

COMMENTARY:**Developing Cultural and Linguistic Competence in the Renal Field**

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Racial and ethnic disparities in health care have been well documented. This article emphasizes the importance of expanding our definitions of culture and including linguistic competency in the field of cultural competence. Social workers need increased training and self-awareness in cultural competency to increase their effectiveness in the renal field. In addition, dialysis settings require a commitment to improved health literacy. Further research is needed on the globalization of the health care workforce and its influence in health care delivery and staff relations. Lastly, renal consumers, health care teams, dialysis providers and government entities need to collaborate on cultural competency strategies and interventions for patients, staff and the community.

INTRODUCTION

While working in a variety of dialysis settings over the past 15 years, I have observed some of the following examples from a variety of age groups. Each situation brought new challenges, testing the awareness and skills of the social worker and fellow dialysis staff:

- A 24-year-old Latino immigrant new to the United States received social service information, which was translated by the unit secretary. The social worker observed the secretary include her own opinions and ideas about the patient's adjustment to dialysis and his social service needs, rather than translate directly for the social worker.
- A 36-year-old transgender Latino male became furious with a male Filipino nurse who smiled when the patient expressed much anger for being placed on the hemodialysis machine late. The patient felt the nurse was making fun of him and was "prejudiced against people like me." This male nurse reported feeling embarrassed for being shouted at and had smiled out of nervousness, attempting to present a "public face."
- A 47-year-old white unit director called a 33-year-old African-American unit secretary "Mama" and made slang remarks to a few of the African-American patients. These interactions were observed by a social worker who asked the patients how they felt about these comments. They reported that they tolerated this behavior and other inappropriate comments by the clinic staff, not wanting to upset them. They felt "vulnerable" with their health care delivery at the clinic and stated they did not want to "rock the boat."
- A 51-year-old Hispanic woman returned to dialysis after losing kidney function from her kidney transplant. She reportedly experienced heart palpitations from taking her immunosuppressant medications and stopped taking her medications, not realizing the importance of (and dire consequences of stopping)

immunosuppressant drugs in maintaining kidney function. She did not contact the transplant clinic until it was too late to preserve the transplanted kidney's functioning. She returned to hemodialysis treatment and the clinic, remorseful and ashamed by these events.

- A 68-year-old African-American man needing a medical procedure was reluctant to go for medical tests because of mistrust due to a family member's poor experience at a particular hospital and this patient's own complicated medical history. He had experienced numerous invasive procedures over the years. In addition, memories of the unethical treatment performed as part of the Tuskegee Syphilis Study created much anxiety and mistrust about the medical system. This renal patient was labeled "paranoid and delusional" by a white male nephrologist.
- A 70-year-old white woman who did not want a female Filipino nurse to provide direct treatment stated, "I can't understand a word she's saying," complaining about the nurse's strong accent and her inability to understand the nurse sufficiently. She reported feeling uncertain and frustrated by their verbal interactions, especially when medication instructions were provided, and stated, "Why can't they learn to speak English in this country?"

In almost every dialysis clinic in the United States, health care professionals and the patient-consumers and family members they serve face these "challenges" each day. Culture and linguistic competency has an enormous influence in these verbal and written encounters (Betancourt et al., 2002; Campinha-Bacote, 2003; Siegal, 2007; U.S. Department of Health and Human Services, 2001, 2005).

Many researchers hold the view that cultural competence includes linguistic competence. This article emphasizes the importance of linguistic competency in our discussions about cultural competence. Language is inclusive of culture,

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which is encoded in language. Not all readers may share this view; the term “cultural and linguistic competence” is used throughout this article where appropriate (U.S. Department of Health and Human Services, 2005).

Defining Cultural Competence

When many health care practitioners think of cultural competency, they immediately start discussing effective race relations. This definition of cultural competence is narrowly defined. There are literally hundreds of definitions of cultural competency and numerous Web sites readily available to assist in this important work (Appendix A).

By considering definitions of cultural and linguistic competency in health care, one can create a broader definition, which entails most, if not all, of the challenges we face within the dialysis setting. Betancourt et al. (2002) states cultural competence is “...the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients’ social, cultural, and linguistic needs.”

Similarly, the Health Resources and Services Administration (U.S. Department of Health and Human Services, 2005) curricula quoted the American Medical Association in a 1994 publication that cultural competence is

the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences; self-awareness; knowledge of the patient’s culture; and adaptation of skills.

For clinicians seeking to understand their own biases, the mnemonic “ASKED” is useful in helping them work with patients from a variety of cultures. The mnemonic summarizes The Process of Cultural Competence in the Delivery of Health Care Services Model (Campinha-Bacote, 2003; Table 1). The most important elements of this mnemonic are simply ASK. “A” is for *awareness*, the ability to recognize

Table 1

Cultural Competency in Health Care Delivery: Have I ‘ASKED’ Myself the Right Questions?

| | |
|-------------|---|
| Awareness: | Am I aware of my personal biases and prejudices toward cultural groups different than mine? |
| Skill: | Do I have the skill to conduct a cultural assessment in a culturally sensitive manner? |
| Knowledge: | Do I have knowledge of the client’s worldview and the field of biocultural ecology? |
| Encounters: | How many face-to-face and other encounters have I had with clients from diverse cultural backgrounds? |
| Desire: | Do I really want to be culturally competent? |

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one’s self and the relationship to one’s own, and others’ cultures; developing mindfulness, rather than maintaining a “mono-cultural” mindset (that is insensitive to the needs of various ethnic and cultural groups), a “one size fits all” approach to health care delivery, which is not effective, and paying attention in reflective and creative ways. “S” is for *skills*, the ability to develop tools useful in providing effective care, especially in communication and conflict resolution skills, and choosing appropriate forms of behavior in given situations. “K” is for *knowledge* about various cultures, even if one is not completely versed in a particular culture. It is the attainment of learning aspects of a given culture, through reading culture-specific writings and experiences within the group and their community, personal encounters, etc. It is the ability to ask thoughtful questions to illicit information.

Linguistic competency, while linked to cultural competency, requires additional skills and understanding. Kaiser Permanente (as cited in U.S. Department of Health and Human Services, 2005) defined linguistic competence in its National Linguistic & Cultural Programs, stating:

Linguistic competence recognizes that language and culture are interconnected. Language reflects culture while shaping it at the same time. Culture shapes our thinking, which in turn shapes our language. This powerful interrelationship affects all human interactions. Linguistic competence involves more than just the ability to speak and understand another language. It involves the knowledge of the cultural orientation that helps create meaning from language. Void of the ability to communicate in a common language, people are forced to cope with limitations that are disorienting, frustrating, and stressful. Dealing with these limitations at a time of illness or duress has a direct impact on the quality of care a patient can receive, and the health system’s ability to provide basic good medicine. A linguistically competent health care professional understands the intrinsic cultural meaning of a message and is able to elicit and send the right cultural response. This can be accomplished by sharing the same language and cultural understanding, or, by taking action to obtain appropriate assistance in facilitating intercultural communications. Thus, a health care professional’s level of linguistic competence depends on personal knowledge, skills, and attitude. The appropriate action is optimized by a linguistically competent system of care or hindered by its absence. (p. 16)

The National Center for Cultural Competence (NCCC) at the Georgetown University Center for Child and Human Development defines linguistic competence as:

The capacity of an organization and its personnel to communicate effectively and convey informa-

tion in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. The organization must have a policy, structures, practices, procedures, and dedicated resources to support this capacity. (2004a)

In addition, one must step outside the clinics to create alliances with various community groups, both sectarian and non-sectarian, government and non-government, to be exposed to a particular group, thus increasing one's understanding and knowledge base. Socializing within the community and experiencing life cycle events with patient populations and fellow staff assists one in developing our knowledge and sensitivities.

The social work profession is the best equipped to initiate cultural competency training and culturally sensitive programs in the dialysis settings to develop effective communication, resolve conflicts, influence administration to build culturally competent language services and assist the dialysis clinic's multicultural and multi-national dialysis teams in working effectively and developing creative patient and staff programs.

Professional Use of Self

Professional use of self is at the core of social work training and professional values. Renal social workers must start with self-awareness of cultural challenges that affect one's feelings, attitudes and professional actions. Becoming culturally skilled is an active, ongoing process, necessitating a life-long commitment to culturally competent practice and not simply attending a yearly seminar.

In 2007, Mike Cervantes and I co-presented a workshop at the National Kidney Foundation Spring Clinical Program "Diversity in Dialysis: Sustaining our Differences." Here was a Latino Catholic male from a working class family, raised in a small town in California, who was a "first generation" in his family to attend college, presenting this diversity workshop with a white Jewish female from an upper-middle class family, raised in urban Los Angeles, also the first in the family to complete college. These specific aspects of our backgrounds *spoke volumes* about our distinct cultural identities, each cultural element being unique, transformative and powerful in our lives.

Despite these obvious differences, we also shared many other cultural identities: we are both professional social workers, with a unique professional calling and perspective, having worked in the dialysis "culture" for many years; we are both religious and active in our religious communities; we are both in the "baby boomer" generation; we are both parents who have been married for more than 25 years; we are both upper-middle class and highly educated; and we share liberal politics and beliefs.

Why do I share these aspects of our personal cultural identities? We were able to observe *specific communication*

dynamics that not only were influenced by our own unique personalities, but also the specific cultural groups to which we belong. We were able to observe both the differences and similarities in our encounters, sometimes causing misunderstandings (infrequently), yet also committed to understanding and resolving these issues, which ultimately brought about a richness to our professional and personal relationship. More importantly, we have been able to use various aspects of our cultural identities in engaging with our patient populations, building rapport and creating meaningful connections (e.g., being raised in Southern California, attending public high schools known to our patients with rival football teams, sharing similar roles as wife and mother, etc.). These shared aspects of our cultural identities provided many unique opportunities to bond with our patients. They also provided richness to our encounters amidst the "sterility" of the medical clinic.

A new field, trait psychology, examines the dominant paradigm in personality psychology, providing a sound basis for a revival of culture and personality studies. We can embrace both the differences and similarities—and all the elements that make up our identities, much of it being culture. When one understands the variety of cultures each of us is a part of, we have the opportunity to understand these multi-layers with our patients and our fellow workers.

Defining Culture

Both seen and unseen cultural elements need to be examined. These cultural characteristics have profound influence upon those with whom one works. According to Zastrow and Kirst-Ashman, "Culture is the configuration of shared attitudes, values, goals, spiritual beliefs, social expectations, arts, technology, and behaviors that characterize a broader society in which people live" (2007). Using this definition, one can explore observable culture—not only related to race, but also to ethnicity, gender, age and physical attributes (e.g., obesity, disabled persons, religious dress, height, etc.) All of these unique, identifiable components are visible. Each of these groups has culture associated with them positive and negative factors about their own particular group. They share "cultural membership" in the group, whether they want to or not.

There are also other discernible characteristics that shape patients' self-perceptions and relationships. People of the same race may be members of different cultures within the racial group. Aspects of culture also include language usage, nonverbal communication, accent, clothing and other adornments, tattoos and body piercing, etc., which are all examples of culture and identity. None of these elements should be taken for granted, as they reflect a person's life history and identity.

In addition, there is significant information about each and every person we engage with that is invisible to the eye, yet has profound influence on one's cultural and personal identity, such as birth order, the region of the country they are from, their national origin, their social roles (e.g., wife,

mother, daughter, sister, step-parent, etc.), sexual orientation, marital and couple status, occupation, religion, life experiences (e.g., divorce, cancer survivor, immigrant, veteran, etc.) and other social groups that contribute to their life experience. Each of these cultural groups impacts the layers of one's identity. Each of these elements embodies culture with its powerful influences.

Social workers have a long history of advocating for various populations, yet they spend a surprisingly small amount of time in workshops throughout the country, examining all aspects of culture and their effect on patients, co-workers and clinics. If more time was spent designing qualitative evidence-based research and educational programs devoted to these areas, many of the conflicts and misunderstandings occurring in the workplace could be minimized. Effective training in intercultural communication and conflict resolution would enhance and improve the "Dealing With the Difficult Patient" many social workers are familiar with in the renal community.

Current Training and Publications

Renal social workers' training in diversity is often devoted to a single hour-long session, with a panel of "representatives" of each race speaking to their audience. Sometimes they are patient-consumers providing personal stories of their own experiences within their racial group and the impact of kidney disease on their life. More often, it is a panel of racially diverse social workers describing various attributes associated with their own particular racial group. The panelists are given 10 to 15 minutes each, followed by a question-and-answer session to describe characteristics of their particular race, not having enough time to describe the various ethnic populations of that particular racial group. For example, "African American" generally refers to all people of African descent living in America; however, there are also people from the Caribbean or African countries who do not readily identify with the term. Each racial group has many ethnic subgroups, maintaining specific cultural leanings and influences.

These workshops aim to assist social workers in effectively understanding the dynamics of that racial group and provide "tips" on increasing effectiveness in the renal setting. The frustration of the panel—and the attendees—is usually palpable. At the end of these programs, the conclusion often centers on the additional time needed to devote to this issue ... but rarely is more time devoted!

Many of these programs attempt to provide a list of "do's and don'ts." However, oversimplification of the understandings of a particular culture is common. For example, when working with Latinos and attempting to serve them adequately, one must understand where they were born, if they speak English, how acculturated they are in America, how much education they have acquired, how recent their immigration is (if at all), their degree of religiosity and spirituality, family dynamics, etc. Then one must understand the unique cultural norms within each group (Hispanic/Latino

being extremely diverse and rich in many cultures) and the "label" they self-identify with (e.g., Mexican-American, Hispanic, Latino, Chicano, Spanish, Guatemalan). One must not oversimplify these groups, but rather query key elements of cultural information within a particular group, as there is much variance.

I have yet to see a one-hour program devoted entirely to the understanding of working with African Americans or any other racial group, despite the fact that statistically there is an epidemic of kidney disease within the African-American population. The research documents the risk factors for hypertension and diabetes within this population, in addition to extensive risk factors within the African-American family and community. Some renal organizations have created brochures for African Americans to understand the risk factors associated with kidney disease. In addition, materials devoted to kidney donor awareness have been developed for this particular population. More needs to be done, especially partnering with churches, grassroots groups and community medical clinics, schools and media outlets within the African-American community.

Health Literacy and Linguistic Competence

Latinos are being horribly underserved within the renal community, despite their group also developing kidney disease of huge statistical proportions compared with other ethnic groups in the United States. The patient informational materials and directions in Spanish are most commonly a direct translation of materials in English. Safer and Keenan (2005) report that most health care materials are written at a tenth-grade level or higher. Translating these materials into Spanish, directly from English, continues to create numerous challenges for Latino patients and their caregivers.

Kidney disease and its management is very complex, with patients and their families needing more tools to effectively self-manage this disease. The challenges of managing dialysis, medications, diet, fluid control and effective relationships with the doctors and dialysis team are numerous. Research has already demonstrated the huge amount of time a dialysis patient must maintain in his or her own care. Without correct information and support systems in place, their health outcomes are observably affected, especially the effects of non-adherence (Russell et al., 2007).

As such, the effects of non-adherence can be as minor as nausea or as serious as increased cardiovascular disease and death. In addition, the dialysis clinics' "profitability" is affected by patients' non-adherence, with increased hospitalizations (less billable days in the clinic) and death. The health information and instructions for self-management provided for these patients, especially those monolingual in a language other than English, is critical to these outcomes.

If the social worker cannot speak Spanish, another dialysis team member might be brought in, spur of the moment, to assist with translation—a renal technician/bio-med specialist, a unit secretary, even members of the cleaning staff. The

status of these other dialysis team members may not create learning opportunities for them to become more professionally trained and clinically appropriate in their translation skills and services. Neither is given the increased prestige within the renal field or the remuneration for such services—all of which are vital to the treatment and well-being of the patients.

The guidelines and ethics of professional translators are numerous, yet such improvised and unprepared translations are usually performed by clinic personnel, sometimes with the knowledge of the dialysis clinic managers and owners (and exploitation of the staff person's role, with less pay, prominence or training). Family members often help with translation, but the emotional complexities are numerous, which can influence the translation.

Larger corporations need to devise appropriate training in translation services for dialysis team members already performing these duties to strengthen the skills and professionalism required to better serve our patients and their caregivers. I have yet to see a training program on the effective usage of “professional” translation services, especially within the larger dialysis corporations, who have an adequate amount of funds to provide for this training. In addition, the CMS-contracted (nonprofit) Renal Disease Networks, as the watchdogs for Medicare-funded facilities, need to monitor the linguistic and translation training within their particular communities.

There is a lack of appropriate Spanish patient materials. The health literacy issue creates major obstacles for the Latino patients, especially when most of our monolingual Spanish-speaking renal patients have limited formal education in English to help them understand the complexities of renal disease. While working in a dialysis unit with a large Spanish-speaking population in East Los Angeles, CA, I observed the majority of seniors completed a first- to second-grade formal education. Compounding this challenge, the research suggests that the highest grade level of education completed is often higher than the actual level of literacy (Safeer & Keenan, 2005). In addition, renal diet, fluid control and pill management is confusing and overwhelming for many patients, even highly educated ones. Developing culturally sensitive materials that are written in easier-to-understand formats would assist with greater understanding about kidney disease management, adherence to treatment and minimization of unnecessary hospitalization and/or fatal results.

I have questioned the national representatives of the large renal organizations about the lack of appropriate Spanish materials with sensitivity and knowledge about health literacy and usually received the same answer—lack of funds. However, the cost associated with one educational dinner at a national renal gathering is in the thousands! Why aren't we social workers being adamant that a portion of these funds be used to assist with new Spanish translation brochures and materials as an adjunct to the pharmaceuticals' professional

training and outreach being provided? Why aren't we social workers initiating the improvement and correction of this problem, by working with the national renal organizations and creating “think tanks” or creating and developing culturally competent patient educational materials, better translated materials and other useful educational media, such as videos/DVDs, audio CDs, picture books, interactive games, increased Internet usage and social networking, etc.? These think tanks can be made up of renal professionals, renal consumers (patients and their families) and community activists and researchers in social work, public health, medicine, health literacy, government, media and other groups.

Non-professionals, the consumers themselves, with the advice and input of other professionals, could translate and develop better materials, after passing through extensive review process to ensure informative, understandable translations, with little variation or room for error. In addition, focus groups could be created to test these materials' understandability and usefulness. Bottom line: exact translations of the current dialysis materials cannot be an acceptable form of addressing linguistic competency.

Lastly, such “linguistic focus groups” and the development committees could create and influence effective marketing campaigns and distribution of materials within the dialysis units, community clinics, employee groups and corporations, media, etc. Currently, there is an alarmingly small number of professionals influencing public relations and marketing campaigns, without using the experience and skills of the cultural communities they serve. I have spoken directly with many of the professionals who write and distribute such educational materials, many of whom possess a master's degree in Public Health and few with significant media training.

Globalization of the Health Care Workforce

The U.S. medical system and general public have witnessed a dramatic increase of immigrant doctors, nurses and allied medical staff working in the U.S. health care field. This rapid globalization of the nursing workforce, for example, has foreign-trained nurse entrants to the U.S. nurse workforce increasing at a faster rate than that of U.S.-educated new nurses (Aiken et al., 2004). The influences, both positive and negative, are numerous. The implications for health care delivery are directly affected by these statistics. Although the literature in the nursing and medical fields have observed these startling statistics and effects on health care, the renal community has all but ignored the impact and unique challenges of this situation in the dialysis clinics.

Increased interdisciplinary programs to assist these workers, both American and foreign-born, need to be developed to improve their ability to work together effectively as a team. The need is great. As social workers, we have been called upon numerous times to assist in inter-staff conflicts and staff conflicts with patients. More research, multidisciplinary discussions and training, on local and

national levels, with commitments from all the renal professional associations, End-Stage Renal Disease Networks and patient advocacy groups, need to be initiated. It is time we demand the renal organizations, big dialysis companies and pharmaceutical companies assist us in developing the training and skills to improve this unique challenge for improved health care delivery.

Expanding Definitions and Improving Work

When health care practitioners state, “we’re all human beings/we’re all the same” and are uncomfortable with differences among human beings, preferring a one-size-fits-all approach, they are missing important opportunities for better care. The “excuse” of organizations not having adequate funding, with the “illusion” of funding, is simply not true. Funds are available for diversity work/cultural and linguistic competency research and training. U.S. government entities and nonprofit organizations alike are dedicated to improving health care outcomes. In addition, it is time the larger dialysis providers supply financial and time-allotted commitments for their staff to pursue tangible solutions for better cross-cultural care and effective multi-national/multi-ethnic dialysis team management.

I served as faculty and curricula development for National Kidney Foundation’s unique interdisciplinary program, “Seize Chronic Kidney Disease, Celebrate Collaboration.” Mike Cervantes and I developed and lead the diversity training at these four meetings throughout the United States, in addition to the development and execution of additional curricula for the project. This training was cutting edge in that it engaged multidisciplinary teams to study and work together for an entire day, collaborating on issues of care delivery in the chronic kidney disease (CKD) stages and perceptions of patients in the dialysis units. Mike and I developed and facilitated diversity training program, during the “Seize CKD” programs, incorporating the cultural self-assessment tool I developed the year before (Appendix B; Siegal, 2007; Siegal & Cervantes, 2007).

The reviews and feedback of the “Seize CKD” program were positive. More training needs to be funded and developed, with increased commitment for these programs, and time to collaborate on a multidisciplinary level. In addition, increased communication is vital with the multi-layered management in dialysis companies.

Another area of investigation and activism is the employee practices of the dialysis companies. The National Association of Social Workers has clear mandates that National Delegate Assembly delegates be representative of the entire membership, reflective of all areas of culture (e.g., race, gender, sexual orientation, geographic areas, etc.). This is an excellent example of ways that the Council of Nephrology Social Workers can create policy statements and recommendations for more representative hiring practices in the dialysis units.

We can (and should) work with other professional renal associations and companies to encourage the recruitment,

training, hiring, promotion and retention of multicultural and international professional and support staffs that both reflect and represent the constituencies they serve in their dialysis clinic. In addition, more needs to be done to encourage minorities to enter the medical field. I have held numerous discussions with patients’ children and grandchildren, encouraging them to continue their higher education and training, possibly considering a career in dialysis.

It is unjustifiable that clinics do not hire and retain staff members who are representatives of the same patient populations they serve. For example, if a clinic treats more than 50% African-American patients in their clinic, it is inexcusable not to have any African Americans working in the clinic. Although all care is delivered in a professional manner, the companies must look to attend to the unique needs of their patient-customers by having ethnic and cultural staffs that reflect the majority of their constituency in their clinic. I believe this “mirroring effect” of hiring and retaining multi-ethnic staff members will have positive impact on health care delivery. This has been demonstrated in cases in which caseloads in community mental health settings are influenced by the backgrounds of their staff. While I understand the challenges of staffing in smaller communities, it is possible for dialysis clinics situated in large urban areas to provide this optimal recruitment and staffing.

There is much work to be done. There are innovative ideas, techniques, new collaborative relationships and resources throughout the United States. It is incumbent upon social workers to speak out for the disenfranchised and most vulnerable. We must initiate discussions with other renal disciplines, especially the doctors, clinic owners and administrators, large corporations and governmental entities, attending their professional society meetings and conferences (to which we social workers have previously had little access) to professionally network and collaborate.

We should be strategic in meeting our objectives of providing optimal health care through increased cultural competency and linguistic skills. We must also provide the evidence-based research and program development that demonstrates the financial “bottom line” being improved by cultural and linguistic competencies. We have the social work profession’s mandate to correct the current system, ultimately influencing better renal care for all. Gene Roddenberry said: “If man is to survive, he will have learned to take a delight in the essential differences between men and between cultures. He will learn that differences in ideas and attitudes are a delight, part of life’s exciting variety, not something to fear.”

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APPENDIX A

Useful Web Sites

The following Web sites and telephone numbers, particularly those run by foundations and the Centers of Excellence, are a source of current information on issues related to cultural competence and diversity. Many have ongoing newsletters and alerts. They consistently produce new statistical and educational material that will be useful in keeping curricula current and focused on emerging and important issues in patient care and public policy. Many have bibliographies or are linked to bibliographies. This extensive list was created by the U.S. Department of Health and Human Services in 2005.

I invite you to examine these useful resources, and continue your knowledge and skills development in cultural and linguistic competency:

1. The California Endowment: **www.calendow.org**
2. California HealthCare Foundation: **www.chcf.org**
3. The Commonwealth Fund: **www.cmwf.org**
4. Chinese American Medical Society: **www.camsociety.org**
5. The Cross Cultural Health Care Program (language issues, training, interpretation): **www.xculture.org**
6. Association of University Centers on Disabilities: **www.aucd.org**
7. Diversity Rx: **www.diversityrx.org**
8. EthnoMed (ethnic medicine guide): **www.ethnomed.org**
9. The Henry J. Kaiser Family Foundation: **www.kff.org**
10. Hablamos Juntos Resource Center, Models, Approaches, and Tools: **www.hablamosjuntos.org/resourcecenter/default.asp**
11. Kaiser Permanente National Linguistic & Cultural Programs: **510.271.6386**
12. Institute for Diversity in Health Management: **www.diversityconnection.com**
13. Manhattan Cross-Cultural Group (physician educators in cross-cultural medicine): Contact Tessa Misiaszek by e-mail at **gmisiaszek@adelphia.net**
14. McGill University Department of Psychiatry, Division of Social and Transcultural Psychiatry: **www.mcgill.ca/tcpsych**
15. The National Alliance for Hispanic Health: **www.hispanichealth.org**
16. National Council on Interpreting in Health Care: **www.ncihc.org**
17. National Hispanic Medical Association: **www.nhmamd.org**
18. National Asian Women's Health Organization: **www.nawho.org**
19. National Center for Cultural Competence/Georgetown University: **www.gucchd.georgetown.edu/nccc**
20. North East Consortium on Cross-Cultural Medical Education and Practice: contact Ed Poliandro by e-mail at **e.poliandro@att.net**
21. Office of Minority Health Resource Center (provides publications and resources on minority health issues): **www.omhrc.gov**
22. The Park Ridge Center for the Study of Health, Faith and Ethics: **www.parkridgecenter.org/cgi-bin/showpage.dll?id=1880**
23. Perspectives of Difference, Teaching Diversity and Cross-Cultural Competence in Health Care: A Trainer's Guide: **www.mwelchatpodsdt.org**
24. Society for Medical Anthropology: **www.medanthro.net**
25. Stanford Geriatric Education Center Cross-Cultural Geriatric Medicine: call **650.494.3986** or visit **www.stanford.edu/group/ethnoger**
26. Transcultural C.A.R.E. Associates (Dr. Josepha Campinha-Bacote's, Founder and President): **www.transculturalcare.net**
27. Transcultural Nursing Society: **www.tcns.org**

APPENDIX B
CULTURAL SELF-ASSESSMENT

All of the following elements provide opportunity for cultural identifications and influence the ways we experience the world, relate to others, and develop our values, beliefs, worldview, etc.

Gender _____ Race/ethnic group _____

Physical attributes (e.g., body size, height, hair, tattoos, "accent," etc.) _____

Physical challenges or medical issues _____

Country of origin/part of country (city, town, village, etc.) _____

Socio-economic status and social class (childhood/adulthood) _____

Education _____ Occupation (employee/employer) _____

Birth order (blended family?) _____

Social relationships (e.g., son, sister, wife, mother, step-parent, aunt, godparent, boyfriend, etc.) _____

Sexual orientation/marital/couple status _____

Religion/spiritual practices (childhood/adulthood) _____

Politics (family of origin/adulthood) _____

Community and/or social groups (e.g., sorority, sports club, civic group, hobbies, etc.)

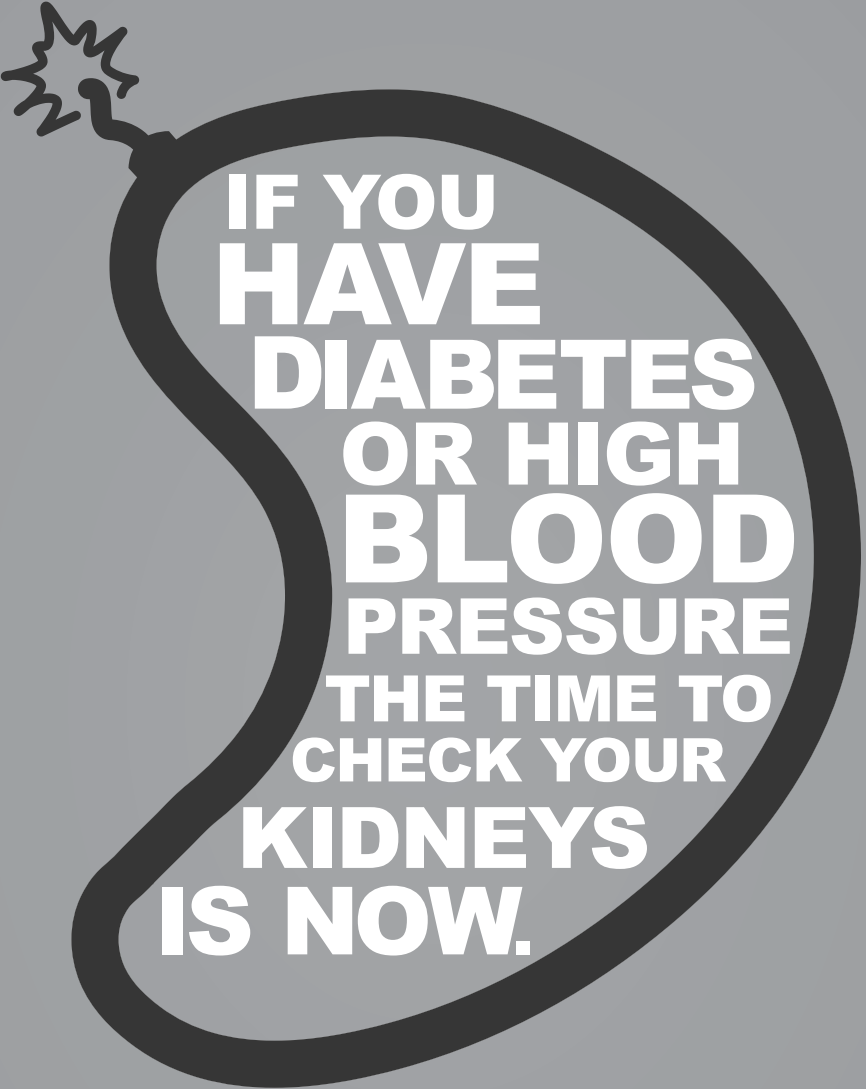
Life experiences (e.g., divorce, cancer survivor, veteran, immigrant, award-winner, etc.)

Beliefs that cause you to identify with a "group" (e.g., pro-life, anti-war, environment, etc.)

Other?


New NKF National Outreach Campaign

The National Kidney Foundation has launched a multimedia campaign designed to increase awareness of kidney health and the vital importance of early detection. Here is one of the print ads in the new "Love Your Kidneys" campaign. The full campaign can be viewed in the "About Us" section of www.kidney.org.



**IF YOU
HAVE
DIABETES
OR HIGH
BLOOD
PRESSURE
THE TIME TO
CHECK YOUR
KIDNEYS
IS NOW.**

Your kidneys are essential for life. So if you have diabetes, high blood pressure or a family history of kidney disease, you should talk to your doctor about getting a kidney screening. The National Kidney Foundation offers free screenings all around the country. Just check our website to find one near you. Early detection of kidney disease can make a big difference. If you're at risk for kidney disease, getting screened just might save your life.

 National Kidney Foundation
LOVE YOUR KIDNEYS™ kidney.org