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Cultures: How different are they? A nursing perspective

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Cultures: How different are they? A nursing perspective

Abstract

Chapter one will explore nursing models for culturally competent care and review three different theorists. First theorists, Campinha-Bacote (2008), will explain the model of cultural competence. Second theorist, Giger and Davidhizar talks about the model of transcultural nursing. Their theorist, Leininger, will explain cultural care diversity and universality theory/model. Chapter two will explain the differences between the first three cultures which include Muslim, Jewish, an Chinese. This will include the types of foods they may eat, religions they follow along with religious practices , and what each culture may find as social norms. When talking about social norms, with each culture, the way each of them perceive health care and when will they seek for it will be evaluated as well. Chapter three will explore the perception and expression of pain in Muslim, Jewish and Chinese culture. Chapter four will describe health care disparities in Muslim, Jewish, Chinese, African American and Mexican culture. These health disparities can be impacted by a culture's beliefs and alternative medicines. Chapter five will discuss recommendations for nurses, on caring for a person from different cultures for that they feel more comfortable in American hospitals.

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A NURSING PERSPECTIVE

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Sanduni Silva

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Introduction

In nursing, there are many different aspects that influence a patient feeling satisfaction with their care. As a nurse, it is their duty to make the patient feel as comfortable as possible; after all, comfort greatly impacts how fast a patient heals. Cultural competency is not something nurses thoroughly learn during nursing school, yet it is very important in nursing practice. There is no specific class, subject, or idea that nurses are taught in regard to culture. Bachelor of Science in Nursing (BSN) level it transcultural nursing is often integrated into course work. When beginning a nursing career, it is important to start knowing and understanding various cultures. Holistic care, which is caring for the patient as whole, is emphasized greatly in the nursing field. This means a patient's nursing needs must be handled. Mental and financial health of the patient should be managed as well. This paper will focus on the importance of culture and providing nursing care while examining three cultural theorists in selected cultures with social differences, perception and response to pain, health care disparities, and recommendations for nursing care. With holistic care, family members of the patient are taken care of as well.

What is cultural competency in nursing? Jirwe (2008) describes it as a skill a nurse should acquire in able to care for a patient who has a different culture from their own. Campinha-Bacote (2008) states that every patient should have a cultural assessment done on them because each patient has their values, beliefs, and practices. Jirwe (2008) also states, “a level of performance demonstrating the effective application of knowledge, skills, attitudes and judgement to practice safely and effectively in a multicultural, multiethnic society” (p. 8-9). The goals of the American Association of Colleges of Nursing (AACN, n.d.) are to, “provide

resources and exemplars and to facilitate implementation of cultural competencies in baccalaureate nursing education” (p. 2). AACN explains there are five competencies that are essential to know as a nurse who is providing culturally diverse care. The first competency is to apply knowledge from a certain culture that can influence health care. The second competency uses suitable sources in implementing culturally competent care. The third competency encourages safe and quality care for all different populations. The fourth competency promotes social justice. This can include protecting and honoring the health of defenseless populations and to avoid health disparities and much as possible. The fifth and final competency instructs nurses to participate in growing cultural competence (AACN, n.d.).

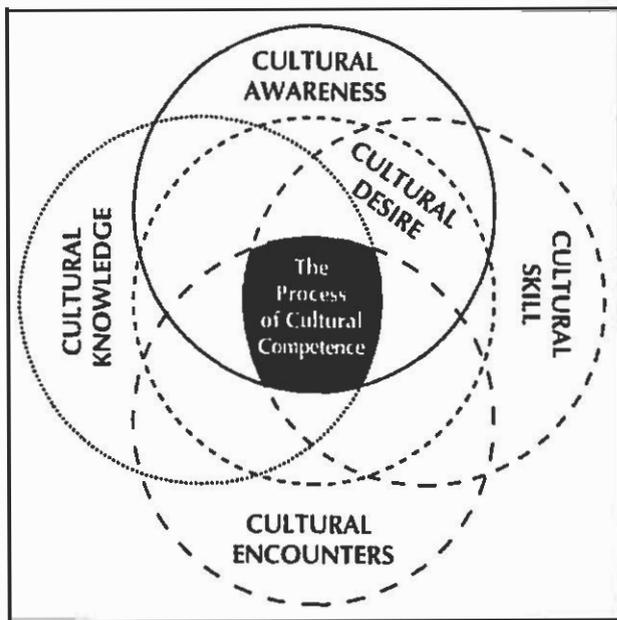
Chapter One – Exploring Nursing Models

Three theorists have been chosen to be reviewed. These theorists have explored ways in which nurses can improve their skills and knowledge in cultural competency. A nurse in America may be exposed to different cultures. To make sure nurses can give the most adaptive care possible, they must first know why certain cultures adhere to specific rituals. Nurses should aid culturally diverse patients so they can participate in desired alternative medicine.

Campinha-Bacote

The Process of Cultural Competence in Delivery of Health Care Services describes the process in which the healthcare provider continuously strives to achieve the ability to effectively work within in the cultural context of a client. It is composed of cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desires (Campinha-Bacote, 1989) (see Figure 1: Process of Cultural Competence in Delivery of Health Care Services).

Figure 1: Process of Cultural Competence in Delivery of Health Care Services.



(Campinha-Bacote, 1989)

This model defines cultural awareness, knowledge, skill, encounter, and desire. The Process of Cultural Competence (Campinha-Bacote, 1998) explains that to be culturally competent, you must know the cultural competence process. With cultural awareness, the nurse must be aware of a patient's values, beliefs, lifestyle, and practices. This way the nurse can explore the patient's biases and prejudices. If the nurse is unable to consciously reflect on the patient, this can have the nurse impose her/his own cultural beliefs and values unintentionally. With cultural knowledge, the nurse would research other cultures than their own and explore different "worldviews." Having the nurse understand the patient's culture can help the nurse confidentially interact with the patient. Cultural skill is when the nurse performs a cultural assessment on a patient. With the cultural assessment, the nurses take information directly from the patient. In a cultural encounter, someone from one culture with someone from another culture, this would be considered a cross-cultural interaction. The last concept is cultural desire. Cultural desire is when someone has the incentive to engage themselves in the cultural

competence process. Cultural assessments were necessarily not specific culture groups, but should always be conducted on every single patient, even if the patient's culture is the same as the nurse's (Campinha-Bacote, 1998). People can have differing views and takes from the same culture. A nurse can never assume the patient has the same exact culture as the nurse.

Giger and Davidhizar

The second model is the Transcultural Assessment Model. Giger and Davidhizar (2002) explain that the model has six concepts of human diversity and variation. These six concepts include communication, space, social orientation, time, environmental control, and biological variations. This model focuses on the involvement of patients in the cultural assessment process. The first concept, communication, is where the nurse assesses the person's primary spoken language, the tone of voice used during conversation, pronunciation, the meaning behind silence, and even includes nonverbal communication. Nonverbal communication can be difficult to master, since a nurse should be able to read something as slight as a person's body language. The next concept is space, which correlates with nonverbal communication. Naturally, humans can recognize personal space. When it comes to personal space, people are able to determine someone else's comfort in relation to others, body language, and judging personal/intimate/public space. When it comes to social orientation, the concept where a person's understanding of culture, ethnicity, leisure, work, and friends in their everyday life can change from person to person. Social orientation is described as one specific person, rather than a whole group of people in that culture. Time is the third to last concept in the Model of Transcultural Nursing. Time is perceived differently within different cultures. Time can be in reference to lifespan, in relation to length of events, and as something that is outside of human control. The environmental control concept is seen as the environment being shaped by the culture

surrounding it and how environments can inhibit or enable a person's health behaviors. Lastly, biological variations are needed to avoid stereotyping. Biological variations are differences between body structure, body weight, skin color, and genetic predispositions to certain diseases. This model promotes assessments on the patient. The Giger and Davidhizar's Model can also be used to explore different issues on the six areas in practice. It encourages flexibility, understanding, and compassion. This model also encourages the involvement of the patient (Giger & Davidhizar, 2002).

Leininger

The Leininger's Cultural Care Diversity and Universality Theory/Model is recognized as a very well-known model, as is the Sunrise Model (Leininger, as cited in Tomey & Alligood, 2002). These two models emphasize the importance of giving the best standard care along with being knowledgeable about a patient's cultural background. People from diverse cultural backgrounds can benefit from how the model allows nurses to assess, diagnose, plan, implement, and evaluate (Leininger, as cited in Tomey & Alligood, 2002). AACN (n.d.) explained how there are certain "assumptions" on how to care for a person that relates to being culturally competent.

The Leininger Model, as cited in Tomey & Alligood (2002), explains that when it comes to care, it is necessary to the patient be cured/healed, and one cannot be cured without being properly taken care of. Without the proper attention and effort, a patient cannot heal properly on their own. If so, the healing process would be much longer, and this may result in further damage. The Leininger Model, as cited in Tomey & Alligood (2002) further explains that every culture has their own rituals for care. This could be an explanation to why Asian culture and Native American cultures use acupuncture or herbs for certain healing purposes. If a patient is aware that the nurse is unable to work with the patient's beliefs and values, this will be perceived

as noncompliance and can further stress the patient (Leininger, as cited in Tomey & Alligood, 2002). This can create a negative nurse-to-patient interaction and will make the nurse's job more difficult, but also the patient will feel he/she is being hospitalized in a non-welcoming environment. The last assumption mentioned in Leininger's model, as cited in Tomey and Alligood (2002), is with every culture the nurse should be consistent in their care, which includes the patient's cultural preservation, the way the patients' and their families need to be taking care of, the way the nurse is accommodating the patient's culture into care, and changing or "repattern" the patient's cultural care routines.

The three culturally competent nursing models assessed hold the same core idea. Campinha-Bacote Model of Cultural Competence and Giger and Davidhizar's Model of Transcultural Nursing both made distinct points to give each patient a cultural assessment regardless of if the patient and nurse share the same culture. Giger and Davidhizar's model, can be the most helpful for a new-grad nursing student due to the description of the six areas in which a nurse should be aware of with each patient. These being the ability to know how a patient communicates, the space the patient may need to feel comfortable, the social orientation, the way the patient perceives time, the reason why the patient does particular things because of their environmental control, and lastly their biological variations on whether that certain culture is more prone to a disease than someone from another culture.

Chapter Two – Cultural Differences

Awareness of cultural differences can benefit the nurse when determining which questions to ask patients' during their cultural assessment. Nurses need to be aware of the way a patient eats their food or if special arrangements need to be made to better assist the patient with their religious practices. Nurses should also be careful about patients' social norms to avoid

unintentionally upsetting the patient or making them feel uncomfortable in any way. Muslim, Jewish, and Chinese cultures will be evaluated.

Muslim Culture

Muslim culture is more commonly known as Middle Eastern Muslim. According to Sharon Pluralism Network (SPN, 2017c), there are many different types of Muslim cultural groups other than the Middle Eastern Muslims. These would include Asian, African, European, and American Muslims. Each of these Muslim cultures have their own practices and traditions, but they all share the belief of “Oneness of God,” “the Holy,” scriptures, and all Prophets. Pork, and its by-products, along with alcoholic drinks are considered forbidden, or “haram.” Alcohol is permitted when used in medicinal practice. Meat can only be eaten if it is halal. This is where the meat is killed in a way where the animal is blessed with the name of God before being killed for meat. The broad Muslim culture goes off of the Lunar Cycle rather than the typical Solar calendar. The Lunar cycle is 11 days shorter than the Solar Calendar. The fewer number of days accounts for Ramadam; it doesn’t fall on the same day every year. Fasting is commonly exercised during Ramadam which refrain from food and drinks from dawn to sunset. Forgiveness, reflection, and charity are encouraged. Praying five times a day is mandatory. While women have the option to pray at home, men are encouraged to pray at the mosque (a Muslim place of worship). This way other Muslim men can stay connected. Muslims can pray at home, at work, during travel in the car, or even in a plane. Prayer mats are sometimes even kept in cars. Whenever a Muslim patient needs to pray, the nurse can suggest a family member to provide a mat for the patient. The patient would need to face the direction of Ka’aba, located in Mecca. The nurse should allow the patient peace and quiet, for praying requires full concentration. Talking or having unfocused thoughts are forbidden, unless in an emergency.

Older patients are allowed to pray while sitting or lying in bed, due to age and illness. Fridays are similar to Christian Sundays when most Muslims choose to go to the mosque to pray. Inside the mosques, stepping on prayer mats with shoes on is considered discourteous. Before a person can pray, nurses must understand that the patient must be clean in order to pray. Muslim households avoid having pets inside of their homes due to animal saliva being considered dirty. Avoiding pets in general is recommended, so in Western culture where animals are seen as family, Muslims may avoid the pet and this can be considered as offensive where none should be taken (SPN, 2017c).

Muslim women aim to dress modestly. Women from various parts of their Muslim culture may dress in specific ways (SPN, 2017c). Most women wear a head covering called a hijab. In other parts of the culture, the hijab is worn along with a long cloth that covers the whole body. This body covering is to prevent the woman's body figure from being seen. Some women cover from head to toe and only expose their eyes. It is extremely disrespectful to criticize women for wearing a hijab. In some countries, it is obligated for the women to wear a hijab, while in the U.S. it is optional. Social distance is important when it comes to Muslim women. If the woman takes a small step back during an interaction, this means the woman is uncomfortable and the women would appreciate if one would respect her space. When speaking to a Muslim woman and even the elderly, keeping direct eye contact can be very uncomfortable for them. Glancing at their eyes from time-to-time would be more acceptable, while also nodding and tilting your head will show interest in the conversation. Children are taught not to stare into the eyes of a person who holds authority over them because this is considered disrespectful. Western culture, in contrast, might perceive this as an expression of guilt (SPN, 2017c).

When it comes to elders, Muslims are very strict about showing respect (SPN, 2017c). Pointing fingers directly at elders or addressing them without a Mr, Mrs, or Miss is very offensive. Nurses should continue such formality unless the patient clarifies otherwise. Opening doors, standing up to greet guests, not interrupting, and having proper posture is appreciated when speaking to elders. When it comes to greeting people, in American culture people usually will give a hug or a handshake. When it comes to Muslim culture, usually shaking hands is not normal with the opposite gender. However, some Muslims won't shake hands at all. To judge whether one is willing to shake hands, the non-Muslim should wait to see if the Muslim will offer their hand. If the Muslim does not offer their hand, they will greet you with a head nod and a smile (SPN, 2017c).

When entering a Muslim person's house, it is polite to remove the shoes when entering, because shoes are considered dirty (SPN, 2017c). Even if shoes are removed, feet from one person touching another person's is also considered disrespectful so an apology is usually expected. A slight bow is known as a greeting to some cultures, but is considered disrespectful in Muslim culture due to the belief that bowing should be done only towards God. The article also mentions that when handing something over to a Muslim person, the right hand should be used because using your left hand is considered to be rude (SPN, 2017c).

Jewish Culture

There are different ways a person can be considered Jewish. According to SPN (2017b), traditional Jewish Law defines a Jew as the biological child of Jewish mother or someone that has converted to Judaism. Judaism states that whether a person is born Jewish or converted, the person is eternally Jewish. Groups of Jewish people do not recognize conversions to Judaism and frown upon the action. There are three main denominations when it comes to Judaism that lay

outside of Israel: Orthodox, Reforms, and Conservatives. Orthodoxism is split into two sects, Modern Orthodox Judaism and Haredi Judaism. Modern Orthodoxism is identified by their style of dress (SPN, 2017b). Many married modern Orthodox women are starting to cover their hair with hats or wigs (Kress, 2017). Haredi Judaism can be distinctly identified by the men who wear black suits and wide-brimmed black hats (Weiss, 2017). The women wear long skirts, head coverings, and thick stockings (Weiss, 2017). SPN (2017b) states, conservative and Reform Jews, celebrate Shabbot customs. Shabbot is Hebrew for Sabbath. Sabbath begins at sundown on Friday evening and ends sundown on Saturday (SPN, 2017b).

SPN (2017b) explains, Orthodox Jewish refrain from any type of work during this time. This would include driving a car and using a cell phone. Something as little as leaving the lights on is a traditional practice since turning them off is considered 'work.' Timers are used to have lights turn off automatically to prevent turning the lights off themselves. Cooking food in advance is recommended, since preparing food themselves is banned during Sabbath. If any work is done it is considered as disrespecting the observation. Sabbath is celebrated with a candle light ceremony and prayers prior to the beginning of Sabbath. This is done no matter the denomination. The Orthodox members are seen walking around their synagogues Saturday mornings. The Conservative and Reform Jews do not celebrate the strict traditions of Sabbath, but they still engage in the Shabbot prayers, candles, and eating of the traditional braided bread. Conservative Judaism is based off traditional Jewish laws. Reform Judaism, also known as Liberal or Progressive Judaism, is described as a religion rather than a race. At a Reform Jewish synagogue, both men and women equally participate in prayer and allows mixed seating between both sexes (SPN, 2017b).

SPN (2017b) explains that Jewish people can only eat kosher foods. Kosher means “fit, proper or correct” and excludes pork and shellfish. Their diet also refrains from mixing any meat with dairy, while fish with dairy are allowed. Meat that is kosher needs to be slaughtered in a way that is humane with all the blood from the animal is drained. Certain utensils are used for dairy, while separate utensils are used for meats. Conservative and Reform Jews both follow kosher traditions, but may not follow them to a certain extent. Offering candy or any type of food to an Orthodox child is not appreciated because they may not be aware of their dietary law, but are still expected to follow it (SPN, 2017b).

SPN (2017b) states that women are viewed as separate but still equal. Emphasis on gender role is not weighed more on one than the other. However, women’s responsibilities differ from men’s. In orthodox synagogues, the women and men are separated with a wall or curtain. Women are not allowed to pray with men at the Torah, a scroll of scriptures. Praying at the Torah is left to the men while the women’s role is to take care of the children and the house. As mentioned earlier, the Conservative and Reform Jews encourage women and men to pray together and be active members of the service. Orthodox Jews may ignore others that are not from the same religion as them. This happens since the Orthodox believe that they should never be distracted from their own religion. It is disrespectful for a man to shake hands with an Orthodox woman, and also for a woman of another culture to touch an Orthodox man. Orthodox women and men believe in dressing modestly, and women avoid showing their hair, arms, and legs (SPN, 2017b).

People may hear of a young teen having a Bat or Bar Mitzvah. SPN (2017b) explains that a Mitzvah is known as a “good deed.” Helping others and conducting good deeds is a main focus of the religion. When a child gets to a certain age the child is accepted into the synagogue’s

community. The mitzvah is performed for the child as an initiation of coming into the community of adults. For females, it is considered a Bat or Bas Mitzvah, while for males it is known as a Bar Mitzvah. This ceremony helps the children recognize that they are going to start taking on the responsibilities of a Jewish adult. The phrase “Mazel tov” is a way of saying congratulations. This can be said during a Bar or Bat Mitzvah, or can also be said during a birth of a child or a wedding (SPN, 2017b).

Chinese Culture

SPN (2017a) states that most Chinese people are expected to be addressed as Mr, Mrs, or Miss. In Chinese culture, people are used to introducing themselves by their last name, but Chinese people in American culture will introduce themselves by their first name due to cultural mixing. Chinese culture usually does not use direct eye contact. Direct eye contact is seen as impolite by the older generation. Not only is this common with Chinese culture but Japanese culture as well. Eye contact is considered polite in American and Arabic culture. Some Chinese people have adapted to U.S. culture in America, but the elderly and shy ones may not. Greetings with a Chinese person may not include a smile unless the Chinese person is confused or embarrassed. If interacting with a Chinese person who is smiling, do not mistake the smile as them understanding or agreeing but the patient may need an interpreter. Shaking hands with Chinese women and men is acceptable. Bowing is not as common in Chinese culture as it is with Korean and Japanese culture. Someone from an older generation may bow but shaking hands has been the norm in recent times. If a Chinese person steps closer during a conversation this is just a gesture that they are interested in the conversation. In formal situations, a Chinese person may stand with hands loosely intertwined together behind their backs. Beckoning someone with a finger is considered poor etiquette. It is best to wave the whole hand with the palms of the

fingers pointing downward. Pointing at people is considered rude yet acceptable when towards an object. In Southern China and Hong Kong a person taps on a table with two fingers as a gesture of appreciation. Someone from an older generation may also find excessive praise as indecent. Giving and accepting direct praise the first time is encouraged. As in Muslim culture, Chinese culture similarly finds receiving objects with the left hand as offensive. Using both hands to hand something over is a sign of respect and is more acceptable than handing something over with one hand. Removing your shoes before entering a home is polite and if not done, it is extremely disrespectful. If shoes are kept on for any reason, an apology is expected to the home owner (SPN, 2017a).

Zimmerman (2015) specifies that rice is the major food source with tofu as the main source of protein in Chinese culture. The Chinese word for rice is *fan*, which can also be used for the word “meal” (Zimmerman, 2015). Kelly (2016) expresses that vegetables and spices are common for each meal. Dessert is not common with Chinese culture. Fruit and tea is preferred in place of dessert. Meals are eaten around a circular table instead of square. They do this because it is easier to share their meals with one another (Kelly, 2016). Kelly (2017) states that traditional Chinese have breakfast between 7:00am and 9:00am. Breakfast usually consists of soy-bean milk, porridge, steamed buns, or rice noodles. Lunch is eaten between 12:00pm and 2:00pm, while dinner is eaten around 6:00pm and 8:00pm. Lunch and dinner will include rice or noodles with vegetables and sometimes meat. Dinner is the most important meal of the day for the Chinese and enjoyed with family (Kelly, 2017).

Chapter Three - Pain

Nurses are trained to treat their patient according to their stated pain level. There are times when the nurse should watch for non-verbal cues from patients who don't verbally express their pain. Informing

the patient of possible pain medication may help the patient better express their pain verbally to their nurse. The way a person reacts to pain is culturally adapted from past experiences and how they were taught to deal with pain growing up (Mantanky, 2009).

Muslim Culture

Branden & Broeckaert (2010) explains that Muslims view pain with two core concepts. The first concept involves a positive importance to one's soul prospects in the afterlife when suffering through pain. Muslims still believe that every patient who is experiencing pain has the right to seek pain medication. The second concept includes a rationale for patients who choose to take pain medication. Although Islam is known to advise against alcohol and drugs, there is no contraindication as long as the pain medication is not abused. Pain is viewed as Allah's (God's) plan and that everything happens for a reason (Branden & Broeckaert, 2010). Rassool (2015) states, "From an Islamic perspective, health is defined as a state of physical, psychological, social and spiritual wellbeing and is viewed as one of the greatest blessings God has bestowed on humankind" (p. 3). Muslims deal with sickness patiently. They incorporate medication and prayers through the process of pain. During a Muslim patient's healing period, the family and community members have a huge role. When deciding whether pain medication should be taken, family members may be involved. Sickness is a great opportunity for spiritual reward and a reminder to better their health. Death is not a negative concept, since death is the pathway to meet God and taking care of oneself is a religious role. Muslims do believe that spiritual duties are a bigger priority over biopsychosocial needs (Rassool, 2015).

There are traditional healing methods in Muslim culture, and they are quite common to use before pharmaceutical measures. Folk remedies based off of Prophetic medicine are used (Rassool, 2015). The Rassool (2015) study found the following:

This healing tradition derives from passages in the Qur'an, Hadith (Prophetic traditions) and Sunnah (way of life) of the Prophet Muhammed; it includes the use of dates, fig, pomegranate, capers, fenugreek, aloe, chicory, indigo, senna, dill, mustard, olive and truffle. Muslims

sometimes also use olive oil, honey, or nigella sativa seeds to prevent and treat certain ailments.

(p. 4)

Rassool (2015) affirms that olive oil is the primary dietary source of fat in Mediterranean diet, and this results in a lower mortality rate in connection to cardiovascular diseases. Olive oil shows evidence in reducing inflammation, blood clots, and metabolizing carbohydrates efficiently. The nigella sativa seeds and oils are used to treat anyone with stomach pains, a variety of respiratory conditions, improve the circulatory and immune system, and improve the kidneys and liver. Honey is mentioned in the Qur'an (Muslim religious book) to help healing. In the past, honey was used as wound dressing, and some commercial brands use it for burn treatments and wound care. Muslims who have diabetes may use honey as a home remedy. A study found that honey helps with reducing body weight and blood lipids. Some Muslims use cupping, also known as hijama, for various ailments. Cupping is mostly used for migraine headaches, jaundice, nausea, trouble sleeping, and even muscle pain. Some folk remedies may contraindicate pharmaceutical medication (Rassool, 2015). If any folk remedies are being used for an illness, nurses and doctors should be aware of them to ensure safety.

Tayeb, Al-Zamel, Fareed, and Abouellail (2010) explains that there are three domains Muslims require for quality care when in relation to death. The first is religious faiths and beliefs, second is self-esteem and body image, and the third is concerns about family security. The first domain relates to the Muslim patient being intact with his/her faith and beliefs. This would include making sure there is a Shahadah to prompt the patient before death. A Shahadah is a witness that assures there is only Allah, while Muhammad is Allah's servant and his messenger. There should also be someone at bedside to chant chapters from the Qur'an. The Muslim patient will wish to die facing towards Mecca (Tayeb et al., 2010). Muslims face Mecca to participate in their daily prayers as well. Tayeb et al. (2010) further explains that the patient may also request to pass away at a mosque or even in Mecca. The nurse would inform the patient that there is no way to bring the patient to Mecca if in critical condition. If the hospital has certain areas where Muslims can pray, the patient can be taken there. Muslims prefer to pass away on a Friday or

during Ramadam. The second domain is in relation to a patient's self-esteem and body image. The patient is concerned about how he/she is viewed by their family members and friends. The nurse should make sure the patient has clean clothes that are free of urine or stool, making sure the patient has good hygiene and making sure the body looks as normal as possible after death. The third domain includes the patient being concerned about his/her family's security. The patient needs to feel content that his/her family will have no financial trouble after their death (Tayeb et al., 2010).

Jewish Culture

Mantanky (2009) expresses that Jewish patients are more easily open to expressing their pain levels. They believe their pain should be recognized by others. Just because a Jewish patient is complaining excessively might not mean they have intense pain, they want to be heard and listened to (Mantanky, 2009). According to Jewish Virtual Library (JVT, 2017), the patient may have an "exaggerated" look, but the pain may not be as intense. In Judaism, it is accepted for people to show extreme sympathy for the person suffering. Suffering can only be seen in illness and poverty, not in death. If a person from the Jewish community is suffering, enjoying oneself is frowned upon since they should be there for the suffering patient. Jewish people believe that they are suffering due to sin. They believe suffering can be bypassed if sin is avoided. The patient just has the need for others to listen and validate their pain. Jewish patients are seen as being sensitive and emotional about pain and are considered to have a low threshold for it (JVT, 2017).

As stated by Rosenn (2017) no one dies alone. Being there for a patient who is dying is a way of accompanying God at bedside. The article explains that having someone at bedside is kind and serves as one of God's disciple to be there for someone who is going through a challenging time. It is important for the nurse to show real companionship towards the patient. Nurses can get used to treating a client's pain with pain medication, but forget about having compassion towards the patient who is experiencing pain (Rosenn, 2017). Staff (2017) explains that Jewish people are banned to live in a city where there is no doctor. Refusing medical treatment is not allowed either, unless for a sensible reason. Suicide, or helping

one with suicide, is also forbidden. Humans are not seen as being fully responsible for their own bodies, but that their bodies are received from God. They should not receive medication or treatment that does not have evidence to support it as harmless. Judaism does not allow participation in activities that are dangerous to their health. This includes recreational drugs that alter the mind and give a “high” feeling. Smoking cigarettes is seen as dangerous. Rabbinical authorities frown upon smoking cigarettes but do not ban it to avoid having a large amount of Jewish people breaking Jewish law (Staff, 2017).

Although in Judaism they believe in using all modern treatments and medicine to cure oneself, the main purpose in life is to thrive (Dennis, 2017). Dennis' (2017) article states:

Just as Jews believed that illness can have supernatural origins, it can likewise be treated via magical, theurgic, and other supernatural means. In practice, all this has meant that amulets, spells, exorcisms, and potions were a regular part of the healer's arsenal of treatments (p. 1).

Dennis (2017) further explains evil spirits are seen as the reason for many illnesses. There is a special text, among the Dead Sea Scrolls, that can fend against demonic attack. It can protect against fevers, chest pain, and any complications with childbirth. Some may believe a seizure means the person is possessed. Special diets, certain foods, exercises, and other healthful practices are home remedies that may be used. Olive oil and left-over wine can be used for extra medicinal power. Certain herbs can be used to counteract illnesses. Jewish culture incorporates natural remedies, but modern medicine and treatments are the options used first (Dennis, 2017).

Chinese Culture

Tung and Li (2015) specified that Chinese American cancer patients had insufficient pain relief due to an inadequate administration of pain medication. The article explains that this is caused by culture. Being able to understand why these patients have inadequate pain management can help effectively treat pain with necessary interventions. There are six reasons the article explains to why Chinese Americans would have barriers to receiving pain medication, this includes stoicism, Buddhism, Confucianism, effects of patient-provider difference in social status, English language acculturation, and fear of

addiction or side effects of pain medication. Stoicism means experiencing joy or suffering without showing much emotion. Someone who practices stoicism views pain as a weakness. When showing weakness, they believe it looks indecent and others may find the patient as attention-seeking. This results in the patient not expressing true pain levels until it becomes intolerable. Taiwanese patients also value stoicism. A study was done and showed that Chinese American patients reported the lowest pain scores, using different types of pain scales.

Buddhism is the third largest religion in the United States. In Buddhism, one cannot live without suffering, including physical and emotional pain. Chinese patients may decline pain medication in consideration of dealing with their pain since it is part of living. They also believe in karma, which is the belief of “what goes around comes around,” and the illness or pain is from a previous sin done earlier in their life or from a previous life. Refusing pain medication is a way of accepting their karma. With Confucianism, the Chinese view family decisions more importantly than their own, including social values. Confucianism involves collectivism and familism, where physical and emotional pain is a family problem. Discussing family issues outside of the family is considered disrespectful. This would include Chinese patients refusing to let health care professionals know their pain score without consulting their family members (Tung & Li, 2015). This results in nurses, and other healthcare professionals, to assess pain inaccurately in these patients. Tung and Li (2015) further explain that effects of patient-provider difference in social status can be a barrier since Chinese culture emphasizes on social status. This includes age, income status, social status, and occupation. It is inappropriate to complain to someone who has a higher social status, which may be the nurse or doctor. Chinese patients believe that good patients do not complain or bother the staff, so they are seen as easy patients. Doing this can make the patient suppress their pain expressions (Tung & Li, 2015), so this results in making it harder to assess their pain.

Tung and Li (2015) also state English language acculturation is a language barrier with Chinese patients. A study was done on Chinese American cancer patients, and only fifty-four percent of them reported that they had pain relief when receiving opioids. The Chinese patients who had a greater

comprehension with the English language reported higher pain scores than the ones who did not understand English as well. The study also showed that Chinese patients reported lower pain scores and diminished facial expressions in relation to pain with healthcare professionals from a different ethnicity. These results correlate with the fact that Chinese patients are unable to communicate their pain and receive inadequate treatment for their pain. Medicinal addiction and/or side effects are a huge concern for Asians in general. Heavy sedation without the actual relief of pain is a concern with pain medications (Tung & Li, 2015).

Tung and Li (2015) explain that when a Chinese patient refuses pain medication the health care professional should investigate the reasons why. Although staff cannot change the patient's beliefs, they should not force their own beliefs on the patient (Tung & Li, 2015) but should give the patient necessary information about relieving pain. Tung and Li (2015) further explains, relationship building will be important for these patients because it can be hard to join family discussions about the patient's treatment (Tung & Li, 2015). Having a strong relationship can ensure that the patient will feel more comfortable in expressing their pain, so they don't feel like they are talking to a complete stranger about their needs.

A nurse should make sure the patient has a goal and the nurse should help reach that goal. The nurse should also be a good listener, build trust, accommodate for language barriers, be culturally competent, and understand gender issues (Mantanky, 2009). Understanding that pain is different for each patient and to use pain assessment tools can help the nurse accurately determine pain levels.

Chapter Four – Health Disparities

Healthy People (2014) defines disparities as a greater or lesser health outcome within different populations. This can include the difference in religion, gender, or age. It can also be a difference in social, economic, or environmental disadvantage. Over the years the absence of diseases indicated good health (Healthy People, 2014). This is not the case. Calvillo et al. (2009) state that limited resources, education, inaccessibility to quality healthcare, and unhealthy living

conditions will most likely lead to increased health disparities. Increased health disparities can contribute to certain diseases without the proper resources. Healthy People (2014) continues to state, having good quality education, quality foods, safe housing, reliable transportation, health insurance, clean water, and a culturally sensitive health care provider that can make a huge impact on whether the patient is able to receive good quality health care. Islamic, Jewish, and Chinese culture have been explored. This section will include African-American and Mexican culture in relation to cultural health disparities.

Muslim Culture

Racial-ethnic disparities are when a specific race is more prone to a disease or illness than another. For example, compared to white adults, other minority adults are at a higher risk of developing type 2 diabetes (Gary-Webb, Golden, Sumner, 2013). As discussed earlier a huge part of Islamic culture is the participation of Ramadan. This is the holiday when Muslims fast from dawn to dusk. This can lead to Muslim patients at higher risk of dehydration, dramatic weight loss, irritability, and having a lack of concentration (Laird, Amer, Barnett, & Barnes, 2007). Fasting before puberty, which they are not required to do (Laird et al., 2009), can affect their hormones negatively and other growth factors that are very important during that stage of life. During Ramadan, staying up late to feast is normal. For children who need to wake up for school the next day will lose sleep and this can affect growth as well.

The Qu'ran preaches for women to breast feed their babies up to 30 months, while also emphasizing on avoiding alcohol and drugs, and not eating too much or too little (Laird et al., 2009). The Qu'ran also states parental discipline for children is necessary (Laird et al., 2009). This will increase the chances of children having healthy lifestyle by staying out of dangerous activities that other children may be participating in. Children who have not reached puberty yet

automatically go to Heaven since they are never responsible for any sins (Laird et al., 2009). This belief will ease parents if their child dies because it assures their child will go straight to Heaven. Seventy-five percent of Pakistani Muslims marry within families, first cousins or other close relatives (Laird et al., 2009). Middle-eastern and other Muslim populations participate in this custom as well, which leads their children to have higher rate of birth defects (Laird et al., 2009).

Laird et al. (2009) state that female genital cutting (FGC) is common in Islamic culture. Many healthcare professionals are not aware of the complications that come with this procedure. This procedure is illegal to perform in the US (Laird et al., 2009), but still happens in underground clinics. Laird et al. (2009) further explain that females who have undergone FGC are at a higher risk of urinary tract infections and gynecological disorders. These girls will most likely experience social, sexual, and emotional complications. Health care professionals must realize that these patients need special care when giving birth (Laird et al., 2009).

Laird et al. (2009) also explains how Muslim patients will prefer same-sex providers to avoid contact between the opposite sex. Not being able to ingest alcohol or pork may conflict with the consumption of some medications unless it comes down to an emergency situation, where the patient's health is more important than the religious concept. Consulting with the patient on their choices can help. Muslim patients suffer from religious discrimination. Their surrounding environment may treat them as threatening, and this can be a factor in their access to care (Laird et al., 2009).

Laird et al. (2009) express that Muslims believe the physical body has a right to healing, and are taught to seek medical attention whenever necessary. Mental illnesses are negatively stigmatized in Islamic culture. Mental illnesses are not to be discussed since they prefer to cope

with private prayers (Laird et al., 2009). Prayer is believed to be almost as powerful as medicine. Some patients believe that not being able to access medicine can be okay for them because they believe prayer can work just as well (Muslim Culture, n.d.). This can affect any illness these patients have, and worsen without the proper treatment. Education on the importance of medicine and how it works within the body can be beneficial for these patients to understand how to properly take care of themselves, while also allowing them to still use their cultural healing methods.

Jewish Culture

With Jewish culture, pig with other animals cannot be ingested even though most insulin has traces of pig. The patient should be warned of insulin with traces of pig. Letting the patient know this will establish a patient/nurse bond.

Marian Joy Library (MJL, n.d.) states Sabbath is observed by Jewish people which happens from Friday evening to Saturday evening. This is when use of electronics are forbidden in order to live a pure life within this time. In hospitals, an actual bell would be used versus a call light and manual over electric doors. Expecting mothers may bring another woman with them to help her with personal and physical needs during childbirth. There may need to be arrangements for patients who are observing Sabbath, so as to avoid paperwork. Major health disparities can occur in relation to Sabbath, where patients feel their illness is not worth breaking Sabbath (MJL, n.d.).

Karmanos Cancer Institute (KCI, n.d.) states, cancer is considered shameful to a Jewish family. Jewish families might decline early cancer detection methods to avoid such shame. Making sure these patients know the importance of regular checkups can help these patients be more involved with their own health. Although much research has not been conducted on Jewish

health disparities compared to Muslim, Chinese, African-American, and Mexican patients, there is still a lot to consider when taking care of these patients. Understanding their dietary needs and that they may be observing Sabbath should be implemented by every health care team member associate with that patient's care.

Chinese Culture

Asian Americans are the fastest growing minority group in the United States (AAHI, n.d.). California is home to a higher number of Asian Americans than all other states, followed by New York is second and Texas is third (Office of Minority Health [OMH], 2017a). AAHI (n.d.) expresses, hepatitis B is a one of the larger issues for Asian patients and is responsible for half of the deaths in the U.S. for hepatitis.

In relation to Asian Americans with mental illnesses, the numbers are very high. Asian patients who are 65 years or older are at a higher risk of suicide in America. Asian American adolescents were observed to have the highest numbers for depression. Research by Chen and Hu (2014) says the reason that cancer and cardiovascular disease are the two leading causes of death within American Asian patients is because of higher hypertension rates. AAHI (n.d.) states that they have the lowest cancer screening rate and are usually diagnosed at later stages of cancer. This could be because forty-six percent of them in the U.S. cannot speak English well and only twenty-two are publically insured. In America, two million Asians do not have health insurance, while sixteen percent of Chinese are uninsured. This interferes with their access to healthcare. All these statistics are a result of language and cultural barriers (AAHI, n.d.). While these statistics are shocking, there is an initiative not being taken to make sure these numbers decrease. Many Asian Americans are afraid their doctors will not understand their culture (AAHI, n.d.), and may search for health care providers that come from the same culture as them.

Having to take an extra step to find a culturally similar doctor can be another milestone to finally having regular access to health care.

Not all Chinese American disparities are related to their language or cultural barriers but can be factored in with their genetics. When it comes to Chinese culture, there are many differences that lead to health disparities, including cancer and cardiovascular disease (AAHI, n.d.). Chinese patients can feel intimidated by American medicine and find it complicated to deal with hospital and clinical bills. Chinese Americans are afraid of getting deported or being exposed for lacking health insurance (OMH, 2017a). They are six times more likely to die from liver cancer. Body mass index is a huge contributor to increased chances of hypertension. About forty-three percent of Chinese Americans have a family history of hypertension compared to 38.8% of Caucasians with a history of hypertension. Chinese Americans that were seen to have controlled blood pressure were the ones who were married, rather than their single or widowed counterparts. Patients who are unemployed or have family issues have higher levels of hypertension. Social support and family resources are beneficial to reduce health disparities (Chen & Hu, 2014). Asian Americans have the highest life expectancy compared to all other ethnic groups in the United States, living up to 85.5 years old (OMH, 2017a).

African-American Culture

OHM (2017b) states, African Americans, also known as black culture, make up 12.7% of U.S population. Forty percent of African-American adults are more likely to die from breast cancer, two times more likely to die from cervical cancer, and twenty percent more likely to receive treatment for depression (Families USA, 2014). African Americans have higher risks of stroke, cancer, asthma, influenza, pneumonia, diabetes, HIV/AIDS, and homicide (OMH, 2017b). One of the biggest health disparities within African Americans is sexually transmitted

diseases within the youth population (Watts, 2014). HIV/AIDS is the leading cause of death for African American males between ages 35 and 44 (Davis, 2009). In 2002, twenty-seven percent of all new HIV/AIDS patients ended up contracting the disease by sharing needles with someone who had HIV/AIDS or having sex with drug users (Davis, 2009). Health disparities with African American children affect infant mortality by double, along with sudden infant death syndrome and asthma (Families USA, 2014). African Americans are more prone to certain diseases and illnesses, and this can be correlated with where they live. Resources African Americans have are very limited. The average household income is about \$33,762 a year while non-Hispanic white households average around \$56,565 a year (Families USA, 2014). About forth-three percent of African Americans use Medicaid, compared to 32.7% of whites (OMH, 2017b). Eleven percent of African Americans don't have insurance at all, while only six percent of whites are uninsured (OMH, 2017b).

Watts (2014) explains that health disparities can be high in the African American culture due to structural factors. This can include not scheduling appointments, a lack of transportation, hectic work schedules leading to inability to see health care provider, and prolonged waiting times in waiting rooms. All these factors will result in increased visits to the emergency department (Watts, 2014).

Nutrition can be an important factor when it comes to certain diseases. African American cultural foods contain lots of fats, sugars, and sodium (Davis, 2009). The culture tends to enjoy indulging in fried and salty foods. They enjoy barbecuing foods that can be served with gravies and sauces (Ewing, 2015). Baked goods and pies are popular within the culture as well (Ewing, 2015). This type of eating behavior increases the chances of this population gaining unnecessary

weight. Some African American families tend to be less active (Davis, 2009), which compounds with health issues related to poor eating habits.

Spirituality is important in black culture (Johnson, Elbert-Avila, & Tulsy, n.d). They believe that God is liable for their physical and spiritual health (Johnson et al., n.d). They work towards restoring harmony to heal the root cause of the sickness (Meharry Medical College, 1992). Going to church to pray for healing is sometimes practiced in addition to seeking medical help. They have unique practices that they believe help treat certain conditions, for example placing a silver quarter on the back of one's neck when their nose is bleeding (Mitchem, 2007). Another home remedy is using sweet oil drops in the ears to treat earaches (Mitchem, 2007).

Mexican Culture

Mexicans share similar health disparities as African-Americans do and more. This can be due to a significant number of illegal immigrants that are afraid to go to a hospital or healthcare facility, making an illness even worse without the correct resources. Mexicans' morbidity and mortality rates are increasing each year due to socioeconomic factors like education, lifestyle behaviors like alcohol intake and physical activity, access to preventative health-care, and even racial discrimination (Centers for Disease Control and Prevention [CDC], 2004). The study by Vega, Rodriguez, and Gruskin (2009) shows that more than one half of the Latinos in America are healthier than the domestic Americans in the U.S. Diabetes is the number one disease Latinos deal with in the U.S., but another leading factor is homicidal events that happen within younger Latino men. Homicide is not considered a physical health disease, but being homicidal can correlate with mental health. While diabetes is the number one reason for Latino mortality rates, liver disease comes in second, then liver cancer. The health disparities within Latinos correlates with unequal socioeconomic factors. Immigrants who come to the U.S. carry unhealthy eating

habits and lifestyle to the U.S., while their children learn American eating style which may be healthier. Latinos do have a decreased chance of seeking healthcare. Latinos are the number one population to not have insurance, perhaps due to working for employers who do not provide it. With Mexico bordering the U.S., there is an increased likelihood of illegal Mexican immigrants inside the U.S., and illegal immigrants in the U.S. have a lower mortality rate than U.S.-born Mexican Americans (Vega, Rodriguez, & Gruskin, 2009). The CDC (2004) states that recent immigrants have an increased risk of diseases and illnesses. This can be related to not being educated on the resources we have here in America and also a language barrier.

Chapter Five – Recommendations & Conclusion

Calvillo et al. (2009) state that it is necessary for a nurse to pay attention to patients' health and illness beliefs. This can include religious beliefs, their primary language, values, and other socioeconomic factors that may impact their health (Calvillo et al, 2009). Nursing involves not only taking care of the patient, but the patient's family as well. The family can be just as involved in the patient's care as the patient themselves. Understanding where the patient comes from culturally, their environmental background, and the way they interact can help both the patient and the nurse to communicate better. Once this is done, the nurse can provide information to other healthcare team members such as doctors or surgeons.

Socioeconomic status plays a huge role on whether a group of people have reliable access to healthcare. Nurses can help with this by assessing the patient and determining whether the patient has regular access to care. If not, there may be an underlying issue with the patient that they might not know about. Language barriers are another way certain groups will not have access to healthcare the way English speaking patients do. In hospitals, patients who do not speak English can speak to a translator to help communicate with the nurse and even reduce

stress for the patient. Good eating habits can be taught to patients who come from a culture of bad eating habits through education.

The more contact a patient has with their nurse, the smaller the health disparities. Patient-centered care can help decrease disparities by providing the patients with their needs to feel comfortable. Making sure we see what culture they are from, their eating habits, where they work, and the environment they live in can all help the nurse to better provide for the patient. Nursing is looked at as a very caring and compassionate job. Some may say that nowadays nurses only want to clock in and clock out. Some nurses try to stay in the patient's room as little as possible to avoid talking to the patient. This type of nursing is in no way caring and compassionate. No patient deserves to have a nurse who comes into work to follow doctor's orders without knowing why the patient is getting a certain medication or is not invested in the patient's care. It is important to be fully invested in the patient's care to make sure the nurse is doing everything they possibly can for the patient while also making them feel taken care of.

References

- American Association of Colleges of Nursing. (n.d.). Retrieved from <http://www.aacnnursing.org/Portals/42/AcademicNursing/CurriculumGuidelines/Cultural-Competency-Bacc-Tool-Kit.pdf?ver=2017-05-18-143552-023>
- Asian American Health Initiative. (n.d.). Who are Asian Americans?. Retrieved from <http://www.aahiinfo.org/english/asianAmericans.php>
- Branden, S., & Broeckaert, B. (2010). Necessary interventions: Muslim views on pain and symptom control in English Sunni e-Fatwas. *Ethical Perspectives, 4*, 626-651. doi: 10.2143/EP.17.4.2059849
- Calvillo, E., Clark, L., Ballantyne, J., Pacquia, D., Purnell, L., & Villarruel, A. (2009). Cultural competency in baccalaureate nursing education. *Journal of Transcultural Nursing, 20*(2). Retrieved from <http://journals.sagepub.com>
- Campinha-Bacote. (1998). The process of cultural competence in the delivery of healthcare services: A culturally competent model of care. Cincinnati, OH: Transcultural C.A.R.E. Associates
- Centers for Disease Control and Prevention. (2004). Health disparities experienced by Hispanics --- United States. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5340a1.htm>
- Chen, M., & Hu, J. (2014). Health disparities in Chinese Americans with hypertension: A review. *International Journal of Nursing Sciences, 1*(3), 318-322. doi: 10.1016/j.ijnss.2014.07.002
- Cosio, D., & Lin, E. (2015). 6 traditional Chinese medicine techniques. *Practical Pain Management*. Retrieved from

<https://www.practicalpainmanagement.com/patient/treatments/alternative/6-traditional-chinese-medicine-techniques>

Davis, K. (2009). Statistics on health disparities among African Americans. *Wellness Consumer Health Information*. Retrieved from

<http://www.netwellness.org/healthtopics/aahealth/currentstats.cfm>

Dennis, R. (2017). Jewish healing & magic. *My Jewish Learning*. Retrieved from

<http://www.myjewishlearning.com/article/jewish-healing-magic/>

Ewing, J. (2015). Cultural diversity: Eating in American – African-American. *Family and Consumer Sciences*. Retrieved from <http://ohioline.osu.edu/factsheet/HYG-5250>

Families USA. (2014). African American health disparities compared to non-Hispanic whites.

Retrieved from <http://familiesusa.org/product/african-american-health-disparities-compared-to-non-hispanic-whites/>

Gary-Webb, T., Golden, S., & Sumner, S. (2013). What are health disparities? *Hormone Health Network*. Retrieved from <http://www.hormone.org/hormones-and-health/scientific-statements/health-disparities>

Giger, J., & Davidhizar, R. (2002). The Giger and Davidhizar transcultural assessment model.

Journal of Transcultural Nursing, 13(3), 185-188.

Healthy People. (2014). Disparities. Retrieved from

<https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>

Jewish Virtual Library. (2017). Suffering. Retrieved from

<https://www.jewishvirtuallibrary.org/suffering>

Jirwe, M. (2008). *Cultural competence in nursing*. Retrieved from

<https://openarchive.ki.se/xmlui/>

- Johnson, K., Elbert-Avila, K., & Tulsy, J. (n.d.). Traditional healing methods. Department of Medicine. Retrieved from <https://sites.google.com/site/africanamericanhealthculture/home/traditional-healing-methods>
- Karmanos Cancer Institute. (n.d.). Population studies and disparities – Ultra-Orthodox Jewish cancer research. Retrieved from <https://www.karmanos.org/?id=664&sid=1>
- Kelly. (2016). The top ten differences between Chinese and western eating. *China Highlights*. Retrieved from <http://www.chinahighlights.com/travelguide/difference-between-chinese-and-westem-eating.htm>
- Kelly. (2017). China's mealtimes – when, what, and how Chinese eat. *China Highlights*. Retrieved from <http://www.chinahighlights.com/travelguide/chinese-food/dining-time.htm>
- Kress, M. (2017). Orthodox Judaism today. *My Jewish Learning*. Retrieved from <http://www.myjewishlearning.com/article/orthodox-judaism-today/>
- Laird, L., Amer, M., Barnett, E., & Barnes, L. (2007). Muslim patients and health disparities in the UK and the US. *US National Library of Medicine, 92*(10), 922-926. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2083249/>
- Mantanky, J. (2009). Cultural responses. *Diversity in Pain Management*. Retrieved from <https://diversityinpain.wordpress.com/cultural-responses/>
- Marian Joy Library. (n.d.). Jewish Orthodox. Retrieved from http://www.marianjoylibrary.org/Diversity/documents/jewish_orthodox.pdf
- Meharry Medical College. (1992). Traditional healing methods. *Journal of Health Care for the Poor and Undeserved*. Retrieved from

<https://sites.google.com/site/africanamericanhealthculture/home/traditional-healing-methods>

Mitchem, S. (2007). African American folk healing. *NYU Press*. Retrieved from

<https://nyupress.org/books/9780814757321/>

Muslim Culture. (n.d.). 3. Traditional healing methods pasts & present. Retrieved from

<https://sites.google.com/site/muslimculturegroup4/home/-traditional-healing-methods>

Office of Minority Health. (2017a). Profile: Asian Americans. (2017). Retrieved from

<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=63>

Office of Minority Health. (2017b). Profile: Black/African Americans. (2017). Retrieved from

<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61>

Rassool, G. (2015). Cultural competence in nursing Muslim patients. *Nursing Times*. Retrieved

from <https://www.nursingtimes.net/roles/nurse-educators/cultural-competence-in-nursing-muslim-patients/5083725.article>

Rosenn, R. (2017). Feeling another's pain. *My Jewish Learning*. Retrieved from

<http://journals.sagepub.com.ezproxy.emich.edu/doi/full/10.1177/1084822314547962>

Sharon Pluralism Network. (2017a). Chinese culture. Retrieved from

<http://sharonpluralism.org/cultural-protocols/chinese-culture/>

Sharon Pluralism Network. (2017b). Jewish culture. Retrieved from

<http://sharonpluralism.org/cultural-protocols/jewish-culture/>

Sharon Pluralism Network. (2017c). Muslim culture. Retrieved from

<http://sharonpluralism.org/cultural-protocols/muslim-culture/>

Staff, M. (2017). Jewish health and healing practices. *My Jewish Learning*. Retrieved from

<http://www.myjewishlearning.com/article/jewish-health-healing-practices/>

- Tayeb, M., Al-Zamel, E., Fareed, M., & Abouellail, H. (2010). A “good dead”: Perspectives of Muslim patients and health care providers. *Annals of Saudi Medicine, 30*(3), 215-221.
doi: 10.4103/0256-4947.62836
- Tomey, A., & Alligood, M. (2002). *Nursing theorists and their work*. St. Jouse, MO: Mosby
- Tung, W., & Li, Z. (2015). Pain beliefs and behaviors among Chinese. *Sage Journals, 27*(3). doi: 10.1177/1084822314547962
- Vega, W., Rodriguex, M., & Gruskin, E. (2009). Health disparitites in the Latino population. *Epidemiologic Reviews, 31*(1), 99-112. <https://doi.org/10.1093/epirev/mxp008>
- Watts, M. (2014). African American history and health disparities. *Prevention Research Center*. Retrieved from <http://prc.sph.umich.edu/2014/02/african-american-history-health-disparities/>
- Weiss, R. (2017). Haredim (Charedim). *My Jewish Learning*. Retrieved from <http://www.myjewishlearning.com/article/haredim-charedim/>
- Zimmermann, K. (2015). Chinese culture: Customs & traditions of China. *Live Science*. Retrieved from <http://www.livescience.com/28823-chinese-culture.html>