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Cultural Sensitivity Beyond Ethnicity: A Universal Precautions Model

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Abstract

Cross-cultural healthcare research has grown exponentially in recent years, focusing primarily on the healthcare-related needs of ethnic and linguistic minorities. However, by approaching cultural sensitivity from an ethnic/linguistic perspective, the practitioner runs the risk of relying on essentialized or stereotyped accounts of cultural groups, as well as overlooking the needs of other groups (e.g., gays, elderly, physically challenged) that may validly be viewed as “cultures” and profitably studied with the tools of cross-cultural scholarship. This essay argues that Hofstede’s paradigm of cultural dimensions can serve as a useful foundation for providing culturally sensitive care following the model of Universal Precautions as a metaphor.

Introduction

The growing linguistic and ethnic diversity in the U.S. has increased the healthcare community’s awareness of the need to provide service in the presence of significant cultural diversity. Cultural differences between care recipients and providers frequently result in problems such as increased patient acuity, duplicated diagnostics and other unsatisfactory outcomes.^{1,2} In response, practitioners have sought to improve their sensitivity to cultural difference and to articulate standards of culturally appropriate care.^{3,4}

The question arises as to how practitioners can best learn to provide culturally sensitive care. One possibility is to educate providers about the health related practices and values of cultural groups most frequently encountered in clinical practice. Although this approach provides in-depth knowledge of specific cultural factors that can disrupt or enhance appropriate care to a particular patient population, it also requires decisions about which groups to include or exclude from consideration. A further concern is that such learning is never complete: a cultural group’s practices change over time, differ among sub-groups, and vary regionally.

Universal Precautions in cultural competence

Rather than making tightly focused, culture-specific learning the center of intercultural health curricula, practitioners can be sensitized to factors that universally influence cultural behaviors, following an approach similar in principle to the Universal Precautions model. As a tool for promoting infection control, Universal Precautions calls practitioners to approach all patients as if they were infectious for blood borne disease, and to act conscientiously to avoid contamination.⁵ This principle has recently been adopted in health literacy, urging practitioners to assume that all patients require health teaching.⁶ Similarly, Universal Precautions provides a useful model for culturally appropriate care: rather than focusing on the specific characteristics of a given culture, this model urges practitioners to structure their care on the assumption that cultural differences exist in every clinical encounter, and must be conscientiously addressed through assessment and care plan management.

Using the Universal Precautions model in practice requires a reliable general cultural assessment method. One of the most influential scholars of intercultural communication, Geert Hofstede, has articulated four primary parameters of cultural difference, or cultural dimensions that provide a

basis for such a universal cultural needs assessment.⁷ Using Hofstede's cultural dimensions within a Universal Cultural Precautions approach allows practitioners to apply principles of culturally appropriate health care to groups not traditionally identified as "cultures," but who nevertheless share beliefs, values and practices: groups as diverse as the obese, the disabled and the elderly. A further advantage is that by attending to common dimensions of all cultures, practitioners can avoid essentialism, i.e., the oversimplified or stereotyped conceptualizations of culture that can lead to erroneous assumptions about clients' health-related beliefs.

Cross-cultural research in health care

Practitioners seeking to provide culturally sensitive and socially equitable health care can draw upon a broad foundation of medical, sociological, and ethical scholarship, consistent with the fundamental commitment to holistic, individualized care to those in need. Such care reaches beyond the categories of ethnicity, language, and religion to capture the uniqueness of each client. The traditional cultural categories of ethnicity and language discussed in the cross-cultural literature can be a starting point, but not an ending point. Thinking of a client as "Asian" or even "Taiwanese" provides an incomplete picture if other important characteristics such as gender, age, education, geographic location, employment, and marital status are not considered.

Cross-cultural research suggests that individuals have membership in multiple cultural groups. Hofstede defines culture as "any human collectivity or category: an organization, a profession, an age group, an entire gender, or a family"⁷ (p. 10). Such groups within cultures may be referred to as subcultures or co-cultures. Co-cultures, like dominant cultures, possess values, practices, and beliefs that distinguish them from other cultural groups. Following Hofstede, medicine itself constitutes a co-culture.

Hofstede asserts that each culture and co-culture is characterized by a visible system of *symbols, rituals, and practices*, as well as intangible *values*. Symbols are used intentionally to reinforce group cohesion and identity. Because they tend to be visible, they give clues about an individual's cultural affiliations. However, symbols must not be confused with values, which Hofstede characterizes as "feelings with arrows to them" pointing toward polarities such as good vs. evil, or normal vs. abnormal⁷ (p.6). For example, in using the *symbol* of the headscarf, a Muslim woman may express a variety of religious, cultural, or political *values*.⁹ Formed early in childhood, values are not rational constructs (although they determine what we define as rational and irrational). Because they are not bounded by rationality, individuals may simultaneously hold conflicting values (e.g., "cookies are unhealthy and undignified," and "cookies are delicious and fun").

An important contribution of Hofstede's research is the acknowledgement that groups such as homosexuals, vegetarians, and the physically disabled represent co-cultures with characteristic practices and values. This awareness is particularly useful when addressing clients' wellness needs. By understanding that vegetarian and diabetic clients are excluded from the dominant culture by their inability to share in the potent cultural symbols of Thanksgiving turkey and Halloween candy, practitioners can provide culturally competent care that surpasses simple nutritional information.

Hofstede and Culture's Consequences

In the course of his three decades of work with organizational and national cultures, Hofstede has identified four primary dimensions of cultural difference: *power distance, uncertainty avoidance, individualism, and masculinity*. These dimensions represent four separate but interdependent continua along which culturally influenced attitudes of both nations and individuals can be assessed concerning such clinically important issues as authority, emotional display, and the appropriate roles of individuals in family and society. Hofstede's work has been used in psychology, in the comparison of ethnic groups' attitudes to clinical care, and as a method for coordinating work of health care professionals.¹⁰⁻¹³

A basic familiarity with Hofstede's dimensions can enable practitioners to efficiently gather the information necessary to formulate culturally sensitive and appropriate plans of care for their individual patients. Rather than restricting their thinking to the health-related practices of specific cultures, practitioners can reflect on four general paradigms that function as continua upon which to place individual patients in order to better understand their needs. The four parameters and their relevance to the clinical encounter are discussed below.

Power distance

Hofstede defines *power distance* as "the extent to which the less powerful members of institutions and organizations within a country expect and accept that power is distributed unequally"⁷ (p. 98). At the heart of power distance is the question of inequality within the social hierarchy. High power distance cultures are found in Arab countries, Latin America and Malaysia. Israel and European Union countries, especially Scandinavia, are among the lowest power distance cultures. Cultures with *low power distance* emphasize equality between actors, deemphasizing individuals' social rank during interpersonal interactions. Open, frank debate may be encouraged despite differences in social status. Status markers are minimized, e.g., adults may address each other by first name, regardless of rank.

While healthcare practitioners may view social inequality as

inherently negative, it must be noted that social structures that enforce inequality provide stability and predictability: when one knows the "pecking order," one always knows the proper way to behave. Thus, displays and signs of social status are particularly important for *high power distance* individuals. Those in high power distance cultures tend to be comfortable with a steep ladder of hierarchy, presuming those above them as worthy of respect. Such respect comes at a price for the social elite, however: within high power distance cultures, low-status members may expect care and patronage from social superiors. Furthermore, superiors are frequently blamed for social dysfunction, while personal responsibility is de-emphasized for the lower-status groups.

The culture of medicine shows a mixture of both high and low power distance behaviors. Consistent with high power distance culture, doctors, nurses and aides each have specified codes of dress, conduct, and competencies, all of which contribute to stability and predictability within the clinic. On the other hand, such values as patient autonomy and informed consent resonate with the values of low power distance, in which lower-status members may enter into discussions on a relatively equal footing with superiors.

Patients' expectations for high vs. low power distance behaviors can be crucial for the success of the therapeutic relationship. Practitioners who downplay power distances in the effort to create a more equitable, collaborative environment may unintentionally increase distrust in patients with high power distance expectations. Hofstede reports that those in lower status positions appear more concerned with social hierarchies than better educated, higher-status members of a society, who may tend to downplay power distances. This factor may be especially significant when patients are experiencing increased vulnerability due to illness and the unfamiliar clinical setting. Conversely, however, patients from low power distant cultures may experience distress when they find their status as "patient" restricts their independence or access to high status health practitioners.

Uncertainty avoidance

The parameter of *uncertainty avoidance* refers to the amount of effort an individual is willing to invest to maximize the probability of obtaining a desired outcome or reduce unexpected events. To cope with uncertainty, individuals may adopt such behaviors as dependence on authority, intolerance of ambiguity, traditionalism, superstition, rigidity, and ethnocentrism. While such behaviors can be productive (by reducing anxiety associated with uncertainty, energy is freed for creative pursuits), Hofstede warns that these proclivities can also "destroy people's autonomous judgment"⁷ (p. 147). Belgium and Greece are highly uncertainty avoidant, as are many Latin Americans countries. In contrast, cultures and

individuals with low uncertainty avoidance (prominently, Jamaica and Hong Kong) are more tolerant of risk and diversity of opinion, and live by fewer rules.

Significantly, Hofstede draws a distinction between anxiety and fear of risk (p.145).⁷ He notes that the uncertainty avoidant seek to minimize anxiety in "a situation in which anything can happen and one has no idea what. As soon as uncertainty is expressed as risk, it ceases to be a source of anxiety. It may become a source of fear, but it may also be accepted as routine" (p.148).⁷ The culture of medicine, with its concern for reducing patient injury and empirically evaluating the efficacy of treatment, tends toward the higher end of the uncertainty avoidance continuum. Even across cultures, healthcare workers demonstrate high uncertainty avoidance relative to laypersons.¹⁴

Hofstede found that those with high power distance scores tend towards high uncertainty avoidance as well. Thus, it would be reasonable to predict that a patient who demonstrates preference for high power distance (e.g., using titles and other shows of respect to the practitioner) may prefer explicit directions and detailed explanations about an upcoming procedure. Conversely, a low uncertainty avoidant client may be irritated or made anxious by detailed directions.

Hofstede offers several comparisons between low and high uncertainty avoidance that have relevance to patient care. Lower uncertainty avoidant individuals are more inclined to read books, newspapers and the Internet, and use more processed or convenience foods. Higher uncertainty avoidant individuals aren't willing to take chances with their nutrition: they're more inclined to spend money on "pure" foods, such as bottled water, fresh fruits and vegetables. They also prefer clearly defined values and practices: experimental drugs hold little appeal compared to accepted treatments. Other observations made in educational settings are relevant to health care: instructors in low uncertainty avoidant environments seek dialog with students. "I don't know" is an acceptable statement.

Predictably, this contrasts strongly with high uncertainty avoidant cultures, where teachers are expected to have answers. Similarly, high uncertainty avoidant groups value leaders who can control uncertainties, are visibly involved in operations and management, and preside over a clear and well-ordered hierarchy. Low uncertainty avoidant workers prefer leaders who formulate strategy, but are less concerned about who carries it out. (p. 169-170).⁷ This could have relevance for patient satisfaction in health maintenance organizations, where patients may be cared for by a number of different practitioners in the course of a single illness.

Individualism and collectivism

This dimension focuses on the relationship between an individual and the groups (e.g., family, work, society) of which he or she is a part. Collectivism is that end of the continuum where the group is viewed as the fundamental unit of society, while at the other extreme, individualism, the single person is viewed as central. Individualist culture places high value on the rights of the person to autonomy and self-determination, as well as responsibility for decision-making, personal wellbeing, and happiness. The U.S., Great Britain, and Australia are by far the world's most individualistic cultures. Collectivist cultures, in contrast, expect a high degree of emotional and material interdependence among its members, and social disruption can result when the group cannot assume responsibility for the welfare of its members. Pakistan, Latin American and Asian cultures, score the highest in collectivist attitudes.

Medical culture itself is based strongly upon the individualist values of autonomy and self-determination. Even as students, doctors and nurses are encouraged to develop independence and responsibility for personal action. Hospital policies likewise reflect individualist values: the practice of informed consent, for example, is predicated on the assumption that patients are independent agents responsible for their own decision making, unless some exigency forces them to exercise this right indirectly through their appointment of health care proxies and durable powers of attorney. Clinical routines also value patients' individual privacy over social support. Patients are frequently separated from family members and significant others when they enter the treatment process, a separation that becomes progressively more pronounced the further the patient advances from waiting room to procedure room, with the effect that the patient is most likely to be isolated from trusted others at times of highest anxiety (e.g., waiting in pre-op holding areas).

The contrast between the individualist character of medical practice and collectivist patient cultures is especially significant in the area of decision-making. Although highly individualistic patients may appreciate practices of informed consent and autonomous decision-making, patients from collectivist cultures may be threatened and disoriented by these same practices. As stated, collectivist cultures expect a high degree of interdependence between members of their group, and major decisions are most frequently made through collaboration between several generations of family members. Because U.S. culture tends to be more individualist than any other world culture, practitioners should be particularly sensitive to the likelihood that their patients seek greater interdependence with trusted loved ones than is afforded by current medical protocols and practices.¹⁵ Again, the success of the therapeutic relationship depends on the ability of the practitioner to determine at which end of the

individualist/collectivist continuum the patient lies, to best anticipate the degree to which significant others should be brought into decision-making and other aspects of the patient's care.

High and low masculinity

This continuum is perhaps somewhat anachronistically named, in that it rests upon gender stereotypes no longer as meaningful as when Hofstede first defined it in 1986. *High masculine* cultures value achievement, control, and social power, as well as a high level of differentiation in gender roles. Japan is the most masculine national culture identified by Hofstede. The lowest are the Scandinavian countries, where relatively less emphasis is placed on distinct gender roles, cooperation is valued, and achievement must not come at the expense of interpersonal relationships or others' wellbeing.

Another important characteristic addressed by the parameter of masculinity is attitudes toward science and social progress. High masculine cultures tend to value proactive problem solving and may view science positively as a means for addressing all manner of difficulties. The motto at the high end of the masculinity continuum is "don't just stand there; do something!" Individuals with high masculinity scores tend to embark upon the solution of problems without a clear plan for the ultimate outcome of their efforts, trusting that the solution will reveal itself in the course of action. The motto for those of low masculine culture, in contrast, is "look before you leap." Low masculine individuals show greater willingness to tolerate problems while possible solutions are weighed for their efficacy and unintended sequelae.

Despite the low masculine sentiment of Galen's injunction, "first do no harm," the culture of U.S. medicine nevertheless tended toward the high masculine end of the continuum since the days of Benjamin Rush. In recent years, however, holism, homeopathy, and other patient-centered philosophies have increased awareness of detrimental and unintended consequences of overly aggressive medical care. The cultural conflicts between aggressive, high masculine health care and low masculine folk medicine is captured in Fadiman's account of the treatment of an epileptic Hmong child, *The spirit catches you and you fall down*, a book that has become standard reading in holistic and intercultural medicine courses.¹⁶

Attention to clients' level of masculinity is essential to establishing trust in the clinical interview. Low masculine patients tend to favor cautious "wait and see" treatment, rather than aggressive action that may cause unintended consequences. In contrast, high masculine patients may become distrustful if they suspect that effective treatments are being withheld due to unwarranted caution or economic concerns. As medical treatment becomes continually more

technologically complex, and rising health care costs paradoxically compel us to be more judicious in its use, the quality of the relationship of the patient and practitioner will increasingly depend upon practitioners' ability to assess patients' attitudes toward aggressive, 'masculine' treatment.

Conclusion

As when following Universal Precautions in infection control, practitioners must assume the presence of cultural difference and assess for its potentially disruptive effects in the clinical interview. While careful research will be required to develop Hofstede's cultural dimensions into a comprehensive tool for assessing patients' attitudes toward healthcare, awareness of these dimensions is nevertheless useful in cross-cultural clinical encounters. A cultural assessment based on these four dimensions promises to improve cultural sensitivity in several ways. First, it serves as the underpinning of a Universal Cultural Precautions

approach, allowing the practitioner to attend to cultural differences in each clinical encounter. Secondly, awareness of cultural dimensions is economical, requiring practitioners to attend to four measures, rather than complex generalizations about specific cultures. Thirdly, cultural dimensions permit practitioners to make assessments that apply specifically to their individual clients' needs. Instead of "one-size-fits-all" cultural assessments, a client can be assessed at the moment of the clinical interview, taking full account not only of the client's cultural background, but also membership in diverse co-cultures, e.g., gender, religious affiliation or sexual preference.

Finally, Hofstede's cultural dimensions provide a tool for assessing groups that are not traditionally considered cultures, but share distinctive beliefs and practices – e.g., women, diabetics, Fundamentalists, athletes and any of the infinite diversity of people in our care.

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