

Episode 7.09Show Notes

Cultural Aspects of Ageing

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# Infographic Points

Please place here 5 points that you would like the infographic to have on it. They need to be short to fit. The aim is to give people a practical aide memoir they could put up in the office whilst making them want to listen for more!

1. asdf
2. asdf
3. asdf
4. asf
5. asfd

# #MDTeaClub

*Please leave here any questions and/or links resources that may stimulate discussion in addition to those below e.g. charitable sites, guidance, papers, comment pieces.*

# Social Media / Website

Iain:

Jo: <blockquote class="twitter-tweet" data-lang="en"><p lang="en" dir="ltr">How do we learn? Cognitive science is showing us what really works! A fantastic Zine (a self-published magazine with images which is designed for public sharing) by @ncasemare <a href="https://t.co/JdamlkgwtC">https://t.co/JdamlkgwtC</a> Thanks <a href="https://twitter.com/ImpactWales?ref\_src=twsrc%5Etfw">@ImpactWales</a> <a href="https://t.co/HVhockeMIU">pic.twitter.com/HVhockeMIU</a></p>&mdash; Helen Bevan (@helenbevan) <a href="https://twitter.com/helenbevan/status/1109451346044956672?ref\_src=twsrc%5Etfw">March 23, 2019</a></blockquote>

<script async src="https://platform.twitter.com/widgets.js" charset="utf-8"></script>

Iain:

<https://twitter.com/jamesfrith1981/status/1115513317760602112?s=19> photo on phone.

Other:

# Main Show Notes:

# Learning Outcomes

## Knowledge:

* Understand cultural aspects of ageing in relation to ethnicity in particular
* Recall conditions and situations in which culture needs to be actively considered as part of a care plan

## Skills:

* To feel more confident with being able to anticipate and discuss cultural considerations, different to your own with your patients.
* To be able to adapt care plans to the individual

## Attitudes:

* To consider cultural competence as a core component of person centred care.

# Definitions:

Culture difference is increasingly seen as a crucial factor to consider when undertaking health and social care assessments, planning intervention and support.

**Culture** refers to a group or community who share common experiences, beliefs, traditions, history, language, which shapes the way its members understand the world. It includes groups we are born into, such as race, national origin, gender, class, or religion or groups we choose to join.

Culture will be a strong part of people's lives, influencing their views, values, hopes, worries and fears and impacting on the way they behave.

**Cultural knowledge**: what you know about characteristics, history, values, beliefs, and behaviours of another ethnic or cultural group

To develop **cultural awareness,** one needs to understand self and own biases, to ensure they are not impacting on the way you interact with a person from another culture, this self-awareness enables a person to become;

**Culturally sensitive** – by being curious, showing empathy and respect, and not making value judgments.

The following questions can help you determine your level of sensitivity.

* How accepting are you of people from a different cultural background?
* What stereotypes and prejudices do you associate with the ethnic group you identify with?
* How are your beliefs, values and outlook on life, different from people of other backgrounds?
* What is your attitude toward older people who are difficult to understand because of an accent or difficulty speaking English?
* How do I overcome my prejudices?

With respects to cultural identity it is important to consider the following:

* everyone has a cultural identity, regardless of whether they recognised or defined it themselves. Sometimes, culture is seen simply as “just the way we do things”;
* culture and cultural identity are dynamic and constantly changing;
* people may be influenced by and identify with more than one culture or cultural group;
* it is the choice of the individual as to which culture they identify with regardless of their cultural background;
* Though religion can influence cultural beliefs, often people separate their culture from their religion;
* A person’s culture can affect their health. As culture may have a bearing on the choices a person makes when managing their health. An example of this include Punjabi patients who believe eating Karela (Bitter melon/gourd) will treat their hypertension rather than tablets.

### Practical Definition

Essentially synonymous with person centred care.

In this episode we are going to concentrate predominantly on ethnicity, accepting that there are many more ways to look at this and we are likely to do further episodes in the future focusing on religion and other subcultures.

The structure of this episode will be

1. Thinking about definitions of culture and influence of these on ageing in a wider sense than just healthcare
2. More practical application of the healthcare system and adaptations / considerations to make more inclusive.

# Key Points from Discussion

## Culture Applied to Ageing

Examples of cultural aspects of ageing include:

Native Americans prize the virtue of wisdom, younger members seeking the wisdom of Tribal elders to help explore their current problems.

In Vietnam, elders have a strong influence in family decision-making and are regularly looked to for their advice.

In Asian cultures, (i.e. Japan and China) senior members of the family are treasured and it’s the norm for elders to live with and be cared for by younger generations.

In Korea, special festivities honour advanced birthdays. A *hwan-gap,* or 60th birthday, is a time when children celebrate their parents’ passage into old age (impact of advances in health have impacted life expectancy). At 70, there’s another celebration known as a *kohCui* which means “old and rare.”

Aboriginal communities: believe specific foods are only for older member of the community, for example Aboriginal people believe wildcat and kangaroo are to be reserved for elders and will cause physical harm if eaten by younger people.

In Hindi culture the suffix “-ji” is added to names to show deference and respect and demonstrate an appreciation of the older persons place in society

In the Philippines, elders are honoured with a symbolic gesture called the *mano po*, in which the younger person takes the hand of the older person and touches the back of the older person’s hand to the younger person’s forehead.

Different cultures have their own rules about body language and interpretations of hand gestures, for example some cultures point with the entire hand, because pointing with a finger is extremely rude behaviour, in other cultures direct eye contact is considered disrespectful

**Cultural Competence:**

It is important to remember that cultural competence is not just in relation to ethnicity but also a person’s sexuality, disability or socio-economic status.

Weaver (1999) identified the following factors as important for developing cultural competence:

critically reﬂecting upon and identifying one’s own beliefs and bias;

* recognising the impact of colonial histories;
* increasing knowledge and awareness of differing cultural groups;
* understanding and valuing the notion of diversity;
* recognising the level of historical or contemporary distrust between various groups;
* appreciating the signiﬁcance of difference in the helping relationship, including the impact of power dynamics. (Weaver, 1999, p. 218)

***(cited in Maidment, J. Egan, R & and Wexler, J. 2016. Social work with older people from culturally and linguistically diverse backgrounds: Using research to inform practice*. Available from:** [**https://www.researchgate.net/publication/310740847\_Social\_work\_with\_older\_people\_from\_culturally\_and\_linguistically\_diverse\_backgrounds\_Using\_research\_to\_inform\_practice**](https://www.researchgate.net/publication/310740847_Social_work_with_older_people_from_culturally_and_linguistically_diverse_backgrounds_Using_research_to_inform_practice)**.**

Yu (2009) identifies two false assumptions implicit in cultural competence:

* that the way in which people interact with health and social care is inevitably shaped by their culture, which does not allow for an individual view of the impact of their culture;
* that all members of a group conform to the same cultural practices with the same intensity.

Yu, S. W. K. 2009. The barriers to the effectiveness of culturally sensitive practices in health and social care services for Chinese people in Britain. [*European Journal of Social Work*](https://www.ncbi.nlm.nih.gov/pubmed/21208326)

In addition, Wills et al (2017) identify how prioritising cultural identity can have the potential to ignore or minimise the importance of other aspects of an older person’s identify such as sexuality/gender. This reductionist view having the potential to attribute the reason for a person’s behaviour to culture alone rather than any other reason (Williams & Soydan, 2005)

Rosalind Willis, R. Pathak, P. Khambhaita P. & Evandrou, M. 2017. Complexities of cultural difference in social care work in England, [*European Journal of Social Work*,](https://www.tandfonline.com/doi/abs/10.1080/13691457.2016.1255597)

Maidment et al (2016) research found that the following were, in some cases, more important than understanding a particular cultural background, although they acknowledge that understanding culture is helpful:

* respect;
* empathy;
* genuine interest;
* giving time/being patient especially if communication is difficult and time consuming;
* active listening
* showing tolerance and acceptance of difference, which aids in establishing a meaningful connection with the individual;
* combining compassion with care and honesty.

i.e. person centred care

*Maidment, J. Egan, R & and Wexler, J. 2016. Social work with older people from culturally*

*and linguistically diverse backgrounds: Using research to inform practice*. [Aotearoa New Zealand Social Work.](https://www.researchgate.net/publication/310740847_Social_work_with_older_people_from_culturally_and_linguistically_diverse_backgrounds_Using_research_to_inform_practice)

However, despite having access to training on working with culture and diverse, the literature demonstrates that white practitioners still experience anxieties, for example in Gunaratnam (1997) study of hospice work, staff expressed fears that they would offend service users and their families at a sensitive time. They were also afraid of being viewed as racist if they asked questions about culturally specific practices.

(Gunartanum, Y. 1997. Cuture is not enough: a critique of multi-culturalism in palliative care. In Field, D. Hockey, Small, N (Eds). Death, gender and ethnicity. Routledge, London or Gunartanum, Y. 2007. Interculture palliative care: Do we need cultural competence? International Journal of Pailiative Nursing 13. pp. 470-477 doi:10.12968/ijpn.2007.13.10.27477)

Proctor and Davis (1994) discuss how practitioners fear that admitting to a lack of cultural knowledge makes them appear professionally incompetent. This barrier to asking questions having the potential that the practitioners could end up providing inappropriate care without meaning to. This fear of acknowledging difference likely to stem from a ‘**colour-blind approach’**, with practitioners feeling that they should not ‘notice’ ethnicity in order to treat everyone equally, ignoring cultural difference with respect to food, hygiene for example (cited in Willis et al, 2017. p. 693).

((Proctor, E.K. & Davis, L.E. 1994. The Challenge of racial difference – skills for clinical practice. Social Work. 39 pp. 314-323 doi:10.1093/sw/39.5.504)

**Research:**

There is little research that considers the older person from different cultural backgrounds and the impact of ageing within a predominately white, British culture.

In 1928 Robert Parks discussed the concept of the ‘marginal man’ a person who lives in two separate cultures, not fully integrated into either culture, which has the potential to significant impact on their identity and personal consequence.

Park, R. E. 1928. Human Migration and the Marginal Man*.* [*American Journal of Sociology*](https://www.jstor.org/stable/2765982)

An area of practical implementation of this is in caregiving and the role of family versus formal carers in different cultural backgrounds

Sung & Dunkle (2009) states that it is a traditionally held believe that Asian societies are more respectful towards their elders than western society due, in part, to a strong link to Confucianism, which sees the family and filial piety (respect for father, elders and ancestors) as fundamentally important. Huang-Hei (2003) suggesting there are two forms of filial piety;

* reciprocal, which sees care being provided due to love and a wish to repay parents for the sacrifices they have made; and
* authoritarian, which encourages obedience and compliance and could be considered a means of social control.

More commonly filial piety is defined as a set of attitudes and behaviours, which demonstrate love, respect and care towards parents, which can lead to elderly parents having strong expectations of their children.

(Sung Kyu-Taik & Dunkle. 2009. Roots of Elder Respect: Ideal and Practices in East Asia. Journal of Aging, Humanities and the Arts. 3 (1) pp 6-24. DOI: 10.1080/19325610802652069)

(Kuang-Hui Yeh. 2003. A test of the Dual Filial Piety Model. Asian Journal of Social Psychology. 6. pp215-228 <https://doi.org/10.1046/j.1467-839x.2003.00122.x>)

In research undertaken by Sung (1995 + 1998), with Korean families six dimensions of filial piety were identified:

* showing respect
* fulfilling responsibilities
* harmonising families
* making repayment
* showing affection
* making sacrifices

Sung K-T. 1995: Measures and dimensions of filial piety in Korea. [*The Gerontologist*.](https://www.ncbi.nlm.nih.gov/pubmed/7750781)

Sung K-T. 1998: An exploration of actions of filial piety. [*Journal of Ageing Studies*](https://doi.org/10.1016/S0890-4065(98)90025-1).

Laidlaw et al (2010) research compared three different cultural groups; two were based in the UK and comprised a sample of older adult Chinese immigrants and UK born older adults. The third group were older Chinese adults living in Beijing. They wished to exam whether older people in Eastern and Western societies have similar expectations for filial support and whether the ageing process influenced this expectation. They found:

* The two Chinese groups had similar attitudes to filial piety;
* The Chinese immigrants and UK participants had similar attitudes to ageing;
* Chinese older people living in China have a more negative experience of ageing;
* The concept of filial piety remains strong in emigrants despite becoming part of a new culture over time;
* Psychosocial loss contributes to an expectation of filial piety – linked to a negative expectation or experience of ageing (loss/being de-creped), which engenders a feeling of helplessness.

Laidlaw, K. Wang, D. Coelho, C & Power, M. 2010. Attitudes to ageing an expectations for filial piety across Chinese and British cultures: A pilot exploratory evaluation. [Ageing and Mental Health](https://www.ncbi.nlm.nih.gov/pubmed/20425647)

This compares to Western societies who tend not to have a philosophy of care, which encourage sacrifice and care for the older generation. Instead older people can be viewed as a burden or a drain on resources (World Health Organisation, 2002).

**How culture influences healthcare in the ageing patient:**.

Most healthcare services stem from what already exists. As most migration of people from minority ethnic groups happened from the 1960s there have been fewer older people from those communities. Hence, healthcare issues which arise with advanced age tend to match the needs of the English Caucasian community, but do not necessarily match the needs of people from other cultures. However, nationally there is a drive to develop services so they match the need of people from all cultural backgrounds. This is especially important now as the population of older people in the black and minority ethnic communities is growing rapidly.

Older patients from all backgrounds may not seek medical support when they require it. The older generation tend to be more stoic, especially those that have lived through years of hardship. The older generation often have respect for healthcare staff. Advice given is often received well and taken. There may be times where older patients may not agree with the advice and treatment plan given, this is usually because they do not understand the advice given or the advice given is against their cultural beliefs.

Understanding information is usually a problem when the patient’s first language is not English. Conversations about fertility, sexuality and contraception can particularly be difficult, and are often influenced by cultural beliefs.

**Common medical issues in older patients affected by culture:**

DNACPR

End of life care

Incontinence

Dementia/Cognitive Impairment

**DNACPR/EOLC - potential challenges**

May not be part of their culture or against their cultural beliefs.

IT may not ‘exist’ in the countries they have come from (South Asian Communities).

They believe in treatment ‘till the end’ (Middle Eastern and South Asian Communities).

Palliative care and DNACPR is seen as withdrawal of treatment and care and viewed as being unethical and unkind.

Health care staff need to be aware of their patients’ cultures and religions in order to tackle such situations. Being aware will make holding discussions with patients and their family members on DNACPR/EOLC much easier.

In certain cultures there are community ‘leader’, religious figures, family ‘elders’ or other key family members whose presence in such meetings can be beneficial. Ask early if this is the case.

Using an interpreter where the patient’s first language is not English is very important.

When a patient dies cultural/religious beliefs can have a bearing on how the body should be treated and how quickly the funeral should happen.

**Incontinence:**

In some cultures the idea of passing urine and stool is perceived as being a ‘dirty’ act. In some Indian communities living in India, toilets are not kept at home and people will defecate and pass urine in communal toilets, away from their own homes. One of the hand’s is used for the action of cleaning oneself after defecation, the hand used (though washed) is recognised as the ‘dirty’ hand, while the other hand is perceived as being ‘clean’ and is used to eat and drink with.

Being incontinent of urine or faeces regardless of your background is difficult for a person. It can affect their social life, their sex life and their home life. Often people will not seek advice to help them with their incontinence.

In certain cultures incontinence is accepted as part of ageing and the loved ones of the sufferer support them in helping them wash and clean. In these communities sufferers may not seek support/help from healthcare services, it is believed incontinence is part of the ageing process. Research undertaken by Doshani et al (2007)identifies the following areas can support women to seek help:

* access to a female GP and if possible a GP with a similar ethnic background
* They would prefer to see an allied professional i.e. nurse, physiotherapist, the research indicating that they assumed they would be female.

(Doshani, A. Pitchford, E. Mayne, C.J. & Tincello, D, G. 2007. Culturally sensitive continence care: a qualitative study among South Asian Indian women in Leicester. *Family Practice.* Vol. 24 (6) pp 585-593. doi:org/10.1093/fampra/cmm058)

**Dementia and Cognitive Impairment:**

Some cultures still do not recognise dementia/cognitive impairment as a medical problem. Some cultures believe patients who suffer from cognitive impairment have become unwell due to ‘black magic’/’witchcraft’/’voodoo’, ghosts or spiritual beings.

Some cultures will believe it is part of ‘normal’ ageing and will not seek help.

In some cultures cognitive impairment in family members is not noticed, as family elders are taken care of by their younger family members. As their function reduces other family members help/support them. These patients only get diagnosed or seek further help when they become acutely unwell and are seen in hospital or by their general practitioner.

**How can healthcare staff improve their knowledge about different cultures?**

* Reach out to your local communities and meet with them to learn about their healthcare needs and concerns.
* Use local community leaders and staff (from the same culture as the audience you wish to support) to reach those communities.
* Work with local and national charities to hold health screening and education events.
* Review your local services and strategies regularly in order to match your local communities cultural needs.
* Make use of interpreters e.g. language line or face to face.

Using an interpreter:

When working with people where English is not their first language it is important to ask what their language of preference is and to consider using an interpreter, the dilemma being whether this is a paid interpreter or a family member (ethical considerations) – concerns expressed that the questions asked or responses are not always fully translated.

A UK study of nursing care found that nurses believed they were unable to provide the ‘total patient care’ that they would normally provide, because they could not discuss it with patients

Murphy & Macleod Clarke, 1993, p. 448 cited in Willis et al 2017. p.687).

Be aware of major festivals/celebrations of the various communities you wish to support. This is important as this is usually the time when they can become unwell or need more support. For example there is often a spike of admissions from the South other family members help/support them.

## MDTeaser

And not its time for the #MDTeaser - our MDT item guessing game….

This series the game is based on that TV classic catchphrase….

Iain - I am going to describe an image to you Jo… your job is to guess the catchphrase / MDT item etc.

And for you we have one - go to twitter and check out the pinned tweet to out feed to the latest clue! First correct guess gets a mug!

## The Gallery

If you have something you would like us to include - a poem, passage from a book etc then please let us know via Twitter etc etc.

**Curriculum Mapping** To Be Completed

This episode covers the following areas (n.b not all areas are covered in detail in this single episode):

* NHS Knowledge Skills Framework
  + Core: Equality and diversity level 4
  + HWB1 Promotion of health and wellbeing and prevention of adverse effects on health and wellbeing - Level 1
* Foundation curriculum
  + 2. Delivers patient centred care and maintains trust
  + 16. Demonstrates understanding of the principles of health promotion and illness prevention
* Core Medical Training
  + The patient as central focus of care
  + Relationships with patients and communication within a consultation
  + Personal behaviour
* GPVTS program
  + 2.01 The GP Consultation in Practice
    - Core Competence: Practising holistically and promoting health
    - Core Competence: Community orientation
  + 2.02 Patient Safety and Quality of Care
    - Core Competence: Community orientation
  + 2.03 The GP in the Wider Professional Environment
    - Core Competence: Practising holistically and promoting health
    - Core Competence: Community orientation
  + 3.03 Care of Acutely Ill People
    - Core Competence: Communication and consultation
  + 3.06 Women’s Health
    - Core Competence: Maintaining an ethical approach
  + Geriatric Medicine Training Curriculum
    - 6. The Patient as Central Focus of Care
    - 12. Relationships with Patients and Communication within a Consultation
    - 24. Personal Behaviour
    - 29. Diagnosis and Management of Chronic Disease and Disability

**Feedback**

We will add feedback to this as we receive it! The website will have the most up to date version always available: [www.thehearingaidpodcasts.org.uk/mdtea](http://www.thehearingaidpodcasts.org.uk/mdtea)

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Check out our infographic *A sip of…* on the website page for this episode,summarising 5 key points on this topic. It’s made for sharing!