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COURSE OBJECTIVES

* Indicate racial/ethnic health disparities among minority groups.
* Identify key terms about various aspects of culture (race and ethnicity, sex and sexism, religion, and social economic status, etc.).
* Recognize various types of discrimination in nursing and healthcare.
* Recognize his/her types of personal privilege (racial, gender, etc.).

Hi, my name is Dr. Sara Smock Jordan and today we’re going to be talking about “Applying Culture to Working with Families and Individuals in Healthcare.” We’re going to do an overview of the course today. We’re going to start off by talking about understanding the major aspects of culture. This includes going over how we define race and ethnicity; the biological versus social construction of race; and the major ethnic minority groups in the United States. We’re also going to talk about social economic status. We’re going to talk about sex, gender and sexism, religious toleration, oppression and power, which include white privilege and racism, and then we’re going to spend some time on racism itself and the health disparities that occur in ethnic and racial minority groups here in the United States.

The goal for this course is for the registered nurse to gain information about aspects of culture, including race, ethnicity, social economic status, sex and gender, religion, oppression and power, including racism as well and how this impacts his/her practice.

Some objectives that we’re going to cover: We’re going to indicate racial and ethnic health disparities among minority groups in the U.S.; identify key terms about various aspects of culture (including race and ethnicity, sex and sexism, religion and socio-economic status); recognize various types of discrimination in nursing and healthcare; and recognize his or her types of personal privilege, whether that’s race or gender.

Why are we talking about culture as it applies to the healthcare system? First of all, systemic racism still occurs in U.S. healthcare and we’re going to talk about specifics. A lot of people understand that racism has happened throughout the years, especially in healthcare,
but it’s still currently happening and there are health disparities for racial and ethnic minority groups.

Research shows that African American, Latinos, Native Americans and Asian Americans receive poorer quality of healthcare in the United States and we’ll talk about those specifics during this course. There are multiple studies that show white patients receiving better treatment than black or Hispanic patients. Racial prejudice still exists today in the healthcare system and we’re going to talk about that more specifically as well.

Religious discrimination still occurs in healthcare today and we’re going to go over some of the major world religions so that you have some ideas about details about their belief system. Belonging to low status, so this could include poor, women, ethnic minorities, and uneducated individuals, causes stress responses that are linked to negative health outcomes. The most important thing is culture affects our daily life, especially our professional life.

Let’s start with culture’s effects on daily life. There are a lot of major things that culture includes in our daily life, personally and professionally, and here’s a list of several: Traditional ideas and related values. Our culture affects how we value things, what our values are individually, what our family values are, what our cultural values within that context or sub context, sub culture; learned, shared, and they’re transmitted from one generation to another. Whether we realize this or not, we teach our children and our grandchildren, our nieces and nephews, everyone around us in younger generations, culture, what’s important to us and that was transmitted to us from a previous generation.

Culture organizes life and helps interpret existence. Culture plays a role in questions like the meaning of life and how we organize our life; our daily practices; when we might get up; rituals or practices we do in the morning; what we do before we go to bed. It also provides identity, beliefs, values, and behavior. It influences how we would identify ourselves, whether that’s racially or ethnically, religiously; behaviors that we may partake or not partake in.

It’s a way of being. It really includes everything from the food we eat or the food we don’t eat to our belief system and world view. And it’s a way social group has learned to respond to life’s problems such as: birth, rituals, death, funerals, weddings, marriages -- all of these different aspects of life that influence culture, are part of our everyday life and part of the people around us that we work with.

We’re also going to talk about comparing cultural paradigms in America. Even though this is a melting pot in the United States, there are several different paradigms that exist within our country and I think it’s important to visit those before we apply those to the nursing and healthcare setting.
The first one is nature and the environment. Different ethnic groups are going to view nature and the environment differently. Asian, Native American, and Latino Americans are going to see harmony with nature. They’re going to want to preserve things in terms of animals and plant life and be one with nature. Other groups such as European Americans tend to have a mastery over nature. It’s what we can create and how we can make nature better. So, there are some differences there in terms of nurturing environment with different ethnic groups.

Time orientation is another important one and I think especially for healthcare professionals. European Americans really orient towards the future. We come with goals; we plan; we talk about where we want to be in five years -- that is more unique to that particular ethnic group. Asian and Latino cultures tend to be more past- and present-oriented. They may talk or focus more on the past, things that have happened to them, or currently what is going on. They may be less likely to think about future and this can apply to health needs as maybe health consequences in the future, or planning treatments in the future for ailments that they may be having.

The third one is people relations. Native Americans and Latino Americans value cooperation, so these patients as well as colleagues and others that you may work with are going to want to work together. They’re going to want to have a team environment and this is very important to know about these ethnic groups. European Americans are encouraged more to compete, so I’m sure in your studies and school, going through a nursing program and being around other health professionals that are being educated, there is this nature of competition: Who is going to get the highest grade, who is going to get the best internship, whatever it might be. So, I think these are important differences to be aware of as well.

The fourth one is work and activity. European, Asian, and African Americans are described more as “doing” than compared to Native Americans who are more described as “being.” Depending on your ethnic background and your cultural background, you may be focused on getting tasks done, being very productive at work, versus maybe being with your clients and sitting there with them and spending time. You may notice that Native American clients, if they come to the hospital or your clinic, may really want you to spend more time with them and be more personable with them.

The last one is human nature. African and European Americans see human nature as good and bad. You’re either born as good or you’re born as bad and you have to make adjustments from there. Asian, Native, and Latino Americans see human nature primarily as good. These are some differences that you might notice with patients in terms of how they see themselves, valuing or judging themselves, perhaps their behavior or their family or the nature of their illness versus others who may see human nature as innately good, may not do a lot of self-blame.
We are going to cover some of the major aspects of culture, now that we’ve done an overview of some basic cultural components. We are going to talk about race and ethnicity, religion, socioeconomic status, and sex and gender.

Let’s first start with race. I think it’s important to define what race is and that there are different views and theories on race. Traditionally, race has been thought of as having a biological basis -- that people belong to certain races because they have certain characteristics that are similar. For example, archeologists would say looking at bones can determine one’s race. That certain races may have certain facial features, larger noses, perhaps different types of hair, maybe curly, maybe coarse, maybe lighter or darker and skin color as well we know is related to race. This has been based on population thinking that groups are based on populations according to race and a lot of the medical community has used this really as a cash cow for pharmaceutical drugs. Research is done on perhaps African Americans showing that they are at greater risk for high blood pressure (hypertension) and so pharmaceutical companies will target this particular group with their ads and advertisements that this certain race should take this type of medication because of their health risks.

We’ll talk a little bit about social construction of race and how that differs in theory, but this has been kind of the basis of the theory or idea of race until more recently. More recent scholars would say that race is more of a social construction. That skin color really varies gradually from latitudinal differences and the intensity of ultraviolet component of sunlight. Those that live closer to the equator -- groups that do have darker skin tones -- and those that live further away from the equator have lighter skin tones. That doesn’t mean if you decide to move to Central or South America that you’re automatically going to have darker skin but we’re talking about evolution of generations that generations living in a certain climate will adapt and, therefore, their melatonin will adapt to that particular climate situation.

Social construction of race also talks about, there’s a social way to categorize individuals into groups so that it’s just easier. It’s not necessarily a biological basis, but it’s easier to put people into groups so we can identify them and perhaps even use stereotypes.

There’s also been found to be more variants within a racial group than between racial groups. We know that from our current research and the human genome is almost 99.9% similar, so there’s actually very little difference between groups and more variation occurs within a racial group or ethnic group than between racial or ethnic groups. There’s also evidence that all humans originated from Africa and theories on this have been challenged here and there more recently but that is part of the social construction of race that we all really originated from the same part of earth and, again, there are scientists that are continuing to challenge that theory.
Based on all of this information, it’s really more helpful as a nurse -- as a healthcare professional -- to refer or ask questions about ethnicity versus race. First of all, race is kind of a loaded term. It has more of a negative connotation than ethnicity and ethnicity is really more accurate. What we’re interested in, for the most part, is understanding where a patient is from; where their ancestors are from. Asking about their ethnicity gets that information more specific and clear versus what race someone is.

Knowing someone’s ethnicity is important because that may help better understand their culture, their values, their beliefs, perhaps even religious orientations, practices, etc.

Now, we’re going to spend a little time talking about some of the major minority ethnic groups in the United States. We’re also going to talk about health disparities for these groups. I want to use a word of caution. I know these groups are categorized, kind of pigeon-holed and there are some characteristics that are common of people in these ethnic groups; however, every person and every patient is an individual and we need to remember that just because someone is identifying and has a history and ancestry of being Asian and they live in America, does not mean that all Asian Americans are the same, that they all have the same customs or belief systems. I do want to use that as a word of caution. This can be a general educational overview of some of the challenges that these groups might face and how to help the health disparities in these particular ethnic groups.

I want to first define what a minority ethnic group is. This is not based on the percentage of individuals who belong to a certain group. Right now in our country, whites or Caucasians are in the majority group, although right now we are numerically in the majority that will change over the next few years. Minority status is more about power and resources. Those in minority ethnic groups have less power and resources than those in the majority group. All cultures throughout the history of time have had groups in power or individuals in power and those that are not in power have fewer resources.

Some characteristics of minority ethnic groups specifically are that they have a pattern, a disadvantage, or inequality. They’ve experienced some type of mistreatment within their culture. Another characteristic is that they share available trait or characteristic. This may be a physical trait or a characteristic from their country of origin. They are also a self-conscious social unit. They are aware that they’re part of a minority ethnic group. This is usually determined at birth, specifically for ethnic groups -- minority ethnic groups -- and historically they tend to marry within their own group; however, more recently, we notice people in this country are marrying those of different ethnic and racial groups. So, that part of characteristic of being in a minority ethnic group has changed over the last few years.
Let’s start with black or African Americans. First of all, a lot of people will think, “Well, someone has darker skin; they appear to be black; I’m going to call them an African American.” Not all people that are black prefer the term African American because their ancestors are not always from Africa or maybe they just don’t identify with being part African. So, black or African American are acceptable terms to use. Sometimes, people think that using black is not politically correct, but some individuals and patients will identify as black versus African American. There are over 45 million African Americans in the U.S. population, so that’s about 15.2% currently.

Some characteristics about African American families are that fathers tend to take a more peripheral role so this might be in childcare, discipline, supporting a family unit (this would be important to know as a nurse), that if you notice, especially if you’re working in labor and delivery, post-partum care, that fathers may or may not be around. It’s more of a matriarchal culture, so mom or grandmother may be in charge of discipline, taking care of the kids, making decisions, etc.

They are often suspicious of professionals. What you know from the history of this country and the treatment of African Americans and black individuals is that there has been a lot of racism and continues to be racism. This is something to know and be aware of as a healthcare professional that they may be suspicious and it may take time to build trust with them. Couples tend to stay together for life, although they’re not necessarily monogamous. Over the last few years, we know that rates of HIV (human immunodeficiency virus) in African American or black women have increased, partly so because they will stay married to their husbands, but their husband may go outside of the marriage and bring an STI (sexually transmitted infection) into the marriage, specifically HIV. So, that is something that’s more of a current trend, but to know that if they’re together, they usually stay together for life.

Religion is a major influence for black or African Americans. This is important to remember as well when working with this group.

Here are some health disparities for this group. They have the highest rate of heart disease and stroke compared to other ethnic or racial groups. Obesity in African American women has the largest rates when compared to Mexican women. Diabetes is prevalent; the prevalence is twice as large when compared to white adults. Infants of African American mothers have the highest death rates. African Americans have had the highest homicide rates since 2009 and, again, I mention HIV, the highest rates of HIV when compared to other racial
and ethnic groups and what’s noticeable is they are prescribe less HIV treatment medication than their white counterparts. We’ll talk about racism and healthcare later on, but this is definitely something to be aware of.

The largest rates and deaths are from colorectal cancer, when compared to other ethnic and racial groups. These health disparities all come from the Center for Disease Control [and Prevention] (CDC), as recent as 2014. As I previously mentioned, the population thinking puts groups into racial or ethnic groups and then says they’re at higher risks for this or that. Again, using a word of caution, just because a patient of yours is black or African American it doesn’t mean that these things may fit. However, research has shown, when we specifically look at individuals and how they identify ethnically and racially, these are some of the health disparities that we find.

Caribbean societies: This is a group of individuals who may appear black, but actually come from Caribbean society. They have some similarities with African Americans or black individuals. They are close with extended family; non-blood family members are often given family names, identifiers like Aunty and Uncle; they have a strong religious and spiritual value system; educational orientation is important as well as work. But it’s important to know that those from Caribbean societies do differ from black and African American individuals.

Here are some differences: More are first generation immigrants, so perhaps one adult in the family comes to the United States and establishes work and residency and then others may come. They also have different stereotypes. They tend to be good and industrious black individuals – they are given that label. And there are some gender paradoxes. Men may have more than one family with children, so if you’re working with someone who has darker skin and you would maybe label them African American or black and you notice that they meet some more of these identifiers or characteristics, I would ask, I would always ask where they’re from; where their ancestors are from; where they’re originally from ethnically.

Latinos: We’re going to talk a little bit about this particular ethnic group. Nations were originally, these were nations originally conquered by Spain, except Brazil who was conquered by Portugal and that’s why they speak Portuguese. They’re the only country in South America that doesn’t speak Spanish. Fifty-four million Latinos currently reside in the United States, which is about 17% of the population. Of course, this is always increasing and rising and changing over the years. They share a deep connection to extended family, so if they’re in the hospital or they’re having a doctor’s appointment, you may notice that they bring family members more so than other ethnic groups. Catholicism tends to be a major religion with this particular group. “Machismo” is actually a term that was developed by American feminist scholars to describe behaviors in Latino men that are characteristic of taking care of, especially the women and their family. This term “macho” that you’ve probably heard from, is derived
from this wood. Immigration is a big issue with Latinos and Latino Americans as well as discrimination and racism.

Here are some of the different terms that Latino Americans may use. This encompasses a lot of people from a lot of different countries and they don’t all prefer the same term, so it’s important to be aware of some of these. Some of these you may have heard of and others you may have not, but it’s important to realize that just because someone appears to be Hispanic or Latino, that they may not identify that way.

There are some Latino health disparities. First of all, obesity for female Mexican Americans is greater than white, non-Hispanic females. Diabetes, periodontitis, higher rates of HIV than white adults, and teen birth rate is twice the rate of non-Hispanic whites. These are all things perhaps to consider or to screen for if you’re working with Latino or Latina patients.

American Indians and Alaska Natives: So, 5.2 million or only 2% American Indians and Alaska Natives reside in the United States. Their religion is very different from other ethnic groups because it’s so integrated into their lives that it’s really difficult to know when the religion begins and when it ends — it is just all-encompassing of whom they are. In terms of defining their religion, they may not have a specific word or definition of what their religion is called and it may vary from tribe to tribe, their practices. There is not one universal religion and so just being aware that their belief systems, their practices, everything about what we would define as religion is just so interweaved with who they are as a person, it may be hard for them to define that specifically. It has a focus on nature which goes a lot with the nature and environmental component of culture that we talked about earlier. Sometimes, they’ll take hallucinogens to create greater insight and communicate with the Gods and if a Native American, American Indian has a card, they are allowed to use these types of hallucinogens in their religious ceremonies and services. Shaman and medicine men communicate with the Gods and that’s important for healthcare workers to know, that they may have visited or worked with a Shaman or medicine man or find that to be an important part of their healthcare that they would like to continue.

Health disparities of American Indians and Alaska Natives: The prevalence of mental health disorder over a lifetime, especially for American Indians is 70%, that’s very high. Suicide is also very high among American Indians and Alaska Natives and it tends to be the highest for adolescents and young adults, of any other ethnic group. Substance abuse has high rates of binge drinking behavior, highest compared to whites and non-Hispanics, and also this group has the highest rate of smoking, although there has been some decline in recent years. They have the highest rate of drug-induced deaths when compared to other racial and ethnic groups. A lot of preventative things here with substance abuse that nurses and healthcare providers need to be aware of, as well as prevalence in mental health disorders and potential for suicide.
Asian Americans: This group has kind of been termed as the model minority because their disparities as well as their challenges, perhaps, aren’t as great as some other ethnic groups, but they are still considered to be an ethnic minority group here in the US and they have experienced disadvantage over the years. 18.2 million Asians, including those with more than one race have been identified, but people that identify as only Asians make up 14.7 million of the U.S. population. As you can see the Chinese, Philippine, Asian Indians, Vietnamese, Koreans, and Japanese are the largest groups of Asian Americans. This is the largest ethnic minority category because so many countries fall under Asian American.

Again, they are considered the model minority. This has to do with their culture and the collectivism. They want to fit in; they don’t want to swim against the flow. They want to do what they are told and they don’t want to stand out because they represent their group and their family. The way they look, speak, and dress tends to be conforming and so you’re not going to... they won’t have as much of a chance to perhaps make a stink about something or stand up for something perhaps based on their culture.

They have non-Judeo Christian beliefs, so these are some of the things that might be helpful to remember when you’re working with Asian Americans, that they can be offended by Judeo Christian beliefs or assumptions that they would want to follow this belief system. Family members are highly dependent on one another. They tend to have male-dominated families, so even an older son may have more power in the family than a mother and, as nurses, that’s important to know if you’re delivering healthcare to an individual and the family is present, that even an older son may have more say than the patient’s wife.

Reserved emotion expression and internalization of strong feelings: So, they may develop more diseases and mental disorders in which they are holding things in, emotionally, versus being more reactive emotionally. Health disparities of Asian Americans and Pacific Islanders: In 2010 Asian American women over the age of 18 were least likely to have had a Pap test compared to other women. Again, this is important in terms of preventative health. The leading causes of death in 2010 were cancer, heart disease, stroke, unintentional injuries or accidents, and diabetes; but these rates are lower than other racial or ethnic groups. Again, although these were the leading causes, again, this is model minority group because of their diet and their conduct and behavior; they often have less health disparities than other groups.

Young Asian Americans and Pacific Islanders had acute Hepatitis B incidents that were 1.6 times greater than their non-Hispanic white counterparts in 2008. So, this rise of Hepatitis B in this young adult population is important to be aware of as well.

Now, we’re going to talk about social class. These are some of the common issues associated with those of low socioeconomic status. As you can see from the list here, a lot of
these you may be aware of: Obesity, preventative health problems, substance abuse, legal problems, housing issues, lack of access to resources, mental health problems, social impairment, emotional impairment, slower learning capabilities, depression, disease and disability, and teen pregnancy.

I’m going to spend a little time on Affordable Care Act (ACA) -- prevention in public health. This is obviously a new wave in healthcare and it impacts the services that we give and those that are helped and I just wanted to point out here that the U.S. National Prevention Strategy strategic directions and priorities are listed as including: healthy and safe community environments -- creating those; clinical and community preventative services (preventative care for low SES individuals); empowering people; trying to eliminate health disparities among low income groups. And the priorities really go along with these strategic directions: really promoting tobacco free living; prevention of drug misuse and excessive alcohol use; healthy eating; active living; injury-free and violence-free living; reproductive and sexual health; mental and emotional wellbeing. These all really meet the health disparities that we just went over for ethnic minority groups. A lot of times people in ethnic minority groups are in lower socioeconomic status groups as well -- not always, but sometimes. So, you’ll see that these strategic directions and priorities really help in terms of prevention in public health.

We’re going to talk a little bit about class privilege and these class privilege examples are modifications from Peggy McIntosh’s White Privilege examples that we’ll talk about later, but I wanted you to look over these. One of the reasons that this is important is because, as a healthcare professional, whether you realize it or not, as a nurse, you will probably be middle class, maybe middle upper class, depending on your family income and so a lot of these class privileges you will have. The people you are working with will not be in a class privilege situation, they will be low SES (socioeconomic status). I think it’s important to realize what some of these are: I can easily speak with my attorney or physician; if you are of middle class or upper class, people appear to pay attention to my social class; the ‘better people’ are in my social group; I can deny social class privilege by asserting that all social classes are essentially the same. “Everybody just needs to do hard work and they would be able to not be in a poverty-stricken situation.” That’s actually not true. The cycle of poverty has a lot of research over the years to show that it’s more than just ambition and hard work, that there are a lot of other sociological factors that are accounted for that. “I can be sure that my social class will be an advantage when seeking medical help or legal help.” Again, those with more resources, those with insurance are more likely to get care and better care than those that don’t. “If I get offered a job over someone with more experience, it is because I deserve it, not because of social class.” Again, that’s a privilege that those of higher social classes have. And “people are usually careful with their language and grammar around me.” So, if you perceive someone’s social class to be middle or upper class, you may speak using more proper language; you may
be more professional with them than someone who is being addressed from a lower social economic status.

We’re now going to be talk about sex, gender, and sexism. It’s important to define the difference between sex and gender. A lot of times these two get combined or confused. Sex is the biological differences between men and women and there are several ways to look at those biological differences: Hormones, chromosomes, etc. There is also gender. This is the social and cultural meaning attached to femininity or masculinity. What’s feminine, what’s masculine; what do women do, what do men do? You can see gender is on a continuum. It ranges from masculine to gender neutral to feminine and so any one of you, as a nursing professional, can range in any part on the continuum, just like your patients may. They may present one way, but biologically they may have male body parts, but present very feminine. So, some terms that are important to use or to be aware of, that these individuals might be gender variant or transgender which is a broad umbrella of terms used to describe people which their sex and their gender don’t always match up. Cisgender is a term we use that describes those that are born of a particular sex and their gender matches up with that sex: So, born a woman and being feminine, that would be someone who is cisgender or being born with male parts/hormones/chromosomes and presenting themselves as a male -- that would also be considered to be cisgender. Most individuals are cisgender or some variation of that or more gender neutral and then a small part of the population would be considered gender variant or transgender.

Sexism is the subordination of an individual woman or group of women and the assumption of the superiority of an individual man or group of men based solely on sex. I’m sure in healthcare you’ve noticed that sexism comes out quite a bit, whether it’s in nursing or physicians, with aides -- whoever it might be, that sexism can play a really big role. There are different types of sexism that we’re going to cover today: Ambivalent sexism which includes both “hostile” and “benevolent” prejudice towards women.

So, hostile sexism is what we typically think of when we think of sexism -- people making derogatory remarks, usually towards women; this view of women as trying to control men through a feminist ideology or sexual seduction – “It’s the woman’s fault that she was raped because look at what she was wearing.” That’s an example of hostile sexism. Some other examples are “women seek to gain power by getting control over men” or “most women interpret innocent remarks as being sexist.” These again, are more blatant forms of sexism that most people would recognize.

Benevolent sexism, though, is different. It’s more about actually women being put on a pedestal or women being taken care of. A lot of women may not see this as sexist because it seems favorable, specifically to women. Chivalrous attitude towards women seems favorable,
but is actually sexist because it casts women as weak creatures in need of men’s protection. Examples like: “Women should be cherished and protected by men.” “Many women have a quality of purity that few men possess.” And “A good woman ought to be set on a pedestal by her man.” In some cultures, ethnic groups, and religions, actually adhere to this and value this as part of their belief system. It’s very important to realize that not only our western culture feminist ideology would say that this is considered to be sexist, that a lot of individuals and groups actually promote this, including women and so this is very important to realize, as a healthcare professional.

Gender bias and sexism in healthcare: Here are some examples of some biases and sexism that occurs. Gender bias in healthcare is largely a result of gender bias in the generation of knowledge. So, how knowledge is generated from the top down; from researchers -- medical researchers; and we get information about women’s needs and women’s issues. Women are more likely to be prescribed anti-anxiety drugs, sleeping pills, and medication for mental health problems than men. So, it’s this idea that women are more anxious or have more mental health needs than men and so, therefore, we would prescribe them more medication. Women experience problems related to equality and quality of healthcare as it regards to access to specialists, one consequence of which is the increased prescription of symptomatic treatments. Again, women are more likely to probably see their nurse or nurse practitioner/physician than men, but they also experience inequality in regards to the quality of healthcare that they receive.

Now, we’re going to talk a little bit about religion and how this plays into culture and understanding your patient. Religion plays a role in how we treat other people; how we live our lives; how we fulfill family roles; how we behave sexually or not, or abstain; how people dress; and how they eat, in terms of their diet and how they prepare food. Religious toleration is a term that is described as the condition of accepting or permitting others’ religious beliefs and practices which disagree with one’s own. For most of us, perhaps, we have religious or spiritual beliefs and a lot of times we work with patients who have very different religious or spiritual beliefs. Religious toleration doesn’t mean that, “I’m just going to accept your beliefs as my own”, but it says that “It’s okay that we disagree and that I’m going to honor your beliefs the best that I can within the context of being a nurse.” One example is “Healthcare employees are not permitted to use their own religious convictions as a basis to deviate from their employer’s legitimate expectations that policies and procedures will be followed.” It is not appropriate for a nurse to impose their own values or religious beliefs upon a patient just as we should honor each patient’s religious beliefs to the best that we can.

An example of intolerance in nursing is that the EEOC (Equal Employment Opportunity Commission) sued Shade Crest Healthcare for religious discrimination and retaliation. They
actually had a nurse who was wearing a headdress and the nursing home prohibited religious headwear and fired the worker in retaliation of the federal agency charge so they were sued for this. Again, it’s important not only for nurses and healthcare professionals, but for institutions and agencies to realize that discriminating based off religious beliefs is not constitutional.

Here are some characteristics of all religions. First of all, all religions, for the most part believe in a supernatural being or beings; they have an organized set of beliefs; and set of rituals used to gain order over oneself and one’s social environment.

I’m going to go over a few basic principles of some of the major world religions so that you’re aware, if your patient’s identify from one of these religions or belief systems, some of the values that they may possess, or beliefs. Hinduism believes that there’s a unity of everything. They have a caste system which categorizes people in terms of those with more power and resources and abilities and finances than others. They also talk about having enlightenment and this has occurred through going through cycles of birth and death and this is measured by karma, so depending on past lives, their new life is determined in which caste system they may be on, ranked in, is based on karma of past lives.

Judaism is another religion -- a world religion -- where they believe in the inherent goodness of all people and they don’t require a savior for their original sins. A lot of times, Jewish Americans are not recognized as Jewish, perhaps they may be seen as white and maybe there are assumptions made there that they’re Christian or that they come from another faith group, but it’s important for Jewish Americans and patients to be recognized as coming from this group.

Buddhism, while there are different forms of this, reincarnation is a very important part of this religion. They do go through lifecycles of birth and death and karma does affect reincarnation to the next life. They don’t believe in any type of God or need a Savior, prayer, or believe in eternal life after death. They believe that you are reincarnated and this is based on karma, similar to Hindu beliefs.

Shinto is a Japanese religion and it’s closely tied to nature. It believes in various nature deities.

Islam is another faith that was founded by the prophet Mohammed. Muslims follow a strict monotheistic religious belief system in which there is one creator who is just omnipotent and merciful. Drugs, alcohol, and all illicit substances of any type as well as gambling should be avoided and they strongly reject the idea of racism.
Sikhism is another religion that is becoming more prominent in the United States and this is the belief in a formless God who can be known through meditation. Sikhs pray many times a day and are prohibited from worshiping idols or icons. A Sikh also believes in karma and reincarnation, but they reject the caste system that the Hindus believe in.

We’re now going to talk about oppression and power and how that relates to ethnicity, gender, sex, as well as socioeconomic status. Let’s give some examples first of oppressed groups. These can range from people of various sexual orientations and gender representations; people of color; ethnic, minority groups; physically or mentally challenged individuals; those that are uneducated; poorly educated or low income; women; young and elderly individuals; atheists; and religious minorities.

Let’s talk about reducing some oppression. First of all, it’s important to become aware of our own racism and role in oppression, so recognizing how white privilege leads to oppression and segregation, which we’ll talk about some white privilege examples; become aware of our learned assumptions and behaviors that contributes to oppression; and learn to separate ourselves from oppressive assumptions. White privilege goes hand in hand because 87% of nurses in the U.S. today are considered to be Caucasian or white, so there’s a lot of privilege that we have being white that will carry over into our professional roles as nurses and healthcare providers.

Here are some examples of white privilege taken from Peggy McIntosh’s book chapter called, “Unpacking the Invisible Knapsack.” Those that are white can be pretty sure that their neighbors in such a location will be neutral or pleasant to them, because of their skin color; they can go shopping alone most of the time and can be pretty assured that they won’t be followed or harassed; they can turn on their television or look on the front page of the newspaper to see people of their race widely represented; when white people are told about our national heritage or about “civilization”, whites are told that people of their color made it what it is; those that are white can be sure that their children will be given materials that testify to the existence of their race; and if you’re white, you can use checks, credit cards, or cash and they can count on their skin color to not work against them in the appearance of financial responsibility; white people are never asked to speak for all whites, like other people are of their particular minority racial ethnic groups; and whites can be pretty sure that if they talk to the person in charge, that they would be facing someone of their particular race.

These are all examples of white privilege and it’s important to talk about that first before we talk about racism. Racism includes prejudice and several types of discrimination. Prejudices are our thoughts that we have about particular groups, stereotypes, perhaps, and we all have prejudices. Discrimination is actually the behavior that we do. We may discriminate against someone based on our prejudices or just, we may be asked by our
employer or someone else to pick someone because they are an ethnic minority, even if we
don’t believe they’re better suited for a job.

Defining racism: Racism is the belief that objective or alleged differences between racial
groups are justification for asserting the superiority of one racial group over another. This is not
just, “I think one group is better than another”, it’s actually a justification for asserting
superiority, power. So, for racism, a group that is in power finds that they need to assert their
power over another group and that is considered to be racism. There are two types: one is
individual and one is institutional. Individual racism occurs within an individual person and an
institution type of racism means that an institution has policies or procedures that are innately
racist in nature.

There was a study done in 2000 where they interviewed undergraduate students about
racism and they found that today’s white individuals or Caucasians expressed their racial views
in a more sanitized way than they would have several decades before. It’s considered in our
society not okay to be racist, even though a lot of people still are racist and behave in such a
way. They did an interview and they also completed a survey. What they found that was
interesting in their study, and I think really applies to everyone, especially in healthcare is that
there were discrepancies in their reports. When they were asked about interracial marriage on
a survey, 80-90% of people approved of those in different ethnic or racial groups intermarrying.
When they interviewed them, only 30% approved and so individuals might say, “Well, I
wouldn’t do that, but it is okay if other people do that.” That is considered to be a more
sanitized way to say, “I wouldn’t marry someone of another group because I don’t agree with
that or I don’t think that’s right, but someone else can do that.” That is still considered to be
racist, but people would say, “I’m not racist, but I wouldn’t do that.”

Whites say that blacks use discrimination as an excuse and they really need to work
harder and complain less. The participants really showed racist views but when they were
interviewed, in their survey they were more accepting, but when they were interviewed about
how that would pertain to them in particular and how they make decisions about their
life, they
still tended to have more racist views.

The history of racism in the medical field is the next area that we’re going to talk about.
The first half of the 20th century, black women were victims of involuntary sterilization and
hysterectomies. You’re probably aware of the Tuskegee Syphilis study in 1932 and this tested
the untreated effects of syphilis in men. Giving men syphilis and then not giving them
treatment and then testing the effects postmortem of syphilis on men. They targeted African
American men or black men because they were not able to always read, they were uneducated,
so they didn’t really know what they were signing up for and they took advantage of this group.
In 1939, the Negro Project involved early birth control that was tested in the black population, so these pills were given to black or African American women and they had high amounts of hormones that caused risks for hypertension and stroke. IUDs (intrauterine devices) were silent killers due to infection that they used this particular racial group to test their birth control project on.

In 1951, a black woman was treated at Johns Hopkins, originally for cancer. They stopped her radiation treatment and used antibiotics because they believed she had a venereal disease. Her cells were examined without her consent and later used for developing the polio vaccine and it was not until 1970 that she was recognized, but her children still have not received compensation, even after her death, for this discovery.

Examples of current differential racial treatments: So, you may say “Historically, yes, we’ve had a history of racism in this country, especially in the field of medicine”, but these are some current examples. Some clinical trials are set up to automatically exclude women of color. In breast cancer studies, for example, most research is done on the estrogen-positive form of the disease and not the estrogen-negative form common among African American women. The research that’s actually being done is not addressing the needs of African American women.

A study of emergency room care found that predominantly black children with sickle-cell disease got less attention to pain than non-black, apparently mostly white children with bone fractures. So, discriminating treatment, again, based on perception of pain, from skin color.

Another study found that black patients on Medicare, with circulatory problems were much more likely to have a leg amputated than their white counterparts.

Black patients are less likely to receive kidney transplants than whites and black patients with lung cancer are less likely to receive the best surgical treatment than white patients. These research findings and studies are not that old and it’s really astonishing that differential racial treatments still occur in healthcare today.

For the last part of our course, we’re going to talk a little bit about tips on working with racism. First of all, it’s important to be aware of your own prejudices and biases so that you don’t discriminate in the work force. It’s important to become culturally-sensitive and knowledgeable of different ethnic groups: Things such as asking someone’s ethnicity versus someone’s race; becoming aware of religious and culture practices in particular groups is important; as well as differences with each individual -- that each individual patient is their own person and to be knowledgeable and aware. Asking questions is always helpful and important.
Being aware of society’s races and practices and victims to it, so I shared some research on racism, racial differential treatments that are still occurring, and I think it’s important to be aware of those; and how your patients may be affected by that and what you can do to help bridge the gap there with those health disparities. Being sensitive to peoples’ experience of racism, so some people may have personal experiences of racism and others may suffer from this intergenerational transmission of racism in which they hear from their parents, their grandparents, perhaps even their great-grandparents, what it was like firsthand to be segregated, to be treated differently, but even today, lots of individuals, minorities, people of color have experienced racism firsthand and so they may be skeptical, especially if you’re a white nurse. That’s very important to remember.

Realize our own forms of racism: The study that I shared about “I’m not racist but...” If you start a sentence with that, that’s probably not a sentence that you should finish, especially in a professional setting. Being very aware of that and if you are racist, if you do have racist views, to be very aware to check those and perhaps to have an environment where you have colleagues who can be helpful with that, so that you don’t cause harm or health disparities to your patients.

Accept differences due to race, so understand that although there are ethnic racial differences that it’s important to realize that people’s experiences as well as their cultural differences are going to vary. Understand that people have been hurt because of racism. A lot of times, people in a majority position, or white people will say, “Well, they’re just playing the race card; they’re upset, they think they’re being discriminated against.” And it’s really important to realize that if you’ve not been in that situation -- if you’ve not been in their shoes - - if you’re not part of an ethnic minority group, that you really don’t know what their experience is, or their group’s experiences. And be sensitive to that hurt -- maybe having frank conversations with patients, if you realize there’s some resistance with a patient, maybe it’s due to race. Maybe you can ask them what they’d feel more comfortable with, getting to know them, spending a little more one-on-one time with that patient, to be able to create a bond and a trust. Hopefully, that will increase better patient outcomes, adherence to protocols and medications.

Thank you again for watching this course on “Applying Culture to Working with Families and Individuals in Healthcare.” It’s been a privilege to share some of this information with you today and I hope it impacts your patient care and creating a lesser gap in disparities in cultural groups.

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