

Chapter 2

Historical and Conceptual Foundations of Ethnogeriatrics

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2.1 Historical Development of Ethnogeriatrics

The concept of *ethnogeriatrics* was developed based on an identified need by educators and clinicians to have a discrete term to describe the unique issues in care of the rapidly increasing number of elders from culturally diverse backgrounds. As indicated in Fig. 2.1, it is conceptualized as the intersection of the fields of aging, health, and ethnicity, and as such is inherently multidisciplinary and interprofessional.

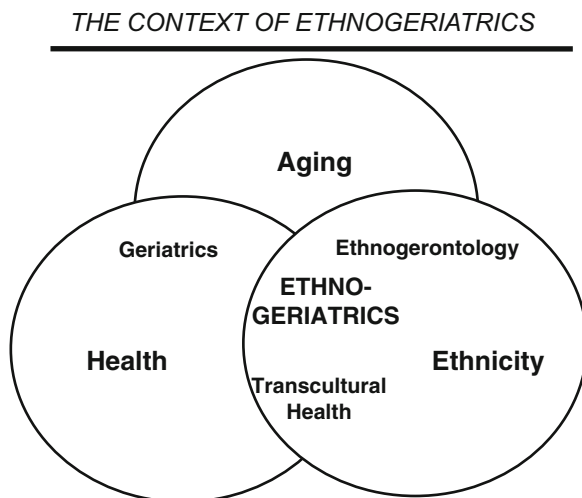
Cultural influences on health and health care have been recognized for several decades in the disciplines of medical anthropology, transcultural nursing, clinical psychology, and social work. It was not until the late 1980s, however, that its application to clinical geriatrics and geriatric training began to be explored in a systematic way. Likewise, the field of gerontology had included cultural diversity and minority status in courses and textbooks on aging since some of the major pioneering work in the 1970s, but its application to the health care disciplines was not clearly drawn until late in the decade of the 1980s. Dr. Jacqueline J. Jackson, Professor of Sociology at Duke University, is usually credited with coining the term “ethnogerontology” in the late 1970s to describe the arm of gerontology that explores ethnic, racial, and minority issues. In 1987, Core Faculty members of the Stanford Geriatric Education Center (SGEC) at Stanford University School of Medicine adapted the term “ethnogeriatrics” from Dr. Jackson’s contribution to describe health care for elders from diverse ethnic and cultural backgrounds [1].

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Fig. 2.1 The context of ethnogeriatrics



2.1.1 Ethnogeriatric Education

To explore the degree to which health care training programs in various disciplines had included ethnogeriatrics in their curricula, two small assessments were undertaken in 1988; one looked at inclusion in textbooks, and the other in courses. SGEC Core Faculty members reviewed 41 geriatric textbooks in their own disciplines, 17 of which had some reference to ethnic issues [2]. See Table 2.1.

A modest effort was also undertaken in 1988 by SGEC to assess the curricula in ethnogeriatrics being taught in colleges and universities in the U.S. Listings of courses in the *National Directory of Educational Programs in Gerontology* published by the Association of Gerontology in Higher Education (AGHE) in 1987 [3] were reviewed for content in “ethnic” or “minority” or “cross-cultural” issues. Of the 404 colleges and universities listed, 41 had at least one reference to courses with ethnogerontological content, 16 of which were associated with health care training programs. A request for information was sent to the 16 programs, all of which were on the East or West Coast, and responses were received from 8. In the process 4 other programs with similar courses were identified. Only one course combined the three components of health, aging, and ethnicity; it was taught in a vocational nursing program in a community college in California. Another nursing program reported that a cultural emphasis was included throughout their curriculum, some of which applied to geriatric care. The most common pattern was a course offered in ethnicity and aging in an anthropology or ethnic studies program that was open to students in different fields, including health care disciplines [1].

Federal initiatives were a major impetus for the development of ethnogeriatric education in the late 1980s in two significant ways: funding preferences for the multidisciplinary Geriatric Education Centers (GECs), and an important federally funded conference in 1988 and its resulting book. Beginning in 1987, the Bureau of Health

Table 2.1 Percent of geriatric textbooks with ethnogeriatric content, 1988

Discipline	Number of geriatric textbooks reviewed	Percent with some ethnogeriatric content
Medicine	15	13
Nursing	15	47
Occupational therapy	1	0
Psychology	3	100
Social work	7	71

Source: Yeo (1991)

Professions (BHPr) in the Health Resources and Services Administration (HRSA) which funds multidisciplinary GECs included a funding preference for “institutions that demonstrate a commitment to increased minority participation—or efforts to recruit minority faculty” [4]. In 1989, the preference was expanded to include linkages with predominantly minority educational institutions or health facilities and “developing curricula or expanding teaching concerning minority elderly” and “providing trainees with experience in caring for minority elderly” [5]. Similar preferences were continued through the 1990s, providing an incentive for the applicants for GEC funding throughout the U.S. to implement or expand their training programs in the developing field of ethnogeriatrics in the multiple disciplines they train.

In order to provide curriculum resources and to encourage health care training programs to expand their offerings in minority aging, BHPr and the Health, Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the National Institute of Mental Health sponsored a 2-day invitational conference in February, 1988, *Minority Aging: Essential Curriculum Content for Selected Health and Allied Health Professionals*. Approximately 100 experts attended and shared background papers, which were published in 1990 in a volume by the same name as the conference, edited by Dr. Mary Harper of ADAMHA, who was a major advocate for the development of the field of ethnogeriatrics [6].

The early 1990s found educational programs in ethnogeriatrics blossoming on many fronts. Some of the important contributions include the following:

- A symposium on the ethnogeriatric contributions of GECs at the 1990 American Society on Aging meetings documented the development of 24 modules or teaching units by 12 GECs, 13 monographs, 7 videotapes, 36 conferences sponsored by 20 GECs, 13 clinical training sites, and 3 computerized bibliographic databases [7].
- In 1991, the Association for Anthropology and Gerontology (AAGE) compiled a collection of 30 course outlines and resources from various universities in *Teaching About Aging: Interdisciplinary and Cross-Cultural Perspectives* [8].
- In 1991, Virginia Commonwealth GEC sponsored a teleconference seen by an audience of several thousand, *Ethnic Diversity: Barrier or Benefit in Health Care for the Elderly*.
- In 1992, a 2-day conference, *Ethnogeriatric Curriculum: What Should We Teach and How Should We Teach it?* sponsored by Stanford GEC, Meharry GEC, and Palo Alto Veterans Administration Geriatric Research, Education, and Clinical Center (GRECC) was attended by 94 faculty from 11 disciplines and 16 states.

The decade of the 1990s saw increasing emphasis on ethnogeriatrics in health care training programs in multiple disciplines, in multidisciplinary education, and in policy discussions, as well as development of a comprehensive model curriculum. Ethnogeriatric education was recognized as part of the growing recognition of the need for not only more trained geriatricians in particular, but also geriatrically trained dentists, nurses, social workers, psychologists, and allied health personnel. A report was commissioned by the Select Committee on Aging of the U.S. House of Representatives in 1992, *Shortage of Health Care Professions Caring for the Elderly: Recommendations for Change* that included two chapters advocating ethnogeriatric education [9, 10].

In 1995, an invitational National Forum on Geriatric Education and Training sponsored by BHPPr brought together experts in geriatric education, funders, providers, consumers, and policy makers to assess needs for geriatric education for all disciplines and make recommendations in 11 component areas, one of which was Ethnogeriatrics. The result of the National Forum was a series of White Papers developed by the experts in each area and published by BHPPr later in 1995 [1].

Later in the decade BHPPr funded an effort by faculty from 30 GECs working as the Collaborative on Ethnogeriatric Education to develop a basic curriculum in ethnogeriatrics that could be used in any discipline or in interdisciplinary education. The result was the Core Curriculum in Ethnogeriatrics consisting of five modules: Introduction and Overview; Epidemiology of Health Conditions; and three modules on Culturally Appropriate Geriatric Care: Fund of Knowledge; Assessment; and Health Care Interventions, Access, and Utilization. The first edition was disseminated in 1999 [11], and in 2000, a second edition of the Core Curriculum that was more comprehensive was developed by 21 faculty authors from the Collaborative [12]. It was designed to be the generic curriculum for any discipline, with a minimum of ethnic specific information that could then be supplemented by the geographically appropriate modules from the Ethnic Specific Modules for each training program. The Ethnic Specific Modules of the Curriculum in Ethnogeriatrics was again supported by BHPPr and developed by 29 faculty authors from GECs working as the Collaborative in Ethnogeriatric Education; it consisted of 12 modules, each focusing on elders from a specific racial or ethnic population [13]. The Core Curriculum and the Ethnic Specific Modules of the Curriculum in Ethnogeriatrics were made available in hard copy and online at <http://web.stanford.edu/group/ethnoger/> in 2001. Based on information from the online survey and other sources of information, over 200 training programs are known to have used the Curriculum in Ethnogeriatrics in some way, and many more students and providers have used it as well.

2.1.2 Clinical Ethnogeriatrics and Ethnogeriatric Research

While the need for ethnogeriatric education was being recognized during the 1990s, a parallel advocacy movement was happening in relation to clinical ethnogeriatrics and ethnogeriatric research, which helped to institutionalize the field. These efforts

were led by the three national professional organizations in aging—the Gerontological Society of America (GSA), American Society on Aging (ASA), and American Geriatrics Society (AGS), all of whom developed task forces on minority aging or ethnogeriatrics in the early 1990s that have successfully brought attention to the needs of minority elders. In 1991, GSA sponsored an invitational conference with funding from the National Institute on Aging to bring together potential researchers and scholars to develop a “Minority Aging Research Agenda.”

But it was AGS that led the movement to recognize ethnogeriatrics as an important area in clinical care as well as health care research. AGS allowed members interested in the field to organize an Ethnogeriatrics Advisory Group in 1992, which was then accepted as a permanent AGS Ethnogeriatric Committee in 1998. During those years, the members of the Advisory Group developed an Ethnogeriatrics Position Paper outlining the need for better clinical care for diverse elders, and ethnogeriatric research and education; it was endorsed by the AGS Board of Directors and updated in 2006. The Ethnogeriatrics Committee has also been successful in implementing many clinically oriented ethnogeriatric symposia during AGS annual meetings, but one of its most successful ventures has been the development of a series of three volumes, *Doorway Thoughts: Cross-Cultural Health Care for Older Adults*. The first two volumes provide information on cultural issues, health risks, and recommendations for clinical care for older adults in 15 specific ethnic populations in the U.S.; the third volume focuses on religious diversity and provides background and clinical suggestions for working with elders and families from 9 faith communities [14–16].

One of the most important landmarks in the institutionalization of ethnogeriatrics has been the establishment of the section on Ethnogeriatrics and Special Populations in the *Journal of the American Geriatrics Society (JAGS)*. As a leading journal in geriatric care, the section in *JAGS* reflects an important commitment to support the field of ethnogeriatrics and promote ongoing research to broaden its base of knowledge. It continues to attract submissions from dozens of authors each year.

2.2 Conceptual Foundations of Ethnogeriatrics

Just as the field of geriatrics itself is more applied than theoretically based, ethnogeriatrics has very few all-encompassing theories. Perhaps this reflects the youth of the field, so that as more scholars become involved in critical analyses, more theoretical paradigms may evolve. As indicated in Fig. 2.1, ethnogeriatrics is at the intersection of three well-developed fields—aging/gerontology, health and health care, and ethnicity or culture, so it has borrowed from those parent fields and their subfields of ethnogerontology, geriatrics, and transcultural or cross-cultural health and adapted many of their perspectives. In addition, each of the health care disciplines, such as medicine, nursing, and social work, has its own theoretical perspectives in exploring the effects of culture on health care, and some of these have been adapted and incorporated into ethnogeriatrics.

To highlight the bases of ethnogeriatrics, some of the critical components that comprise the field are reviewed below, with an emphasis on what makes the ethnogeriatric perspective unique.

2.2.1 Demographics: Our Ethnogeriatric Imperative

One of the primary motivations for the development of the field of ethnogeriatrics was the realization that elders from the very diverse ethnic minority populations are growing faster than the majority non-Latino White population. It is common for articles on ethnogeriatrics to begin by pointing that out, thus providing a rationale for the importance of the topic. The projections are for elders from the five population categories considered by the U.S. Census to be ethnic minority (African American or Black, American Indian and Alaska Native, Asian American, Hispanic or Latino American, and Pacific Islander American) to grow from 20 to 40 % of all older Americans by the middle of the twenty-first century. This projection has been called our “Ethnogeriatric Imperative” [17, 18]. The other part of those projections is the diversity and subpopulations of elders included in the categories that are used by the Census, so that the data presented only by the official five “ethnic minority” populations severely underrepresent the diversity that geriatric providers are expected to see because of the vast heterogeneity of elders *within* each of those five minority populations, as well within the majority White population itself. To illustrate that diversity and some of the relevant characteristics of the diverse elders, data in Table 2.2 was compiled from the 2010 U.S. census data.

2.2.2 Epidemiology: Risk of Diseases Among Diverse Elders

Along with the size of the populations of older adults from diverse backgrounds, knowledge of their epidemiological profiles is important for ethnogeriatric care. The risk for morbidity and mortality differs among the various older populations [17]. An important example is the risk for diabetes, which is higher than the non-Hispanic White population in all of the ethnic populations that have been studied, but especially among American Indian, African American, and Latino elders.

2.2.3 Acculturation: Cultural Competence and Cultural Humility

A major part of the relevance of ethnogeriatrics lies in the importance of bringing insights about unique cultural issues that affect the health care of older adults. Elders who grow up in ethnic enclaves in the U.S. or who have emigrated from their countries of origin, especially those known as “Followers of Children” who immigrate late

Table 2.2 Selected demographic characteristics of older Americans by ethnicity, aged 65 and over, U.S. Census, 2010, developed by Gwen Yeo, Ph.D.

Populations	Number 65+	Percent of 65+	In poverty (%)	With disability# (%)	Living alone (%)	Education*** <9 yrs. college+ (%)	Speak little or no English** (%)
Total older Americans	40,267,984	100%	9.4	37.2	27.3	12	41.2
<i>Racial categories*</i>							
<i>(Non-Hispanic/Latino)</i>							
African American/Black*	3,374,381	8.40%	20.2	43.9	29	19.4	29.4
American Indian*	179,819	0.40%	20	51.1	22.2	25	32.2
Asian Americans*	1,376,471	3.40%	12.8	32.7	13.6	23.4	45.5
Asian Indian	173,427		7.8	31.2	6.9	20.6	54.2
Cambodian	13,424		19.4	50.3	7.1	61.7	15.2
Chinese	366,761		18.5	31.3	15.4	30.3	42.1
Filipino	289,312		6.9	34.2	8.8	17.8	57.2
Hmong	7,849		23.4	51.1	6.5	84.4	6.5
Japanese	178,691		6.1	32.8	25.9	6.6	44.6
Korean	142,519		20.8	25.3	18.8	19.6	44.6
Laotian	11,027		17.9	43.6	6	60.1	11.7
Vietnamese	126,226		16.9	39.1	9.4	36.7	27.8
Native Hawaiian & other Pacific Islanders*	29,568	<0.01	9.2	42.7	13.2	16.6	32
White	32,209,431	80.00%	7.4	36.2	28.4	12.5	44
Two or more races	399,457	1.00%	13.3	46.6	26.3	13.1	43.5

(continued)

Table 2.2 (continued)

Populations	Number 65+	Percent of 65+	In poverty (%)	With disability# (%)	Living alone (%)	Education *** <9 yrs. college+ (%)	Speak little or no English** (%)
Hispanic/Latino	2,781,624	6.90%	19	41.6	18.2	43.8	21.3
Mexican	1,423,951		18.4	43.8	15.6	52.1	16.5
Puerto Rican	312,064		23	44.4	19.7	65.2	19.4
Cuban	301,515		21.8	38.9	20.6	35.4	29.1
Dominican	90,415		31.7	42.7	17	60.5	11.6
Central American	157,598		17	35.8	13.6	47.5	22.4
South American	217,568		14.8	31.3	16.4	24.4	33.5

Notes:

*All racial frequencies are “alone,” as opposed to “in combination with one or more races”

**Speaks English “not well” or “not at all”

***Reported as “less than 9 years” and “some college no degree, associate degree, bachelor’s degree, or graduate or professional degree”

#Civilian non-institutionalized population

Source: U.S. Census Bureau. Number 65+ in each racial or ethnic category are from the 2010 decennial census. Percent figures in poverty, with disability, living alone, education level, and speaking little or no English are all from the American Community Survey 3 year or 5 year estimates through 2010. Retrieved from www.census.gov

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in life to their host country to live with adult children, bring with them many of the culturally based health beliefs. Many of those beliefs influence their interactions with providers due to differences in beliefs about: when and whether the elders should see their providers for certain conditions; etiology of the conditions; how the conditions should be treated; how providers should behave during clinical encounters; and roles of the older patient and family members in decision making, to mention a few. Examples of health beliefs that are not consistent with the biomedical model of Western health care are those that define health as balance between elements in their bodies, and illness as an imbalance. These can be those that are based on the ancient traditional Chinese medicine theories of *yin/yang* balance, sometimes translated as cold/hot; these theories are still widely held in China and many other Asian countries. Other balance theories are found among immigrants from Mexico and Latin America and from the Indian subcontinent who practice the ancient systems of Ayurvedic medicine. In many cases, elders who adhere to the balance theories believe that balance can be restored by eating foods or drinking liquids from the category that is considered too low (e.g., fruit considered “cold” if they have too much *yang* or “hot”), or drinking herbal teas prescribed by their traditional providers.

Many elders who are less acculturated to the U.S. mainstream culture and its health care system prefer to utilize a culturally based (“alternative”) health provider using a non-Western health system with which they are familiar, if one is available. These providers have their own systems of assessment and diagnosis; then they may prescribe herbal medicines, rituals, or behaviors. However, in many cases, the elders may also consult Western biomedical providers and do not disclose any culturally based treatments or herbal medications they are using.

Effective ethnogeriatric care for culturally diverse elders requires some knowledge of the range of culturally based health beliefs the Western providers may encounter and the skills to adapt to the different beliefs appropriately (*cultural competence*), while resisting the temptation to assume that the knowledge applies to all older adults from that specific cultural background. *Cultural humility* was suggested as a counterpart to cultural competence to emphasize the importance for clinicians not to assume they know all about cultures; it also emphasizes the importance of self-evaluation and critique, establishing a partnership with patients, and reducing the power differential between provider and patient [19]. However, cultural competence and cultural humility are not really contradictory but complementary, and cultural humility can be seen as a crucial and necessary attitude for providers to manifest in order to successfully apply their knowledge and skills in ethnogeriatric cultural competence.

2.2.4 Historical Experiences: Cohort Analysis

The unique historical experiences of specific population cohorts of ethnic elders have a direct influence on their health risks and degree of trust of health care providers. Some knowledge of periods of discrimination and experiences before and

during immigration of particular cohorts is extremely important in taking an adequate social history with older patients and understanding their perceptions and attitudes. Examples are the Boarding School experiences of large numbers of older American Indians, the internment of many older Japanese Americans during World War II, the severe discrimination and segregation experienced by African Americans in the South until the 1960s, and the difficult experiences in refugee camps in various waves of immigrants from Vietnam. Cohort experiences of eight populations of ethnic elders have been described in a Stanford GEC monograph, *Cohort Analysis as a Tool in Ethnogeriatrics: Historical Profiles of Elders from Eight Ethnic Populations in the United States* [20].

2.2.5 Clinical Skills in Ethnogeriatric Care

Some of the important skills geriatric providers need to care for the increasingly diverse population of U.S. elders are part of the basic foundation of the field of ethnogeriatrics.

Language Access: Use of Interpreters. As evidenced in Table 2.2, over half of older adults speak little or no English in many of the U.S. ethnic population, and in some it ranges to 80 % or more. As a consequence, communication issues loom large in successful clinical encounters with ethnically diverse elders. Many with limited English proficiency (LEP) come to health care appointments with younger family members expecting them to be their interpreters with English speaking clinicians. While using untrained interpreters is a common practice because of the difficulty, expense, or time to access trained interpreters, there is growing evidence that using ad hoc interpreters, such as untrained family members or friends, results in increased problems. Professional interpreters have been found to decrease communication errors, increase patient comprehension and satisfaction, and improve clinical outcomes [21]. They have also been found to decrease the chance of critical errors and to decrease lengths of stay and readmission rates [22, 23]. It is particularly important not to use children for health care interpreting, not only because they are less likely to have adequate vocabulary in one or both languages, but also because it can be a very traumatic experience for the children themselves. It is fortunate for effective health care for LEP elders that professionally trained interpreters are increasingly available through phone and video interpretation systems. It is also important because it is a way for health care providers to meet the mandate required by Title VI of the 1964 Civil Rights Act for equal access regardless of ethnic background.

Showing Culturally Appropriate Respect. Most other cultures tend to express more value and respect for elders than is usually found in the U.S. with its emphasis on youth culture. For that reason, both culturally diverse elders and their family members expect that clinicians will clearly show respect to their older family members. How that respect is expressed, however, depends on the degree to which clinicians are familiar with ethnic specific norms for greetings, touching, body language,

establishing rapport, and nonverbal communication such as gestures. Examples include whether to greet the elder first, what name to use, whether or not it is appropriate to shake hands, particularly with a patient of a different gender, whether or not to have direct eye contact, whether to bow, and whether to begin the encounter with “small talk” rather than launching directly into the purpose of the visit. Nonverbal communication such as gestures can be misinterpreted when a clinician uses a hand motion that has a different meaning in another culture. In some Middle Eastern cultures, for example, showing the bottom of one’s shoe to another person can be considered a serious insult. (See the series, *Doorway Thoughts: Cross-cultural Health Care for Older Adults* [14–16], developed by the Ethnogeriatrics Committee of American Geriatrics Society for more information.)

Appropriate Assessment. For clinicians to do appropriate geriatric assessments with elders from diverse populations, they frequently need to be concerned with language differences and interpreters, taking social histories in the context of the elder’s cohort experiences, and showing culturally appropriate respect. While doing a physical exam, it is important for clinicians to be aware of parts of the body that are particularly culturally defined as sensitive so that permission should be granted to touch them, or they need to be kept covered as much as possible.

Also, the assessment instruments that are used for geriatric conditions such as cognitive status and depression need to be culturally and linguistically appropriate. In addition to translations into the elder’s language, issues in cognitive assessment include literacy levels, familiarity with the items mentioned in the questions, and cultural appropriateness [24–27]. Ideally the measures should be validated in the populations involved. A study of the appropriateness of the Geriatric Depression Scale in six populations of Asian elders in New York City found that some of the statements were too extreme culturally for the elders to endorse, and the item “prefer to stay at home” could be interpreted as a positive cultural value rather than as a reflection of depression [28].

Cultural Conceptions of Illness: Explanatory Models. Medical anthropologists such as Arthur Kleinman and colleagues advise clinicians to include an effort to elicit patients’ own explanatory model of their illness in clinical encounters [29, 30]. By understanding the patients’ perspective about the causes and expectations of their conditions, some recommendation based on the older patients’ understanding can be incorporated with the clinicians’ own suggested management of their conditions and presumably increase likelihood of adherence. Examples of types of culturally based explanatory models would be lack of balance, blockage of the flow of Xi (or vital energy), a hex or spell having been cast on the elder, having disrespected one’s ancestors, soul loss, or lack of adherence to religious prescription.

A number of models of techniques to elicit and utilize patients’ explanatory models have been suggested. In the original 1978 article on the subject of explanatory models, Kleinman and colleagues suggested questions that could be used in the clinical encounter to gain an understanding of the patient’s perspective, such as “What do you think caused your condition?” [29]. Since that time other authors have supplemented those eight questions with additional ones that could be used as well.

Another model that has been used widely is the LEARN model by Berlin and Fowkes [31]. It suggests a mnemonic to lead clinicians through the following steps:

- *Listen* with sympathy and understanding to the patient's perception
- *Explain* your perception of the problem
- *Acknowledge* and discuss the differences and similarities
- *Recommend* treatment
- *Negotiate* agreement.

A model specifically for geriatric care was introduced by Kobylarz and colleagues [32]. In the mnemonic ETHNIC(S): A Framework for Culturally Appropriate Geriatric Care, reminders are given to the geriatric provider for the following topics to cover along with recommended questions to ask: Explanation, Treatment, Healers, Negotiate, Intervention, Collaborate, Spirituality/Seniors.

Working with Families is an important part of all geriatric care, but even more important for most elders from culturally diverse communities for a variety of reasons. Those who have immigrated to the U.S. as middle aged or older adults are likely to be more dependent on their younger family members because they are less likely to be English proficient and may not be familiar with the transportation, communication, and other U.S. technology to be able to function independently. In many cultures, care of older adults is the responsibility of the younger family members, so that clinical encounters are likely to include multiple generations. In some cultures, specific members of the family, such as the oldest child or the oldest male in the family, are expected to be decision makers for health issues for older family members. In some cases, that person may be in a different city or even a different country.

A common situation in which geriatric providers work closely with family members is when the spouse or adult child is the family caregiver for an elder who has dementia. Because of the strong expectation of family responsibility and filial piety in many cultures, the caregivers are frequently under extreme stress to provide all the care with little or no outside help and still maintain their employment to support their family. Whereas there are likely to be large extended families to provide assistance in their countries of origin, that is much less likely after the elders and adult children have emigrated. Compared to mainstream white families in the U.S., most ethnic minority families are much more likely to resist institutional placement for their elders in advanced stages of dementia, and some have strong guilt feelings if they are forced to do so.

Ability to include and work with younger family members while not excluding the older patient are important skills in ethnogeriatric care. Sometimes clinicians feel a conflict between the U.S. ethical requirements of autonomy that asserts each patient should be fully informed of their situation and make their own decisions and the requests of younger family members who ask that their parent not be told of their diagnosis of cancer or other serious diseases. Usually these requests come from a desire and cultural mandate to protect their older parent, and the feeling that if the parent is informed of bad news, they will give up hope. If possible it is advisable to anticipate that situation by asking the older patient early in the clinical relationship who they would like to be informed about their medical condition and who they would want to make decisions about their care.

End of Life Care. Each culture has its own distinctive norms for appropriate ways to handle death and dying, most of which have evolved over many centuries. As older adults face the process of dying in the U.S. health care system, they and their families may face cultural dilemmas in trying to adapt to a different set of expectations. One area where this occurs is in the decision whether or not to use hospice care. Because of the strong mandate to protect and care for elders in many cultures, the idea that they would relinquish the effort to do everything possible to save the elder's life is something many would not consider. The same dilemma may occur in decisions about use of feeding tubes or ventilators, especially in cases where they may want to keep the elder alive to preserve the possibility of a miracle cure, or they feel that death should be on God's timing.

There are cultural differences in the preferences for place of death, with some preferring to die in the hospital and others at home. There are also many culturally or religiously prescribed rituals surrounding death that may be important to family members, some which may be difficult to accomplish in a hospital setting. Examples are the importance of dying facing Mecca, the washing the body of the deceased, and prescriptions of who should do the washing.

Many elders express the preference to "go home to die" or to be buried in their country of origin. Given the expense and other resources necessary to make these arrangements, families and clinicians frequently face challenges trying to adhere to the elders' wishes.

2.3 Conclusion

The development and institutionalization of the field of ethnogeriatrics has been a gradual process of recognition of the need and the unique factors associated with health care for the growing populations of culturally diverse elders in the U.S. Because it has its roots in multiple disciplines, its growth depends on the support it receives from policy makers, faculty, researchers, and clinicians in those disciplines. The theoretical and conceptual bases of the field need to be recognized for their value, and empirically tested for their validity. Emerging insights need to be identified, codified, and disseminated so that the field can be strengthened and the health and well-being of diverse older adults can be increasingly improved.

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