CNE Objectives and Evaluation Form appear on page XXX.

CNE SERIES

# Improving Cross-Cultural Awareness and Skills to Reduce Health Disparities in Cancer

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*Delivering culturally sensitive care gives health professionals an opportunity to help reduce racial and ethnic disparities attributable to patient-provider interactions in the diverse settings across the continuum of care. Dealing with a cancer diagnosis is stressful; dealing with that diagnosis in a setting that is culturally unfamiliar or with a provider who speaks a different language can make the experience frightening. The nurse must be attuned to the cultural needs of the cancer patient and family members/significant others.*

The diversity that makes the United States so unique brings great challenges as well as opportunities when it comes to providing quality health care regardless of race and ethnicity, cultural background, and language proficiency. Racial and ethnic minorities and other disadvantaged groups disproportionately have poorer health status and outcomes due to health disparities in access to care; limited adoption of healthy behaviors; lack of access to maternal and infant health care; limited English proficiency; socioeconomic status; miscommunication in patient-provider interactions; and the prevalence of diseases such as diabetes, heart disease, HIV/AIDS, and cancer (Agency for Healthcare Research and Quality [AHRQ], 2006; Smedley, Stith, & Nelson, 2003). Delivering culturally sensitive care gives health professionals an opportunity to help reduce racial and ethnic disparities attributable to patient-provider interactions in the diverse settings across the continuum of care.

*Health disparities* refer to gaps in the quality of health and health care across racial and ethnic groups, including differences in cancer incidence, prevalence, mortality, or access to cancer care and services (see Table 1 for Web sites about health disparities in cancer). The 2006 National Health Disparities Report released by the AHRQ indicated specific areas where racial, ethnic, and socioeconomic disparities exist in quality of health care and access to care. For example, many racial and ethnic minorities are significantly less

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C-Change is a not-for-profit organization whose mission is to eliminate cancer as a public health problem, at the earliest possible time, by leveraging the expertise and resources of our members. C-Change is the *only* organization that assembles cancer leaders from the three sectors – private, public, and not-for-profit – from across the cancer continuum – prevention, early detection, treatment, and quality of life. C-Change invests in the resolution of problems that cannot be solved by one organization or one sector alone. For more information about C-Change, visit www.c-changetogether.org.

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**Table 1.**
**Selected Web Sites**

| Diversity and Cultural Competence |
|---|
| http://www.culturediversity.org/cultcomp.htm |
| http://www.diversityrx.org/HTML/DIVRX.htm |
| http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3 |
| http://sis.nlm.nih.gov/outreach/multicultural.html |
| http://www.cdcnpin.org/scripts/population/culture.asp |
| http://www.adventisthealthcare.com/disparities |
| http://kphci.org |
| http://www.hrsa.gov/culturalcompetence/qualityhealthservices |
| **Health Disparities in Cancer** |
| http://crchd.cancer.gov/definitions/examples.html |
| http://www.cancer.gov/statistics/ |
| http://iccnetwork.org/cancerfacts/ |
| http://iccnetwork.org/pocketguide/ |
| http://www.cdc.gov/cancer/healthdisparities/statistics/ethnic.htm |

**Table 2.**
**U.S. Breast Cancer Incidence and Mortality Data 2000-2003**
**(Based on SEER Incidence Data and NCHS Mortality Data)**

| | Incidence Rate (per 100,000 women) | Mortality Rate (per 100,000 women) |
|---|---|---|
| All Races | 129.1 | 25.8 |
| White | 134 | 25.3 |
| Black | 118 | 34.3 |
| Asian/Pacific Islander | 88.6 | 12.6 |
| American Indian/ Alaskan Native | 74.4 | 13.4 |
| Hispanic | 89.1 | 16.2 |

**Source:** Ries et al., 2005.

likely than non-Hispanic whites to receive colorectal cancer screening and prevention services (AHRQ, 2006). The Centers for Disease Control and Prevention (CDC) and the National Cancer Institute (NCI) both report various cancer incidence and death rates by race, ethnicity, and gender. Among women, incidence rates for all cancers are highest among Whites, but death rates are highest among Blacks. For example, breast cancer incidence is lower in Black women than White women but the mortality rate is higher (NCI, 2006) (see Table 2). Also, Black men have higher rates of incidence for all cancers and cancer-related deaths when compared to White, Hispanic, Asian/Pacific Islander, and American Indian/Alaska native men (CDC, 2007). Table 3 demonstrates the higher incidence rate of colorectal cancer among Black men and women compared with Whites (NCI, 2006). Addressing disparities in cancer screening, as well as problems with patient-provider communication that may affect delayed diagnoses and failure to seek treatment, can have a positive impact on the health of all groups (Phillips, Williams-Brown, & Belcher, 2004).

Lack of knowledge about health disparities, communication barriers, and sociocultural differences between a provider and patient can contribute to racial and ethnic disparities in health outcomes (Matthews-Juarez & Weinberg, 2006; Smedley et al., 2003). According to experts at the Institute of Medicine (Smedley et al., 2003), "Health disparities exist even when differences in treatment attributable to insurance, access to care, health status and other factors are eliminated" (p. 160). Because of persistent disparities in health and health care, cultural competence among health providers is needed to improve quality of care and patient outcomes.

## Providing Culturally Competent Care

The delivery of quality cancer care will continue to become increasingly complex as the growth of racial and ethnic minorities continues. It is important to first understand the difference between race and ethnicity. *Race* is a sociopolitical concept that defines discrete and separable population groups based on common inherited physical characteristics, such as skin and hair color, and facial features. *Ethnicity* refers to a population within a larger society that shares a common ancestry, history, or culture, such as cultural norms, religious traditions, language, and dietary preferences (Phillips et al., 2004). To reduce disparities and ensure the best chance for positive outcomes, health providers involved in cancer screening and prevention services, as well as cancer treatment and management, are increasing their cultural awareness and skills in providing culturally competent care to both racially and ethnically diverse popula-

**Table 3.**
**U.S. Colorectal Cancer Incidence and Mortality Data 2000-2003**
**(Based on SEER Incidence Data and NCHS Mortality Data)**

| | Men | | Women | |
|---|---|---|---|---|
| | Incidence Rate (per 100,000) | Mortality Rate (per 100,000) | Incidence Rate (per 100,000) | Mortality Rate (per 100,000) |
| All Races | 61.7 | 24 | 45.3 | 16.8 |
| White | 61.4 | 23.4 | 44.7 | 16.2 |
| Black | 72.9 | 33.4 | 56.1 | 23.4 |
| Asian/Pacific Islander | 51.2 | 15.4 | 35s.7 | 10.5 |
| American Indian/Alaskan Native | 52.7 | 15.6 | 41.9 | 11 |
| Hispanic | 47.3 | 17.3 | 32.7 | 11.3 |

**Source:** Ries et al., 2005.

tions. One definition of cultural competence follows:

> *Cultural Competence* is acquiring and integrating knowledge with awareness, attitude, and skills about culture and cultural differences that enables Health Care Professionals to provide optimal and expert care to patients from different racial, ethnic, socioeconomic, and cultural backgrounds (Matthews-Juarez & Weinberg, 2006, p. 13).

Training in provision of culturally competent care allows providers to assess their own cultural self-awareness (e.g., beliefs, values, biases, assumptions) and knowledge about other cultures (e.g., communication styles, health beliefs, practices of different populations), as well as recognize the effect of culture on communication between providers and patients, adherence to treatment, patient satisfaction, and health outcomes. Communication problems with nurses were more likely to be reported by Blacks, Hispanics who spoke Spanish at home, and patients with less than a high school education when compared with Whites, individuals who spoke English at home, and patients with any college education (AHRQ, 2006). Lack of diversity among health care providers, poor communication between providers and patients, and health systems that do not meet the needs of diverse patient populations can have a negative impact on the quality of care and contribute to health disparities (Betancourt, Green, & Carillo, 2002). However, providing culturally competent care requires a commitment on behalf of an entire institution — personnel, programs, policies, and resources — to embrace cultural competence and reduce health disparities.

## Cultural Competence in Cancer Care: Building Cultural Awareness, Knowledge, and Skills

Matthews-Juarez and Weinberg (2006) provided health care professionals with a detailed passport to prepare for the journey toward cross-cultural competency in cancer care (see also http://iccnetwork.org/pocketguide/). They described characteristics of various racial/ethnic and disadvantaged groups and the prevalence of cancer among them; discussed the importance of understanding culture in relation to cancer screening, diagnosis, treatment, and management; and presented models to enhance cultural competency skills during health care encounters with all patients. The passport was not meant to be a comprehensive review of complex cultural issues that may affect cancer care; rather, it provided health professionals with a framework for understanding the importance of culture, as well as its influence on the health beliefs and practices of various racial/ethnic and disadvantaged groups seeking cancer care.

In order for health care professionals to care effectively for all patients, it is imperative that they understand their own cultural background, beliefs, and values; local population demographics; and the health beliefs, practices, and health-seeking behaviors of different populations. Some approaches to assessing personal cultural awareness and building cultural knowledge and skills are worth noting (see Table 4).

*Assess personal attitudes and awareness.* Self-awareness is the first step toward improving cultural competency skills when providing cancer care to patients from diverse racial/ethnic backgrounds and their families. First, the health care provider must answer some questions about personal identity:

- Into which cultural/ethnic/socioeconomic/religious group was I born?

**Table 4.**
**Improving Cultural Competence**

| Ourselves |
|---|
| • Explore our communities and cultures.<br>• Engage in self-awareness.<br>• Seek out information.<br>• Increase culture-specific awareness.<br>• Make conscious effort not to act on our stereotypes and assumptions.<br>• Strive to prevent miscommunication. |
| **Interacting with Others** |
| • Listen with respect, openness, and patience.<br>• Establish trust.<br>• Show concern and empathy.<br>• Treat each person as a unique individual.<br>• Look at the situation from the other person's perspective.<br>• Be sensitive to face-saving needs.<br>• Tolerate ambiguity. |
| **Within Organizations** |
| • Increase recruitment and retention of diverse staff.<br>• Assist limited-English proficient clients with finding interpreter services or providers who speak their language.<br>• Seek ongoing diverse client feedback.<br>• Expand outreach activities.<br>• Develop programs and advertising geared toward diverse client populations. |

**Source:** Anand, 1999.

- With which groups do I currently identify?
- What values are important to me?
- What is the primary communication style used in my family?

Next, the provider must recognize how his or her cultural background affects personal perceptions, biases, and assumptions about other cultures. For example, although nodding may signal agreement to a health care provider, some Latino patients nod or say "yes" even when they do not understand or agree with the provider. Finally, the provider should reflect on the role of attitudes, behaviors, and beliefs in a medical encounter and how he or she interacts with people from a different culture:

> How comfortable (or uncomfortable) am I with patients who speak English with a heavy accent or have limited English proficiency? Stand very close/very far away during an examination? Are not on time for appointments? Do not make eye contact? Never/always ask questions? Bring extended family to appointments or (in the case of female patients) allow a male relative to answer for them?

Once the provider has examined any personal biases and assumptions and their effect on cross-cultural medical encounters, he or she can determine opportunities for learning and improving trust and communication.

*Understand culture and its influence on cancer prevention and control.* The culture of health care is viewed differently by different groups and can affect their perceptions of cancer and attitudes toward prevention and treatment. For example, some individuals from Black and Latino cultures and rural Appalachians believe there is little an individual can do to alter fate (known as *fatalism*). For example, an Appalachian patient is diagnosed with lung cancer; high rates of mortality are found among Appalachians for this and other cancers. Because Appalachians value faith and religion, often believing that their lives are controlled by fate, this patient might see such a diagnosis as "God's will" (Matthews-Juarez & Weinberg, 2006). Therefore, when the patient enters the health care system, he or she may feel powerless and defer to the expertise of the health provider.

Often, stereotypic beliefs about various racial/ethnic and disadvantaged groups, as well as prejudice and discrimination within and outside medical settings, also influence perceptions. For instance, physicians may believe that Black patients are less likely to comply with treatment and more likely to engage in destructive health behaviors than White patients (Van Ryn & Burke, 2000). In fact, many Blacks lack trust in the health care system, often turning to their families for support when diagnosed with cancer and to their faith for healing. Integrating practices and beliefs into cancer care from the health care provider and actively engaging the patient in decisions about treatment help establish trust and respect between patient and provider. Therefore, effective communication is necessary to understand the patient's views about cancer, discuss potential risks and benefits of cancer screening (e.g., PSA testing for prostate cancer), and share decision making about cancer treatment. To build trust and help patients feel respected and valued, the provider must:

- Be aware of the prevalence of diseases for specific populations and existing health disparities.
- Be ready to change his or her own behavior and attitudes.

- Avoid the use of stereotypes during the medical encounter.
- Work with patients and families to eliminate barriers to care and achieve positive outcomes for cancer prevention and treatment.

*Building cross-cultural knowledge and skills.* Each cultural group has a set of beliefs, behaviors, values, languages, and customs. The extent to which an individual within each culture adheres to these varies tremendously. However, the provider with a general knowledge of the most common characteristics will have an advantage when interacting with a patient from that specific cultural group. The health provider must be willing to explore history, language, and other cultural aspects of different populations in order to understand cultural influences on health beliefs and practices of patients with cancer (see Tables 5-7). The provider should ask:

- What is the race and ethnic distribution of my county?
- What are some of the health beliefs, practices, and health-seeking behaviors of different populations in my community?
- Which one of these beliefs, practices, and health-seeking behaviors challenge my own personal values?
- How many countries are represented by my colleagues?
- How many languages does my patient population speak?
- Which languages are the most prevalent?
- Can I remain objective and caring when faced with a cultural clash?

Becoming culturally competent means raising self-awareness and increasing knowledge about populations the provider encounters, understanding cultural and health beliefs of different groups, and communicating in ways that show respect for different perceptions of health care and cancer. The provider should continue to

**Table 5.**
**General Health Beliefs and Practices of Latino Populations**

- *Respeto* is highly valued in interpersonal interactions; Latinos both respect authority and expertise and expect to be treated politely and respectfully.
- Some Latinos believe there is little they can do to alter fate (*fatalismo*). It can influence an individual's decision to seek health care and adhere to preventive health care recommendations.
- Family is a core aspect of medical decision making.
- Some Latinos believe that symptoms of illness reflect specific occurrences, such as a traumatic event (accident or witnessing a death) or chronic, negative life circumstances, especially in interpersonal relations.
- They may use traditional sources of health care, such as folk healers and herbal medicine; in some cases, these sources are used in addition to allopathic medicine.
- When communicating with a doctor, Latinos may nod as a sign of respect and not necessarily because of agreement with a treatment regimen.
- Language and health care coverage are major barriers for this population.
- The provider should greet the patient and family politely and respectfully and establish a personal connection early in the encounter (respeto y personalismo), determine if there are any barriers to language and use a trained interpreter, acknowledge the patient's beliefs and values regarding folk remedies, and be thorough when explaining treatment plans and procedures.

**Source:** Kaiser Permanente, 2001.

**Table 6.**
**General Health Beliefs and Practices of Asian and Pacific Islander Populations**

- Language is a significant barrier.
- There is an interrelationship between universe and body. A person's health incorporates social, environmental, and spiritual aspects that must be kept in balance and harmony (including in one's diet). Good health is achieved through balance of opposing forces (e.g., yin and yang in Taoism; mind, body, and soul in Ayurveda-Indian Medicine).
- Sicknesses are often fatalistically perceived to be an inevitable part of life (e.g., punishment for transgressions in this life and previous lives: Buddhism), an obstruction of chi (Chinese medicine), or punishment from spirits or curses (Shamans may perform certain rituals).
- Some practices include acupuncture to restore flow of chi or energy (Taoism) and wide use of herbal medicine.
- The eldest male may be the primary decision maker.
- Surgery may not be an option because it is believed to disrupt humoral balance in the body or result in "soul loss."
- The provider should determine an Asian patient's nationality, age, and language proficiency among other things to help gauge familiarity with western medicine and adherence to traditional concepts; arrange for an interpreter, when needed; offer treatment to complement traditional practices; and consider any counterindications with herbal remedies.

**Source:** Kaiser Permanente, 2003a.

**Table 7.**
**General Health Beliefs and Practices of Black Populations**

- Spiritual or religious experiences may shape beliefs about causes of illness, as well as treatment decisions. Faith and prayer may be seen as ways to heal.
- Some Caribbean Blacks may turn to religious beliefs, if illness is thought to have supernatural causes (e.g., evil spirits).
- Some Blacks may be suspicious of blood tests or other treatments based on mistrust of the health care system, as well as traditional beliefs about maintaining the proper balance of blood in the body (e.g., loss of blood will make them weak).
- Notions of fate (fatalism) are typical, probably due to an inability to control many factors influencing their lives (e.g., socioeconomic status or environmental hazards).
- Family and friends play an important role in successful treatment and healing.
- Black patients prefer to be greeted politely and introduced properly (such as using *Mr.* or *Ms.* – especially for older patients – to show respect).
- For the patient who is terminally ill, it may be preferable for the doctor to discuss the diagnosis with the patient's family (e.g., Somalis, Ethiopians, Eritreans).

**Source:** Kaiser Permanente, 2003b.

build personal awareness and cross-cultural skills by learning about other cultures present within the local community, interacting with different people from the cultural groups, and keeping abreast of demographic trends and health disparities in the community.

## Cultural Competence Standards

The health care provider involved in patient care is in a unique position to affect health outcomes directly for racial/ethnic minority and disadvantaged patients. The U.S. Department of Health and Human Services (USHHS) Office of Minority Health has established **C**ulturally and **L**inguistically **A**ppropriate **S**ervice (CLAS) Standards to ensure the use of communication strategies that meet the needs of diverse populations to improve health (USDHHS, 2001). The 14 standards have three main areas of focus.

**I.** *Culturally Competent Care (Standards 1-3)*

This group of standards asks whether or not the clinician provides care in a manner that is compatible with the patient's health beliefs and practices. Does the provider's health care organization have a plan to recruit diverse staff and leadership that represent the communities served? Is the provider being given education and training in culturally and linguistically appropriate service delivery?

**II.** *Linguistically Appropriate Services (Standards 4-7)*

This group of standards asks the organization to provide language assistance to the patient of limited English proficiency at all points of contact. Are there processes and systems in place that can assure the competence of bilingual staff and trained interpreters, discourage the use of family members as interpreters, and provide patient-related written materials and signage in languages most commonly encountered in the local service area?

**III.** *Organizational Supports for Cultural Competence (Standards 8-14)*

This group of standards asks the health care organization to develop and implement a strategic plan to incorporate culturally and linguistically appropriate services. These standards also address improvement in demographic data collection in all electronic medical records, community involvement in the development of a data collection plan, and availability of public information concerning progress toward successful innovations in implementing the CLAS standards.

**Table 8.**
**LEARN and Four Habits Models**

| **LEARN Model of Cross-Cultural Encounters: Guidelines for Health Practitioners** (Berlin & Fowkes, 1982) | |
|---|---|
| **L** | isten with sympathy and understanding to the patient's perception of the problem. |
| **E** | xplain your perceptions of the problem. |
| **A** | cknowledge and discuss the differences and similarities. |
| **R** | ecommend treatment. |
| **N** | egotiate agreement. |
| **Four Habits Model of Highly Effective Clinicians** (Frankel & Stein, 1999) | |
| 1. | Invest in the beginning. |
| 2. | Elicit the patient's perspective. |
| 3. | Demonstrate empathy. |
| 4. | Invest in the end. |

## Improving Cross-Cultural Communication

Cultural differences can influence communication — verbal and nonverbal. For example, language, eye contact, and gestures can be interpreted differently in cross-cultural health care encounters. Evidence shows that communication is linked to patient satisfaction, adherence, and health outcomes (Smedley et al., 2003). Negative outcomes of ineffective communication may be increased when cultural and linguistic barriers are present (Ngo-Metzger et al., 2006). Matthews-Juarez and Weinberg (2006) discussed ways to maximize health care encounters with the patient from racial/ethnic minority and disadvantaged groups and the families. They offered several models for building and practicing new skills, and suggested methods for implementing the models in health care settings. Two models commonly used in cross-cultural encounters include the *LEARN Model* and the *Four Habits Model of Highly Effective Clinicians* (see Table 8).

The basic premise of these models is to invest time at the beginning of a clinical interaction. For instance, a greeting or welcome in another language will show the patient that the provider is making an effort to connect on a personal level. Shaking hands, showing a pleasant demeanor, and addressing the patient with the title *Mr.* or *Ms.* and last name also makes the patient feel respected and valued.

The provider should ask the patient questions, not only about disease symptoms, but about individual perception of the illness and why he or she became ill. This approach provides good cultural insight into the patient's view of illness, which can be useful when recommending treatment. Wheth-

er the provider agrees with the patient's perspective or not, demonstrating sympathy/empathy will communicate concern and a commitment to the patient's best interest. Last, the provider should validate the patient's understanding and agreement with the treatment plan by asking questions such as, "Do you understand what I am asking you to do?"and "Do you need assistance with next steps?" before saying a warm good-bye.

It is impossible for all care providers to be familiar with all cultural nuances. However, failing to remember that each person is an individual and making assumptions about a person or the culture of origin can hurt the trust-building process. The nurse can help eliminate health care disparities by remaining objective and flexible when interacting with the individual who looks, thinks, and behaves differently. Dealing with a cancer diagnosis is stressful; dealing with that diagnosis in a setting that is culturally unfamiliar or with a provider who speaks a different language can make the experience frightening. The nurse must be attuned to the cultural needs of the cancer patient and family members/significant others. Like many issues, cultural competence starts at the local level, with an understanding of who lives in the community, who accesses the medical-surgical unit for care, and what services (such as language interpretation) are available to the patient who may need help understanding the cancer diagnosis, treatment plan, and educational information. It is the nature of the human interaction that is remembered by the patient. ■

*You must truly understand what makes you do things or feel things. Until you have been able to face the truth about yourself, you cannot be really sympathetic or understanding in regard to what happens to other people.* — Eleanor Roosevelt

**References**

Agency for Healthcare Research and Quality (AHRQ). (2006). *2006 National healthcare disparities report* (AHRQ Pub. No. 07-0012). Rockville, MD: U.S. Department of Health and Human Services.

Anand, R. (1999). *Cultural competency in health care: A guide for trainers* (2nd ed.). Washington, DC: National Multicultural Institute.

Berlin, E., & Fowkes, W. (1982). A teaching framework for cross-cultural health care. *The Western Journal of Medicine, 139*(6), 934-938.

Betancourt, J.R., Green, A.R., & Carillo, J.E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches. The Commonwealth Fund, field report: Pub. No. 576.* New York: Author.

Centers for Disease Control and Prevention (CDC). (2007). *Health disparities in cancer: Racial or ethnic variations.* Retrieved January 1, 2008, from http://www.cdc.gov/cancer/healthdisparities/statistics/ethnic.htm

Frankel, R.M., & Stein, T. (1999). Getting the most out of the clinical encounter: The Four Habits model. *The Permanente Journal, 3*(3), 79-88.

Kaiser Permanente. (2001). *A provider's handbook on culturally competent care: Latino population*. The Kaiser Permanente National Diversity Council and the National Diversity Department (2nd ed.). Oakland, CA: Author.

Kaiser Permanente. (2003a). *A provider's handbook on culturally competent care: African American population.* The Kaiser Permanente National Diversity Council and the National Diversity Department (2nd ed.). Oakland, CA: Author.

Kaiser Permanente. (2003b). *A provider's handbook on culturally competent care: Asian and Pacific Islander population.* The Kaiser Permanente National Diversity Council and the National Diversity Department (2nd ed.). Oakland, CA: Author.

Matthews-Juarez, P., & Weinberg, A.D. (2006). *Cultural competence in cancer care: A health care professional's passport.* Waco, TX: Intercultural Cancer Center, Baylor College of Medicine.

National Cancer Institute (NCI). (2006). *Statistics: Cancer incidence and mortality rates.* Retrieved February 8, 2008, from http://crchd.cancer.gov/definitions/statistics.html

Ngo-Metzger, Q.J., Telfair, D.H., Sorkin, B., Weidmer, B., Weech-Maldonado, M., Hurtado, M., et al. (2006). *Cultural competency and quality of care: Obtaining the patient's perspective. The Commonwealth Fund, Pub. No. 963.* New York: Author.

Phillips, J., Williams-Brown, S., & Belcher, A. (2004). Culturally competent care. In C. Varricchio (Ed.), *A cancer source book for nurses* (8th ed., pp. 59-71). Sudbury, MA: Jones and Bartlett.

Ries, L.A.G., Harkins, D., Krapcho, M., Mariotto, A., Miller, B.A., Feuer, E.J., et al. (Eds.) (2005). *SEER cancer statistics review, 1975-2003.* Retrieved March 16, 2008, from http://seer.cancer.gov/csr/1975_2003/

Smedley, B.D., Stith, A.Y., & Nelson, A.R. (Eds). (2003). *Unequal treatment: Confronting racial and ethnic disparities in healthcare: Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press.

U.S. Department of Health and Human Services (USDHHS). (2001). *National standards for culturally and linguistically appropriate services in health care: Final report.* Washington, DC: Author.

Van Ryn, M., & Burke, J. (2000). The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science and Medicine, 50*(6), 813-828.

MSN J0805

# Answer/Evaluation Form:
## Improving Cross-Cultural Awareness and Skills to Reduce Health Disparities in Cancer

### *COMPLETE THE FOLLOWING*

*This test may be copied for use by others.*

Name: _____

Address: _____

City:_____State: _____ Zip: _____

Preferred telephone: (Home)_____ (Work)_____

Registration fee: **Complimentary CNE provided as an educational service by C-Change (www.c-changetogether.org).**

### ANSWER FORM

1. If you applied what you have learned from this activity into your practice, what would be different?

_____

_____

_____

_____

| Evaluation | Strongly disagree | | | | Strongly agree |
|---|---|---|---|---|---|
| 2. By completing this activity, I was able to meet the following objectives: | | | | | |
| a. Identify methods for providing culturally competent care. | 1 | 2 | 3 | 4 | 5 |
| b. Describe ways to build cultural competence in cancer care. | 1 | 2 | 3 | 4 | 5 |
| c. List cultural competence standards. | 1 | 2 | 3 | 4 | 5 |
| d. Define strategies for improving cross-cultural communication. | 1 | 2 | 3 | 4 | 5 |
| 3. The content was current and relevant. | 1 | 2 | 3 | 4 | 5 |
| 4. The objectives could be achieved using the content provided. | 1 | 2 | 3 | 4 | 5 |
| 5. This was an effective method to learn this content. | 1 | 2 | 3 | 4 | 5 |
| 6. I am more confident in my abilities since completing this material. | 1 | 2 | 3 | 4 | 5 |

7. The material was (check one) ___new ___review for me

8. Time required to complete the reading assignment: _____minutes

I verify that I have completed this activity: _____

Comments

_____

_____

### OBJECTIVES

This continuing nursing educational (CNE) activity is designed for nurses and other health care professionals who care for and educate patients and their families regarding cross-cultural awareness and cancer. For those wishing to obtain CNE credit, an evaluation follows. After studying the information presented in this article, the nurse will be able to:

1. Identify methods for providing culturally competent care.
2. Describe ways to build cultural competence in cancer care.
3. List cultural competence standards.
4. Define strategies for improving cross-cultural communication.

### CNE Instructions

1. To receive continuing nursing education credit for individual study after reading the article, complete the answer/evaluation form to the left.
2. Photocopy and send the answer/evaluation form to *MEDSURG Nursing*, CNE Series, East Holly Avenue Box 56, Pitman, NJ 08071–0056.
3. Test returns must be postmarked by April 30, 2010. Upon completion of the answer/evaluation form, a certificate for 1.3 contact hour(s) will be awarded and sent to you.
4. CNE forms can also be completed online at www.medsurgnursing.net.

This independent study activity is co-provided by **AMSN** and **Anthony J. Jannetti, Inc. (AJJ)**.

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Anthony J. Jannetti, Inc. is a provider approved by the California Board of Registered Nursing, Provider Number, CEP 5387.

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