

Renal Business Today

What Should Nephrology Doctors and Nurses Know About Cultural Awareness in Dialysis?

By Gordon Lore

Introduction

Several years ago, Vanderbilt University's School of Nursing presented a program in which nurses discussed "the impact of diversity on the healthcare system." They traced the demographics of underrepresented patients and their rise in the U.S. population.

During the last two decades of the 20th century, the White population in the US increased by only 10% while Hispanics shot up by a whopping 125%! For the first time, Hispanics became the largest minority group, comprising 13% of the overall population. When you throw into the mix the numerous other minority groups, it becomes obvious that the American population is becoming increasingly diverse. Underrepresented groups comprise 30% of the overall demographics. By 2030, that number is expected to increase to 40%.

It is also clear that the workforce has not kept up with the changing demographics. Physicians from underrepresented groups comprise only 7% of the current healthcare workforce with nurses and pharmacists logging in at only 3%. And minority groups are less likely to receive dialysis treatments or kidney transplants.

Healthcare Disparities

Dee M. Baldwin, PhD, RN, FAAN, the Executive Director of Georgia's Office of Women's Health, added that "disparities in health and healthcare have been around for more than two centuries [and] continue to be problematic, with little progress made to eliminate them over time."

"It is well documented that ethnic/racial minorities are disproportionately affected by many healthcare conditions that impact their health..." Baldwin remarked. Among the reasons for this are:

- No health insurance;
- Health behavior;
- Less access to healthcare;
- Environmental factors;
- Discrimination;
- Lack of transportation; and
- Remote geographical locations.

Patient/Doctor Communication

Many minority patients have reported that a big problem in eliminating the obstacles to adequate healthcare involved patient/doctor communication. Baldwin indicated that many patients "mistrusted the system..." They harbored the feeling that the doctor did not listen to them about their chief complaint(s).

"Framing the... discussion around the distinctiveness related to disparities in... healthcare is [necessary] for finding effective solutions to eliminate unequal burdens in health status," Dr. Baldwin concluded.

As the Founding Editor of the Renal Support Network's *KidneyTimes* e-journal, I had the pleasure of working with Margaret S. Washington, MSW, MSPH, on an article she authored on improving communication between the nephrologist and kidney patient. Washington is a vivacious, dedicated, highly energetic woman who has spent several decades of her

professional life caring for kidney disease patients. For 23 years, she was the Executive Director of an ESRD Network of 160 dialysis facilities and 10 renal transplant centers. Washington is also the author of *Doctor, Can You Hear Me? Patient, Are You Listening?* Her many years of experience have taught her that cultural differences can play a major role in doctor/patient communication.

“Ships Passing in the Night”

“**T**here is a mounting crisis in communication between doctors and patients...,” Washington wrote. “Each is intent on making his/her point to the extent that they function as ships passing in the night.”

The author added that dialysis patients enter their clinics with their own problems and are confronted by problems in the unit. This often impacts on their treatment and quality of care. Dialysis patients must “become active partners in their treatment and demand to be treated with dignity and respect.” A critical point involves the patients’ failure to acknowledge the seriousness of their condition and “the need to comply with instructions and the physician’s failure to understand the barriers—psychological, financial or cultural—that may cause patient noncompliance.”

The social worker added that patients must openly and honestly share information vital for the doctor in making an accurate diagnosis and formulating a proper treatment plan.

Dialysis Among the Hmong

Since the end of the Vietnam War in 1975, the Hmong people of Burma, Laos, Thailand and Vietnam began immigrating in large numbers to the US, spurred in part by promises made by American forces to safely shelter them in return for their aid. Many had faced “horrendous” conditions in refugee camps.

By 2000, nearly 190,000 Hmong were residing in the US. Like other immigrants, cultural beliefs affect their daily lives. According to Linda Krueger, MS, BS, who wrote an article on a small patient trial relating the experiences of her Hmong patients on hemodialysis (HD), the nurses' beliefs were bound to "impact the Hmong's utilization and understanding... of western healthcare services."

The Hmong can have a very different view of how illnesses may be diagnosed and treated. Traditionally, their view is that the causes of illness include:

- A loss of soul;
- Stress;
- Environmental events;
- Natural hardships;
- Angry, unhappy or offended spirits; and
- "An accumulation of bad blood," which has to be cautiously removed because "the human body has a finite amount of blood to last [a] lifetime."

Krueger also found that "the concept of a chronic illness that can be controlled but not cured is traditionally unfamiliar to the Hmong..." They want their symptoms resolved and are often non-compliant when they are not. Traditional methods of treating illnesses are performed by such "diagnosticians" as egg readers, fortune tellers, herbalists, massage therapists and acupuncturists. There are also shamans who believe that communicating with the spirits can aid in resolving an illness.

The dialysis nurses said they learned a lot from this small but interesting study. Most felt that their Hmong patients were less compliant with their medications, diet, fluid restrictions, and multidisciplinary plan of care. They also felt that the lack of trained interpreters was a significant drawback. Other major problems included the need for transportation, finances, lack of adequate family support, depression, and anxiety.

Additionally, the nurses found that the major theme among their patients was “overwhelming sadness” resulting from such physical symptoms as weakness and fatigue along with an inability to participate in social and familial activities. There were also “feelings of worthlessness” and hopelessness that they may never get a renal transplant. Even the dialysis treatments themselves resulted in sadness, fear, uncertainty and boredom. All the nurses felt they did not have enough time with their patients and had limited knowledge of Hmong culture.

Important data from the study included the following:

- Dialysis nurses need to be more self-motivated to learn about the Hmong culture;
- Communication barriers need to be resolved; and
- The patients said that “more staff are needed.”

In an edited interview with *Renal Business Today*, Krueger responded to a series of questions.

Serious Barriers

Renal Business Today: *What are a few of the most serious barriers to providing adequate care to a culturally diverse dialysis patient population?*

Krueger: Among these are a lack of understanding the various cultures and beliefs, better communication, a lack of adequate translation resources, and misconceptions about cultural beliefs, individual feelings and concerns.

RBT: *How can some of these barriers be broken down?*

Krueger: There should be cultural diversity training for all staff members.

Feeling Better About Treatments

RBT: *How can nephrology nurses make their patients feel better about receiving dialysis treatments?*

Krueger: First, to find out what their patients' beliefs are and what they mean to them and their health. How do they define health and illness? We have to be truthful and respectful of their beliefs [and]... address [their] beliefs, fears, etc., individually.

RBT: *How can the renal healthcare team best be educated about treating culturally diverse patient populations?*

Krueger: Ongoing training... while remembering that prejudices, discriminatory actions, misconceptions and intolerance will not change quickly. I also recommend books written by members of a particular culture.

Cured or Controlled?

RBT: *How do you deal with a belief among diverse patient populations who want their disease to be cured rather than controlled?*

Krueger: Focus on the positive aspects, including the improvements seen, the energy level or overall feeling of improved health, etc... And we should not try to change the beliefs of other cultures to match our own beliefs.

Sensitive Cultures and Upbringing

RBT: *How can the renal healthcare team better relate to different patient populations who are sensitive to their cultures and upbringing?*

Krueger: We need to acknowledge these differences, learn about them, and accept them. We also need to relate to the patients' experiences. Staff needs to be comfortable asking questions. We can also allow

patients to perform their cultural rituals as long as safety is not jeopardized.

The Hemodialysis Diet

Most renal dietitians know that “ethnic and cultural factors influence dietary adherence.” The large number of Hispanic and Black ESRD patients in the US have food preferences that are high in potassium, phosphorus and sodium.

Claudia Morales Lopez, MS, RD, CDN, a Clinical Dietitian at the Montefiore Medical Center, Bronx, NY, suggests some factors contributing to the reasons that dietary management among dialysis patients “is prone to fail.” Probably the most important involves modifying the patient’s lifestyle, including treatment times and “the fact that the patient has to take multiple medications and follow a restrictive diet.” Lopez noted that Hispanics consume more vegetables and fruits, making it more difficult for them to adhere “to a low potassium, low phosphorous diet” limiting some vegetables and fruits. Also, condiments are typically high in salt, an anathema to the renal diet. Therefore, “it is very important for healthcare providers to be familiar with some of the foods that are culturally consumed among [Hispanics].”

Family Resiliency

Nancy White, PhD, RN, a dialysis nurse at the University of Northern Colorado and three colleagues examined the differences in family resiliency between hemodialysis patients and their caregivers among Anglo-Americans, Mexican Americans and South Koreans.

The Korean patients and their caregivers felt that stress over their illness was “significantly greater” than in the other groups. They also scored lower on the resiliency measure.

“Findings of the study support the need to understand the dynamics of family resiliency from a cultural perspective,” the authors concluded.

Cultural Competence

Suzette A. Mahabeer, RN, BScN, MScN, CNS, a Nurse Instructor at McMaster University in Hamilton, Ontario, Canada, conducted “a descriptive study of the cultural competence of hemodialysis nurses.” She emphasized that cultural competence enables nurses to effectively team with their patients from diverse cultures. Mahabeer added that “providers are legally and ethically responsible for providing healthcare consultations and interactions that patients can understand.”

A Canadian study added to the recurring theme that, while the majority of HD nurses were culturally aware, “they were not culturally competent.” Most nurses felt they were only “somewhat” aware of specific diseases among various ethnic groups.

“Ethnic Pharmacology”

The study also demonstrated that most of the nephrology nurses felt “they lacked knowledge... of ethnic pharmacology,” defined as “the study of differences in drug metabolism between ethnic groups.”

“Nurses do not receive formal training in ethnic pharmacology, but it would be beneficial to provide some education in this area to help increase cultural awareness,” the study recommended.

Different Backgrounds

In 2008, Stephen Fadem, MD, a nephrologist practicing in Houston, TX, responded to questions posed by *Renal Business Today*.

“Different backgrounds can introduce issues related to trust or privacy, end-of-life decisions, blood transfusions, medications, personal space and [the] importance of time..., which can wreak havoc with medication schedules,” he remarked. “Other cultures may refuse a medication because a specific component came from an unclean animal.”

Dr. Fadem added that some religions believe that the health of the patient “supersedes any sacred laws.” He said that “Judaism is probably the easiest religion to deal with from a health perspective because the laws allow for anything that will save your life [including using a porcine heart valve or doing dialysis on a Saturday, the Sabbath]. But a Jehovah’s Witness will not allow a blood transfusion and will die.” The nephrologist added that “some patients believe their ills are a punishment or trial from a higher power and... they should accept the disease instead of treating it.”

End-of-Life (EoL) Decisions and Other Components

Judy Kaufman, RN, BSN, CNN, Clinical Director of the Acute Dialysis/Apheresis Unit at the University of Virginia, said her facility has “a wide variety of cultures and social classes.” She added that the African American population finds EoL decision-making “very difficult.” Many families believe that they would be committing a sin” if they made such a decision.

Kaufman believes that “stereotyping these cultures is a mistake.”

“The most important element is seeing the patients as individuals and recognizing what makes them individuals,” she remarked.

Four doctors from the University of Michigan Medical Center in Ann Arbor discussed withdrawing from dialysis in *Advances in Renal Replacement Therapy*. They said that, while withdrawal is common, several reports have indicated that Blacks are only one-third to one-half apt to withdraw from dialysis treatments compared to Whites. The review concluded that “both medical and cultural factors play important roles in the decision about withdrawal, but... cultural beliefs and attitudes are more important.” The authors called for more research in “the medical and cultural aspects of rates of withdrawal.”

The beliefs of some Aboriginal and Asian populations can complicate EoL decision-making. Among these is the belief that “positive thinking promotes health.” While such beliefs *per se* can be positive, they may also “prohibit explicit references to dying and may view giving bad news as disrespectful because these could shorten the life of the patient.”

Other cultural components include whether or not a patient approves of kissing or hugging, even shaking hands. While Hispanic Americans tend to be “touchy” and very friendly, “the Middle Eastern and Orthodox Jewish cultures are the most stand-offish.” For Russian patients, “direct eye contact is a sign of respect and trust,” but they usually do not publicly show their emotions.

“A Diverse Staff”

Loretta Jackson Brown, MSN, RN, CNN, the southeastern Vice President of the American Nephrology Nurses’ Association (ANNA), stressed the importance of having “a diverse staff that is reflective of the patient population.” She emphasized developing individual care programs supporting the individual patient’s cultural beliefs.

“Seek to understand how the patient desires to maintain cultural beliefs and work to find a happy medium in which the required clinical interventions can be adopted while maintaining the wholeness of the patient,” Brown added.

Language Barriers

As the US becomes more diverse, healthcare providers must deal with more language barriers. Many providers believe that meeting vital communication needs is paramount in making treatment choices as patients approach ESRD.

Study data increasingly show that “the availability of early [CKD] education for the total population is suboptimal.” The challenge

becomes even greater for effectively providing this education in culturally diverse areas. This was demonstrated by a small study in Westminster, CA.

“Training was provided for the healthcare education team in understanding cultural attitudes, beliefs and behaviors that would be important in helping patients’ families to actively participate in creating their treatment plan and enhancing the success of patient-family training and education,” wrote W. Anantiyo, of Renal Advantage, Inc., in *Peritoneal Dialysis International*. “Our findings suggest that using culturally diverse nurses in early CKD education and patient communications prepares the patient/family to make better decisions [impacting] quality of life.”

Live Kidney Transplantation (LKT)

Writing in *BMC Nephrology*, researchers from California, Maryland, and Washington, DC, concluded that LKT “is underutilized, particularly among ethnic/racial minorities.” The authors are a part of The Talking About Live Kidney Donation (TALK) Study with the goal of using “research methods to design and test culturally sensitive interventions to improve patients’ shared and informed consideration of LKT...”

The evidence suggests that ethnic/racial minorities are up to 50% less likely than non-minorities to receive [an] LKT.” There are a number of reasons for this, including:

- Lack of knowledge;
- Denying the need for a LKT;
- Difficulties in identifying potential donors;
- Possible recipients’ fears concerning the health of potential donors;
- Mistrust of healthcare;
- Concerns about surgery; and
- Inadequate discussions about LKT.

The authors also believe that “early consideration of LKT may be particularly important in facilitating and preparing for pre-emptive (before the start of dialysis) LKT—which is associated with the most superior outcomes.” Studies show that most patients “do not consider LKT as a treatment option until... they have initiated [HD] and that family and physician discussions about LKT are often suboptimal even when patients report they desire LKT as a treatment.”

“Results from TALK will provide needed evidence on ways to enhance consideration of [an] optimal treatment for patients with [ESRD],” the researchers concluded.

“The Key to Education”

Keith Norris, MD, is Executive Vice President for Research and Health Affairs and a Professor of Medicine at Charles Drew University of Medicine and Science in Los Angeles. He stated that “the increase of CKD is now reaching epidemic proportions.” In the US, minority populations are two to four times more likely to reach ESRD than non-minorities.

Dr. Norris believes that education about kidney disease made readily accessible to minority patients provides the key to making that information “readable and sensitive” to different backgrounds and cultures. He is adamant that educational material should be written in a way that anyone can understand, particularly since many minorities have lower reading levels. English is only a second language for many minorities. Therefore, “health information should be written at or below the seventh or eighth grade level and should be sensitive to minority cultures.”

“Many minorities have little to no access to healthcare and are less likely to trust doctors and hospitals,” the nephrologist added. “Some minority cultures use a local healer... while others look to the church... Early

screening and education teaches a person more about kidney disease, ways to halt the progression, and healthy living tips.”

“Bridging the Racial Divide”

In these more enlightened times, is race still a factor in providing quality healthcare? In an article she wrote for the *Online Journal of Issues in Nursing*, Rosalyn J. Watts, EdD, RN, FANN, makes a possible case that it is.

“Disparities in healthcare provide compelling evidence that issues of race or skin color for the descendants of slaves and other ethnic minorities persist in the 21st century,” Watts wrote. “Nurses providing care for African Americans must bridge the racial divide and incorporate culturally relevant content in their health history. As an integral aspect of their professional growth as culturally competent healthcare providers, they must incorporate the idea of race consciousness, which is described as an awareness of the historical journey of the group, knowledge of disparities in healthcare..., and a self appraisal of one’s attitude and biases toward the group... Bridging the racial divide in health will be a daunting challenge and opportunity for healthcare providers of the 21st century.” And many nurses believe that “culture-related health concerns must be incorporated as key components of the patient’s history.”

Conclusion

An article in *Transcultural Nursing* stated that cultural competence “is an ongoing resolution as we continually adapt and reevaluate the way things are done. For nurses, cultural diversity tests our ability to truly care for patients, to demonstrate that we are not only clinically proficient but also culturally competent, that we CARE.”

The article concluded that “the main source of problems in caring for patients from diverse cultural backgrounds is the lack of understanding

and tolerance. Very often, neither the nurse nor the patient understands the other's perspective.”

The American Nephrology Nurses organization issued a position statement saying that knowledge of cultural diversity is vital in order “to positively influence outcomes for individuals w/kidney disease.” Among these are:

- Every person's “right to safe and effective healthcare with respect for human dignity and ethnic and cultural variations”;
- Present approaches to ethnic differences “are ineffective in meeting health and nursing needs of diverse cultural groups”; and
- It is essential that nurses are educated about “cultural knowledge and its impact on interactions w/healthcare.”

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