Organ Donation Education

1. **Current Statistics:** There are nearly 100,000 people waiting for organ transplants in the U.S. Nearly 5,000 live in New Jersey. Twenty people die every day waiting for an organ. Last year, 12,000 people received organ transplants.

2. **Routine Inquiry:** The *Uniform anatomical Gift Act* requires every health care facility to make routine inquiry regarding each patient’s preference and status with regard to organ donation. The preferred question to ask is, “Have you ever signed an organ donor card?”

3. **Documentation:** The admission database that is completed by the nurse at the time the patient is admitted to a nursing unit includes a prompt to inquire about the patient’s donor status. If a document does exist, it should be copied and placed in the medical record.

4. **Organ Procurement Agency:** Gift of Life Donor Program is our federally designated organ procurement organization (OPO). They recover solid organs, tissue, bone and, in conjunction with the Lions’ Eye Bank, corneas and eyes.

5. **Solid Organ Donors** (heart, lung, liver, kidney, pancreas, small bowel) come from two sources:
   1) patients with devastating neurologic injuries (GCS = 4 or less) who are ventilator dependent and proceed to brain death, or
   2) patients with devastating neurologic injuries who are ventilator dependent but who do not proceed to brain death but their nextof-kin elects to withdraw life-sustaining medical treatment. The second group is classified as “Donors following Cardiac Death” (or “DCD” for short).

6. **Tissue Donors:** All patients are potential tissue donors. Gift of Life Donor Agency should be notified of every patient death, regardless of diagnosis or cause of death, to facilitate request for tissue donation.
7. **Routine Request:** Every death, whether by cardiac or neurologic criteria, must be reported to Gift of Life for appropriate follow-up. If a patient is approaching brain death, or a discussion is beginning regarding withdrawal of ventilator support, a call should immediately be placed to Gift of Life so that evaluation of donor potential can be done in a timely way. The request for donation is made to the next of kin or legally responsible person for every patient who is a potential donor.

8. **Exclusion Criteria:** There are almost no exclusion criteria in place at this time. Cancer that is not limited to the brain would be the most frequent excluding cause. HIV/AIDS, hepatitis, and active infection are all relative criteria.

9. **Donor Patient Care:** Once a potential donor has been pronounced dead by neurologic criteria (Brain Death), the Gift of Life Transplant Coordinator will assume responsibility for guiding patient care. Proper management prior to death is the responsibility of the attending physician in coordination with Gift of Life.

10. **Post-mortem Care:** All post-mortem care of donors is done by the Gift of Life Transplant Staff.

For additional information, please review the following ARMC Policies on our AHS intranet [http://policies.atlanticare.org/armc/Policies/Forms/ActivePolicies.aspx](http://policies.atlanticare.org/armc/Policies/Forms/ActivePolicies.aspx):

- Death, Organ and Tissue Donation (Anatomical Donations) - 867 (formerly 2-265)
- Organ Donation Following Cardiac Death - 877 (formerly 2-265A)
Cultural and Religious Considerations in Organ Donation

The topic of organ donation is viewed differently in different cultures. For the most part, there are very few cultural restrictions or taboos regarding this practice. Most cultures and religious groups see organ donation as an altruistic act that provides a clear benefit to others. However, there are some notable exceptions.

1. **Gypsies do not donate their organs** because their belief is that the body must remain intact so the deceased can travel back through their life to undo any evil they have done in the course of their life. It is believed that the material body of the deceased must remain intact in order for this to be successfully accomplished.

2. Certain **Native American** people do not donate their organs. Their reasoning is a more spiritual view concerning the afterlife. This belief tends to be more strongly held by Native Americans who have not integrated into western culture and who maintain a strong connection to their tribe’s shaman traditions and beliefs.

3. Within the **Jewish** faith, organ donation is usually seen as a “mitzvah” (blessing or good deed) and is generally encouraged as long as everything has been done to sustain a viable life prior to the decision to donate. However, there are some sects and individuals who strongly hold that the body must be buried intact (for this reason amputated body parts are preserved for later burial with the rest of the body).

4. Most **Christian** bodies recognize organ donation as an act of benevolence and are supportive of the practice.

In all cases, the decision to donate or not to donate is a personal choice and while these choices are influenced by culture and religion, they are not dictated or controlled by these influences in every case.

The legal requirements for donation are spelled out in the Uniform Anatomical Gift Act (Amended 2007), NJ Statutes (‘Bark’ Bill) and the Standards of the Joint Commission on Accreditation of Health Care Organizations.

Resources: United Network for Organ Sharing (UNOS) and Gift of Life Donor Program.
The American Nurses Association's

Bill of Rights for Registered Nurses

Registered nurses promote and restore health, prevent illness, and protect the people entrusted to their care. They work to alleviate the suffering experienced by individuals, families, groups, and communities. In so doing, nurses provide services that maintain respect for human dignity and embrace the uniqueness of each patient and the nature of his or her health problems, without restriction in regard to social or economic status. To maximize the contributions nurses make to society, it is necessary to protect the dignity and autonomy of nurses in the workplace.

To that end, the following rights must be afforded:

1. Nurses have the right to practice in a manner that fulfills their obligations to society and to those who receive nursing care.

2. Nurses have the right to practice in environments that allow them to act in accordance with professional standards and legally authorized scopes of practice.

3. Nurses have the right to a work environment that supports and facilitates ethical practice, in accordance with the Code of Ethics for Nurses and its interpretive statements.

4. Nurses have the right to freely and openly advocate for themselves and their patients, without fear of retribution.

5. Nurses have the right to fair compensation for their work, consistent with their knowledge, experience, and professional responsibilities.

6. Nurses have the right to a work environment that is safe for themselves and their patients.

7. Nurses have the right to negotiate the conditions of their employment, either as individuals or collectively, in all practice settings.

ANABillofRights 10.06
Source: http://nursingworld.org/ajn/2001/nov/issues.htm
1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes or the nature of health problems.

2. The nurse’s primary commitment is to the patient, whether an individual, family, group, or community.

3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.

4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care.

5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.

6. The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.

7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.

8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

9. The profession of nursing, as represented by associations and their members, is responsible for articulation nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

ANA – American Nurses Association © 2001
Patient Rights and Responsibilities

Ethics

The primary goal of ethical medicine is to provide the greatest possible benefit to the patient in the most efficient means and at the least possible expense. An ethical decision:

- Recognizes medical realities
- Respects the patient’s convictions.
- Honors the family’s needs.
- Preserves professional integrity.
- Considers economic necessities.

Application to daily clinical practice

A. Patient Rights
B. Patient Responsibilities
C. Advance Directives
D. Principles of informed consent
C. Competency issues
D. Organ Tissue Donation
E. Policies and Procedures

Ethics Mechanism at ARMC

A. Institutional Medical Ethics Committee
   • 27 members from various disciplines
B. Ethics consultation services
   • Anyone can request an Ethics consult
   • Routine clinical consults should be ordered via computer through Social Services
   • Specific issues and/or educational needs can also be addressed
     Available 24 hours a day 1-2135 or call the Operator

Any patient, family or staff member may initiate an ethics consultation for help with

- Unresolved Conflicts
- Ethical Issues

C. Institutional member of Southern Jersey Ethics Alliance

Advance Directive Fast Facts

It is every patient’s right to accept or refuse health care. Advance Directives protect this right if one becomes mentally or physically unable to choose or communicate their wishes due to an illness or injury.

An advance directive is a patient initiated document and can be in the form of a living will, a durable power of attorney for health care (durable power of attorney for finances is not the same), or a combination of both.

An advance directive does not necessarily mean a DNR.
• Only a competent adult can complete an AD.
• The document must be signed in front of 2 adult witnesses. Any hospital employee may witness the AD. However, the designated proxy may not witness the form.
• If a DNR is requested in the Advance Directive, a separate DNR consent form is not necessary, but a physician's order must be written.
• A person can rescind an AD either by verbally telling a health care provider or in writing.
• Communicating wishes to family and physician before a serious event is best assurance to obtain desired care.
• If there is a conflict, e.g. for religious or moral beliefs a health care provider can not abide by an AD, arrangements should be made to transfer the care of the patient to another provider.
• The Ethics Committee may be consulted when issues arise by calling 1-2135.

**Responsibility:**
• It is the organizations’ responsibility to require routine inquiry regarding advance directive and organ tissue donation status for inpatients > 18 years of age.
• It is the admitting nurse’s responsibility to conduct routine inquiry and document required information on the patient data base at the time of admission. If the patient does not have the AD with them at the time of admission – the “intent” is to be documented on the Nursing Database (use patient statements with quotations whenever possible). We should try to obtain the original if possible, copy of the original is acceptable or a new document can be formulated. Place on the Medical Record.
• It is the physician’s responsibility to discuss and document advance directive and organ/tissue donation status with patients when deemed appropriate.
• Emergency Room personnel are not required to withhold or withdraw emergency care in circumstances which would both afford a reasonable opportunity for careful review of an advance directive without endangering the life of the patient.

**Definitions:**

- **Living Will** – A document that contains written instructions that explain the patient’s wishes regarding health care. They are called “living wills” because they take effect while the patient is still alive.
- **DNR** – Do Not Resuscitate – A DNR is a physician initiated order that states resuscitation is not to be initiated in the event of cardiopulmonary arrest and consent by the patient or their legal representative is required. A DNR may be requested, by the patient, in a living will. If so, consent is not necessary but a physician’s order must be written. If there is a disagreement among family members, no order to withhold or withdraw treatment shall be written until the disagreement is resolved. If resolution can not be attained, the courts may be requested to decide surrogacy.
**Patient Rights:**
Patient's have the right to:

a. Reasonable access to care.
b. Care that is considerate and respectful of his/her personal values and beliefs.
c. Be informed about and participate in decisions regarding his/her care, including discharge planning, pain management, education, etc.
d. Participate in ethical questions that arise in the course of his/her care, including issues of conflict resolution, withholding resuscitative services, forgoing or withdrawal of life-sustaining treatment, and participation in investigational studies or clinical trials.
e. The hospital demonstrates respect for the following patient needs
   - Confidentiality
   - Privacy
   - Security
   - Resolution of complaints
   - Pastoral care and other spiritual services
   - Access to protective services when indicated
   - Communication - any restrictions on communication are fully explained to the patient and family and are determined with their participation. Also, the hospital provides effective communication for each patient served, including the hearing and speech impaired and limited English proficiency.
f. The issue of designating a decision-maker in case the patient is incapable of understanding a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.

Patient Rights and Responsibilities can be found in each patient room in the "Guide to Patient Services." This information should be reviewed when the patient is admitted and documented on the patient family education documentation tool.

**Patient Responsibilities**
Patients have responsibilities to help ensure that they receive the best care possible. These including providing accurate and complete information to caregivers about their medical history including present complaints, past illness, hospitalization, medications and perceived risks in their care. They also have the responsibility to respect staff and others while in our facility. To meet their financial commitments including providing necessary information so that bills can be submitted.

The Joint Commission on Accreditation of Healthcare Organizations recommends patients follow the following to help prevent errors in health care (this is also found in the Patient Information Guide)

- Speak up if you have questions or concerns.
- Pay attention to the care you are receiving. Be active in helping to make decisions about your care.
- Learn about your diagnosis, medical tests, treatment plan, medications – *We will be happy to answer any questions.*
- Ask a trusted family member or friend to be your advocate, and to help you understand your care.
Patient Complaints:

If a patient or family member express a complaint, you should:

- Try to resolve at the department level first
- Call the Director of Customer/Community Relations
  - MNLD – 2-3420 or 2-3444
  - City - 1-8020 or 1-8193
  - Evenings, Nights, and Weekends notify the Nursing Supervisor

Informed Consent

**Informed:** refers to information provided to the patient.

**Consent:** refers to the patient’s agreement to the procedure.

Informed consent enables the patient or surrogate decision maker to be informed and involved in making decisions about the patient’s care.

I. **Includes:**

A clear, concise explanation of the patient’s condition
Any proposed treatments or procedures
Potential risks and benefits of the proposed treatment
Alternatives to the proposed treatment including non-treatment
The identity and professional status of individual responsible for authorizing and performing procedures or treatment.

II. **Indications for Written Informed Consent:**

<table>
<thead>
<tr>
<th>Anesthesia</th>
<th>DNR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive Procedures</td>
<td>AMA (against medical advice)</td>
</tr>
<tr>
<td>Operative Procedures</td>
<td>Blood &amp; Blood Components</td>
</tr>
<tr>
<td>Non-Invasive treatment Modalities (i.e. exercise tolerance test, or select psychotropic medications)</td>
<td></td>
</tr>
</tbody>
</table>

III. **Process:**

**It is the Responsibility of the Physician who is to perform the treatment/ procedure to fully explain the proposed plan** and, to document patient decision making.

- Explanation should be in lay terms.
- Any health care worker may act as witness on the informed consent document. Your signature means you observed the patient signing the document. If the witness believes that the patient has had insufficient information or lacks capacity to sign, the
witness should immediately bring this information to the attention of the responsible physician and may refuse to sign the witness statement.

- If legal consent for treatment must be obtained, 2 registered nurses will listen and document the verbal consent received via interpreter services.

**Nursing Liability**

Without patient consent, you might be held responsible if…

- You took part in the battery by assisting with the treatment/procedure
- You knew it was taking place and did not intervene on the patient’s behalf.

*** Educated Consent is different from Informed consent it may be obtained by a Nurse/Social Worker/Physician (who has been educated regarding the process) and is used for testing such as HIV.***

**Organ Tissue Donation**

1. **What are the issues related to organ/tissue donation?**
   
   - Not enough organs/tissues for people waiting.
   - Level of comfort making the request; transplant coordinators have a higher donation rate than when physicians or nurses are making the request.
   - ARMC’s compliance with state law regarding notification of the organ procurement organization
   - Organ/tissue donation is often a source of great comfort to the family, especially in unexpected death.

2. **What is the law pertaining to organ/tissue donation referral?**
   
   - New Jersey law requires that all deaths must be reported to the organ/tissue procurement agency. This agency is known as the **Gift of Life Donor Program** (formerly known as the Delaware Valley Transplant Agency). The phone # is KIDNEY – 1 (1-800-543-6391) OR 1 – 888 DONORS – 1 (1-888-366-6771).
   - The transplant coordinator will speak with the family re: donation with hospital staff assistance.
   - The law allows the procurement agency to audit charts of hospital patients to assess compliance.
   - There must be chart documentation regarding the referral and the decision; we use the Donor Option Referral Form.

3. **Referral Processes**
   
   - Physiological death – notify agency as soon as possible after pronouncement
   - Brain death – notify agency when it is recognized that the patient will most likely not survive; a variety of physiological support systems may need to be initiated, and the transplant coordinator can assist in this. Coordinator will not approach the family until the physician has notified the family of the situation.
4. **What does the Nurse need to Do?**
   - Determine if the patient has already expressed an interest in being a donor, i.e. check the driver’s license or other documents.
   - Be knowledgeable enough about the patient to give good information to the Transplant Coordinator.
   - Call, or have the Secretary initiate the call, and be prepared both with clinical information and the name and phone # where the next of kin will be in the next few hours, so the Coordinator can contact them.
   - Complete the referral form. Document in the clinical record that a referral was made and the outcome. Endorse the information to the person relieving you.
   - Families of post-mortem tissue donors can be informed that the Organ Procurement Organization will be contacting them. However, solid organ donors (brain dead and/or brain injured patients when a decision is made to withdraw life support) MUST be approached by the “designated requester” trained by the Organ Procurement Organization. ARMC has elected to delegate this responsibility to Gift of Life. Research has shown a negative impact on donation when families are approached too soon or in the wrong way. Making a timely referral, to Gift of Life is the best move. You can always contact Social Service or obtain a consult with John Jamieson, Director of Pastoral Care and Chair of the Ethics Committee (Beeper 525-5161).
   - Provide physiological support for the brain dead patient.
   - Apply moistened saline dressing over the eyes, after the family visitation is over.

**Abuse & Neglect**

**Reporting**

If the physician/healthcare provider assess that a patient’s medical findings are inconsistent with the patient’s caregiver’s explanations for injuries, or assess that the patient is living in an unsafe circumstance and/or not receiving proper care supervision, or the patient confides domestic abuse, Case Management will be consulted for a Social Service follow-up. During off shifts or ambulatory care settings the healthcare provider/administrative supervisor may elect to contact the proper agency for intervention. When physical assault is suspected and gunshot/stab wounds are present local law enforcement agencies will be notified.

Remember - Patient safety is of primary importance.

Characteristics for abuse and neglect can include the following:

- Medical/Physical Indications of Abuse/Neglect
- Behavioral Indications of Abuse/Neglect
- Indications from the Family/Caregiver
- Indications of Possible Financial Exploitation
** In instances where alleged rape/sexual molestation are suspected documentation and collection of evidence must follow very specific guidelines. Specific educational preparation is necessary. For additional information - Refer to the policy statement and procedural guidelines.

Child Abuse & Neglect
Elder/Vulnerable Adult Abuse & Neglect
Domestic Violence

**Cross Cultural Health Care:**

**Cross Cultural Communication & Cultural Competency**

*Language Access Services are available at no cost to the patient or their responsible party*

**ARMC ID 3102: Communication with Limited English Proficiency Patients**

AtlantiCare will provide interpretive services or interpreters as necessary to assist communication with Limited English Proficiency (LEP) patients in accordance with the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, Executive Order 13166, regulatory and accreditation standards. Linguistically and culturally appropriate communication and access to care for all individuals is available in both inpatient and outpatient settings throughout AtlantiCare Health System.

Limited English Proficiency patients include patients whose native language is a language other than English and who “cannot speak, read, write or understand” the English language at a level that permits them to interact effectively with health care providers.

AtlantiCare will inform patients of their right to receive language assistance services in verbal and written documentation at their first point of contact with AtlantiCare Health System. AtlantiCare will provide appropriate linguistic services at no cost to the patient / responsible party.

Patients are not required to bring their own interpreter as a condition of care. A third party medical interpreter will be utilized to assure thorough and accurate information in all clinical and non-clinical situations including but not limited to the following: obtaining a medical history, explaining treatments and medical procedures, assisting patients at discharge and determining if patient is alert or coherent.

*Services Available: Telephonic Service, Contracted Service, Translated Documents*

**ARMC ID 3103: Communication with Deaf/ Hard-of-Hearing Impaired Patients**

AtlantiCare will provide language access services/ interpretive services as necessary to assist communication with Deaf/ Hard-of-Hearing Impaired patients in accordance with the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, Executive Order 13166, regulatory and accreditation standards. Linguistically and culturally appropriate communication and access to care for all individuals is available in both inpatient and outpatient settings throughout AtlantiCare Health System.

Deaf/ Hard-of-Hearing Impaired patients will have an equal opportunity to participate in and benefit from all services provided in places of public accommodation under the Americans with Disabilities Act (ADA).
Title III of the Americans with Disabilities Act requires businesses and agencies to remove many frustrating barriers to communication and offer this service free of charge to the patient.

Patients are not required to bring their own interpreter as a condition of care. A third party medical interpreter will be utilized to assure thorough and accurate information in all clinical and non-clinical situations including but not limited to the following: obtaining a medical history, explaining treatments and medical procedures, assisting patients at discharge and determining if patient is alert or coherent.

Services Available: TTY Machine, Contracted Service
REQUEST/REFUSAL FORM:

MEDICAL INTERPRETER

Limited English Proficiency
Deaf/ Hard-of-Hearing Impaired

☐ Limited English Proficiency ☐ Limited English Literacy ☐ Deaf ☐ Hard-of-Hearing Impaired

PATIENTS NAME: ________________________________

DATE: ______ TIME (1-REQUEST): ______ TIME (2-ARRIVE): ______ TIME (3-DEPART): ______

PRIMARY LANGUAGE PREFERRED: ________________________________

INTERPRETERS NAME AND ID NUMBER (1) ________________________________

(2) __________________________________________

TYPE OF INTERPRETATION SERVICE (circle): telephonic service contracted interpreter staff interpreter

COMMENTS: ______________________________________________________________________________________________

AtlantiCare is committed to providing quality care and quality access to care to all members of our community. To meet your needs we have language access devices and interpreter services to ensure that optimal communication occurs between the patient and provider(s) at AtlantiCare. You are entitled by law to have Language Access Services available to you at no cost. If you would like a certified language interpreter, we will arrange one for you in a timely manner.

I, __________________________________________, understand that I have a right to free Interpreter Services by AtlantiCare to communicate with my health care provider. I understand by waiving this service, I am waiving my rights entitled to me by law. I understand that I do not have to use family or friends to interpret my medical information and AtlantiCare recommends that I do not use family or friends to interpret confidential information. AtlantiCare will provide me with a certified language interpreter to help me understand: my diagnosis, treatment, or care at no cost to myself or my responsible party.

I AM REQUESTING:

YES, I am requesting to have a certified language interpreter provided by AtlantiCare.

NO, I have been advised in a linguistically appropriate way and I do not wish to have a certified language interpreter provided by AtlantiCare. I will communicate with my providers on my own.

NO, I have been advised of my rights and I wish to use a family member, friend, or someone in my responsible party to interpret for me during my stay with AtlantiCare:

Relationship to patient (Circle): Mother Father Child (+ 18 yrs old) Friend Other ________________________________

Authorization to Disclose Health Information Form

AtlantiCare Health System reserves the right to require a certified medical interpreter to assist whenever the provider is not comfortable that a family member/friend is competent to translate technical medical information sufficient to support the patient's ability to provide informed consent.

I understand that at any time I can change my mind about this request by completing a new Request/Refusal Form

Patient Signature: ____________________________ Date: ______________

Parent/Guardian’s Signature: ______________________ Date: ______________

Witness Signature: ______________________________ Date: ______________

Witness only verifying request for interpreter service

A copy of AHS’s written Administrative Policy and Procedure on Communication with LEP/Deaf/HoH Impaired patients is available upon request.

White Copy: CHART Yellow Copy: PATIENT
Stereotyping vs. Generalizing

The difference between a stereotype and a generalization lies not in the content, but in the usage of the information.

A stereotype is an ending point, no attempt is made to learn whether the individual in question fits the statement.

Healthcare professionals deal with many types of diversity each day. We interact with patients, clients, colleagues, and many others who are in some ways different from each other and some ways similar. In reality, every one of us is different even if we share a cultural bond. For example, if we gather a group of nurses into a room some may have backgrounds in MedSurg, Intensive Care, Maternity, OR, etc. There are some who graduated from Diploma programs, LPN programs, AD, BSN, MSN, MA, MS, PHD, etc. They are all nurses, some will have similarities and yet there will be differences.

This diversity, this uniqueness is what helps make patient care delivery strong. The cornerstone of cross-cultural relationships is awareness and acceptance of people’s cultural patterns and beliefs that are different from our own. Consider the similarities and differences as they relate to you personally and professionally.

The term "cultural competence" embodies the knowledge, attitudes, skills, and protocols that allow an individual or system to render services across cultural lines in an optimal manner. Cultural competency permits individuals to respond with respect and empathy to people of all cultures, classes, races, religions and ethnic backgrounds in a manner that recognizes, affirms and values the worth of individuals, families, and communities. It has been characterized as a continuum that encompasses several stages which include:

- understanding one's own cultural background,
- acknowledging the patient's different culture, value systems, beliefs, and behaviors,
- recognizing that cultural difference is not synonymous with cultural inferiority,
- learning about the patient's culture, and
- adapting optimal health care delivery to an acceptable cultural framework.

Cultures vary in their beliefs of the cause, prevention, and treatment of illness. These beliefs dictate the practices used to maintain health. The value of "good health" is also variable. Too often we interpret the behavior of others as negative because we don't understand the underlying value system of their culture. The natural tendency is to assume that our own values or customs are more sensible and right.
The following list provides a general comparison of “traditional American” values with values commonly found in some other cultures.

<table>
<thead>
<tr>
<th>Traditional American Values</th>
<th>Other Cultural Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal control over environment</td>
<td>Fate, Destiny, &quot;God's will&quot;</td>
</tr>
<tr>
<td>Change and variety</td>
<td>Tradition</td>
</tr>
<tr>
<td>Competition</td>
<td>Cooperation</td>
</tr>
<tr>
<td>Individualism</td>
<td>Group Welfare</td>
</tr>
<tr>
<td>Future orientation</td>
<td>Past orientation</td>
</tr>
<tr>
<td>Directness</td>
<td>Indirectness/&quot;In Your Face&quot;&quot;</td>
</tr>
<tr>
<td>Informality</td>
<td>Formality</td>
</tr>
<tr>
<td>Time importance</td>
<td>Human interaction importance</td>
</tr>
<tr>
<td>Duration of life</td>
<td>Quality of life</td>
</tr>
<tr>
<td>Nuclear family</td>
<td>Extended family</td>
</tr>
</tbody>
</table>

**Examples of Potential Differences within other Cultures**

**Notion of Time:** Participants and health-care staff may differ on the value of time. Most of us are ruled by time schedules. If "being on time" and "not wasting time" are not familiar concepts to the participant, a 9 o'clock appointment may not be kept until 10 or 11 o'clock. Many cultures mark time by major events—births, deaths, marriages—that repeat themselves throughout the life cycle. Many Western cultures mark time in a precise, linear system that is oriented toward work, future, and money.

**Decision Making:** Decisions regarding medical screening and treatment might not be decided by the individual, but by group or family agreement. Some cultures put a high degree of trust in the personal physician regarding all health matters. For some ethnic groups, respect for authority and politeness in public may prevent a person from raising questions or participant may make an effort to "please" us. Many cultures accord great respect to the elderly. This can affect how one is perceived and how well materials or programs are accepted in the community. A participant also may be uncomfortable with your sex, educational level or race. For some cultures a person is not defined or named individually but in relation to their parents or spouse. They do not have an individual identity. Some cultures do not speak in positive terms about a spouse, children, or possessions because they feel it brings attention which could cause bad luck. Oral communication is frequently the most important mode of information transfer. A participant may not be literate in English or his/her native language. A participant may have different standards about the appropriateness of being asked for certain types of information (e.g., income data, functional status data, and sexual orientation information). Consider using teams, for example both a male and a female, to question participant. Emphasize that while some questions may not be appropriate to them, they have to be asked of everyone. Direct questioning may be considered an inappropriate means of questioning. Information may need to be gathered indirectly.
**Age** – different cultures place different value on age. Many societies honor the aged, for those advancing years bring wisdom, power, prestige, and respect. In Japan for example, on a person’s 88th birthday they are added to a list of national treasures.

**Assertiveness** – For many cultures, confrontation and disagreement are unacceptable behaviors, and maintenance of relationships and harmony are the highest priorities. Some cultures view Americans as “pushy & demanding.”

**Clothing** – Some cultures wear specific articles of clothing, and some require members to keep their bodies completely covered in public. Wearing traditional clothing or jewelry of another culture can be considered inappropriate and send misleading messages. Clothing often has cultural codes and rules.

**Collectivist/individualist** – cultures have very different priorities and goals. Collectivists believe that considering the needs and feelings of others ensures the well-being of the individual, it reflects less on personal goals and more on harmony and interdependence of group members (family, extended family, work team, tribe, and religion). Individualism places great importance on personal goals, individual needs come before those of a group – independence and self-reliance are greatly valued and they believe that taking care of oneself contributes to the well-being of the group. The US ranks highest in individualism and Southeast Asia the highest in collectivism.

**Color** – has much cultural significance. For example - traditional mourning colors are white in China, yellow in Mexico, and black in the US. In Central America red, indicates strength.

**Death & Dying** – have many implications, i.e. with some cultures discussion about declining health can aggravate a condition. Death and funeral customs vary between cultures, religions, and families. It is important to ascertain if there are certain customs that need to be adhered to at the time of death or in preparing the loved one after death. Knowing ahead of time if there are specific practices or customs can assist you. Asking and demonstrating caring in a professional manner can really be helpful to the patient and the family.

**Eating habits** – affected by cultural conditioning – when to eat, how to eat, and what to eat. For example, pork and animals that scavenge are forbidden for Muslims. Buddhists are often vegetarians because they abhor killing. Orthodox Jews do not eat pork, shellfish, nor certain parts of beef. Food for curative effects is also a cultural consideration – Iranians, believe that honey has the power to heal a wound. People from Central America and the Caribbean mix honey with lemon for a tea to soothe upper respiratory problems. Many people believe that garlic and ginger are cure-alls. Some believe there must be a balance of cold foods and hot foods to maintain good health.

**Eye contact** – it is important to most American when listening or speaking. In some cultures it is polite to look away and make only fleeting eye contact. For them direct eye contact is considered impolite, disrespectful or intimidating (i.e. Asian cultures).

**Families** – relationships among family members vary among cultures. Matriarchal or patriarchal leadership in families varies. Extended family interactions also vary.

**Personal space** – varies. In some cultures personal space extends at least two arm lengths, and standing too close implies aggressiveness. For others standing nose to nose is comfortable –
when someone enters your personal space, you need to stay put rather than backing away and embarrassing the person (unless they are in a threatening demeanor).

**Touch** – varies among cultures – some cultures frown upon body contact and/or contact between members of the opposite sex. This can extend to physical examinations.

**Resources**
Ten Tips for Communicating with Patients from Other Cultures

1. Spend a few minutes in small talk at the beginning of the visit before getting down to the medical task at hand. This can be done in English, or if your language skills are sufficient, in the patient’s native tongue.

2. Show respect for the patient’s beliefs about illness and health care.

3. Don’t assume the patient dislikes you, doesn’t trust you, or isn’t listening because he or she avoids eye contact.

4. Determine what other culturally determined health care resources and methods the patient has used or continues to use while under care.

5. Verify how the patients will take the medication or follow the treatment plan.

6. Don’t assume that the patient understands you and will follow your medical advice simply on the basis of his or her nod and a verbal, “Yes, yes.”

7. Be aware of the basic beliefs, values, and mores of various cultures.

8. Understand the value of the family’s presence and role in the illness and recovery process.

9. Use an interpreter whenever appropriate.

10. Don’t stereotype cultures (“All Mexican Americans like to be touched, all Asians do not)

SOURCE: Joanne Desmond, The personal touch, Life in Medicine, Sept 1994; p.9
L-E-A-R-N Model

- 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
- Recommend treatment
- Negotiate agreement

Check Your Knowledge

1. A DNR is the same as an
   Advance Directive
   a) True
   b) False

2. If a patient/family expresses a complaint you should
   a) Call the director of customer community relations immediately
   b) Keep on working they’ll forget about it soon enough
   c) Try to resolve on the unit/department level first

3. Patient Rights include:
   a) Informed about Discharge Plan
   b) Information about medical situation
   c) Confidentiality
   d) Privacy, respect,
   e) All the above

4. Informed consent includes:
   a) A clear, concise explanation of the patient’s condition
   b) Any proposed treatments or procedures including potential risks and benefits of the proposed treatment
   c) Alternatives to the proposed treatment including non-treatment
   d) The identity and professional status of individual responsible for authorizing and performing procedures or treatment.
   e) All the above

5. The doctor must obtain informed consent for all the following except:
   a) Anesthesia
   b) DNR
   c) Transfusions
   d) HIV testing

6. NJ law requires
   a) The Nurse caring for the patient MUST counsel families regarding organ donation
   b) All deaths must be reported to the organ tissue procurement agency
   c) Only deaths of people under the age of 70 must be reported
   d) None of the above
7. Indicators of abuse can include:

   a) Medical/Physical/Behavioral Indications of Abuse/Neglect
   b) Indications from the Family/Caregiver
   c) Indications of Possible Financial Exploitation
   d) All the above

8. In instances where alleged rape/sexual molestation are suspected documentation and collection of evidence must follow very specific guidelines. Specific educational preparation is necessary.

   a) True
   b) False