Introduction to Clinical Ethnogeriatrics

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“Introduction to Clinical Ethnogeriatrics”

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The following members of the CME Committee have indicated they have no conflicts of interest to disclose to the learners: Kathryn Rios, M.D.; Valerie Barnes, M.D.; Anthony Galicia, M.D.; Sandra G. Raff, R.N.; Sue Lindeman; Janet Bruman; Jane Finney; Tami Robertson; Judy Hyle, CCMEP; Christina Mourad and Kevin Williams.

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Faculty Disclosure Statement:
As part of our commercial guidelines, we are required to disclose if faculty have any affiliations or financial arrangements with any corporate organization relating to this presentation. Drs. Morioka-Douglas and Yeo have indicated they have no conflicts of interest to disclose to the learners, relative to this topic.

Drs. Morioka-Douglas and Yeo will inform you if they discuss anything off-label or currently under scientific research.
Objectives for the Webinar

• Understand the importance of ethnogeriatric care
• Explain ways organizations can provide more culturally competent care for older patients
• Demonstrate appropriate ways of showing respect and communicating with older patients in cross cultural interactions
Ethnogeriatric Imperative

- Increasing numbers of elders from diverse ethnic backgrounds
- One-third of U.S. population 65+ are projected to be from one of the four minority categories
- Vast diversity within ethnic minority and majority populations

Ethnogeriatric Imperative
Projections of Percent of Ethnic Elders in U.S.
Over 65 Years of Age

Vast Diversity Within Ethnic Categories

- African-Americans origins from various regions of the United States, the Caribbean, Central or South America, or Africa.
- Hispanic or Latino populations may include Mexican-Americans, Puerto Ricans, Cubans, as well as those from the Dominican Republic, and South or Central America.
- Asians may also include those with origins in China, the Philippines, Japan, Vietnam, Cambodia, India, or other areas.
- The category of American Indian/Alaska Native includes over 500 federally recognized tribes.

American Geriatrics Society
Position Statement On Ethnogeriatrics
Created in 2003 and updated in 2006
Consequences Of Diversity for Geriatric Care Providers

- CELEBRATE THE DIVERSITY
- APPRECIATE THE COMPLEXITY!
- NEED FOR CULTURAL COMPETENCE

Definition of Cultural Competence

A set of integrated attitudes, knowledge and skills that enable a health care professional or organization to care effectively for patients from diverse cultures, groups and communities
Complexities of Culture

• Individual embedded in multiple layers of social systems, each with its own constantly changing culture or subculture
• Different parts of culture are expressed at different times
• Some parts of culture are unrecognized
• Continuum of acculturation
• Health care has its own culture

Organizational Competence

CONTINUUM OF CULTURAL PROFICIENCY

Destructiveness Blindness Proficiency
Incapacity Competence

Cross et al, 1989
From the perspective of CEOs: What motivates hospitals to embrace cultural competence?

A national survey of hospital CEOs found that their first two concerns are clinical and financial outcomes; diversity issues ranked as number twelve of fifteen critical focus areas for organization success. However, the inextricable link between quality of care and racial, ethnic, and linguistic diversity is well documented, making diversity and cultural competence efforts highly relevant for all leaders interested in improving clinical outcomes and patient safety.


Incentives for Organizational Cultural Competence

- Accreditation (Joint Commission)
- Regulations and Standards (Title VI and CLAS standards)
- Opportunities (Medical homes & health reform)
- Health Equity (Reducing disparities)
Title VI, Civil Rights Act of 1964

"No person in the United States shall, on ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Standards for Culturally and Linguistic Appropriate Services (CLAS)

- 14 Standards for Health Care Organizations
- 4 Mandated – Language Services
- 9 Recommended as Mandates – Cultural Competence
- 1 Voluntary-Public Information

http://www.omhrc.gov/CLAS
CLAS Mandates

- Standard 4
  Health care organizations must offer and provide language assistance services, 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.

- Standard 5
  Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

- Standard 6
  Health care organizations must assure the competence of language assistance 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).

- Standard 7
  Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Increased Patient and Provider Satisfaction

- A number of health care organizations indicate that projects designed to implement any of the CLAS Standards have improved patient and provider satisfaction with the health care process.

  - Making The Business Case For Culturally And Linguistically Appropriate Services In Health Care: Case Studies From The Field,
  - Alliance of Community Health Plans Foundation, 2007
How Medical Homes Can Advance Health Equity
Ignatius Bau, JD
The California Pan-Ethnic Health Network

http://www.cpehn.org/pdfs/Medical%20Homes.pdf

Strategies for Organizations to Reduce Cultural Barriers

- Hire ethnically diverse staff
- Provide trained interpreter services
- Train staff on history and culture of clients, cultural competencies
- Recruit cultural navigators (guides) from patient populations
- Diversify board and administrators
Does Cultural Competency Training of Health Professionals Improve Patient Outcomes?

The first systematic review to critically assess the quality of studies that determine whether educational interventions to improve the cultural competence of health professionals are associated with improved patient outcomes.

The studies, albeit of limited quality, reveal a trend in the direction of a positive impact on patient outcomes.

Acculturation Level Affects Needs

While some older adults adapt easily to the U.S. society and its norms, many others do not. Such cultural isolation may lead to unrealistic expectations and miscommunication during health care encounters. It is important for health care professionals and systems to help educate less acculturated older adults about the U.S. health care system and how to navigate it most effectively.

American Geriatrics Society
Position Statement On Ethnogeriatrics
PROVIDER CULTURAL COMPETENCE

• Why not just be warm and caring and treat patients the way you would like to be treated?
• I know about “hot and cold”, isn’t that enough?
• Older patients and their families don’t expect us to know about their cultures.

PROVIDER CULTURAL COMPETENCE

Attitudes
Knowledge
Skills
The Cultural Sensitivity Continuum

- **Fear**  Other group feared.
- **Denial**  Other group doesn’t exist.
- **Superiority**  Other group is inferior.
- **Minimization**  Cultural differences minimized.
- **Relativism**  Differences appreciated.
- **Empathy**  Fuller understanding.
- **Integration**  Situations assessed, appropriate actions taken


Cultural Humility

- Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

Does Cultural Competency Training of Health Professionals Improve Patient Outcomes?

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Lie DA, Lee-Rey E, Gomez A, Bereknyei S, Braddock, 2010

Cultural Competence Requires:

• Awareness of one's personal biases and their impact
• Knowledge of
  • Population-specific health-related cultural values, beliefs, and behaviors
  • Disease incidence, prevalence or mortality rates
  • Population-specific treatment outcomes
• Skills in working with culturally diverse populations
  • Curriculum in Ethnogeriatrics, Collaborative of Ethnogeriatric Education,
Health Related Cultural Values and Practices

• Non-Western non-biomedical traditions  
e.g. balance theories
• Traditional treatments  
e.g., herbal medicines that might interact with prescriptions, coining and cupping
Why should we pay special attention to “Ethnic Elders”? 

Can’t we just treat them the same as the rest of their ethnic group?

Different Health Risks

- More ethnic elders in the largest populations are
  - poorer,
  - less well educated and
  - have more chronic health conditions than the average older Americans.
- They seem to have the same health conditions as their white counterparts, but often
  - develop them at an earlier age and
  - live with chronic disease for a greater proportion of their lives.
- This greater degree of chronicity and disability significantly impacts their functional status and quality of life.

American Geriatrics Society Position Statement on Ethnogeriatrics
2007 All Cancer Sites Combined. Cancer Death Rates in Men by Age and Race and Ethnicity, United States
Rates are per 100,000 persons.

Poverty
Percentage of 65+ Population Living in Poverty, 1998

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families, January 2001, US Administration on Aging, DHHS
**Education Level**

Percentage of the 65+ Population with a High School Diploma or Higher or a Bachelor’s Degree or Higher, by Race and Hispanic Origin, 1998

<table>
<thead>
<tr>
<th>Race and Hispanic Origin</th>
<th>High School Diploma or Higher</th>
<th>Bachelor’s Degree or Higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>67.0</td>
<td>14.8</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>71.6</td>
<td>16.0</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>43.7</td>
<td>7.0</td>
</tr>
<tr>
<td>Non-Hispanic Asian and Pacific Islander</td>
<td>65.1</td>
<td>22.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>29.4</td>
<td>5.4</td>
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</tbody>
</table>

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families, January 2001, US Administration on Aging, DHHS

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**Percent of 65+ Who Speak Little or No English, 2000**

Yeo, IoM, 2008
Living Arrangements – Older Men

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families, January 2001, US Administration on Aging, DHHS

Living Arrangements – Older Women

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families, January 2001, US Administration on Aging, DHHS
Cohort Analysis

- Cohort analysis is a tool to understand the impact of historical experiences of various ethnic cohorts on the lives of elders.
  - Helps to understand influences on elders’ trust of providers and attitudes toward the health care system.

- Influence of an event differs based on the age of elder at the time.
  - Not all individuals who identify themselves as members of the ethnic group will have been influenced by all events.

- Use of cohort analysis in clinical care:
  - Incorporate quickly into family health history
  - Taking relevant social histories.

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Cohort Experiences – Mexican American Elders

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<tr>
<td>Heritage of Loss of Land</td>
<td>Massive Immigration</td>
<td>WWII Participation</td>
<td>Chicano Movement</td>
<td>Increasing Political Power</td>
</tr>
<tr>
<td>Mexican Revolution</td>
<td>Depression</td>
<td>Immigration</td>
<td>Bilingual Education</td>
<td>Anti-Immigrant Bias</td>
</tr>
<tr>
<td>Repatriation</td>
<td>Urbanization</td>
<td>Latino Arts and Media</td>
<td>Welfare Reform Movement</td>
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<tr>
<td>GI Forum</td>
<td>Deportation and Amnesty</td>
<td>Anti-Bilingual Education Trend</td>
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</tbody>
</table>
### Historical Events: Japanese American Elders

<table>
<thead>
<tr>
<th>Decade</th>
<th>Events</th>
<th>Age Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990s</td>
<td>First apologies and redress payments sent to survivors of WWII Concentration Camp</td>
<td>Young Adult &amp; Middle Aged</td>
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<tr>
<td></td>
<td></td>
<td>Middle Aged &amp; Young Old</td>
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<tr>
<td></td>
<td></td>
<td>Young Old &amp; Old</td>
</tr>
<tr>
<td>1980s</td>
<td>High rates of &quot;outmarriages&quot; - marrying outside the Japanese community.</td>
<td>Young Adults &amp; Middle Aged</td>
</tr>
<tr>
<td></td>
<td>1988 - Civil Liberties Act, apology/payment of $20,000 to 60,000 survivors.</td>
<td>Middle Aged &amp; Young Old</td>
</tr>
<tr>
<td></td>
<td>Commission on Wartime Relocation/Internment of Civilians reviews Executive Order 9066 constitutionality, reports &quot;personal justice denied&quot;.</td>
<td>Young Old &amp; Old</td>
</tr>
<tr>
<td>1970s</td>
<td>&quot;Model minority&quot; label begins.</td>
<td>Adolescents &amp; Young Adults</td>
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<tr>
<td></td>
<td>Sansei (third generation Japanese Americans) enter mainstream professions</td>
<td>Young Adult &amp; Middle Aged</td>
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<td>Middle Aged &amp; Young Old</td>
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### Skills in Ethnogeriatric Care

Skills in Ethnogeriatric Care
Stereotypes v. Generalizations

- Stereotypes:
  - Provide an ending point.
  - No attempt is made to learn whether the individual in question fits the statement.
- Generalization:
  - Is a beginning point.
  - It indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual.
  - Helps one generate hypotheses about the patient’s belief systems.
  - Generalizations may be inaccurate when applied to specific individuals, but anthropologists do apply generalizations broadly, looking for common patterns, for beliefs and behaviors that are shared by the group.
  - It is important to remember, however, that there are always differences between individuals

Galanti, G, Caring for Patients from Different Cultures

(http://www.ggalanti.com)

Stereotypes v. Generalizations

“. . . Stereotyping patients can have negative results. An example is the assumption that Mexicans have large families. If I meet Rosa, a Mexican woman, and I say to myself, ‘Rosa is Mexican; she must have a large family,’ I am stereotyping her. But if I think Mexicans often have large families and wonder whether Rosa does, I am making a generalization.”

Galanti, G, Caring for Patients from Different Cultures
■ Is your patient there on time?

Monochronic and Polychronic Time

Monochronic time
Doing one thing at a time
Assumes careful planning and scheduling

Polychronic time
Human interaction is valued over time and material things, leading to a lesser concern for 'getting things done' -- they do get done, but more in their own time.

The Dance of Life: The Other Dimension of Time, by Edward T. Hall
Working with Families

- Extremely important in many cultures in which family is responsible for elder care.
- Potential tension if family members expect to make decisions for elder.
- Common request of physician: don’t tell Mother she has serious illness because she will give up hope.

Demonstrating Respect (Deference) To Older Patients In Culturally Appropriate Ways

- Acknowledge and greet older persons first.
- Generally, use formal term of address (Mr., Mrs.), at least initially.
Non-verbal Communication

- A. Pace of conversation
- B. Physical distance
- C. Eye contact
- D. Emotional expressiveness
- E. Body movements
- F. Touch

Body Movements

- Body gestures can be easily misinterpreted based on what is considered culturally appropriate.

- Individuals from some cultures may consider some types of finger pointing or other typical American hand gestures or body postures disrespectful or obscene (e.g. Filipino, Chinese, Iranian), while others may consider vigorous hand shaking as a sign of aggression (e.g. some American Indian) or a gesture of good will (e.g. European).

- Nodding may not mean agreement but rather just mean “I’m listening.”

- When in doubt, ask an interpreter or other cultural guide.
Touch

- While physical touch is an important form of non-verbal communication, the etiquette of touch is highly variable across and within cultures. Practitioners should be thoroughly briefed about what kind of touch is appropriate for cultures with which they work.

Demonstrating Respect (Deference) To Older Patients In Culturally Appropriate Ways

- Consider use of informal conversation prior to formal assessment.
- It may not be respectful to ask business oriented questions without first acknowledging the patient in a more personal way. For example, Mexican Americans may prefer to begin a conversation with questions such as "How is your family?" or "Did you have to travel long to come here?" before they wish to respond to more formal questions such as "What brings you here today?"
Demonstrating Respect (Deferece) To Older Patients In Culturally Appropriate Ways

- Avoid the "invisible patient syndrome": Older patients need to be talked to and with, rather than talked about. Talking to someone else in the room as if the patient weren't there, or is incapable of understanding demonstrates disrespect, even in the presence of family members or an interpreter.

Working with Interpreters

- Speak in short units and ask short questions.

- Avoid technical terminology, abbreviations, and professional jargon (or explain them thoroughly).

- Avoid colloquialisms, abstractions, idiomatic expressions, slang, similes, and metaphors.

- Encourage the interpreter to translate the patient's words as closely as possible rather than paraphrasing or polishing with professional jargon.
When Using Interpreters

- During the interaction, look at and speak directly to the patient, not the interpreter.
- Position the interpreter to the side and slightly behind the patient. The provider should face the patient.
- Listen, even though you do not understand the language and look for nonverbal cues.
- Be patient. Interpretation takes time when done right.
- Have the interpreter ask the patient to repeat as accurately as possible the information that has been communicated, to see if there are gaps in understanding.

Statements That Facilitate Empathy: Queries

- Would you (or could you) tell me a little more about that?
- What has this been like for you?
- Is there anything else?

Statements That Facilitate Empathy: Clarifications

- Let me see if I have this right.
- I want to make sure I really understand what you’re telling me. I am hearing that...
- I don’t want us to go further until I’m sure I’ve gotten it right.
- When I’m done, if I’ve gone astray, I’d appreciate it if you would correct me. OK?


Statements That Facilitate Empathy: Responses

- That sounds very difficult.
- That’s great! I bet you’re feeling pretty good about that.
- I can imagine that this might feel...
- Anyone in your situation would feel that way...
- I can see that you are...

Kleinman's Tool To Elicit Health Beliefs
In Clinical Encounters

- What do you call your problem? What name does it have?
- What do you think caused your problem?
- What does your sickness do to you? How does it work?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?


Arthur Kleinman's 8 Questions

1. What do you call your problem?
2. What has caused it?
3. Why do you think it started when it did?
4. What does it do to you?
5. How severe is it?
6. What do you fear most about it?
7. What are the chief problems it has caused you?
8. What kind of treatment do you think you should receive?

The LEARN Mnemonic,
A Communication Tool For Clinicians

- Listen with sympathy and understanding to the patient's perception of the problem.
- Explain your perceptions of the problem.
- Acknowledge and discuss the differences and similarities (of these perceptions).
- Recommend treatment.
- Negotiate agreement (on a plan of care, including therapies and medications).


Crossing Cultures:
Five Simple Steps to Improve Health by Improving Communication

Resources

- Doorway Thoughts: Cross-Cultural Health Care for Older Adults, Volumes 1, 2, & 3
  - Developed by American Geriatrics Society Ethnogeriatrics Committee

  - Available at
    http://www.americangeriatrics.org/publications/shop_publications/

Use of Standardized Assessments

- Depression: Geriatric Depression Scale has been translated into 40+ languages. See www.stanford.edu/~yesavage/GDS.html

- Cognitive Assessment: Many translations of standard measures. Cognitive Abilities Screening Instrument (CASI) developed specifically for assessment in different cultures