The ETHNIC(S) Mnemonic: A Clinical Tool for Ethnogeriatric Education

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Geriatrics healthcare providers need to be aware of the effect that culture has on establishing treatment priorities, influencing adherence, and addressing end-of-life care issues for older patients and their caregivers. The mnemonic ETHNIC(S) (Explanation, Treatment, Healers, Negotiate, Intervention, Collaborate, Spirituality/Seniors) presented in this article provides a framework that practitioners can use in providing culturally appropriate geriatric care. ETHNIC(S) can serve as a clinically applicable tool for eliciting and negotiating cultural issues during healthcare encounters and as a new instructional strategy to be incorporated into ethnogeriatric curricula for all healthcare disciplines. J Am Geriatr Soc 50:1582–1589, 2002.

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Healthcare organizations, providers, and policy makers are becoming increasingly interested in the delivery of more culturally responsive services to our nation’s diverse population groups. Reasons cited by the Georgetown University National Center for Cultural Competence include: “(1) responding to current and projected demographic changes in the United States; (2) eliminating longstanding disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds; (3) improving the quality of services and outcomes; (4) meeting legislative, regulatory, and accreditation mandates; (5) gaining a competitive edge in the marketplace; and (6) decreasing the likelihood of liability/malpractice claims.”

It is projected that, by 2030, older people from populations classified as racial and ethnic minorities (African American, American Indian/Alaska Native, Asian/Pacific Island American, and Hispanic American) will constitute one-fourth of all older Americans. Currently, minority older people constitute more than 16.1% of all older Americans (≥65). Between 1999 and 2030, the older minority population is projected to increase by 217%, compared with 81% for the older white population. For example, the number of older African Americans will increase by 128%, older American Indians/Alaskan Natives by 193%, older Asian/Pacific Island Americans by 301%, and older Hispanic Americans by 322%.

These broad classifications encompass many different cultures of origin, and diversity is often greater within than between groups in terms of health beliefs, attitudes, and perspectives on the delivery of health care. Healthcare providers who care for older minority patients need to recognize this heterogeneity, avoid stereotyping and “cookbook” approaches, and employ therapeutic strategies that result in more culturally appropriate care.

The goals of Healthy People 2010 focus on the elimination of health disparities while improving the overall health of the American people. Many of the health-promotion and disease-prevention objectives apply directly to the care of older people from diverse backgrounds. Older people from different racial and ethnic minority groups continue to experience troubling health disparities in access to care, service utilization, quality, and health outcomes. The literature reveals a consistent gap in deaths from heart disease, cancer, and stroke, the three leading causes of death in older people.

Healthcare policy makers and other advocates have proposed cultural competency as a strategy for reducing racial and ethnic health disparities. Healthcare providers need to understand the effect of factors such as socioeconomic status, education, race/racism, ethnicity, culture, sex, disability, and sexual orientation on the health and functioning of the older population. The American Medical Association (AMA) has defined cultural competency in clinical care as “the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. Cultural competence involves an awareness and acceptance of cultural differences; self-awareness; knowledge of the patient’s culture; and adaptation of skills.”

Healthcare providers in geriatrics become more culturally competent only with the support of the healthcare...
system. Cultural competency must also be institutionalized; techniques that have been proposed include, but are not limited to, cultural competency training, medical interpreter services, recruitment and retention of a diverse health professions workforce, coordination with traditional healers, collaborating with community health workers, culturally competent health promotion, involvement of family and community members in decision making, and administrative and organizational accommodations.10

Healthcare delivery systems have multiple, often-competing responsibilities to comply with legislative, regulatory, and accreditation mandates in the delivery of culturally and linguistically competent healthcare services to all patients served. Recent federal requirements seek to ensure that all people entering the healthcare system receive equitable and effective treatment in a culturally and linguistically appropriate manner.11-13 Although some improvements have been made in addressing cultural and language barriers through the availability of bilingual staff, face-to-face medical interpreter services, contracted community language banks, and telephonic interpreter services in hospital settings, the real-time availability of these language services, specifically in ambulatory office settings where older patients receive most of their health care, remains problematic.

ETHNOGERIATRIC EDUCATION FOR HEALTHCARE PROFESSIONALS

Improving the quality of services provided through integrating cultural competency training into health professions schools is an area of growing interest.14 Movement towards this effort in medical education at the undergraduate15,16 and graduate17,18 level include the Liaison Committee on Medical Educations’19 and Association of American Medical Colleges’ (AAMC)20 recently approved cultural diversity accreditation requirement and the American Council for Graduate Medical Education’s21 incorporation of attitudes, knowledge, and skills in humanism, professionalism, and cultural sensitivity into training for medical students and physicians. Professional societies such as The Society for Teachers of Family Medicine,22 The American Academy of Pediatrics,23 and The American College of Obstetricians and Gynecologists24 have published relevant recommended guidelines. Family medicine,25 internal medicine,26 pediatrics,27 and psychiatry28,29 have also developed educational programs in this area.

As related specifically to geriatric healthcare training, the term “ethnogerontology” first appeared in the 1970s in literature describing cross-cultural aging.29 In 1987, core faculty members of the Stanford Geriatric Education Center adapted the term “ethnogeriatrics” specifically for health care for older people from different cultures. The members of the national collaborative on ethnogeriatric education have recently revised a core curriculum in ethnogeriatrics to provide a comprehensive and detailed curriculum for all types of healthcare providers to increase their cultural competency in the care of older people.30 To improve the access and use of services and ultimately the quality of care older people from diverse backgrounds receive, a core ethnogeriatric curriculum has been proposed at every level of healthcare professional training.31 A critical next step is the operationalization and integration of this curriculum into geriatrics educational programs and demonstration of its effect on clinical practice.

THE ETHNIC(S) MNEMONIC

Once cross-cultural areas of differences are recognized as being important in health care, a means of addressing them is needed, based on a more thorough understanding of these differences and their implications. The concept of the illness explanatory model (EM), developed by Kleinman et al.,32 has been used to develop specific teaching techniques for understanding patients’ perceptions of their illnesses and effective methods of negotiating acceptable treatment. EMs are not intended to replace the standard medical history-taking process but rather are proposed to serve as a framework within which to facilitate communication during clinical encounters. Existing EM frameworks include Listen, Explain, Acknowledge, Recommend, Negotiate (LEARN),33 Background, Affect, Troubles, Handling, Empathy (BATHE),34 and Explanatory model, Social and environmental factors, Fears and concerns, Therapeutic contracting (ESFT).35

In applying the EM concept to cross-cultural clinical encounters, Levin et al. developed the mnemonic, ETHNIC, as a practical interviewing tool and framework for clinicians to use in addressing cross-cultural healthcare issues with their patients.36 The ETHNIC mnemonic was designed to be integrated into the routine 15-minute visit between physicians and their patients in the ambulatory office setting, the hospital, and other ambulatory settings but is also applicable in other healthcare settings. It focuses on the acute and chronic sick visit but can also be applied to preventive care measures. The present authors have broadened the mnemonic to ETHNIC(S), by including the letter “S” for Spirituality and to remind the practitioner to elicit the health and illness beliefs and practices of seniors and their caregivers. Each letter refers to an aspect or domain of the cultural aspects of health and illness that are important for the healthcare provider to explore explicitly. Table 1 presents the mnemonic with suggested probes to elicit additional information.

Description of ETHNIC(S) Mnemonic

Explanation (E)

Within the context of geriatric healthcare interactions, the lack of questioning or explanations offered by an older patient may reflect a passive role that sometimes can impede cross-cultural understanding. Some older people may be reluctant to provide a response initially, whereas others may avoid this issue with a reply like, “That’s your job doc.” Gentle prodding and the use of normalizing phrases from the provider, such as, “I often learn important things from hearing people’s ideas about why they are ill and what they think should be done about it” may be effective in eliciting this information.

If patients do not offer explanations, ask what concerns them about their problems. Included in the explanation is also the inquiry of how older patients perceive that others view their condition. This is important to elicit because the opinions of other caregivers, whether present in the clinical setting, at home, or living miles away, may be as important to patients as their own explanations.
Finally, the role that the media may play in this aspect should also be noted, if the patient offers. This may facilitate subsequent communication with the patient using a common point of reference. Many older people receive health information from a diversity of sources of variable reliability. Healthcare providers from one cultural background may have limited awareness of the media sources used by patients from different cultural backgrounds.

**Treatment (T)**

In inquiring about treatments or interventions that patients have employed before the current encounter, the healthcare provider needs to be explicit in asking about any and all treatments that a patient is willing to share at the time of the encounter and not just the ones that a patient perceives would be acceptable to the provider. The strong desire of many older patients to seek the approval of the physician may lead them to present just that information that they feel the physician will agree with and avoid other information that might provoke disagreement or disapproval. Older patients from varying cultures traditionally use complementary and alternative medicine (CAM) treatments; these should be explored explicitly. Foster et al. reported that 30% of Americans aged 65 and older were using alternative medicine in 1999, with the two most common modalities being chiropractic and herbal.\textsuperscript{37,38} To encourage patients and their caregivers to talk about CAM, providers should ask open-ended questions such as “Are you doing anything else for this symptom/illness/condition?” or “Are you taking any over-the-counter remedies such as vitamins or herbs?”

**Healers (H)**

Similar to the above treatment issue, this item explicitly seeks to explore all providers, both medical and alternative healers that older patients might be consulting in addition to their usual source of health care. Given the increasing prevalence of alternative healthcare utilization by many older people, especially for chronic conditions such as arthritis and cognitive impairment, this item is important to allow the patient to disclose any other sources of healthcare. This item also implicitly acknowledges the provider as another healer but not necessarily the sole healer for the patient.

Many practitioners find it challenging to work with alternative providers and need to strike a balance between respect and autonomy for their older patients’ choices and
potential adverse interactions of treatments. Encouraging discussion of alternative providers and their treatments establishes a certain level of trust that can help facilitate further communication.

**Negotiate (N)**
This item tries to establish whether the older patient is willing to work with the current provider to seek outcomes that will be mutually acceptable to the provider and the patient. This item builds on the previously identified beliefs in a jointly acceptable manner. Negotiation implies that both parties are actively seeking to work together. When applied to the care of an older patient for whom a caregiver is involved, that individual, whether a family member or involved friend, needs to be explicitly acknowledged as well. In the particular areas of providing end-of-life care to culturally diverse older populations, this item may focus on functional outcomes or symptomatic relief. This item also explicitly allows for the identification of expectations from the patient or caregiver that the provider would otherwise consider unrealistic.

**Intervention (I)**
With interventions, providers and older patients or their caregivers discuss and mutually propose their courses of action (e.g., clinical preventive services, diagnostic testing, medication, psychosocial counseling, rehabilitation) in addressing the needs identified earlier. This item allows for the blending of clinically appropriate healthcare services within the context of the developing culturally competent encounter. Careful attention to a patient’s responses as revealed through the prior steps can assist providers in constructing a more effective bridge between the scientific understanding of the symptom/illness/condition and a patient’s comprehension of the situation. Those clinical interventions that the provider may have been ready to propose before proceeding through the earlier steps can now be modified and individualized based on the information received and processed in the above steps. In chronic disease states being managed during end-of-life care, there is great variability in the potential interventions that the provider or the patient individually might consider appropriate but now, at this stage in the process, can be more likely agreed upon.

**Collaborate (C)**
Collaboration refers not only to the patient and provider directly involved with the encounter, but may also involve caregivers or family members, any other healers the patient may have identified earlier, professionals from other disciplines, and community resources. The item does not necessarily ask for the patient to agree with all that the provider has proposed but rather to mutually discuss and share information about how the therapeutic relationship can best develop. The item is similar to “therapeutic contracting,” which has been proposed in other patient encounters in which the physician and other providers seek to effect change, but emphasizes the interactive nature rather than a provider-dictated course of action.26

Some older patients may choose not to make a meaningful agreement here, especially in the course of a brief first encounter. Instead, the initial focus of collaboration would be on the development of a trusting interpersonal relationship that may eventually become a therapeutic alliance. Further understanding of the patient’s responses and relationships can help guide decisions about the need to work with other individuals and organizations.

**Spirituality (S)**
Spirituality is often a neglected factor in the health care of older patients.39 The concept of spirituality is found in all cultures and is expressed in a patient’s search for ultimate meaning through participation in religion or belief in God, family, naturalism, rationalism, humanism, and the arts. The AAMC Task Force Report on Spirituality, Cultural Issues, and End of Life Care40 has proposed outcome goals for physicians to incorporate awareness of spirituality, and cultural beliefs and practices, into patient care in a variety of clinical contexts.

Although recognizing the value of spirituality in the abstract, many healthcare providers feel uncomfortable addressing the topic during the course of direct patient care. In addition, many older patients and their accompanying caregivers may not expect to be asked about their perceptions of the influence their spiritual beliefs have on their health conditions. Nevertheless, healthcare providers should be prepared to respond to spirituality issues that their older patients coping with chronic illnesses, advance directives, and end-of-life care might raise. The role of prayer as an intervention for illness or disease and the spiritual meaning that the suffering can bring to illness experiences for some individuals are both examples of how spirituality has great relevance in the care of older people from varied cultures. Having the provider acknowledge these issues in the presence of the patient can demonstrate cultural sensitivity to an issue often not addressed during clinical encounters. In instances in which the older patient is struggling with end-of-life issues, having the healthcare provider raise the spiritual dimension of the patient’s experience may itself provide for hope and important meaning for the encounter. Once the issue is raised, some older patients may then provide a spiritual history, which can be recorded as part of the social history, but, sometimes, spiritual issues may arise earlier in the encounter and can help develop rapport. The ETHNIC(S) mnemonic does not have to be followed in a linear fashion. It can provide an opportunity to explore spiritual issues at any time and allows for rapport to be developed to facilitate this degree of sharing of cultural and spiritual perspectives. It also may facilitate providers sharing their own spiritual beliefs and values, when appropriate, with the patient. This can often enhance the therapeutic relationship between provider and patient in a unique and often mutually satisfying way.

**Clinical Application of the ETHNIC(S) Mnemonic**
The following case vignettes provide selected examples from our experiences in caring for culturally diverse older patients and illustrate the clinical application of the ETHNIC(S) mnemonic. The health- and illness-related attitudes, beliefs, and values discussed in each individual case should not be used to stereotype or generalize about a particular ethnic group.
Case 1. Meaning and Management of Chronic Illness

A 65-year-old Hispanic man presents to the physician’s office with poorly controlled type II diabetes mellitus. Although his native language is Spanish, he speaks “limited English” and says that he does not need an interpreter. The nurse’s intake note says that he is here for a “routine check-up” and has “not been feeling well lately.” The patient has been coming to the office for 1 year but is seeing this physician for the first time. His medical record indicates that he often has expressed somatic complaints that the doctors have not been able to match with any specific diagnosis beyond his diabetes mellitus. Chart notes also indicate that his prior office visits have often occurred only when his “home remedies” have not been effective in helping his vague symptoms. He has undergone diabetic teaching and told a diabetes educator that he understands diabetes mellitus as meaning “high blood sugar,” and he must “cut out eating sweets.” He is supposed to be taking two different oral diabetic medications every 12 hours, for a total of four pills, although, based upon his most recent blood work, it appears that he is not adhering to his medications.

At this particular visit, he complains of fatigue and, as the physician asks more about each symptom, he raises additional complaints of dizziness and headaches. In response to the physician asking about what his own explanation is for all these problems, he says, “The diabetes is not what is making me sick. I feel symptoms all over my body and think I may have been cursed.” (E) He has gone to a curandero several times over the past year (H and S) who has performed certain ceremonies involving the application of oils to the body and burning incense to try to dispel the curse (mal). He believes that this healer is the only one that can remove the curse. For his headaches, he drinks bitter herbal teas that his family sends from his county of origin that he must sweeten to make drinkable but feels are helping. (T) The patient wants to keep going to both this office and to his “other healer” (the curandero) because “both can help me.” He was afraid to mention the curandero to the previous physicians because “they wouldn’t understand.”

The physician responds by acknowledging his concerns that his symptoms could be a combination of his beliefs about the curse and his diabetes mellitus (E and N). The physician comments that the blood work results suggest that the patient is probably not taking the medication prescribed. The patient replies that the curandero told him that he is probably taking too many pills and that is why he has not yet been able to remove the curse (E). The physician then suggests a modification of his current prescription medication regimen so he takes fewer pills daily (I). The patient agrees to give this a try (N). The physician also asks him to bring in the herbal medications that he is taking so that the office staff can determine what he is actually taking and asks him to follow up the following month.

Case Comment

In the above case, the use of the ETHNIC(S) tool allowed the physician to develop a therapeutic alliance with the patient and explore the meaning and management of his chronic illness. The physician and patient established a rapport that allowed the patient to share his explanation for his current symptoms that had previously not been revealed. Although the specific health and illness beliefs described here are clearly individual to this patient and not generalizable to all patients of Hispanic descent, their detail and relevancy for the treating physician are important. Some Hispanics may consider illness to be “unnatural,” and curanderos or espiritistas may be sought to assist with physiological, psychological, social, or spiritual maladjustments. The physician here neither validated nor repudiated the advice and care the curandero provided but simply acknowledged this individual as another healer who had seen the patient.

Diabetes mellitus is a chronic condition that is often challenging to treat because of the multiple interactions of diet, medications, and lifestyle factors, which are greatly influenced by culture. The patient’s recent use of complementary and alternative treatments should be evaluated because of concerns such as toxicity and the potential for dangerous medication interactions.

Case 2. Addressing End-of-Life Care Issues

An 87-year-old Chinese-American woman is admitted to the hospital with vomiting and weight loss. She speaks a dialect of Mandarin and requests that her two sons serve as interpreters during the emergency room assessment and subsequent admission. She has been seeing a neighborhood Chinese woman known for her skills in traditional herbal medicine from local markets as her only healthcare provider for years at home, where she lives with her extended family (T and H). Her sons and their families apparently managed months of progressive fatigue and associated functional decline at home until the vomiting could not be relieved and the family insisted on bringing her to the hospital.

Initial emergency room medical investigations revealed significant anemia, abnormal liver function tests suggestive of possible metastatic disease, and a gastric outlet obstruction noted on radiological studies. Through the family, the inpatient clinical team requests that the patient be asked for her consent to undergo an upper endoscopy procedure. Her son reports that his mother consents but that the results of any biopsies are only to be reported to the family (her two sons) and not to the patient herself.

As part of the admission process to the hospital, the attending physician requests a Chinese-speaking interpreter through the hospital language bank, and a dietary worker is identified who can adequately speak the patient’s own dialect. With the family members absent and using this nonrelative interpreter, the patient states that her vomiting made it impossible to stay with her sons anymore and that this is what is wrong with her (E). She confirms that she would agree to anything her sons wish her to have done in the hospital and that she wishes them to be informed of the results of “all tests.” She wishes only to be directly told “what I must do next.” She signs the consent for the endoscopy that subsequently reveals an extensive gastric malignancy (N). The gastric outlet obstruction is partially relieved through laser ablation done as a palliative procedure. The diagnosis of metastatic gastric cancer with its poor prognosis is given to her family only, and,
through her son’s interpretation, the patient is told the endoscopy was able to “open her stomach a little” (I). The family appears grateful to learn that the vomiting may be relieved and, away from the patient, report “knowing” that their mother was dying before bringing her to the hospital.

The patient’s nausea appears to be better controlled, but she refuses to eat the soft diet hospital food presented to her. She does, however, begin to eat the rice her family brings from home, because they report that she has never had food presented to her without rice (C). The family is pleased that her vomiting is now improved and wishes to take the patient home. They are made aware of the poor prognosis, including the potential for hemorrhage and recurrent gastric obstruction and will consider hospice services. The patient and her family express much gratitude that she is able to return to her son’s home where, according to the family, she will be much more comfortable dying in accordance with her religious tradition (S).

Case Comment
In the above case, the use of the ETHNIC(S) tool allows the hospital-based clinicians, patient, and family to explore and address culturally appropriate end-of-life issues. Clinicians need to understand the diverse ways that people experience and cope with death and dying and develop greater awareness and sensitivity to preferences in end-of-life decision making. The use of language interpreter services illustrated in this case allowed the treating clinician a better perspective about the patient’s own wishes and perception of her condition. In this particular instance, they were well represented by her children in this close-knit Asian family but are reflective of only this particular case.

Clinicians must access appropriate interpreter services for their patients. The Office for Civil Rights (OCR) August 30, 2000, Policy Guidance12 provides an important discussion about acceptable language assistance options that can be used when caring for patients with limited English proficiency (LEP). According to the OCR Policy Guidance, keys to Title VI compliance in the LEP Context include: “(1) Having policies and procedures in place for identifying and assessing the language needs of the individual provider and its client population; (2) A range of oral language assistance options, appropriate to each facility’s circumstances; (3) Notice to LEP persons of the right to free language assistance; (4) Staff training and program monitoring; and (5) A plan for providing written materials in languages other than English where a significant number or percentage of the affected population needs services or information in a language other than English to communicate effectively.” The problems that can occur when family members or friends are used as interpreters are discussed, and the prohibition against the use of minor children is emphasized.

Case 3. Negotiating a Mutually Acceptable Therapeutic Plan
A 78-year-old Italian woman who has been visiting her son in the United States for the past month is brought to the hospital clinic for recurrent knee pain. She is being seen for her third appointment in 2 weeks and complains of worsening left knee pain. As per the patient’s own wishes, her son acted as her interpreter for the first two of these appointments, but an Italian-speaking neighbor has come with her for this visit. At the time of her first appointment, the diagnostic impression was osteoarthritis, confirmed by x-ray, and a prescription for a nonsteroidal antiinflammatory medication was written. Weight reduction and a knee brace were also advised, along with a referral for physical therapy. She returned a few days later for the second appointment, having neither filled the prescription medication nor seen the physical therapist, and reported that the knee was worse. Sample medications were given to the patient, along with reinforcement about needing to adhere to a routine walking program and see the physical therapist. At today’s return appointment, she continues to say, “My knee is no better after having taken all the pills.”

Working with the Italian-speaking neighbor, the physician asks the patient about what she thinks is causing her knee pain. She initially responds by looking away, stating that, “I wouldn’t presume to play doctor.” With further gentle questioning however, she reports feeling that her knee pain must mean that “something bad is going to happen,” because her last episode of knee pain happened back in Italy just before the death of her husband (E). That episode of arthritic flare-up had almost made it impossible for her to walk behind his funeral procession until her physician gave her a “shot in the knee” that helped immensely (T and H). She is currently visiting her son in the United States because of his marriage ceremony, which is coming up in 5 days, and fears not being able to walk again. She wishes she could now receive a shot but reports that her son had previously told her, “Doctors in this country don’t do such things.” She felt intimidated about asking for such a shot during prior visits with her son present, but now, with him absent, specifically asks if she might receive a knee injection (N). She wants to be able to walk up the aisle at her son’s wedding without a cane. Afterwards, she plans to return to Italy, where she will use the rather “unsightly knee brace” that she already has but did not bring with her to this county. She is overjoyed to learn of the possibility of receiving an intra-articular steroid injection and agrees to go to physical therapy only after learning that this was not a first step for a subsequent joint replacement surgery but rather for local modality treatments (I and C).

When, at the end of the encounter, the physician inquires about how the wedding plans are going, she admits to being upset with her son for “not having a church wedding.” She reports not sleeping but instead spending most evenings “walking the floor and worrying.” She thinks that this has also worsened her knee pain. The name of an Italian-speaking priest is provided, should the patient wish to discuss her concerns about this matter (S).

Case Comment
In the above case, the use of the ETHNIC(S) tool allows the physician to explore cultural and psychosocial issues surrounding the patient’s symptoms. Together they negotiated a mutually acceptable therapeutic plan in the context of an acute encounter. The patient initially chose to have a family member (her son) serve as an interpreter. Although
the therapeutic interventions proposed in the patient’s first two clinical encounters were medically appropriate, the patient did not initially accept them. This case also illustrates how older minority patients have differing ideas of the meaning of their own illness from those of their healthcare providers. Clinicians who are able to effectively elicit the meaning of illness from their patients can develop a deeper relationship, which may foster improved therapeutic outcomes. ETHNIC(S) can be used with patients from all racial, ethnic, and sociocultural backgrounds.

CONCLUSIONS
Cultural and linguistic competence is an essential component of providing health care to older patients. The mnemonic ETHNIC(S) provides a framework for cross-cultural interviewing that physicians and other healthcare professionals can use and easily integrate into ethnogeriatric curricula. It is neither a scoring sheet nor a detection scheme to uncover hidden cultural issues but rather a clinically applicable tool for eliciting and negotiating cultural issues during healthcare encounters. These issues are relevant in the wide variety of ambulatory, home health, hospital, and long-term care settings where older patients receive services.

Although ETHNIC(S) can be helpful in facilitating cross-cultural communication during clinical encounters, it does not address important systemic, institutional, or interpersonal barriers to access and culturally competent care. These include poverty, classism, ageism, racism, sexism, homophobia, other forms of bias, prejudice, and discrimination. Additional limitations include the need to address disability-related issues and communication impairments that are common in older people, such as hearing, language, and cognitive barriers. Future empirical research is also needed to study the effectiveness of ETHNIC(S) and other techniques designed to enhance cultural competency in health professions training programs and clinical care settings.

Developing cultural competence is an ongoing, lifelong journey for individuals, families, organizations, and communities.\(^\text{49,50}\) The cultures of patients and their caregivers, healthcare providers, and healthcare systems may not be in concurrence. It is important that differences in expectations, priorities, therapeutic goals, and roles be recognized. Maintaining “cultural humility,” avoiding stereotyping, engaging in mutually respectful communication, and fostering empowerment in relationships are critical.\(^\text{51}\) The challenge for practitioners therefore is to develop and nurture cultural competence in the care of their older patients.

REFERENCES