



Factors affecting patient education from cultural perspectives

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Abstract

Introduction: Patient education is influenced by cultural factors. This study aims to find out the role of culture in patient education.

Methods: A qualitative study was conducted on 23 Iranian nurses. Inclusion criteria were minimum 5 years of working experience in clinical nursing. Semi-structured face to face interviews were used to collect the data. Interviews were taped, transcribed and analyzed using content analysis method.

Results: The main theme of 'cultural sensitivity' was extracted from the interviews. Sub-themes were cultural divergence, cultural connection literacy-based instruction.

Conclusion: A dynamic process of patient education is influenced by various cultural factors. Nurses must be aware of the cultural norms in patient education to meet their expectations in a respectful manner.

Keywords: Patient education, Nurse, Culture, Content analysis

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Introduction

Patient education is the most important role of nurses and it is on the basis of patients' rights. It is the criteria for accreditation of a variety of health care organizations (1). Patient education improves patient outcome and causes long-term changes in self care decisions and independent behaviors. Patient outcome is necessary to health promotion, prevention of diseases, and help the process of adaptation Also, it may reduce complications, health care costs and patient readmission (1-3). Nurse's role in patient education is influenced by many factors such as motivation, readiness, understanding of the teaching role, and environmental factors (2). Teaching is a dynamic process and is influenced by social and cultural factors. Thus, nurses must be sensitive to the effects of religion, language, values, socioeconomic and cultural factors (4-6). Cultural care is known as the ethical obligations of nurses and holistic care is related to nurses' awareness of the patient's cultural values. However, despite the emphasis on culture-based education in the nursing world, there are still

problems in this area (7-10). Although the use of native and adapted cultural patterns is a feasible strategy for the establishment of patient education in nursing practice, there are difficulties in providing proper and adequate training to patients (11). Given the lack of qualitative research on patient education from the cultural perspective, this study was conducted to determine the role of culture in patient education.

Methods

A qualitative interpretive approach was used to develop knowledge and conceptual orientation of the phenomenon (12). Semi-structured interviews were used. The taped interviews were written on paper.

All ethical considerations were taken into account to ensure the rights of the participants. Participants were informed about confidentiality of obtained information and clearing of the taped interviews. Participants then had the right to withdraw from the study at any phase of study.

Purposive sampling was used to achieve a diverse sample. According to Lincoln and Guba, 12-20 samples

are sufficient for diversity (13). Data saturation was achieved when researcher noted that collecting more data does not provide deeper understanding of the phenomenon (14). According to “Novice to Expert Theory”, inclusion criterion was a minimum of 5 years of experience in clinical nursing (15).

A consent form was given to interested participants. Questions were answered if participants required any more information. Interviews were conducted at the right time and place. Each interview lasted approximately 45 minutes. The interviews were taped with the permission of participants. An open question was asked at the beginning of each interview, i.e. ‘Please tell me about your experiences in patient education with different cultures?’ Interviews focused on the patient education process and were transcribed and then verified for accuracy. Transcripts were reviewed several times to reach a general sense of understanding. Data were matched and classified. In this case, the raw data were encoded into separate semantic units and then these units were classified based on similarity of their meaning. Data were assessed by 9 nurses volunteered to participate in the validation process.

Constant comparative methods were applied throughout data analysis. To ensure credibility, the analysis results were explained to participants in order to make sure that the participants’ intentions and feelings were fully understood by the researchers. For applicability, researchers were interviewed until data were fully saturated. To enhance consistency, the results were reviewed by two researchers in nursing (16).

Results

23 nurses participated in the study. The mean age of the participants was 34 years (SD=2.53 years). The mean of work experience was 23 years (SD=2.3 years). The main theme of ‘cultural sensitivity’ was extracted from the interviews. It included sub-themes, i.e. cultural divergence, cultural connection and literacy-based instruction.

Theme; Cultural sensitivity: A female nurse with 16 years of experience in clinical nursing says: “In our assessment, if we assess the patients, that it is no clear, we usually do it for less. I don’t say I do not do it, because it is also a wrong expectation. But no, if we assess, our assessment is only a medical assessment. We usually don’t assess culture, cultural beliefs or cultural behavior”. A 46-year-old man with 18 years of experience in nursing represents cultural sensitivity well: “Even the type of eating, eating style and food type, unfortunately, I saw less to consider it. Even as allow ourselves to ask the patient if he/she usually

uses a fork or spoon? In these situations we come to behave almost in accordance with western culture”.

- *Cultural divergence:* One of the participants with experience in theoretical education believes that patient’s opinions are contrary to his scientific beliefs: “they attach the objects to their patient’s hand”. Sometimes we simply stop doing this. Don’t attach it to patient’s hand We need this hand for blood sampling or for serum cath. We simply open it and throw it away. For example, this hemodialysis patient, without being asked to do or even to say his relatives... if you let me attach it to patient’s foot or pin it to her cloth. Often, I open it and put it aside. I say to his wife that we want this hand for serum therapy, what are these things you’ve attached to his arm? Well, at that moment, I can’t think how she may think I’m insulting or disrespecting “as the famous quote” to her beliefs.

- *Cultural connection:* A male nurse with 21 years of clinical experience says: “I am a Fars and I can’t give him good education. Well, I can’t have good communication with him For example a Turkish-speaking patient was taught by a nurse who was familiar with this language”.

- *Literacy-based instruction.* A nurse with 16 years of experience says: “Well, First, we need to consider the level of education in patient. Some of our colleagues think because the patient is ‘patient’, they can talk with any tone”. Another participant says: “A patient at first time may realize talks completely, whereas for another patient, actually, you may need to repeat the same thing 10 times”. A female nurse with 27 years of experience says: “The younger patients have more ability for self learning. Age is very important when we are imparting education to patients. If we want to educate them, we can introduce the book or pamphlet. Elderly patients need to have a caregiver. In addition, they need to be taught how to take self care”.

Discussion

In this study, the sub-themes of cultural divergence, cultural connection, cultural sensitivity and based literacy instruction were extracted. For some reasons, such as knowledge deficiency, nurses don’t incorporate themselves in issues of patients’ culture. But, Berggren (2006), Vydellingum (2006) and Koskinen (2003) showed that knowledge does not prepare nurses to deal with different cultures necessarily (17-19). It seems that conflict among nurses and patients’ beliefs can increase the problems in patient education. Gulbu (2006) showed that people protect their cultural values strongly and also they expect everyone to respect it (20). Also, Christopher (2010) stated a nurse’s religious beliefs can promote the clinical experience without trying to impose his or her beliefs

on the patient (21). Another finding in our study was verbal communication with patients with different languages. Hürye (2008) revealed that different linguistic backgrounds seem to be associated with nurses' stress and interaction challenges (22). Cioffi (2003) revealed same language nurse is a strategy used by nurses to care of patients with different languages. In patients with different cultures or languages, as an effective strategy, bilingual health workers can best be incorporated into patient education (14). Also, Poureslami (2012) suggested that similarity of language and culture is a good approach to patient teaching and can promote patients' knowledge about disease (23). Today, more acceptance and attention are paid to incorporate cultural content into nursing curricula. In this study, although nurses perceived the importance of the cultural differences in patients, because of lack of knowledge in this field, each faced many problems to meet patients' needs. In a cultural-ethnic perspective of asthma patients, Poureslami (2007) showed that similar education leads to more problems for ethnic groups, regardless of cultural differences (24). Janevic (2012) determined the effectiveness of educational interventions in the self management, reducing healthcare costs and improving quality of life in patients with different cultural groups (25).

Conclusion

The results of this study showed that there is much cultural diversity in patients. Therefore, all nurses need to be aware of cultural issues such as lifestyle, language and social status in patient education.

Nurses also need to be sensitive to the families' cultural customs in order to meet their expectations in a respectful way. The results of this study along with other research done in this field can be used to develop patient education programs.

Limitations

Since the approach of this study is qualitative and it can be a reflection of nurses' perceptions, due to the small sample study, its generalization ability is limited.

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