professional interpreters. More coordination within the clinic or pharmacy needs to occur to use these services. Language banks have been used more frequently in hospital settings and draw on employees who speak other languages to serve as interpreters when needed. Because the employees may not have gone through formal medical language evaluation, problems can arise. Also, conflicts can arise if the employee is drawn away from the usual duties to interpret. Professional interpreters may be employed directly by the pharmacy or clinic to assist as needed or on a full-time basis. Outside interpreter businesses and telephone banks also may be used. Costs are always associated with professional interpreters and pharmacy and health care systems should evaluate the need in the setting and desired patient outcomes. Appropriate measures regarding patient confidentiality and privacy should be addressed up front.

Written translations are considered an emergency stopgap in health care settings. Using written communication is limited to patients who are literate in the languages printed. Many times, translations do not account for low and high literacy and can be difficult to read. In a pharmacy, written information often is the primary format to provide patients with information. These translations are more readily available in large institution-based health care settings and accessibility to translations may be limited in pharmacy settings. When bilingual/bicultural personnel trained in appropriate communication interpretation are not available, pharmacists will need to use professional or ad hoc interpreters during patient-pharmacy encounters. When interpretation is required, some of the following guidelines should be considered.

To select an interpreter, it is best to use a professionally trained medical interpreter. If possible, select someone of the same sex as the patient. Avoid using family members, particularly if they are younger than 18 years of age or of a different sex. If using bilingual staff that has not been formally trained, pharmacists should be sure to outline a few key points for the interpreter before the interpretation encounter. On occasion, a patient will bring a family

Riddick S. Improving access to limited-English speaking consumers: a review of strategies in health care settings. *J Health Care Poor Underserved* 1998;(suppl 9):S40-S61.

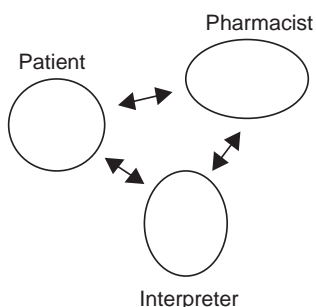
National Alliance for Hispanic Health. *Delivering Health Care to Hispanics: A Manual for Providers*, 3rd ed. Washington, D.C.: Estrella Press, 2004.

member or friend to interpret. Again, caution should be exercised in these encounters.

Before the patient encounter, pharmacists should take a moment to meet with the interpreter. They should encourage appropriate feedback or concerns the interpreter may have. Pharmacists should provide some context of the patient encounter for the interpreter. If using an untrained interpreter, pharmacists should reinforce that he or she should repeat the patient's words and should not add, delete, or paraphrase. Pharmacists should advise interpreters that if any uncertainty, confusion, or embarrassing content arises, he or she should let the pharmacist know. Before the patient encounter, pharmacists should establish where the interpreter will sit or stand in relation to the patient and the pharmacist.

During the patient encounter, the pharmacist should introduce him or herself and the interpreter at the beginning. Any basic words or phrases of introductions the pharmacist can learn in the language will help set a rapport with the patient. Have the interpreter situated to help maintain eye contact with the patient and provide a better flow to direct questions and instructions to the patient (Figure 4-7) (Note: in some cultures, eye contact and direct questions should be directed through a family member. These situations should be evaluated according to culture or on a case-by-case basis). Short phrases, descriptions, and questions should be used. Lengthy descriptions should be avoided as these are more difficult to interpret. In addition, technical terms, jargon, and abstract concepts should be avoided. Pharmacists should observe patients' nonverbal cues and verify patients' understanding of medication use by having them repeat instructions or advice. The Indian Health

A. Patient can avoid direct eye contact with pharmacist



B. Patient maintains more direct eye contact with pharmacist^a

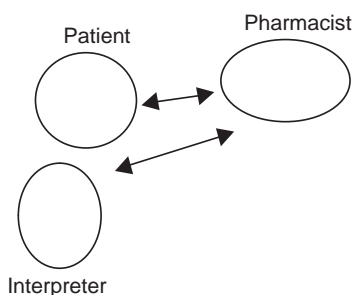


Figure 4-7. Considerations for interpreter interactions.
^aLocation of each person may differ based on situation.

Service model is a good place to start. Although these questions focus on the disease process and drug function, they still serve as a method for pharmacists to confirm drug use.

- “What did the doctor tell you this medicine is for?”
- “How did the doctor tell you to take this medicine?”
- “What side effects do you expect from this drug?”

During patient counseling, consider incorporating questions from the patient explanatory model or other questions to elicit patient beliefs and perceptions about the illness.

- “What are some of your concerns (fears) about the medicine (or specific disease)?”
- “How do you feel/hope this drug will help you?”

Implementing Cultural Competency in the Pharmacy Setting

How do pharmacists approach caring for the diverse patients discussed in the cases of Ms. Bekle and Mrs. Taylor? Consider the image of the successful community pharmacist in the small town. This pharmacist knows all patients who walk into the pharmacy, what their religious background is, where their children go to school, and what activities their family is involved in during the course of the week. To achieve these personalized relationships and trust, the pharmacist fosters relationships in the community by being present at local town events and talking with patients about their lives and not just their medication. This pharmacist is a well-trusted, well-liked, and successful member of the community because the pharmacist knows the community and its members.

The challenge and opportunity for pharmacists in a multicultural and diverse society is to understand themselves in the context of the communities in which they live and work so that they can better serve their patients. Pharmacists should consider the following steps to help them attain this mindset. For each step, pharmacists should critically evaluate their values as individuals and in their pharmacy/clinical settings.

... the final forming of a person's character lies in their own hands.

—Anne Frank (German-Jewish diarist, 1929–45)

Increase Self-Awareness

To increase self-awareness, pharmacists must recognize and understand their own culture. Questions they should ask themselves include: *What values and beliefs shape your world view? What are your own perceptions of health and illness? What myths or stereotypes do you have about other cultures? What is the foundation for your beliefs?*

What is the culture of your pharmacy or clinical setting? Does the staff represent the community where you work? Does it appear open and inviting to people of different backgrounds?

The real scholar is not afraid to ask questions of his pupil.
—Chinese Proverb

Learn About the Cultures in the Community

To learn about the cultures in the community, pharmacists should start by evaluating the community where they work. Questions to ask include: *What is the primary culture(s) of the patients where you work? Take time to learn about these cultures. What are some of the common values and beliefs? What are the common perceptions of health and illness?* If you are in management, set aside time and resources for your staff to work together to better understand these cultures.

Pharmacists must understand the social context of the patients they serve. They should get to know community leaders and visit local markets, community events, and locally run businesses. Pharmacists also can volunteer in a neighborhood community center (Figure 4-8). From a business point of view, this is simply good marketing. The Internet can be used to gather data on the community through census data and the local health department (Table 4-10).

Enhance Communication Skills

To enhance communication skills, pharmacists should ask these questions: *What is the language your patients are comfortable using to describe their health care? Are you comfortable talking with patients from diverse cultures? Are they comfortable talking with you? What type of nonverbal cues are valued in the cultures with which you work? When you counsel a patient, what type of open-ended*

questions do you use to gather information from them? If you serve a large population of patients who speak a different language, take some time to learn phrases of greetings for that culture. The patients will appreciate the gesture. Have patient education materials reviewed by people from the community. In your pharmacy, set aside time and resources to evaluate the use of interpreters and the need for written translation in your setting.

Acquire Skills to Develop and Use Community Resources

By recognizing the health disparities most common in their community, pharmacists can evaluate where in the community they can make a health difference. Some questions to ask include: *Who are the health care and community leaders in the areas surrounding your clinical setting or pharmacy? How can they be useful in bettering the health of your community? Do you tap into the community health centers or public health department for guidance? If you are located near a school and immunizations are not adequate, do you know the school nurse and can you partner with him or her to help improve immunization rates? If you are located near a temple and people in your community have a high incidence of depression, do you know the rabbi? If you are located near a popular restaurant hangout or a local supermarket and obesity and diabetes are highly prevalent, how can you work with these community settings to help address health care problems? Finding the right community partners can take*

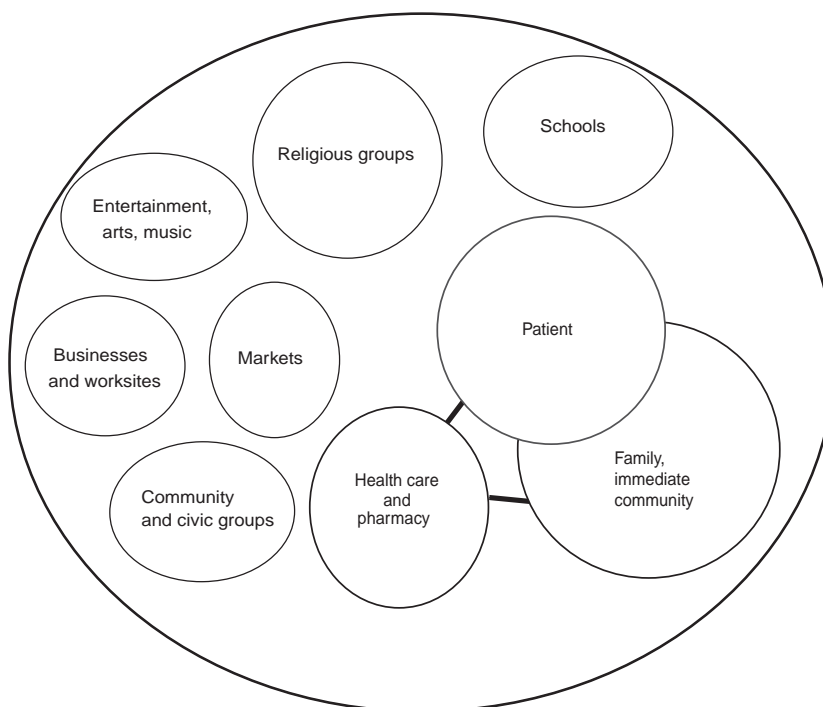


Figure 4-8. Identifying and making community connections. The pharmacist maintains a connected relationship with the patient and family, while understanding and appreciating the social context in which the patient lives. These connections can enhance the patient relationship.

Table 4-10. Resources**Census Data**

American FactFinder. United States Census Bureau <http://factfinder.census.gov/>
United States Census 2000 <http://www.census.gov>

National Health Resources

National Center on Minority Health and Health Disparities <http://ncmhd.nih.gov>
Healthy People 2010 <http://www.healthypeople.gov>
National Vital Statistics Reports <http://www.cdc.gov/nchs/Products/pubs/pubd/nvsr/nvsr.htm>
Office of Minority Health <http://www.hrsa.gov/OMH/>
National Center for Complementary and Alternative Medicine <http://nccam.nih.gov/>
United States Committee for Refugees <http://www.refugees.org/>
MEDLINEplus Health Information <http://www.nlm.nih.gov/medlineplus/>

Other Cultural Competency Resources

African American Health Network www.aahn.com/
American Indian Health <http://americanindianhealth.nlm.nih.gov>
Asian American Health <http://asianamericanhealth.nlm.nih.gov/>
Diversity Rx <http://www.diversityrx.org/>
Ethnogeriatrics/Stanford University <http://www.stanford.edu/dept/medfm/gec/page1.html>
EthnoMed <http://www.ethnomed.org/>
Gay, Lesbian, Bisexual, and Transgender Health <http://www.metrokc.gov/health/glbh>
National Alliance for Hispanic Health <http://www.hispanichealth.org/>
National Center for Cultural Competence <http://www.georgetown.edu/research/gucdc/nccc/index.html>

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Other

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Internet sources in this table accessed August 16, 2004.

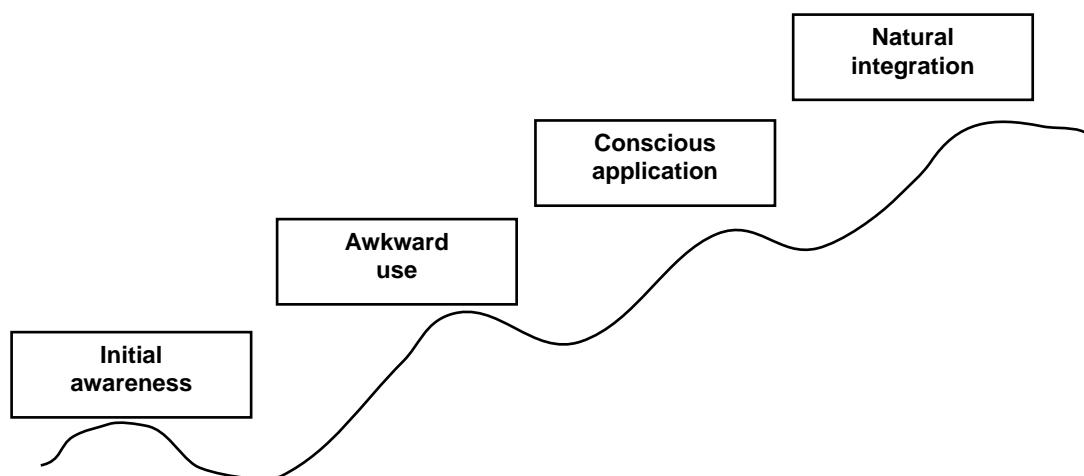


Figure 4-9. Stages of skill learning.

Reprinted with permission from Interpersonal Communication Programs, Inc. Miller S, Wackman D, Nunnaly E, Miller P. Increasing Awareness and Communication Skills. In: Connecting Skills. Workbook. Littleton, CO: Interpersonal Communication Programs, Inc., 1989:2.

time but will add value and trust with the patients and communities you serve.

Attaining cultural competency and proficiency is similar to developing clinical and pharmaceutical care skills—it takes time, patience, and practice. There may be points that are awkward and uncomfortable. With time, these skills can be naturally incorporated into practice settings and into everyday encounters with patients, families, community members, and coworkers (Figure 4-9).

Exploring the Future of Cultural Competency in Pharmacy Practice

The future of cultural competency in pharmacy practice is an open field. Opportunities exist for pharmacists to reengage in their communities and for model practice sites to surface in all pharmacy practice settings, from community pharmacies to long-term care facilities to institutional sites. Pharmacy schools and organizations have an opportunity to develop pharmacists who are culturally competent and to conduct research from pharmacogenomics to pharmaco-economic outcomes to community-based innovations. The literature suggests that the quantity and quality of current research in cultural competency is limited.

Conclusion

When members of the pharmacy community embrace cultural competency in their personal reflections, practices, and systems of care, the concepts of pharmaceutical care, “to responsibly provide drug therapy to achieve outcomes that improve patient quality of life”, expand. Pharmacists traditionally have been trusted in the eyes of the public. Reaching out and engaging communities give pharmacists a

chance to revitalize their practice sites. Through culturally competent practices, pharmacists can provide pharmaceutical care centered on patients’ health beliefs, practices, and cultural context to improve their health and quality of life.

Acknowledgments

The author wishes to acknowledge the expertise of Arthur Islas, M.D., and Carolyn M. Brown, Ph.D., for their evaluation of various sections and cases in this chapter.

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1. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J; Task Force on Community Preventive Services. Culturally competent healthcare systems: a systematic review. *Am J Prev Med* 2003;24(3S):68–79.

This systematic literature review evaluated the efficacy of interventions used in the health care system to increase cultural competence. The authors assessed: 1) recruitment and retention of diverse staff, 2) culturally specific health care settings, 3) interpreter services, 4) provider training, and 5) health education materials. The review of the evidence for each topic revealed a paucity of quantitative and qualitative studies in implementing culturally competent initiatives in health care settings. Although the case for cultural competency in health care has been demonstrated through numerous articles, quality research evaluating the efficacy of specific interventions is still needed. This review article provides a case for the need for more quantitative research in cultural competency.

2. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O 2nd. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003;118(4):293–302.

This literature review focused on the sociocultural barriers to health care for racial/ethnic minority groups using

academic, government, and foundation publications. From the available literature, their results identified organizational, structural, and clinical issues to be at the heart of the barriers. Organizational barriers refer to the lack of diversity in health care leadership and workforce. Structural barriers focus on the lack of interpreter services, bureaucratic process that deter patient care, and lack of referral of racial/ethnic minority groups to specialists. Clinical barriers refer to the difficult cultural interactions and miscommunications that occur between the patient or family and the providers. The paper also describes potential remedies to these barriers and serves as a framework for working to resolve these barriers. However, as with much literature in cultural competency, there is little to no mention of pharmacy, reinforcing the need for increased literature and research in cultural competency in pharmacy practice.

3. Brown CM, Nichols-English G. Dealing with patient diversity in pharmacy practice. *Drug Topics* 1999;143(17):61–8.

This is one of the first comprehensive reviews of cultural competency in pharmacy practice that provides specific steps for pharmacists who work in diverse patient populations. The paper defines cultural competence, examines pharmacists' barriers to working with diverse cultures, explores communication styles of diverse cultures, and explains the importance of understanding belief systems that surround health. This paper also challenges pharmacists to be introspective in understanding their own cultures, while being earnest in learning about other cultures and engaging in their communities. For the pharmacist learning about cultural competency, it provides a good pharmacy-based background with specific action recommendations.

4. Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med* 1999;130:829–34.

This seminal document provides a specific five-module medical school curriculum for working in diverse patient populations, which can be adapted to the pharmacy setting. The authors first explore self-awareness and understanding basic concepts in the cross-cultural encounter. Dynamics of core cultural issues, including communication styles, social interactions, and behaviors, are evaluated in the second module. The next modules examine patients' concepts of illness and explore the social environment in which the patient lives. The final module emphasizes tools for negotiating a patient care plan that incorporates the health care beliefs and values of both the patient and the provider. Although this document focuses on medical curriculum, it also can be applied to pharmacy curriculum.

5. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 2003;111(1):6–14.

This small yet provocative study evaluated the medical interpretation errors during pediatric encounters. Thirteen encounters using Spanish medical interpretation were audiotaped. Hospital interpreters were used in six of the encounters; the remaining ad hoc interpreters included social workers, nurses, and an 11-year-old sibling. A mean 31 interpreter errors occurred per encounter (total = 396 errors) with 63% (250) having a potential clinical consequence. Errors were because of omission (52%), false fluency (16%), substitution (13%), addition (8%), or editorialization (10%). No statistical difference in mean

number of total errors existed between hospital and ad hoc interpreters. Although errors with potential clinical consequences were significantly less ($p < 0.001$) among hospital interpreters, rates for both type of interpreters were still more than 50% (hospital: 53%, ad hoc: 77%). Although there were some flaws in the design of this study, it still raises questions about health care systems carefully evaluating interpreter services and covering the cost of quality interpreter services to improve quality of care and prevent errors.

SELF-ASSESSMENT QUESTIONS

Questions 75–79 pertain to the following case.

Pharmacist’s view: M.R. is a 34-year-old Mexican-American man who has been referred to the pharmacist at a family practice health clinic for diabetes self-management education. He is 5'10" tall and weighs 230 pounds (body mass index = 33). He has smoked one-half a pack of cigarettes per day for 20 years. His past medical history includes type 2 diabetes mellitus for 1 month and hypertension for 1 month. His father died of a heart attack at 52 years of age; he also had diabetes. His mother has diabetes. Today, M.R.’s laboratory test results included blood pressure of 154/82 mm Hg, pulse of 84 beats/minute, fasting blood sugar of 185, and hemoglobin A1C of 9.8%. M.R. received prescriptions for metformin 500 mg 1 tablet 2 times/day and lisinopril 20 mg 1 tablet every morning.

Patient’s view: I am Manuel Romero and I am 34 years old. My parents moved to the United States from Mexico when I was 14 years old. I graduated from high school here and took a few classes at the junior college. I am married now with three children.

I am a manager at a car shop, where I have been working for 18 years. My father used to own the shop, but he died 5 years ago from a heart attack. Ten years ago, he had one of his legs amputated and he started to lose his vision. The doctors said it was from diabetes, but everything happened right after he started using insulin.

The economy has made everything really difficult. Sometimes, I have to work from 8 in the morning until 9 at night and Saturdays for half a day. I notice that I start to get angry more easily recently. My family lives in a mostly Mexican community where we usually speak Spanish. My wife does not work right now because she takes care of the kids. My mother also just moved in with us because she was getting lonely at her home by herself.

The doctor told me to eat less. But all day my mother cooks wonderful foods, and I want to set a good example to the kids that they should eat well. She knows that food with

milk makes my stomach upset, so she prepares me special dishes. We usually have eggs and tortillas in the morning with a couple glasses of orange juice. I do not get to eat until I get home at night and I am starving. I usually eat whatever she makes and I eat a lot of it.

The doctor told me at the clinic last month that I have diabetes. I usually do not go to the clinic because there is not enough time. Then, the clinic started to be open on Saturdays every now and then so I finally took some time off work and decided to go. My mother, my wife, and the people at church said that I should. They told me that diabetes runs in the family. I guess that could be true because my mother has it and my father had it. I was starting to have to go the bathroom during the middle of the night and began feeling tired and thirsty all the time. All of these health things seemed to happen right after I got in a big argument with my neighbor and he gave me the evil eye (we call it *mal de ojo*). Ever since the argument, it seems that I have one bad thing after another that happens with my health.

My mother was trained by her mother to perform cleansings (*limpias*) and she knows a lot about herbs and grows some of them at the house. So, she gave me some teas and *nopales* (cactus) to take when I started having to go the bathroom all of the time. I have not told her about getting mad at my neighbor. I am too embarrassed to admit that I lost my temper. I know that she would want to perform a cleansing if she knew about that situation.

The doctor gave me some sample medicine to start. I am taking them right now but I do not know how I am going pay for the medicine at the pharmacy. He told me to go see the pharmacist there because she works with the drug companies in some sort of special program.

Pharmacist’s view: I have been working for the pharmacy for about a month. I recently moved here from another state to live closer to my family and notice that the community has many patients who are Mexican-American. Although I have had many successful outcomes in helping patients

reach their diabetes goals, it seems that the patients who do not speak much English have more problems with their health and diabetes management. I have an appointment scheduled later today. I looked at the chart and it says that M.R. is a Latin-American man. I wonder if he speaks English and if I will have difficulties working with him even though I did study some Spanish.

(After appointment) It seemed that M.R. and I had a good appointment and he actually spoke English. After reviewing the sample drugs with M.R., I scheduled a follow-up education appointment with him when the samples are finished so he can get his prescription filled. I told him that someone would call him to remind him of his appointment.

Patient's view: (4 weeks later) When I asked the pharmacist how much the drug would cost, I knew that I would not be able to pay for it. So, I started taking half of the pills instead of twice a day like we talked about. I figured that a little was better than nothing. I will go back as soon as I have enough money. I am not sure if they will work, but I will use some of the teas my mother prepares. The pharmacist seemed nice, but we never talked about the special drug program. I wonder if she tried to call me. My wife does not like to answer the phone when I am not at home.

Pharmacist's view: (4 weeks later) M.R. did not return to the pharmacy for his scheduled appointment, and I cannot reach him by phone despite trying to call him three times. I have decided that he is simply nonadherent and that he is not really ready to deal with his diabetes.

75. Which one of the following stages of the cultural competence continuum has the pharmacist demonstrated up to this point in the patient case?
- A. Cultural destructiveness.
 - B. Cultural incapacity.
 - C. Cultural blindness.
 - D. Cultural precompetence.
76. Which one of the following barriers does M.R. face taking his drug?
- A. His acculturation level to United States culture is low and he is marginalized.
 - B. His ability to communicate is compromised because he is bilingual.
 - C. His social context does not allow for him to follow the set patient care plan.
 - D. His belief in complementary alternative medication is preventing him from adhering to his regimen.
77. After discovering that M.R. is only taking half of his drug regimen, which one of the following plans would incorporate his social context in his health care?
- A. Re-review the drugs, reconfirm understanding of use, and set up an appointment to discuss diet.
 - B. Invite M.R.'s wife to participate in the next patient visit to discuss some cooking changes that may occur at home and for the family.

- C. Devote 10 minutes with targeted questions regarding M.R.'s explanation and perceptions of diabetes to evaluate what steps may be appropriate.
- D. Ask the community health worker who works with you and the doctor to plan a home visit to see the patient during the week.

78. You discover more about the mal de ojo experience that M.R. had. Which one of the following is the appropriate management strategy for mal de ojo that addresses M.R.'s experience?
- A. There is no medical treatment known at this time. It will subside with time and M.R. should continue with his other drugs.
 - B. Tell M.R. that he is an intelligent man. He should try to remove these concepts from his thoughts and beliefs.
 - C. Recognize that it can lead to self-harm or suicide and the pharmacist will need to take extra precautions. Suicide is common in the Hispanic population.
 - D. Involve a traditional healer who performs a noninvasive cleansing or sweeping over the body with herbs. The healer may say prayers also.

Several weeks later, the pharmacist is able to reestablish contact with M.R. and he agrees to bring his mother to the clinic because she has diabetes also and she prepares the family meals. The rest of the family is not able to come. His mother, Patricia Romero, speaks English with limited proficiency but is comfortable trying to talk in the language. On greeting Mrs. Romero, the pharmacist shakes her hand warmly, gently touching her on the shoulder and guides her to the education room conversing in a mixture of English and Spanish and allowing time in between for responses: Buenas tardes (good afternoon) Patricia, soy su farmacéutica (I am your [formal] pharmacist). Discúlpame por mi español (Excuse me [informal] for my Spanish). Mucho gusto (pleased to meet you). ¿Cómo has estado (how have you [informal] been)? (Continues in Spanish and English): I am so glad that you could come with your son *Miguel* today. That is a pretty blouse you are wearing! He told me that you are a wonderful cook and prepare some wonderful herbal teas! I am looking forward to learning more about them. How are your grandchildren doing? I have someone who will be in the room to help interpret if we need help.

79. Considering some of the common cultural norms for the Hispanic culture, which one of the following could the pharmacist do to improve her interaction with M.R.'s mother?
- A. Respect her space and privacy for personal contact by not touching her on the shoulder and not continuing with small talk.
 - B. Do not bring up the grandchildren because, although family is important, it is a personal matter.
 - C. Do not try to talk to her in Spanish, particularly when mixing the formal and informal.

- D. Respect the formality of greeting a patient with Señora or Mrs.
80. A pharmacist decides to find more information about the population of the community in which she works. Using the Internet, which one of the following is a primary source of information on the leading causes of death in the United States in Hispanic men 25–34 years of age?
- National Center for Health Statistics.
 - Morbidity and Mortality Weekly Report.
 - Census 2000.
 - National Alliance for Hispanic Health.
81. J.C. recently was promoted to “pharmacist-in-charge.” The Joint Commission on Accreditation of Healthcare Organizations will be conducting its reaccreditation in 6 months. She is responsible for reviewing pharmacy policies and procedures while working with the clinic’s performance improvement committee. Which one of the following is consistent with culturally and linguistically appropriate services and limited English proficiency standards?
- Provide inservice updates regarding cultural, religious, and cognitive differences that exist in the community population (e.g., Hispanic) to the personnel who make clinical decisions. It is not necessary to involve billing, reception, or cleaning personnel who are not involved in medical decisions.
 - Provide interpreter services at no cost to the patient during the peak hours of operation (e.g., weekdays from 8 AM to 5 PM) in a timely manner. It is not necessary to cover extended hour services because these are extra services to the community.
 - Provide written notices and verbal offers to all patients regarding available language assistance services in their preferred language (e.g., drug counseling). It is not necessary to have language services available in every language, just those most relevant to the community demographics.
 - Involve community organizations in the formal structure of the clinic services (e.g., the clinic advisory board) to gain community input. It is not necessary to include the community liaisons in the informal structures (e.g., evening support groups) because they are run by primarily volunteers.

Questions 82–84 pertain to the following case.

Your pharmacy is located near an urban community health center in the Great Lakes region. You have a racially diverse pharmacy staff with five pharmacists (three full-time equivalents), five technicians, two cashiers, one billing clerk, and one cleaning person. Because of the close ties the pharmacy has with the community health center, two of your pharmacists are able to devote 2 days/week providing more comprehensive drug therapy management services, including anticoagulation, asthma, diabetes, and immunizations through collaborative drug therapy agreements with the clinic.

You find that you have been able to adapt, develop, and use quality health education materials for different

populations. With recent changes in demographics, you have experienced an influx of immigrants from Somalia. Your pharmacy staff knows little about the Somali culture. Although some of the patients speak limited English, you realize that there are still gaps in language communication and you currently do not have access to interpreters. Several of the children are using inhalers for asthma. Despite pharmacist confirmation of patient understanding of the drug use with the children and family members, there are frequent reports of children and families returning without adequate refills, with lower peak flow meter readings, or with a report of an emergency department visit.

82. For future patients, which one of the following is considered one of the more effective methods of improving communication that the pharmacy could use to alleviate the asthma drug problems that occurred in this clinical situation?
- Develop asthma patient education handouts in Somali and have them reviewed by members of the community for readability.
 - Ask an older sibling to interpret during the patient encounter because he or she will be able to understand the patient better.
 - Use a trained language interpreter from a phone interpreter service in town.
 - Hire a bilingual staff member who is Somali and provide more formal training for your staff.
83. You try to determine if your pharmacy setting falls within the Title VI requirements for expanding services for people with limited English proficiency. Which one of the following is most consistent with Title VI requirements for limited English proficiency that could influence your pharmacy to expand language services?
- Consistent Somali patient requests to use family members for interpreting because of lack of interpreter resources in the community.
 - Decrease of adherence of medication use by Somali patients because of inability to read the medication labels and lack of understanding of patient counseling.
 - Steady increase of Somali patients over time with at least five families coming to the clinic and pharmacy each day.
 - Steady increase of drug errors in the homes of the Somali patients as seen by increased emergency department visits.
84. If the pharmacists wanted to obtain information about demographic, social, and economic indicators of their community, at which one of the following Web sites could they search?
- National Center for Health Statistics.
 - United States Citizenship and Immigration Services.
 - American FactFinder.
 - Culturally and linguistically appropriate services standards.

Questions 85–87 pertain to the following case.

You are a pharmacist, a 26-year-old African-American man, who grew up in the Southwest and has just completed a residency from the Rocky Mountain area. You are now working in an outpatient clinic in the Southeast region of the United States. The demographic mix includes a large percentage of African Americans who use the clinic services. Some of your patients use insurance, others qualify for financial assistance from state and local programs.

At the anticoagulation clinic, most of your patients' international normalized ratios remain stabilized on regular doses of warfarin and they are adherent to the patient follow-ups and laboratory tests. Spring approaches and you start to notice fluctuations in international normalized ratio in some of your patients. In talking with the community health worker, you make the connection that many of the patients who have experienced fluctuations have admitted using traditional medication and healers.

85. Based on some of the common traditional medicine beliefs among segments of the African-American culture, which one of the following reflects common cultural beliefs and could affect the international normalized ratio?
- A. Using natural laxatives once a year as a form of cleansing the body from “dirt”.
 - B. Eating more pork and red meat because they are cold foods that could make the blood “thin” and cause “low blood”.
 - C. Contacting a priest or magician to remove a “hex”.
 - D. Existing in a state of worry as a form of atonement.

To assist in negotiating across cultures, the pharmacist consults with a community health worker who states that these traditional beliefs are embedded deep into the culture of some of the patients. In fact, many of the patients are members of community churches and see the use of the traditional medicine as coinciding with the Christian observation of Lent. This message is reinforced by a popular local radio talk show every Sunday evening hosted by a pastor.

86. Which one of the following scenarios would you select to approach this clinical situation to maintain patient adherence to anticoagulation therapy and improve patient outcomes in the context of their environments?
- A. You discuss the potential dangers of traditional medicine with certain drugs with the local pastor who hosts the radio show. You gain her trust to help you caution the use of these practices during the radio program.
 - B. You recommend to the prescribing physician that during the spring you switch all of the patients with deep vein thrombosis to low-molecular-weight heparin injections. You recommend that the system absorb the temporary cost.
 - C. You provide increased counseling on the potential adverse events with warfarin. You request the patients come into the clinic for more frequent monitoring.

- D. You work with the prescribing physician and decrease the international normalized ratio monitoring frequency until the Lenten season is over (about 40 days). Patients are asked to report any bruising or bleeding.

You have developed a good rapport with the patients and they regularly make it to clinic appointments. You are ready to take the next steps in the practice and want to avoid numerous blood sampling for the patients. Your pharmacy and laboratory systems decide to explore switching from the laboratory to a point-of-care international normalized ratio monitoring device. To compare and document the change, you need to collect informed consent from your patients. You only want a small sample of 25 patients. Even though you explain the informed consent process carefully, you have difficulty enrolling even five patients.

87. Which one of the following factors could be the strongest obstacle in your ability to enroll patients?
- A. You have not gained trust from your patients because of lack of patient-provider concordance.
 - B. The history of the Tuskegee study is in the collective memory of the community and churches.
 - C. Despite institutional review board approval, the study design is not interesting to the patients.
 - D. The literacy level of the informed consent was not written at an appropriate level.
88. Which one of the following questions explores the patient explanatory model and concept of illness?
- A. What did the doctor tell you the drug is for?
 - B. What do you think will help you to feel better?
 - C. How have you been taking your drugs?
 - D. What do you think you can expect from the drug?

Questions 89–91 pertain to the following case.

The mission statement at Destiny County Hospital in a New England city includes the phrase “... committed to the health care and unique needs of our diverse community.” The hospital was reaccredited through the Joint Commission on Accreditation of Healthcare Organizations a year ago. Virtually everyone in the community without health insurance uses this facility for tertiary care. The private hospitals have not yet been solicited to contract public services extensively. The facility has interpreters and/or phone banks to serve the various language needs of the population, and the hospital has received good feedback in patient evaluations. The staff and the patients served are from diverse backgrounds and fields of expertise.

Unfortunately, your drug use monitoring system indicates that the drug error rate in the emergency department and pain service has increased. Patients have complained of inadequate pain relief treatment and other times that pain medication was administered too liberally. Review of the charts demonstrates appropriate use and charting of the pain scale. Root cause analysis in patients receiving inadequate dosages revealed that the administration had always been on the lower end of prescribed ranges. Root cause analysis also

indicates that these events occurred on certain shifts and with two new nurses who had been hired. These nurses happened to be of Asian descent (one Filipino, the other Vietnamese). Patients (or family members) who felt they received too much pain medication were of African or Asian descent. Further exploration of beliefs surrounding pain in different cultures revealed that many Asian, African, and some Northern European cultures do not complain of pain and have fears of addiction and overdosing.

89. After the root cause analysis, a plan is set in place to resolve future errors. Which one of the following plans will lead to more comprehensive changes in the pain medication use system?
- A. Reevaluate the hiring practices for the pain service and the emergency department. Conduct a mandatory retraining of all people who administer pain medication.
 - B. Update the hospital staff on pain management dosing through the weekly pharmacy newsletter. Reinforce the use of immediate phone consultations for any pain service dosing questions.
 - C. Update the drug labels into different languages. Make sure an interpreter is available for all pain service patients.
 - D. Evaluate various beliefs surrounding pain. Conduct a series of inservices for staff development. Incorporate pain management into training of new hires.
90. Which one of the following types of barriers does the health care system demonstrate in this case?
- A. Organizational.
 - B. Structural.
 - C. Clinical.
 - D. Financial.
91. The upper level administration of the hospital evaluates the errors that have occurred. Given the hospital's described history, mission, and commitment, which one of the following best reflects the rationale that the hospital still needs to evaluate regarding pain medication use?
- A. Decrease liability and malpractice claims.
 - B. Respond to changing demographics.
 - C. Meet legislative, regulatory, and accreditation mandates.
 - D. Eliminate health care disparities.

Questions 92–96 pertain to the following case.

Happy Health Pharmacy and Wellness Center is a successful large pharmacy that provides services to a predominantly Asian-American community on the West Coast. The pharmacy has several bilingual and bicultural employees (technicians, pharmacists, billing clerk, and community lay workers from varying generations) who can speak a range of languages, including Cantonese, English, Korean, Mandarin, Tagalog (a Filipino language), and Taiwanese. They have all undergone training in the use of interpreters and passed language certification courses. The mission statement,

policies and procedures, and staff hiring reflect a desire to serve a diversity of Asian Americans in the community. Nearby are several grocery stores, travel agencies, and restaurants. Happy Health Pharmacy also is located near an acupuncturist, dentist, and physicians' office. The pharmacy works with the local health department on various health outreach initiatives. Among the services/products provided are travel vaccines and information for the families that travel frequently back and forth to East Asian countries, herbal teas and products, health screenings, and grocery store nutrition tours. Once every quarter, a potluck meal is scheduled and a training update on cultural therapeutic management occurs. The local pharmacy schools often consult with the pharmacy as a training site and for practice-based research initiatives.

92. Which one of the following best describes the practices of Happy Health Pharmacy and Wellness Center?
- A. Culturally precompetent.
 - B. Culturally blind.
 - C. Culturally proficient.
 - D. Culturally competent.

Mr. Osuga is a 78-year-old Japanese-American man who visits Happy Health Pharmacy to buy a special tea. He speaks English fluently. Mrs. Kim, a community lay worker and local pastor's wife, is a bilingual (Korean and English) 55-year-old Korean-American woman who assists in the pharmacy to help with translation among the patients who speak Korean. While talking with Mr. Osuga in English about the teas, she tries to convince him to get pneumococcal and influenza vaccinations.

While waiting for the pharmacist to administer the vaccine, she visits with Mr. Osuga. She discovers that he has been in the United States since the 1950s and he was a soldier during World War II and served in Korea. On hearing this information, Mrs. Kim becomes flustered, says a few words to the patient, excuses herself, and begins crying in the back of the pharmacy. When the pharmacist, a 28-year-old Chinese-American woman, Dr. Huang, comes to check on the situation, she sees Mr. Osuga is getting up from his seat, also flustered, and begins to walk toward the exit. Dr. Huang is able to stop him, calm him down, and give him his vaccine. When leaving, the patient seems pleased and explains that he will return to the pharmacy in the future.

When discussing the situation with Mrs. Kim, the pharmacist learns more of the context of the interaction. During World War II, many young Korean women were taken by Japanese soldiers to the camps and served as "comfort women". Mrs. Kim explained that this is a scar in the history of many Korean families. Although she thought that she had been able to overcome her own biases against the Japanese culture, she was reminded of the painful stories and memories that had been passed through history when she talked to Mr. Osuga.

93. Which one of the following types of provider barriers experienced between Mrs. Kim and Mr. Osuga inhibited this patient encounter?
- A. Financial.
 - B. Acculturation.

- C. Personal.
- D. Communication.

94. Recognizing that Mr. Osuga is an older man, which one of the following cultural values and characteristics common to Asian-American culture should Mrs. Kim and Dr. Huang be aware of when first meeting and interacting with him?
- A. They should consider talking openly and directly with him about his health care.
 - B. They should be patient if Mr. Osuga takes a few moments before answering questions.
 - C. They should talk about their families and how lucky and successful they have been.
 - D. They should anticipate that Mr. Osuga will want to ask them for medical advice.
95. Which one of the following places on the virtue matrix would you place Happy Health Pharmacy?
- A. Strategic.
 - B. Structural.
 - C. Choice.
 - D. Compliance.

Mrs. Morales, a 57-year-old Tagalog-speaking patient, comes into Happy Health Pharmacy with new prescriptions for alendronate 70 mg once weekly and a clotrimazole 1% cream nightly for 7 days. A regular patient at the pharmacy, Mrs. Morales brings in her 13-year-old granddaughter to translate today. She usually has her daughter with her. The bilingual staff member is out of the pharmacy for a lunch break and will not be back for 2 hours (3 PM).

96. Given the resources available, which one of the following is appropriate follow-up for Mrs. Morales?
- A. Fill the prescriptions, print out Tagalog-appropriate patient education materials, and allow the granddaughter to translate.
 - B. Ask the patient through the granddaughter if the patient could come back in a couple of hours, fill the prescriptions, and wait for the bilingual staff member.
 - C. Fill the prescriptions, print out Tagalog-appropriate patient education materials, and counsel the patient yourself verifying understanding frequently.
 - D. Avoid using the granddaughter in any translation, speak slowly and loudly while shaking your head, and point to 3 PM on the clock for the patient to return.

Questions 97–99 pertain to the following case.

Dr. Cohen is a young New England pharmacist who has moved to the Southwest area of the United States. Because of some changes in staffing at an Indian Health Service clinic in a rural community, he is assisting them for a short time until other arrangements can be made. In introducing himself to the pharmacy technician, a young man who is from the Ramah-Navajo nation that they serve, Dr. Cohen comes up

close to the technician and shakes his hand firmly and quickly, stating loudly, “Very pleased to meet you!”

The technician introduces Dr. Cohen to the patients as they come for their drugs. As he observes Dr. Cohen, he notices that he stands very close to the patients, talks very quickly and loudly, and often likes to tell jokes. Dr. Cohen tries to acknowledge the eldest person who comes to get the drugs, makes direct eye contact, and asks about the family frequently. He is thorough in his patient counseling, verifies patient understanding, and often gives the patients tips and stories on how to remember their drugs. Dr. Cohen finishes most counseling sessions with “I am sure that if you take this drug like we talked about, it will take care of your medical problems!”

At the end of the first week, Dr. Cohen says that he feels a bit frustrated because he is trying to be warm and jovial with the patients, but they are not responding to him.

97. Which one of the following communication skills does Dr. Cohen display that is in keeping with several American Indian cultures?
- A. He demonstrates openness by standing close to the patients.
 - B. He is respectful of the elders by always acknowledging them and looking at them directly.
 - C. He takes time to talk with them and often relates information in stories.
 - D. He talks at the appropriate pace and volume with the patients.
98. Which one of the following stages of acculturation is Dr. Cohen experiencing?
- A. Marginalization.
 - B. Separation.
 - C. Assimilation.
 - D. Integration.
99. Which one of the following is one of the first actions that Dr. Cohen can do to get to know the community better?
- A. Visit the markets and religious ceremonies every couple of weekends.
 - B. Get to know a few of the community leaders and explain all of the things he would like to do to help with drugs.
 - C. Talk with his technician about the culture and ask him to show him around the community.
 - D. Start a diabetes education class because diabetes is prevalent in Indian Americans.