

Patient Education: Addressing Cultural Diversity and Health Literacy Issues

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Effective patient/family teaching and documented evidence of learning are essential to improved health outcomes for patients, particularly in this era of ever-increasing patient acuity and ever-decreasing length of inpatient stay or service provided. Another reason for placing emphasis on patient education is the fact that teaching patients is highly valued by nurses, especially staff nurses, and brings professional satisfaction in practice (McClure & Hinshaw, 2002). Furthermore, health teaching is included in the American Nurses Association *Nursing: Scope and Standards of Practice* (2004) and is one of the grading criteria used by the Joint Commission on Accreditation for Healthcare Organizations (JCAHO, 2006), which is now called The Joint Commission.

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Patient education is essential in assisting patients to live with illness and to have improved health outcomes. Patient education is also one of the most satisfying aspects of care provided by professional nurses. Additionally, patient education is a qualifier in professional and accreditation standards. The teaching-learning process, how culture influences learning and teaching strategies, and health literacy issues that affect patient education are reviewed.

To facilitate learning, nurses must implement effective patient teaching strategies. This process includes assessing and prioritizing learning needs, assessing learning styles, and implementing teaching strategies designed to address identified learning needs. As part of this process, cultural beliefs and literacy issues must be addressed. Congruence between teaching and cultural values is necessary for successful teaching outcomes.

The Teaching-Learning Process

Learning is defined as the addition of skills and knowledge resulting in mental activity and behavior change. Learning is a change that occurs such as the addition of skills or knowledge that cannot be solely accounted for by development. Learning can be an experience, a consequence, or a discovery and is an active process on the part of the learner. "Sociocultural norms, values and traditions often determine the importance of different health education topics and the preference of a specific learning approach" (Potter & Perry, 2005,

p. 461). The nurse facilitates learning for patients and families by motivating the participants. Success is highly dependent on developing a trusting relationship. The nurse must identify what the participants value. Values are individualized, culturally determined, and will differ for each patient.

When teaching adults, an effective teaching plan must be developed which establishes mutual goals with the participants. These goals must be practical, attainable, relevant, and culturally sensitive. Haber (2001) found that when older adults identified their own goals for change, 92% selected behaviors they were ready and willing to change. These goals should be stated as any expected outcome would be stated. They should be singular, specific, and measurable.

Health care educators must try to impart essential information while considering the mental and physical capabilities of the patient and family. The patient and/or family perception of the illness or problem, the ability to focus and comprehend

the learning activity, health literacy, the physical condition (pain, fatigue, anxiety), and the belief in the probability of benefit will influence whether the information shared will be absorbed and/or utilized.

The nurse assesses what is most critical both to the patient's health and to managing the patient's care upon discharge. Patients expect nurses to prioritize and provide direction (Rankin, Stallings, & London, 2005). For example, if the patient recently had a urinary diversion, the nurse prioritizes learning needs based on what the patient and family will need to manage at home. The nurse may begin by showing the patient how to empty the ostomy bag or what to look for when examining the peristomal skin, and progress to teaching additional steps in the procedure until the entire procedure for changing the appliance is learned. The patient or family will need to know how to empty the bag (this is a survival skill), but they may be able to manage without changing the appliance until learning is reinforced and a home health nurse assists with the procedure. The teaching plan is individualized based on the prioritized learning needs and resources of the patient and family.

Adults learn in order to solve a problem and/or meet an immediate need, so it is imperative to identify what the patient/family believe are the learning needs. If the teaching addresses an issue that the patient/family do not perceive as a need, learning is less likely to occur. If the teaching plan is based on a discussion of learning needs with the patient and family, they are more likely to view the nurse as a partner in the teaching-learning process.

Individuals perceive and process information differently. Individuals learn best when the method for learning matches their

preferred style. Therefore, the nurse needs to assess which teaching strategies are most effective for the patient or family member and individualize the teaching plan accordingly. Too often, nurses focus on a single teaching method, or a method the nurse feels most competent in implementing, rather than on which teaching strategy would be most effective for the patient or family. The most effective teaching utilizes multiple methods to enhance understanding. For the patient with the ostomy bag, providing an explanation of how to empty the bag (auditory), a hand-out with some pictures and reasons for handling the bag a specific way (visual), and practice with the bag (kinesthetic) would incorporate multiple methods of learning and reinforce the learning from the preferred style.

Although it may be a challenge to determine an individual's learning style (visual, auditory, or hands-on), the nurse can simply ask the patient. Another approach is to ask if the patient has a hobby and how she/he became proficient at the hobby, which will indicate her/his, preferred learning style. Did the patient read a book, take a class or learn the hobby by watching a friend/relative? If the patient selects a non-reading style, follow up with a more specific question, such as: "Changing your ostomy appliance is challenging at first. Would you like to watch a video or listen to the steps as I review them?" (Osborne, 2005). "Older adults must practice a new skill or rehearse new information in order to learn it" (Fenter, 2002, in Zurakowski, Taylor, & Bradway, 2006, p. 359). Written information is now a staple of any educational program. However, many patients need a variety of teaching strategies. Videotapes, charts, and demonstration are just a few examples of additional teaching methods beyond print material.

Cultural Diversity and Patient Education

Culture is defined as learned and transmitted values, beliefs, and practices of a particular group of people "that guide thinking, decisions, and actions in patterned ways" (Leininger, 1995, p. 9). Culture is a framework that a person uses in viewing the world, including health and the need for care. Successful teaching plans are congruent with patient and family cultural values (Price & Cordell, 1994). Appreciation and respect for cultural values and beliefs helps the nurse to better understand culturally determined behaviors.

Core beliefs and value systems are held more strongly when people lose control over aspects of their life due to illness (Thomas, 2001). Behaviors associated with response to illness, such as fear, pain, and anxiety, are culturally determined. For example, there are cultural differences in defining the sick role. In some cultures, the sick role is no longer valid after the symptoms disappear. A perfect example of this is a client with diabetes mellitus who is having problems with urinary incontinence. When the diabetes mellitus is under control, the need for special diet, medication, and timed voiding is not evident. Therefore, the ongoing need for care presents a challenge when teaching patients whose symptoms have subsided or who have chronic conditions.

Leininger (1985) found that (a) nursing care that incorporates cultural values and practices will be positively related to patient satisfaction with nursing care, (b) patient compliance to treatment will be greater when the treatment plan incorporates the patients' cultural values and beliefs, and (c) conflict will result if nursing care conflicts with patients' belief systems. Transcultural nursing care can help to improve adherence with the treatment plan, reduce recidivism, and decrease overall costs for health

care (Cater & Spence, 1996, and Leininger & McFarland, 2002, as cited in Leininger & McFarland, 2006).

A culturally competent nurse must develop cultural sensitivity. "Cultural sensitivity can be defined in the broadest sense to be an awareness and utilization of knowledge related to ethnicity, culture, gender, or sexual orientation in explaining and understanding situations and responses of individuals in their environment" (Facione, 1993, as cited in Broome, 2006). It is critical to assess each patient individually and not make cultural assumptions about a patient's beliefs or health practices. Asking the patient and family to define what they perceive as the cause of illness (Rankin et al., 2005) and what health practices the patient continues to follow will allow for development of an individualized culturally sensitive teaching plan. In assessing cultural beliefs, multiple areas should be considered, including the patient's perception of illness and treatment, the social organization including family, communication behaviors, expression of pain, folk health care beliefs, past experience with care, and language.

Family is defined in some cultures as the immediate nuclear family, while other cultures define family as the extended family, which may include close friends and neighbors. After making this determination, the nurse then identifies who the health care decision maker is for the patient. The decision maker could be the patient, the head of the household, or the entire extended family. All key players must be involved in the decisions since they will reinforce or block health care behaviors.

There are vast differences in culturally defined communication behaviors. Before discussion of personal information, it is important to understand cultural practices related to nonverbal

communication during conversation, communication practices related to the opposite gender, and cultural practices of social conversation. In some cultures, individuals maintain eye contact while listening, while in other cultures individuals avoid eye contact. Misinterpretation of these behaviors can lead to miscommunication. Some cultures have gender taboos regarding "private" issues and with whom it is appropriate to speak. There are cultural variances in the tolerance of interruptions and in the preference for social conversation before discussing personal information. Knowledge of culturally determined communication behaviors can avoid misunderstandings.

Cultural beliefs related to illness affect how and when health care is sought and what health practices will be followed. Often individuals will follow traditional health practices before seeking the medical professional, as a last resort. For example, when urinary incontinence is viewed as a normal part of aging and a doctor is viewed as providing help with a problem, an incontinent person may not see a doctor unless he/she has an additional problem. An understanding of cultural influences on health care practices enables the nurse to effectively individualize the teaching plan. Presenting the information in the learner's cultural context (Rankin et al., 2005), and including certain folk practices, if not detrimental, will strengthen the plan of care for the patient.

The individual's or family's past experience with health care providers influences the client's adherence and continuation of use of health care services. Understanding these experiences from the patient's perspective can strengthen the relationship, and misconceptions and culturally offensive behaviors can be avoided (Potter & Perry, 2005).

Finally, the nurse assesses issues related to language. When

English is the second language, individuals may have more difficulty speaking and understanding English during times of stress and illness. Therefore, patients and families may need an interpreter during a health crisis or during times of increased anxiety, but they may not need an interpreter during less stressful times. National Standards for Culturally and Linguistically Appropriate Services in Health Care were created by the Office of Minority Health in 2001 (Kozier, Erb, Berman, & Snyder, 2004). Staff should be sensitive to when and who to use as an interpreter.

The nurse should assess cultural beliefs related to use of an interpreter. For example, in some cultures it is inappropriate to discuss personal, health-related information with someone younger or of the opposite gender (Rankin et al., 2005). This certainly has implications for not using young children as interpreters for their parents. In addition, it is important that interpreters have an understanding of medical terminology to communicate questions from staff and responses from patients correctly. Utilizing an accepted and professional interpreter will promote a more accurate sharing of information and more open communication.

Nurses need to learn as much as possible about cultural beliefs, especially the specific beliefs and practices of patients in their care. The patient's concept of the illness and its cause will help the nurse to assess and prioritize learning needs and to incorporate cultural beliefs into the plan of care. Demonstrate respect for the patient and all family members by using titles, not addressing them by first name, and pronouncing their names correctly. Finally, use materials and teaching techniques that are culturally relevant for the patient and family. Compliance will be greater when the treatment plan incorporates the patient's cultural values and beliefs.

A Case Presentation: Health Literacy and Cultural Diversity

Introduction

The following case was presented in a weekly interdisciplinary unit conference. Staff members were concerned about meeting the needs of this complex patient who required an interpreter for discharge instruction, about the short notice for discharge, and about safety and hygiene issues related to squatting on the toilet.

Clinical Interaction

Mr. T, a 78-year-old Asian male, was admitted to the hospital for acute urinary retention and congestive heart failure. A Foley catheter was inserted to relieve the urinary retention, and the patient was placed on bed rest. Later during staff rounds, Mr. T's nurse was shocked and distressed to find Mr. T in his room squatting on the toilet seat trying to move his bowels. The nurse scolded Mr. T for getting out of bed without assistance and for squatting on the toilet seat instead of sitting.

Mr. T remained in the hospital overnight and was discharged home about 5:00 p.m. the next day with his Foley catheter still indwelling. He was sent home with new prescriptions for furosemide twice daily, digoxin once daily, and potassium once daily. As part of the discharge teaching, catheter care was demonstrated to the patient and discharge medication instructions were discussed. The patient's daughter-in-law acted as translator. The family all nodded their heads and smiled; everyone appeared to understand the instructions and signed off the discharge paper as understood.

Results of Clinical Interaction

Mr. T lives with his wife, who is 75 years old, his son, and his daughter-in-law. His son's job requires that he travel frequently to other countries. A home health nurse visited Mr. T the day after he was discharged from the hospital. The nurse found Mr. T lying in bed with his full urinary drainage bag on the floor. The drainage bag had not been emptied since Mr. T left the hospital. Mr. T had taken his furosemide at breakfast and again at lunchtime since that is what he understood twice a day to mean.

Clinical Implications

Toileting: Squatting for elimination. In many Asian and African countries, squatting toilets are the norm. The muscles used in squatting differ from those used in sitting on a western toilet for defecation. Sikirov (1987) reported that squatting is healthier for the pelvic floor muscle and that squatting affords many advantages for the body even at the present time. Especially when traveling in Africa and many Asian countries, there may be a hole in the floor that requires an individual to squat

in the public toilets even in five-star hotels and restaurants.

In Mr. T's situation, less straining and energy were required for him to squat than to sit on the western toilet. In the aforementioned situation, the nursing staff could have checked on him and provided privacy for him, as long as they deemed that he was in a safe situation. There are no cleanliness issues in using the squatting position providing the seat is in the upright position.

Low health literacy: Medications. Mr. T took furosemide two times as instructed, once at breakfast and once at lunchtime. The question arises as to whether he was instructed on the exact times his medications should be taken. As a consequence of taking his medication incorrectly, he could have become dehydrated and lowered his potassium, which can lead to digoxin toxicity. Prior to discharge, a thorough discussion and written handout (in simple terms with universal signs to facilitate understanding in any language) as to when his medication should be taken might have avoided this problem.

It cannot be assumed that someone understands what is being said because they nod and sign a sheet of paper. Recently reported in the news, a Spanish-speaking patient was seen in the emergency department of his local hospital because he followed the directions on his medication label to take his diuretic and beta blocker "once" a day. In Spanish "once" means 11; he took 22 pills (amednews.com, 2004).

Language issues. English is the second language for Mr. T and his family. When English is the second language, individuals may have more difficulty speaking and understanding English during times of stress and illness. During a health crisis, family members frequently are asked to act as interpreters. In some cultures, it is inappropriate to discuss personal, health-related information with someone younger and/or of the opposite gender. This could have been the situation for Mr. T. when his daughter-in-law was used as the interpreter for his discharge instructions. It would have been more appropriate to get an official interpreter.

Patient teaching. Nurses often learn of a patient's discharge with only a few hours notice and are not given adequate time to ensure that the patient can manage self-care safely. Patients need to know what self-care activities are most important in their personal situations. Detailed instructions regarding medication use should be reviewed and written out for each patient.

Patient needs assessment. A patient needs assessment should include evaluation of the patient and family's knowledge, beliefs, attitudes, and skills for self-care. When time and energy are limited, the nurse needs to know what learning must be

A Case Presentation: Health Literacy and Cultural Diversity (continued)

achieved for survival and how best to achieve this (Rankin, Stallings, & London, 2005). Examples of survival behaviors for Mr. T and his family include:

- The ability to demonstrate appropriate catheter care, which would include emptying the urinary drainage bag. Changing the urinary drainage bag could be addressed later by the home health nurse.
- How to care for the catheter and genital area. What and when to report any change in this area.
- When to take his medications and the potential side effects of each medication. How and when to contact medical assistance if adverse side effects occur.

Cultural behavior. Mr. T and his family nodded their heads, smiled, seemed to understand the instructions and signed off the discharge instruction sheet. These behaviors could be related to Mr. T's cultural values. He did not want the nurse or himself to "lose face" (Chang, 1995). It is important to know what the patient truly understood. Providing patients with a visual and hands-on demonstration and taking the extra step of asking the patient to return the demonstration better ensures understanding. When asking patients to demonstrate, the nurse might phrase the request as, "Can you show me how you are going to do this when you get home? I want to make sure I was clear and that I covered all the steps." This technique places the responsibility of education on the nurse rather than only on the patient.

It is noteworthy that Mr. T's Foley drainage bag was completely full and had not been emptied since

he came home from the hospital because he did not want his daughter-in-law to empty the urinary drainage bag. This is a cultural issue related to gender, family relationships, and the sick role. In this situation the home health nurse could assess the wife's ability to manage the task. She could probably teach the wife to empty the urinary drainage bag. Continued home health care could be provided and should include contacting the physician facilitating the removal of the urethral catheter.

Conclusion

Cultural sensitivity/awareness would have helped Mr. T and his nurses with the following:

- Squatting to eliminate can be safe and is common in African and Asian countries.
- Utilizing an appropriate interpreter
- Taking his medications safely and effectively.

The patient education evaluation technique of return demonstration would have addressed the issues of saving face and health literacy needs as well as measuring the skill attainment of emptying the urinary drainage bag. ■

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Literacy, Low Health Literacy Issues, and Patient Education

In America, literacy is defined as the ability to read and write English. Osborne (2005) reports that a 1992 survey of literacy in the United States found that "nearly half of all adults...have at most, only marginal literacy skills. This means they are apt to have trouble understanding complex text, filling out bank statements and using maps and schedules" (p.132). Therefore, assessment forms, applications for service, maps for large medical complexes, and directions for taking medications will be difficult to

understand for half of the people seeking care. An international literacy survey examined people from "23 countries and found similar results" (Osborne, 2005, p.132). In western countries people are expected to be able to read. Patients are often ashamed, so they may use excuses or other behavior to hide their inability to read. Examples of these behaviors include inability to find glasses, or being late for appointments because they were unable to follow the travel directions (Osborne, 2005). Low literacy does not equate to low intelligence. The World Health Organization in 2001 emphasized the need for improved

health literacy worldwide. "Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health" (U.S. Department of Health and Human Services, 2000).

Low health literacy can affect anyone of any age, ethnicity, and background or education level. "Literacy matters in health care because life threatening or potentially harmful mistakes may happen when people cannot read or understand written information" (Osborne, 2005, p. 11). Literacy impacts understanding and inter-

pretation of meaning. Patients with poor reading skills may have difficulty analyzing instructions or synthesizing new information into existing behavior patterns, resulting in non-adherence with the plan of care. To effectively facilitate learning, nurses must address literacy issues when planning and delivering instructions.

In assessment of learning needs, the nurse should evaluate literacy levels, but this can be difficult to determine in the clinical setting. Do not make assumptions regarding a person's ability to read or the highest grade completed in school. Many people have reading skills significantly lower than the level completed in school. Print material at a fifth grade reading level will be understandable to a greater number of patients. A variety of tools and many word processing programs are available for determining reading level of print material.

When designing print material, utilize short, simple sentences. Summarize key points at the end of each section, write in the active voice, and clarify with examples. Include only relevant information, avoid technical terms and acronyms. When using a medical/technical term like "constipation," provide a brief simple explanation or definition. Test the reading level of the material utilizing a readability scale such as, the SMOG (Statistical Measure of Gobbledygook) readability measure (McLaughlin, 2006). Other readability tools include the Fry Readability Formula, The Suitability of Assessment of Materials Checklist (Doak, Doak, & Root, 1996), and word processing formulas. The most effective assessment for readability is feedback from the user of the document (Osborne, 2005, p.14). Graphics may be helpful, but should only be included if they add clarity to the written content. Graphics should be relevant to the reader, used to reinforce content, and be of good

quality and simple design (Osborne, 2005). Older adults will need larger font (14 point or above). Blue, green, and lavender are difficult colors for older adults to differentiate and should be avoided (Zurkowski et al., 2006).

Be an educated consumer when purchasing patient education materials. Review all print material and assess readability before ordering the material. Invite others to review and select teaching materials, including patients. "After all, patients are the best ones to judge whether materials are understandable, meaningful, useful, appealing and relevant" (Osborne, 2005, p. 31). Use of print material in conjunction with other teaching strategies will enhance patient learning.

The Final Step: Documentation

The Joint Commission (2006) supports culturally and linguistically appropriate services. The 2006 standards have integrated patient education throughout the manual. Patient education goals of the standards focus on understanding of health status, care, and informed decision making; the ability to cope with disease and treatment; and the promotion of a healthful life style. To address these goals requires that practitioners teaching patients and families assess the patient's current knowledge level, learning needs, and readiness to learn. The teaching plan is based on these assessments and is documented in the patient record. Learning objectives or expected outcomes are identified, and the teaching plan is developed. Throughout the teaching-learning process, the nurse evaluates learning outcomes and teaching strategies. Has the patient or family member truly learned? Demonstration of learning outcomes is more than simply repeating facts and information. The nurse evaluates whether the

patient or family member can accurately demonstrate skills or apply information taught. Strategies for evaluation include:

- Direct questioning.
- Return demonstration by the patient.
- Indirect questioning (ask what patients will tell their spouses/families they learned).
- Asking patient to select a meal from a commonly visited restaurant menu.
- Asking patients to assist with their care. ("I brought the supplies for your dressing change. Do as much as you can, and I'll be here to help and guide you.")

The teaching plan is modified as needed, and progress is documented in the patient record. Documentation is crucial as it will guide the home health/ambulatory team in what needs to be taught or reinforced and in how much support the patient and family will need later.

Conclusion

Nurses are teachers and have an obligation to facilitate learning for patients and families. Accurate assessment of learning needs and readiness includes assessment of cultural values and health practices as well as literacy issues. Every effort should be made to ensure that teaching plans incorporate patients' cultural values and beliefs. By addressing cultural and literacy issues, nurses can facilitate successful learning outcomes for patients and families enhancing their ability to cope with illness and improve overall health. ■

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The strength through cultural diversity concept should be integrated into higher education's ideal of providing positive direction toward philosophic experimentation and potential leadership of the society. The best way to see where something is going is to take a look back at where it has been. Brooks asserts that the northern and southern colonies addressed the issue of higher education differently in the Colonial period of American history. She speaks of "geographical and industrial factors" as having been the main agents of diversity (not specifically "cultural," however at least some element of "cultural diversity" is implicit) at this time. 2016. Integrating Health Literacy, Cultural Competence, and Language Access Services: Workshop Summary. Washington, DC: The National Academies Press. doi: 10.17226/23498. The workshop's third panel provided four examples of programs that aim to integrate health literacy, cultural competence, and language access services. Jessica Briefer French, senior research scientist with the National Committee for Quality Assurance (NCQA), addressed how issues of health literacy, cultural competence, and language access are being incorporated into national quality standards and measures. Understanding healthcare literacy, cultural competency, and health disparities/inequalities is essential for providing empathetic care to patients and their family members. Guidelines to provide culturally competent care may enhance the patient experience and improve healthcare provider communication. Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities. Hyattsville, MD: National Center for Health Statistics; 2016. 5. Betancourt JR, Corbett J, Bondaryk MR. Addressing disparities and achieving equity: cultural competence, ethics, and health-care transformation. Chest. 2014;145(1):143-148. Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how cultural diversity such as knowledge transfer, innovation and competitiveness; discussing the challenges from cultural diversity like communication problems and training difficulties; and providing practical recommendations that might help managers to successfully deal with cultural diversity issues in both global and domestic markets. marketing and product development activities in the U.S. industry will also be expected (Elmuti, 2001). Due to the rapid growth rate of globalization and the labor structure change in the workforce of domestic organizations, it is obvious that managing cultural diversity is becoming a big issue to most of the twenty-first century employers of the United States.