

Nurse to Nurse: A Prescription for Cultural Care for Elderly Russian Non-English
Speaking Patients in Nursing

by

Tatyana B. Rusakova, ADN, RN

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Committee

Jeanne Maiden, PhD, CNS, Chair

Barbara Taylor, PhD, RN, Member

POINT LOMA NAZARENE UNIVERSITY

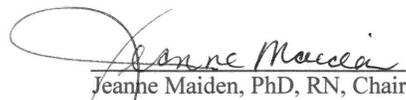
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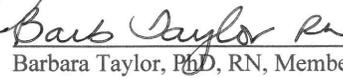
NAME OF STUDENT: Tatyana B. Rusakova, ADN, RN

TITLE OF THESIS: Nurse to Nurse: A Prescription for Cultural Care
for Elderly Russian Non-English Speaking Patients

COMMITTEE:

 12/11/12

Jeanne Maiden, PhD, RN, Chair Date

 12-11-12

Barbara Taylor, PhD, RN, Member Date

Abstract

The growing ethnically and racially diversity of the American population has a direct impact on healthcare providers. Immigration and demographic trends suggest that increasingly the U.S. elderly patient populations are linguistically and culturally diverse. A patient's inability to communicate in the same language as a provider will compromise patient health and safety. In addition, it will expose health care providers to the risk of legal liability for medical errors, malpractice, or deprivation of the patient's right to participate in health decisions. The purpose of this phenomenological qualitative study was to explain the essence of caring for the elderly non-English speaking Russian patients through the experience of Russian-speaking nurses. Leininger's Culture Care Theory and Husserl's phenomenological approach were used for this study. The data was collected through semi-structured individual interviews. Three main themes were noted from the interviews conducted regarding the healthcare of the elderly Russian non-English speaking patients. The three themes were: family connections, period of time living in America (phase of adaptation process), and compliance with treatment. This research paper provided information about Russian culture and cultural competence, as well as strategies to enhance healthcare professionals' capacity to deliver culturally competent services for the elderly Russian non-English speaking patients.

*Keywords: ethnic health disparities, Leininger's theory, elderly non-English speaking
Russian, Russian speaking nurses, cultural care*

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CHAPTER ONE

Introduction

Racial and ethnic health disparities are among the most serious healthcare problems in the United States (Smedly, Stith, & Nelson, 2003). Estimates suggest that these disparities lead to more than 83,000 more deaths per year for Blacks than Whites (Satcher, Fryer, McCann, Troutman, Woolf, & Rust, 2005). Because they also undermine the core value of equality in American society (Smith, 2005), elimination of health disparities has become one of the primary goals of the U.S. healthcare system (Smedly et al., 2003).

During the last century the U.S. population has become more ethnically and racially diverse; however, only recently have healthcare organizations begun to realize the importance of and considerable challenges involved with redirecting their attention to the nation's ethnic subgroups (Krumeich, Weijts, Reddy, & Meijer-Weitz, 2001; Johnstone & Kanitsaki, 2006). Statistics show that in United States approximately 52 million residents (1 in 12) speak a language other than English in their homes (Kepler, 2006). The U.S. Census Bureau reported that as of 2007, 1 in 5 Americans lived in a household where a language other than English was primarily spoken (2011).

Bergelson (2003) posited that in any language there are idiomatic and colloquial expressions that can be easily misunderstood by those who are conversant in the language but not native speakers; thus, it is very important to understand the health beliefs and obtain health knowledge of immigrant populations in the U.S. For these reasons, addressing the healthcare needs of elderly, non-English-speaking Russian patients requires attention not only to language but also to culture, which connects in complex ways for the multi-cultural American patient population (Shpilko, 2006).

All industries face barriers and challenges in finding the right approach to multicultural populations, but the challenge is significantly greater in healthcare than in other industries. There is no margin for error when it a patient's health and/or life are at stake. Failure to provide services based on patient needs and values often stems from a lack of knowledge about the patient's ethnic group (Smedly et al., 2003).

Too often, myths and false beliefs cause clinical staff to develop inaccurate perceptions of a specific cultural group. Even more problematic, however, is that the U.S. healthcare system does not conform to the health-related beliefs and practices of many ethnically diverse groups (Meyerowitz, Richardson, Hudson, & Leedham, 1998).

The topic of culturally competent care for elderly, non-English-speaking Russian patients is also of great personal interest. As a nurse and a Russian immigrant, the author can relate from personal experience the importance of cultural awareness in U.S. healthcare and feels a great obligation to increase nurses' cultural competence through providing educational tools.

The first wave of Russian immigration to America began in 1747 when fur traders arrived in Alaska (Trumbauer & Asher, 2004). Russians were among the first Europeans to discover the North Pacific islands and Northwest coast of North America, and in the late nineteenth century, large-scale emigration from Russia to the United States began.. Since that time, four distinct periods of immigration can be identified: 1880s-1914; 1920-1939; 1945-1955; and 1970s-present (Khisamutdinov, 2002). The primary reasons for emigration were economic hardship, political repression, religious discrimination, or a combination of those factors.

Significance of the Problem

The growing ethnic and racial diversity of America has a direct impact on healthcare providers. Immigration and demographic trends suggest that the U.S. elderly patient populations

continue to become linguistically and culturally diverse. In order to deliver appropriate and safe medical care, effective communication between patients and care providers must be established (The Joint Commission [TJC], 2010). Accordingly, it is vital for healthcare organizations to recognize patient diversity and educate staff to continue delivering high quality care. Healthcare services can no longer be provided using solely English-speaking methods; other cultures and languages must be considered in a knowledgeable and sensitive manner (Clegg, 2003; De & Richardson, 2008).

The national standards for Culturally and Linguistically Appropriate Services (CLAS) issued by the U.S. Department of Health and Human Services help provide equitable, effective treatment for all patients and correct inequities that currently exist in the provision of healthcare. By making CLAS available to diverse patients, the healthcare organization has an opportunity to improve the quality of care and achieve greater health outcomes (U.S. Department of Health & Human Services, 2001). There are 14 standards organized into 3 themes: culturally competent care (Standards 1-3), rules for language access services (Standards 4-7), and organizational support for cultural competence (Standards 8-14; U.S. Department of Health & Human Services, 2001).

Statement of the Problem

Health disparities are differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist between specific population groups in the United States (National Institutes of Health [NIH], 2000). This definition of health disparities assumes not only a difference in health but a difference in the way that social groups who have

persistently experienced social disadvantage or discrimination experience health or health risks in relation to more advantaged social groups (Braveman, 2006). These differences are often attributed to conscious or unconscious biases, provider biases, and institutional discriminatory policies toward patients of diverse socioeconomic status, race, ethnicity, and/or gender orientation (Braveman, 2006).

A patient's inability to communicate in the same language as a provider compromises patient health and safety (Schyve, 2007). In addition, it exposes healthcare providers to the risk of legal liability for medical errors, malpractice, or deprivation of the patient's right to participate in health decisions (Johnstone & Kanitsaki, 2006; Quan, 2010). Specific cultural knowledge about elderly, non-English-speaking Russian patients that can prevent these undesired results needs to be identified.

Statement of the Purpose

The purpose of this phenomenological qualitative study was to explain the essence of the experience of Russian-speaking nurses caring for elderly, non-English speaking Russian patients. In healthcare, the terms *care*, *caring*, and *healthcare* have been used interchangeably. And although Florence Nightingale first used the concept of caring in relation to nursing in the 1800s as "helping people live or survive in their physical or natural environment," its function has never been fully defined or explicated (Nightingale, 1986, p.6). *Caring* is defined for this study as "meeting human needs through caring, empathetic, respectful interaction within which responsibility, intentionality and advocacy form an essential, integral foundation" (Burhans & Alligood, 2010, p. 1694).

Cultural competence is defined for this study as the attitudes, knowledge, and skills necessary for providing quality care to diverse populations (Assembly Bill No. 716, 2002). It has

additionally been described as “an ongoing process that involves accepting and respecting differences and not letting one’s personal beliefs have an undue influence on those whose worldview is different from one’s own” (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007, p. 96). Cultural imposition intrusively applies the majority cultural view to individuals and families (Scheppers, Dongenb, Dekker, Geertzen, & Dekker, 2006); examples that border on cultural imposition are prescribing a special diet without regard to the client’s culture and limiting visitors to immediate family. Healthcare providers should be cognizant of expressing their cultural values too strongly until cultural issues are more fully understood (Giger et al., 2007).

CHAPTER TWO

Literature Review

As the United States becomes increasingly diverse, its healthcare system faces the enormous challenge of providing quality services to patients with limited English-speaking skills. Increased attention to quality improvement and medical error reduction cannot overlook the critical element of effective communication between healthcare providers and patients in ensuring successful health outcomes (Divi, Koss, Schmaltz, & Loeb, 2007).

Barriers to access of healthcare in the United States for immigrant patients have been extensively documented. Documentation of the impact of a language barrier on the delivery of quality care can be found in major governmental reports, including the Institute of Medicine's (IOM) report on racial and ethnic disparities in healthcare (Smedly et al., 2003) and the U.S. Office of Management and Budget's (OMB) congressional report, "Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency" (2002).

Executive Order No. 13166 requires federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them. The order also stipulates that federal agencies work to ensure that recipients of federal financial assistance provide meaningful access to their LEP applicants and beneficiaries (Exec. Order No. 13166, 65 C.F.R. 159, 2000).

Individuals involved in healthcare delivery interact daily with patients from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how healthcare services are delivered and received, it is important that healthcare organizations

and their staff understand and respond with sensitivity to the needs and preferences that diverse patients bring to the health encounter (Schyve, 2007). Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, in the long run, health outcomes (Smedly et al., 2003).

A search of the literature related to providing optimal care to Russian and former Soviet Union (FSU) immigrants was conducted using PubMed, Medline and Google databases. Keywords searched were *ethnically diverse, U.S. hospitals and Russian patients, FSU patients, patient safety, culture, and language*. A manual search was also conducted to maximize the findings on the topic. There was a plethora of literature addressing the relationship between language, culture, and patient safety and addressing specific risks minority patients face when clinical staff do not understand the language or cultural differences (Divi et al., 2007; Quan, 2010).

A critical review of multidisciplinary literature on Russian patients in U.S. hospitals returned few results. Of these results, research reviewed recognized similarities between ethnic groups but omitted analysis of each group individually; this led the author to conclude that although the analysis of minority patients in the literature is extensive, there is a lack of research specifically relating to Russian immigrant patients.

Generally, the research on Russian immigrants and FSU immigrants are combined into one group representing immigrants who speak the Russian language; however, there are significant cultural differences within the regions of the FSU (Encyclopædia Britannica, 2012; Kasatkina, 2011). Therefore, a definition of *Russian* that simply combines all Russian-speaking people into one group is inaccurate and discounts the ethnic differences between these groups.

Additionally, it should be noted that the FSU was a multilingual state, with over 120 languages including Russian spoken natively (U.S. Department of State, 2012).

Intercultural Care and the Immigration Adaptation Process

Intercultural care entails a specific understanding of migratory development and its phases. *Immigration* is the process by which individuals move from one place of residence to another, usually permanently or semi-permanently. Reasons for migration can be economic, social, political, medical, or recreational; in many cases, immigrants were often displaced from a previous life that, while sometimes normal, was all too often characterized by poverty, depression, and violence (Lai, 2004; Thomas & Schwarzbaum, 2006).

Some immigration movements are voluntary, typically including a well-thought out decision and plan, while others are involuntary, spontaneous decisions to escape the home country. Voluntary immigration can seem more involuntary, however, if negative economic, social, or political realities of the home economy influence the decision, giving the immigrant a sense of hopelessness or a perception that he or she has no choice but to emigrate. Moreover, a voluntary immigration may begin to appear involuntary as various aspects make the option of returning home unmanageable.

Regardless of the reasons for immigration, each immigrant will have a different feeling about their relocation experience. These experiences can have an emotional impact on immigrants' adaptation to their host countries, causing anxiety and distrust due to past life events (Bhugra, 2003). Healthcare professionals should be cognizant of patients' immigration experiences and seek a general understanding of the characteristic behaviors and attitudes displayed by "typical" immigrants (Cross, Bazron, Dennis, & Isaacs, 1989).

There are various styles by which the immigrant adapts to his or her new environment. Awareness of these adaptation styles can help healthcare practitioners recognize and identify stressors for patients (Giger et al., 2008). The process of adaptation depends on the pre-immigration lifestyle, the circumstances of travel to the new country, the treatment received following arrival in the new country, and the living environment of the new country. Depending on the severity of the immigration experience, immigrants might not be able to adapt at all and can end up returning to their countries of origin (Poss, 2001).

The adaption process may occur in several processes: complete assimilation, integration, separation, and marginalization (Kasatkina, 2011; Pumariega, Rothe, & Pumariega, 2005). Complete assimilation occurs when individuals are fully immersed in the prevailing culture and slowly abandon the values and beliefs of their home countries. These individuals may even end up losing their native languages or choose not to transmit their native languages to their children (Kasatkina, 2011). Integration is a more traditional approach in which immigrants maintain the culture of their home countries while embracing the values of the new country (Pumariega et al., 2005). In separation, immigrants alienate themselves from the core culture to preserve characteristics of their native cultures. Separation typically occurs when immigrants of the same origin live in close proximity to each other and are able to complete daily tasks without communicating with members of the dominant culture (Casimir, Butler, Jean-Louis, Zizi, Nunes, & Brady, 2010). Finally, marginalization involves immigrants' belief that the host society has completely rejected their cultural values and identities. The most extreme process of adaptation, marginalization fosters antisocial behavior and results in a very limited integration into the new culture (Berry, 1986).

There is little research available on immigrant adaptation processes as they relate to healthcare. However, knowledge about the different adaptation processes can help healthcare providers recognize immigrants' unique needs and identify barriers to access of healthcare services for this population. Additionally, awareness of the challenges immigrants face with social integration can help healthcare providers serve a more diverse population (Campinha-Bacote, 2008).

Russian Immigration History

The first Russians reached America in 1747 when fur traders arrived in Alaska (Trumbauer & Asher, 2004). Russians were among the first Europeans to discover the North Pacific islands and the Northwest coast of North America (Trumbauer & Asher, 2004). The next large-scale immigration of Russians to the U.S. did not occur until late into the 19th century, when immigrants began to arrive in waves. Following the Revolution of 1917, the biggest immigration wave began in 1987 and established an annual total of 700,000 new entries per year (Liberovsky, 2006). Non-ethnic Russians in this group included Jews, Ukrainians, and any other person born and raised in Russia or the FSU.

Acculturation is a process by which one cultural group implements the beliefs and traditions of a host culture (Mills & Henretta, 2001). Acculturation is multidimensional and includes physical, psychological, financial, social, language, and relational adjustment. It is widely recognized in the literature that the process of acculturation can be very stressful for elderly immigrants in the United States because they often lack the financial and educational resources and English language proficiency required for successful adaptation (Benisovich & King, 2003; Lai, 2004; Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2011).

Culturally Competent Care

Cultural competence can be defined in many different ways, as this term constantly evolves with the rapidly changing diversity in society. The general definition is a tradition of similar behaviors, approaches, and regulations that come together in a system, agency, or among professionals to allow them to work effectively in cross-cultural situations (Cross et al., 1989).

The first element of this concept, *culture*, “implies the integrated patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values, as well as institutions of racial, ethnic, religious, or social groups” (U.S. Department of Health & Human Services, 2001). Culture is developed through different social standards, values, and various economic factors. The progress of culture can be different for every individual; however, in order to develop a bond with other people and build social relationships, the dynamic of culture must be shared. Understanding values of diverse cultures builds mutual respect and understanding (Betancourt, Green, & Carrillo, 2002).

Cultural differences impact the healthcare community and, most importantly, influence the delivery of healthcare services (Jezewski & Sotnik, 2001). Culture plays a central role in the way individuals perceive health, symptoms of illness, and healing methods; for example, where one culture believes in using heat to treat a certain ailment, another culture could strongly advise against it. On the other hand, modern healthcare was developed on the concept of ethnocentrism and is strongly focused on the incorporation of technology and science for the treatment of ailments; alternative healing methods are often disregarded as obsolete. The modern healthcare environment is often perceived by patients to be very complex, intimidating, and unfamiliar. This is why it is important to develop a healthcare environment organized around the needs of the patients to be served (White, 2000).

Competence refers to the ability to function within the context of culturally integrated patterns of human behavior defined by a group (Betancourt et al., 2002). *Cultural competence* is defined as “a process that requires individuals and systems to develop and expand their ability and to have respect for cultural diversity” (Haden, Catalanotto, Alexander, Bailit, Battrell, Broussard, & Buchanan et al., 2003, p. 564). Developing cultural competence should increase consciousness, acceptance, and aptitude to learn from and about other health-related cultural beliefs. A key element of developing cultural competency is realizing the importance of effective communication, which requires the disposition to listen and learn from people of other cultures and the establishment of a healthcare environment that provides services in multiple languages (California Cultural Competency Task Force, 1994).

Prejudice is any negative attitude about another person based on his or her group membership. *Stereotyping* can be defined as the process by which people acquire and recall information about others based on race, sex, religion, etc. (IOM, 2002). Prejudice often associated with stereotyping was defined in psychology as an unjustified negative attitude based on a person’s group membership. Stereotyping includes having an attitude, conception, opinion, or belief about a person or group (Giger et al., 2007).

Most healthcare providers find prejudice morally abhorrent and at odds with their professional values (Vaiani, 2009). However, like other members of society, they may not recognize manifestations of prejudice in their own behavior. While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that their diagnostic and treatment decisions, as well as their feelings about patients, can be influenced by patients’ race or ethnicity (Bobo, 2001). In one experimental design, Abreu (1999) found that mental health professionals were more likely to negatively evaluate a hypothetical patient of

unidentified race when subliminally primed with African American stereotype-laden words than when primed with neutral words. And in a study based on actual clinical encounters, van Ryn and Burke (2000) found that doctors rated Black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, and more unlikely to comply with medical advice.

Stereotypes can also influence interpersonal interactions between providers and patients and contribute to disparities in healthcare (IOM, 2002). Although providers may not recognize manifestations of prejudice in their own behaviors, patients could react to providers' behaviors in a way that contributes to disparities. One such instance is of a healthcare provider who fails to recognize individuality within a group, causing the patient to believe the provider is jumping to conclusions about the patient and his or her family (Giger et al., 2007).

Conceptual Framework

Leininger's cultural care theory provided the organizing framework for this study. Together with the Sunrise Model, this theory is perhaps the most well-known in nursing literature on culture and health (Leininger & McFarland, 2006). It draws from anthropological observations and studies of culture, cultural values, beliefs and practices. The theory of transcultural nursing promotes better understanding of the universally held and common understandings of care among humans as well as the culture-specific caring beliefs and behaviors that define any particular caring context or interaction. Leininger argued that the theory of cultural care diversity and universality is holistic and that culture is the specific pattern of behavior that distinguishes any society from another and gives meaning to human expressions of care (Leininger, 1981).

Leininger recognized the comparative aspects of caring within and between cultures, hence the acknowledgement of both similarities and differences in caring in diverse cultures. The

model has implications for how healthcare professionals assess, plan, implement, and evaluate care of people from diverse cultural backgrounds. It has been used in a wide range of nursing specialties and across cultural groups.

The aim of the cultural care theory was to enable nurses to provide care that confirms patients' cultural perceptions of what care should be. Leininger emphasized the significance and position of culture in describing a person's health and manners (Leininger & McFarland, 2006). The roots of her theory are in clinical nursing practice; Leininger discovered that patients from different cultures appreciated care more than the nurses did. Progressively, Leininger became convinced of the need for a theoretical framework to determine, describe, and calculate measurements of care and developed the cultural care theory after analyzing numerous studies of Western and non-Western cultures (Leininger & McFarland, 2006).

Leininger (2001, 2006) outlines several theoretical expectations and descriptions to guide nurses in their encounter of culture care phenomena. The following expectations regarding care and caring were significant when explaining the essence of caring for elderly, non-English-speaking Russian-American patients:

- care (caring) is crucial to treating and healing; there can be no healing without caring;
- each human culture has lay (ethnic, universal, or traditional) care knowledge and practices and usually some professional care knowledge and practices, which vary transculturally;
- cultural care values, beliefs, and practices are influenced by and tend to be rooted in the language, philosophy, religion, relationship, social, political, illegal, educational, economic, and environmental backgrounds of cultures; and

- a patient who faces nursing care that misses the mark of his or her beliefs and values will show signs of cultural conflict, noncompliance, depression, and ethical or moral concern.

(Leininger, 2001, p. 189)

CHAPTER THREE

Methods

The purpose of this phenomenological qualitative study was to explore the experience of Russian-speaking nurses caring for elderly, non-English-speaking Russian patients. This study was based on the experience of Russian-American nurses providing care to this type of patient. The goal of this study was to assist nurses and other healthcare professionals in providing specific care to meet the needs of elderly, non-English-speaking Russian patients.

This study utilized Edmund Husserl's phenomenological approach to focus on the participants' experiences of caring rather than on the nature of caring as perceived by participants. A qualitative research design was used to allow the experience of caring to be discovered inductively within the cultural context (Morse & Field, 1998).

Participants

The participants for this study were seven male and female Russian-speaking registered nurses (RNs; Appendix A) with at least five years of experience providing direct, hands-on adult patient care at the general or intermediate care levels of hospitals, adult healthcare centers, and/or outpatient health services of San Diego, California and Tampa, Florida. Participants were renamed with pseudonyms (N1-N7) to ensure confidentiality.

Data Collection

Participants were informed of the purpose of the study and invited to participate in interviews (Appendix B). Participants were informed at the beginning of the interview of their rights to withdraw any time. They were allowed to choose a quiet, safe environment in which they could freely articulate responses.

The data were collected in Russian through one semi-structured tape-recorded interview and one web conference interview via Skype with open-ended questions (Appendix C). Approval for the study was obtained from the Point Loma Nazarene University Institutional Review Board (Appendix D). Fieldnotes were used to document observations relevant to the interview, such as observations about participants' expressions and behaviors, that could not be captured by voice recordings.

Participation in this research study was entirely voluntary and participants could refuse to participate or withdraw any time during the study. All data were collected anonymously so that there was not any way of linking the data with the participants. Participants were asked to fill out demographic data form prior to interviews. Interviews were 45-60 minutes in length. All interviews were then transcribed verbatim into English.

Data Analysis

The data were analyzed, interpreted, and synthesized using Colaizzi's (1978) methodological interpretations. Colaizzi's analysis was chosen as it allowed analysis to occur simultaneously with data collection (Omery, 1983), the stages were flexible and non-linear (Holloway & Wheeler, 1996), and participants validated their transcripts, thereby enhancing the rigor of the study.

After the transcripts of the interview were read and reread, the interview responses were categorized. This allowed for identification of significant statements and meanings of specific cultural care for elderly non-English-speaking Russian patients. Following this step, the researcher's personal notes were compared with the interview data, and the meanings were organized into theme clusters. The researcher referred back to the original translated transcripts for validation, noting any discrepancies. Then, results were integrated into complete descriptions

of the phenomenon of specific care; the process was concluded when all participants had validated the findings.

CHAPTER FOUR

Results

Three main themes emerged from participant interviews on the healthcare of elderly, non-English-speaking Russian patients: *family connections*, *period of time living in America* (phase of adaptation process), and *compliance with treatment*.

Theme 1: Family Connection

Family involvement and a strong family bond were described as essential to the experience of caring for elderly, non-English-speaking Russian patients. The interaction between the nurse, the patient, and his or her family was best described thus by Russian-speaking nurses surveyed for this research: “*Involving the patient’s family is a must*” (N3). Consequently, for all the participants, the family served as the primary decision-maker in the care of the elderly patients. This description of family involvement appeared throughout the interviews, and participants recommended a family-centered approach for conveying medical information:

...the family makes all the decisions regarding the patient’s healthcare and it is important to build good rapport with them in order to provide high quality care (N4).

Most of the times the family will make a decision on the final treatment plan. The patient won’t make any decisions on their own, so it will be counterproductive if the family is excluded (N5).

In addition, the presence of the family during the discussion of patient's condition and plan of care was an important factor:

If their family is not here, the patient will ask me to wait to go over the specific treatment options so their family is there to listen, ask questions and make the ultimate decision about the healthcare plan (N1).

Participants noted that care and reassurance from the family also played a large role in patient care:

The support that the elderly receive from their family is the best medicine (N7).

The family also played an important role in helping nurses communicate with the patient and facilitate the patient's care and healing:

[I]t is very important to get the family involved, since dealing directly with the patient could be very difficult (N5).

In cases where the patient refused care, the nurse would work with the family to make the patient comfortable with the treatment plan:

Sometimes I am not able to convince the patient one way or another, but I know family can definitely help in such situations (N2).

Finally, participants pointed out the importance of developing trust in the nurse-family relationship. One participant said, *"Always make sure to involve the family during the process. This will make your life easier and the patient will be very happy"* (N6).

Theme 2: Period Of Time Living In America (Adaptation Process)

Participants drew attention to the differences in perceptions of medical care between patients who were new arrivers to the U.S. and patients who had lived in the country for some time. One participant stated, *"...the longer the patient has been in the United States, the more they will comfortable with communicating with me and they are more confident in the quality of health care that they will receive"* (N4). Another noted, *"... patients who have been lived in*

America for a long time felt more at ease with asking specific healthcare questions and were less apprehensive about the healthcare provided “ (N7).

The participants also reported observing that elderly patients who were new immigrant displayed a distrustful attitude, appeared suspicious of healthcare professionals, and were very guarded:

...[they] tend to be suspicious of younger nurses, especially if the nurse is smiling. This type of scenario usually occurs for patients that are new to the United States, as they are not used to people being friendly. Initially, this type of patient believes that the nurse wants something from them or is being unprofessional by smiling at them. As these patients grow more accustomed to the American culture, they begin to understand the friendly demeanor of the nursing staff and become more informed about the hospital rules (N3).

Participants also noted that in the beginning, the elderly patients demonstrated a strong connection to their native cultural practices and health beliefs; however, as time progressed, they became more accustomed to American healthcare beliefs and practices. One nurse described her experience thus:

It is very interesting how I am perceived as a Russian-speaking nurse by the elderly Russian patients who are new to this country. For example, if I were a nurse in Russia, they would all think that I was not smart enough to become a doctor or that I have a bad husband and that's why I am only a nurse and not a doctor. Then afterwards, I would see the same patient come back and they have completely changed their mind on their own. They begin to look at me as their primary health caretaker. This occurs as these patients assimilate into the new American culture (N5).

The nurses also reported that patients who had lived in America for a long time were easier to talk to and were much more receptive to suggestions made by healthcare professionals:

...they are much easier to talk to because they are willing to listen and they try very hard to understand the given situation. For elderly people who have lived here for an extended period of time I just have to remind them of what they have forgotten (N1).

When asked about differences in behavior of patients that have lived in the U.S. longer, one participant noted,

Patients who have lived here for awhile and know the system know there is a big difference between personal and professional relationships. For newcomers it is hard to understand and differentiate the two. It definitely takes some time of getting used to so it is my responsibility to help the patient and the family to understand the laws and professional conduct in the healthcare system” (N6).

Overall, as patients became more accustomed to life in the U.S., they felt more confident, were less afraid to ask questions, and became more familiar with patient healthcare rights.

Theme 3: Compliance With Treatment

Based on participants’ responses, many elderly patients who were new immigrants did not seek formal medical care except for complicated cases. Rather, patients took a proactive role in maintaining their own health and often used home remedies or self-treatment for any symptoms identified before seeking physician care. Historically, Russians have greatly respected forms of alternative medicine (e.g., herbal teas, alcoholic tinctures, and other methods to treat disease and promote a healthy lifestyle) and used them often for traditional care. Participants reported patients’ use of traditional herbal remedies in conjunction with standard Western medical treatments.

Participants reported that although the patients appeared enormously interested in learning the details of their initial treatment plans and indicated their desire to take a proactive role in their healthcare, they were very suspicious of any medicine prescribed for them and appeared reluctant to take medication even after receiving very detailed explanations from healthcare staff:

[they] are very suspicious of everything. They will double and triple check everything that is given to them. They will contact their relatives and friends in the United States and Russia to seek additional opinions and possible care options and involve everyone around them in their healthcare treatment. They will take medication only if it agrees with their understanding of [the] healthcare treatment (N4).

Some patients simply refused to take any prescribed medication, while others believed that pills were only needed when they experienced symptoms:

I had an elderly man who hid his medication in his cheek because he did not trust American medicine and did not want to tell us anything (N2).

...they refuse to take their blood pressure medicine. I continually hear the same type of response for these patients, such as “Why do I need to take this medicine for blood pressure if I feel normal today?” (N3).

On the other hand, participants believed patients remained very cognizant of their healthcare plans and were more likely to gather information on experimental treatments and more inclined to consider such treatments, especially if they had already obtained previous information about them.

One participant observed, “*Most [elderly, non-English-speaking Russian patients] are very highly educated individuals*” (N6). Thus, it was noted that healthcare professionals must treat these individuals with respect and understanding: “*...know what you are talking about and don’t dismiss these patients as ‘old and dumb’ just because they do not speak English. They will ask intelligent questions and will be able to determine if your answers are not based on actual knowledge*” (N5).

Participants also believed these patients had a very high tolerance for pain and were thus more likely to misstate their actual state of health. One participant reported, “*...they can tolerate pain very well and even if they don’t, they have been taught not to complain. They tend to say that they are fine, when in reality the pain level could be extremely high*” (N7).

CHAPTER FIVE

Discussion

In this study, Russian-speaking nurses provided insight on healthcare beliefs, culturally appropriate methods of care, and interpersonal interaction challenges specific to elderly, non-English-speaking Russian patients. The nurses reported that caring for these patients allowed them to share their cultural knowledge and experiences with their peers. Overall, the participants felt that even a limited knowledge of Russian cultural customs and attitudes could help to greatly improve patient interactions and patient-nurse relationships. This is validated in the literature suggesting that patient-nurse trust relations are often influenced by cultural norms and that patient interactions are also impacted by nurses' cultural backgrounds (Takeshita & Ahmed, 2004).

Theme 1: Family Connection

The theme of family connection and involvement emerged in all participant interviews. Based on participants' observations, it was apparent the process of taking care of the elderly patients was a significant responsibility for Russian families. The families treated the patients with respect, went to great lengths to ensure that someone was always available to listen to their concerns and questions, and usually stayed with patients around the clock to make sure they were not alone. In this study, family involvement in patient care was described as a culturally normative behavior. Family was recognized as a very important factor with a significant influence on the patients' emotional, social, and psychological health.

Participants emphasized that getting the family involved and developing a trust in the nurse-family relationship should be a priority for healthcare staff. Similarly, Shpilko (2006) advises nurses caring for elderly Russian patients to determine the role of the patients' families

and highlights that communicating effectively with patients and families is the foundation of providing quality healthcare. Leininger (1981) also argued that including the patient's family in care planning is essential to the delivery of culturally competent care.

Participants reported a tendency for family members to shield patients from their healthcare concerns and worries. As Shpilko (2006) explained, it is the family's "obligation to take on the burden of the truth" (p. 332); such belief demonstrates the intensely familial nature of the Russian community and the importance of their internal support networks. Similarly, Milshteyn and Petrov (2004) found that the problems of the patient were considered family problems and discussed by the entire family. Further, news about the patient's health was delivered to the family, who passed it along to the patient at a later time (Cichocki, 2008). This allows the patient to be surrounded by close family and friends who can provide the support necessary to cope with the news of the illness (Milshteyn & Petrov, 2004). This study corroborates existing research suggesting that the way a healthcare provider communicates information to a patient can be as important as the information being conveyed and that recognizing the role of the patient's family is vital in caring for elderly, non-English-speaking Russian patients.

Theme 2: Period Of Time Living In America (Adaptation Process)

Participants also saw a direct correlation between the length of time patients had lived in America and their perceptions of the overall quality of their medical care. Patients who had lived in the U.S. longer were more confident in navigating the healthcare system than patients who had recently begun their lives in the country. Participants noted that elderly patients who had newly arrived to the U.S. demonstrated a strong connection to their native cultural practices and health beliefs, but as time progressed, they became more accustomed to American healthcare beliefs

and practices. This observation of adaptation was supported in the literature; Polyakova and Pacquiao (2006) posited that elderly Russians who left the Soviet Union to live in the United States experience the twin challenges of aging and acculturation: “Older members often left their homeland for the sake of their children and subsequently face issues of acculturation and aging at the same time” (p. 44). Some studies suggest that low adaptation acts as a barrier to these individuals’ use of health services (Scheppers et al., 2006; Morrison & James, 2009).

Another challenge of adaptation was cultural disconnect between Russian immigrant elders and their assimilated children, who tended to identify more with the modern American culture and lifestyle than with their Russian heritage and traditions (Polyakova & Pacquiao, 2006). This disconnect also magnified the importance of involving patients’ families in the healthcare process. As the children become assimilated and adapt to the new life more quickly than their elderly parents, they are more likely to collaborate with healthcare providers in executing their parents’ treatment plans. As caretakers, they are more likely to accept the health problems presented, understand the treatment options, and encourage their parents to adhere to medical instructions and follow the prescribed treatment plan (Kasatkina, 2011).

The process of immigration adaptation has been a topic of several studies, and increased familiarity with the subject may allow healthcare providers to recognize some of the unique needs elderly immigrant patients have and identify potential limitations to their access of healthcare services (Kasatkina, 2011; Pumariega, Rothe, & Pumariega, 2005). Part of developing adaptation skills for elderly Russian immigrants was expressed through help-seeking patterns in their approach to American healthcare. These patterns are characterized largely by a cultural preference for informal medical care and distrust of formal medicine. When in need of physical or psychological assistance, many Russian-Americans turn first to home- or community-based

practices rooted in their tradition rather than American pharmaceutical approaches. Russians hold these practices in high esteem, often turning to alternative therapies such as reflexology, massage, oil rubs or steam baths, homeopathy, chiropractic care, or other options before considering typical American medicine (Shpilko, 2006; Grabbe, 2000).

Some elderly Russian-speaking immigrants may be distrustful of physicians and reject health recommendations such as prescribed medication or may choose to combine medically-prescribed treatment with home remedies and treatments (Resick, 2008). There was an underlying distrust of formal medical treatment, especially drugs or anything of a chemical nature, which was seen as more harmful than helpful; as an old Russian proverb reads, “Too much of any medicine is dangerous” (Shpilko, 2006, p. 338). Caretakers can greatly benefit being aware of these cultural differences when providing care.

Serving the healthcare needs of elderly immigrant Russian patients can present special challenges. One such challenge, based on the phases of the adaptation process discussed above, is the variety of overall perceptions of the new culture among elderly immigrants patients. Thus, caregivers are not only faced with providing different healthcare needs but also with the need to adjust their approach depending on the patient. Awareness of the obstacles these patients face with social integration can allow healthcare organizations and providers to serve a more diverse population (Campinha-Bacote, 2008). Currently, few healthcare studies have focused on the immigrant adaptation process. Such research examining the typical traits of immigrant patients in each phase, could help the medical community identify leading healthcare practices for diverse patients.

Theme 3: Compliance With Treatment

Differences in healthcare beliefs between the patient and provider (e.g., the explanatory model of health, illness and healing methods) can act as a barrier for and serve to further disadvantage ethnic minority patients (Scheppers et al., 2006). For Russians, these healthcare beliefs are reflected in their active practice of some form of holistic self-care; for example, many use homeopathic remedies or a variety of drugs brought from Russia to treat headaches, indigestion, bacterial infections, and other general ailments (Milshteyn & Petrov, 2004; Kasatkina, 2011; Wheat, Brownstein, & Kvitash, 1983). Generally, these practices are unrelated to what the patient is doing under the direction of American physicians (Wheat et al., 1983). Therefore, it is very important that medical providers respectfully seek to understand what types of self-treatment their elderly Russian immigrant patients may practice. Mutual respect, trust, and joint decision-making will result in the greater likelihood of a positive outcome (Scheppers et al., 2006).

Participants' comments also revealed that patient compliance with treatment is related to their different perceptions of the healthcare system. Because the primary goal of Russian healthcare is to find the root causes of a particular disease or condition (Grabbe, 2000; Benisovich & King, 2003), many Russian immigrants feel that American doctors place too much emphasis on treating the symptoms of the disease rather than trying to understand its cause from a more holistic perspective (Dohan & Levintova, 2007; Borovoy & Hine, 2008). Most Russian patients will want to have active discussions with their care provider about what caused the ailment, how it can be cured or treated, and what specifically will be involved in the process (Borovoy & Hine, 2008).

Patients' perceptions of the quality and volume of information received from their providers can have a profound effect on their reception to the information and their willingness

to use it. Nurses should remember that patients can sense when communication is lacking, and this can lead to patients feeling increased anxiety, vulnerability, and powerlessness. Overall, participants in this study agreed that patients who understand their providers are more likely to accept providers' explanations of their health problems, understand their treatment options, modify their behavior, and adhere to follow-up instructions.

Considering these observations, the results of this study appear to emphasize that effective communication is at the core of providing patient-centered care. Unfortunately, even when providers know what messages to communicate to patients, they do not always have the interpersonal skills to do so effectively. Thus, experience working with diverse cultural groups can improve care providers' interpersonal skills, leading to better patient outcomes and extended provider-patient dialogue that enables patients to disclose critical information about their health problems so that providers can make more accurate diagnoses. Good communication also develops healthcare education and counseling, resulting in more appropriate treatment regimens and better patient compliance. Effective interpersonal communication makes healthcare more efficient and cost effective; thus, patients, providers, administrators, and policy makers all have a stake in improved provider-patient interactions.

Study Limitations and Areas for Future Research

The findings of this study contribute to the understanding of how the actions of healthcare professionals can influence the health of their elderly Russian patients. Small sample size and the qualitative design provided an efficient way to gather information on major cultural differences between these patients and their providers, outline patients' general views on medicine and its purpose, and develop recommendations for healthcare providers and nurses when treating an elderly Russian immigrant patient. However, the small sample size is more

likely to limit the generalizations that can be made from this study and to neglect other important aspects of providing care for this population.

Another limitation is that qualitative methods produce data based on individual experience; therefore the findings might not be applicable to all people in the identified group. Moreover, because most of the participants (more than 85%) were situated in the same geographical area (San Diego, CA), the results might differ in other areas of the country.

Finally, because methodological analysis is open to interpretations, future research targeting a much larger sample of Russian-speaking nurses in a different region of the country is necessary to replicate and expand on the relevance and accuracy of findings outlined in this study.

Currently, there is little research on the immigrant adaptation process as it relates to healthcare. A study examining the typical traits of immigrants in each phase could help the medical community identify leading practices for diverse patients.

Conclusion

The theoretical framework for this study was Leininger's theory of cultural care diversity and universality, which holds care as the essence and unifying focus of nursing because care is embedded in social structure, worldview, language, and environmental contexts (Leininger, 1981, 2001). Cultural diversities and universalities of care exist in all cultures worldwide, and knowledge of them can guide nursing care decisions and actions to benefit patient health (Leininger 2001, Leininger & McFarland, 2006). Understanding a patient's practice of cultural norms can help providers build rapport and ensure effective communication with patients (Betancourt, Green, & Carrillo, 2002).

Russian patients bring their own cultural perspectives and values to healthcare, and many of their health beliefs and practices differ from those traditional to American healthcare. 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 hold culture-specific ideas and values about health and illness, reporting of symptoms, expectations for healthcare delivery, and the role of medication and treatments. Unfortunately, the expectation of many healthcare professionals has been that patients will conform to American values, which creates barriers to care that are compounded by differences in language and education between patients and providers.

This study presented findings relevant to overcoming these barriers to care. First, it was noted that family plays an important role in the diagnosis of illness, treatment, and care of elderly Russian immigrant patients. Therefore, a family-centered health treatment approach was recommended to enhance the overall experience of the patient and the nurse and increase the likelihood of a successful outcome. Family members are equal contributors in the problem-solving process, working with care providers to identify the goals of treatment and to plan realistic strategies to achieve these goals. Additionally, family members played a key role in implementing these strategies to ensure that treatment goals were met. Therefore, it is critically important for the nurses to inform patients and their families of their rights and adhere to the guidelines outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Some healthcare organizations ask patients to sign written consent forms before doctors discuss medical information with family caregivers; this is not part of HIPAA provisions, but may be part of the organization's procedural policy.

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Abstract

The growing ethnically and racially diversity of the American population has a direct impact on healthcare providers. Immigration and demographic trends suggest that increasingly the U.S. elderly patient populations are linguistically and culturally diverse. A patient's inability to communicate in the same language as a provider will compromise patient health and safety. In addition, it will expose health care providers to the risk of legal liability for medical errors, malpractice, or deprivation of the patient's right to participate in health decisions. The purpose of this phenomenological qualitative study was to explain the essence of caring for the elderly non-English speaking Russian patients through the experience of Russian-speaking nurses. Leininger's Culture Care Theory and Husserl's phenomenological approach were used for this study. The data was collected through semi-structured individual interviews. Three main themes were noted from the interviews conducted regarding the healthcare of the elderly Russian non-English speaking patients. The three themes were: family connections, period of time living in America (phase of adaptation process), and compliance with treatment. This research paper provided information about Russian culture and cultural competence, as well as strategies to enhance healthcare professionals' capacity to deliver culturally competent services for the elderly Russian non-English speaking patients.

Keywords: ethnic health disparities, Leininger's theory, elderly non-English speaking Russian, Russian speaking nurses, cultural care

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CHAPTER ONE

Introduction

Racial and ethnic health disparities are among the most serious healthcare problems in the United States (Smedly, Stith, & Nelson, 2003). Estimates suggest that these disparities lead to more than 83,000 more deaths per year for Blacks than Whites (Satcher, Fryer, McCann, Troutman, Woolf, & Rust, 2005). Because they also undermine the core value of equality in American society (Smith, 2005), elimination of health disparities has become one of the primary goals of the U.S. healthcare system (Smedly et al., 2003).

During the last century the U.S. population has become more ethnically and racially diverse; however, only recently have healthcare organizations begun to realize the importance of and considerable challenges involved with redirecting their attention to the nation's ethnic subgroups (Krumeich, Weijts, Reddy, & Meijer-Weitz, 2001; Johnstone & Kanitsaki, 2006). Statistics show that in United States approximately 52 million residents (1 in 12) speak a language other than English in their homes (Kepler, 2006). The U.S. Census Bureau reported that as of 2007, 1 in 5 Americans lived in a household where a language other than English was primarily spoken (2011).

Bergelson (2003) posited that in any language there are idiomatic and colloquial expressions that can be easily misunderstood by those who are conversant in the language but not native speakers; thus, it is very important to understand the health beliefs and obtain health knowledge of immigrant populations in the U.S. For these reasons, addressing the healthcare needs of elderly, non-English-speaking Russian patients

requires attention not only to language but also to culture, which connects in complex ways for the multi-cultural American patient population (Shpilko, 2006).

All industries face barriers and challenges in finding the right approach to multicultural populations, but the challenge is significantly greater in healthcare than in other industries. There is no margin for error when it a patient's health and/or life are at stake. Failure to provide services based on patient needs and values often stems from a lack of knowledge about the patient's ethnic group (Smedly et al., 2003).

Too often, myths and false beliefs cause clinical staff to develop inaccurate perceptions of a specific cultural group. Even more problematic, however, is that the U.S. healthcare system does not conform to the health-related beliefs and practices of many ethnically diverse groups (Meyerowitz, Richardson, Hudson, & Leedham, 1998).

The topic of culturally competent care for elderly, non-English-speaking Russian patients is also of great personal interest. As a nurse and a Russian immigrant, the author can relate from personal experience the importance of cultural awareness in U.S. healthcare and feels a great obligation to increase nurses' cultural competence through providing educational tools.

The first wave of Russian immigration to America began in 1747 when fur traders arrived in Alaska (Trumbauer & Asher, 2004). Russians were among the first Europeans to discover the North Pacific islands and Northwest coast of North America, and in the late nineteenth century, large-scale emigration from Russia to the United States began.. Since that time, four distinct periods of immigration can be identified: 1880s-1914; 1920-1939; 1945-1955; and 1970s-present (Khisamutdinov, 2002). The primary reasons for

emigration were economic hardship, political repression, religious discrimination, or a combination of those factors.

Significance of the Problem

The growing ethnic and racial diversity of America has a direct impact on healthcare providers. Immigration and demographic trends suggest that the U.S. elderly patient populations continue to become linguistically and culturally diverse. In order to deliver appropriate and safe medical care, effective communication between patients and care providers must be established (The Joint Commission [TJC], 2010). Accordingly, it is vital for healthcare organizations to recognize patient diversity and educate staff to continue delivering high quality care. Healthcare services can no longer be provided using solely English-speaking methods; other cultures and languages must be considered in a knowledgeable and sensitive manner (Clegg, 2003; De & Richardson, 2008).

The national standards for Culturally and Linguistically Appropriate Services (CLAS) issued by the U.S. Department of Health and Human Services help provide equitable, effective treatment for all patients and correct inequities that currently exist in the provision of healthcare. By making CLAS available to diverse patients, the healthcare organization has an opportunity to improve the quality of care and achieve greater health outcomes (U.S. Department of Health & Human Services, 2001). There are 14 standards organized into 3 themes: culturally competent care (Standards 1-3), rules for language access services (Standards 4-7), and organizational support for cultural competence (Standards 8-14; U.S. Department of Health & Human Services, 2001).

Statement of the Problem

Health disparities are differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist between specific population groups in the United States (National Institutes of Health [NIH], 2000). This definition of health disparities assumes not only a difference in health but a difference in the way that social groups who have persistently experienced social disadvantage or discrimination experience health or health risks in relation to more advantaged social groups (Braveman, 2006). These differences are often attributed to conscious or unconscious biases, provider biases, and institutional discriminatory policies toward patients of diverse socioeconomic status, race, ethnicity, and/or gender orientation (Braveman, 2006).

A patient's inability to communicate in the same language as a provider compromises patient health and safety (Schyve, 2007). In addition, it exposes healthcare providers to the risk of legal liability for medical errors, malpractice, or deprivation of the patient's right to participate in health decisions (Johnstone & Kanitsaki, 2006; Quan, 2010). Specific cultural knowledge about elderly, non-English-speaking Russian patients that can prevent these undesired results needs to be identified.

Statement of the Purpose

The purpose of this phenomenological qualitative study was to explain the essence of the experience of Russian-speaking nurses caring for elderly, non-English speaking Russian patients. In healthcare, the terms *care*, *caring*, and *healthcare* have been used interchangeably. And although Florence Nightingale first used the concept of caring in relation to nursing in the 1800s as "helping people live or survive in their

physical or natural environment,” its function has never been fully defined or explicated (Nightingale, 1986, p.6). *Caring* is defined for this study as “meeting human needs through caring, empathetic, respectful interaction within which responsibility, intentionality and advocacy form an essential, integral foundation” (Burhans & Alligood, 2010, p. 1694).

Cultural competence is defined for this study as the attitudes, knowledge, and skills necessary for providing quality care to diverse populations (Assembly Bill No. 716, 2002). It has additionally been described as “an ongoing process that involves accepting and respecting differences and not letting one’s personal beliefs have an undue influence on those whose worldview is different from one’s own” (Giger, Davidhizar, Purnell, Harden, Phillips, & Strickland, 2007, p. 96). Cultural imposition intrusively applies the majority cultural view to individuals and families (Scheppers, Dongenb, Dekker, Geertzend, & Dekkere, 2006); examples that border on cultural imposition are prescribing a special diet without regard to the client’s culture and limiting visitors to immediate family. Healthcare providers should be cognizant of expressing their cultural values too strongly until cultural issues are more fully understood (Giger et al., 2007).

CHAPTER TWO

Literature Review

As the United States becomes increasingly diverse, its healthcare system faces the enormous challenge of providing quality services to patients with limited English-speaking skills. Increased attention to quality improvement and medical error reduction cannot overlook the critical element of effective communication between healthcare providers and patients in ensuring successful health outcomes (Divi, Koss, Schmaltz, & Loeb, 2007).

Barriers to access of healthcare in the United States for immigrant patients have been extensively documented. Documentation of the impact of a language barrier on the delivery of quality care can be found in major governmental reports, including the Institute of Medicine's (IOM) report on racial and ethnic disparities in healthcare (Smedly et al., 2003) and the U.S. Office of Management and Budget's (OMB) congressional report, "Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency" (2002).

Executive Order No. 13166 requires federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them. The order also stipulates that federal agencies work to ensure that recipients of federal financial assistance provide meaningful access to their LEP applicants and beneficiaries (Exec. Order No. 13166, 65 C.F.R. 159, 2000).

Individuals involved in healthcare delivery interact daily with patients from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how healthcare services are delivered and received, it is important that healthcare organizations and their staff understand and respond with sensitivity to the needs and preferences that diverse patients bring to the health encounter (Schyve, 2007). Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, in the long run, health outcomes (Smedly et al., 2003).

A search of the literature related to providing optimal care to Russian and former Soviet Union (FSU) immigrants was conducted using PubMed, Medline and Google databases. Keywords searched were *ethnically diverse, U.S. hospitals and Russian patients, FSU patients, patient safety, culture, and language*. A manual search was also conducted to maximize the findings on the topic. There was a plethora of literature addressing the relationship between language, culture, and patient safety and addressing specific risks minority patients face when clinical staff do not understand the language or cultural differences (Divi et al., 2007; Quan, 2010).

A critical review of multidisciplinary literature on Russian patients in U.S. hospitals returned few results. Of these results, research reviewed recognized similarities between ethnic groups but omitted analysis of each group individually; this led the author to conclude that although the analysis of minority patients in the literature is extensive, there is a lack of research specifically relating to Russian immigrant patients.

Generally, the research on Russian immigrants and FSU immigrants are combined into one group representing immigrants who speak the Russian language; however, there

are significant cultural differences within the regions of the FSU (Encyclopædia Britannica, 2012; Kasatkina, 2011). Therefore, a definition of *Russian* that simply combines all Russian-speaking people into one group is inaccurate and discounts the ethnic differences between these groups. Additionally, it should be noted that the FSU was a multilingual state, with over 120 languages including Russian spoken natively (U.S. Department of State, 2012).

Intercultural Care and the Immigration Adaptation Process

Intercultural care entails a specific understanding of migratory development and its phases. *Immigration* is the process by which individuals move from one place of residence to another, usually permanently or semi-permanently. Reasons for migration can be economic, social, political, medical, or recreational; in many cases, immigrants were often displaced from a previous life that, while sometimes normal, was all too often characterized by poverty, depression, and violence (Lai, 2004; Thomas & Schwarzbaum, 2006).

Some immigration movements are voluntary, typically including a well-thought out decision and plan, while others are involuntary, spontaneous decisions to escape the home country. Voluntary immigration can seem more involuntary, however, if negative economic, social, or political realities of the home economy influence the decision, giving the immigrant a sense of hopelessness or a perception that he or she has no choice but to emigrate. Moreover, a voluntary immigration may begin to appear involuntary as various aspects make the option of returning home unmanageable.

Regardless of the reasons for immigration, each immigrant will have a different feeling about their relocation experience. These experiences can have an emotional

impact on immigrants' adaptation to their host countries, causing anxiety and distrust due to past life events (Bhugra, 2003). Healthcare professionals should be cognizant of patients' immigration experiences and seek a general understanding of the characteristic behaviors and attitudes displayed by "typical" immigrants (Cross, Bazron, Dennis, & Isaacs, 1989).

There are various styles by which the immigrant adapts to his or her new environment. Awareness of these adaptation styles can help healthcare practitioners recognize and identify stressors for patients (Giger et al., 2008). The process of adaptation depends on the pre-immigration lifestyle, the circumstances of travel to the new country, the treatment received following arrival in the new country, and the living environment of the new country. Depending on the severity of the immigration experience, immigrants might not be able to adapt at all and can end up returning to their countries of origin (Poss, 2001).

The adaption process may occur in several processes: complete assimilation, integration, separation, and marginalization (Kasatkina, 2011; Pumariega, Rothe, & Pumariega, 2005). Complete assimilation occurs when individuals are fully immersed in the prevailing culture and slowly abandon the values and beliefs of their home countries. These individuals may even end up losing their native languages or choose not to transmit their native languages to their children (Kasatkina, 2011). Integration is a more traditional approach in which immigrants maintain the culture of their home countries while embracing the values of the new country (Pumariega et al., 2005). In separation, immigrants alienate themselves from the core culture to preserve characteristics of their native cultures. Separation typically occurs when immigrants of the same origin live in

close proximity to each other and are able to complete daily tasks without communicating with members of the dominant culture (Casimir, Butler, Jean-Louis, Zizi, Nunes, & Brady, 2010). Finally, marginalization involves immigrants' belief that the host society has completely rejected their cultural values and identities. The most extreme process of adaptation, marginalization fosters antisocial behavior and results in a very limited integration into the new culture (Berry, 1986).

There is little research available on immigrant adaptation processes as they relate to healthcare. However, knowledge about the different adaptation processes can help healthcare providers recognize immigrants' unique needs and identify barriers to access of healthcare services for this population. Additionally, awareness of the challenges immigrants face with social integration can help healthcare providers serve a more diverse population (Campinha-Bacote, 2008).

Russian Immigration History

The first Russians reached America in 1747 when fur traders arrived in Alaska (Trumbauer & Asher, 2004). Russians were among the first Europeans to discover the North Pacific islands and the Northwest coast of North America (Trumbauer & Asher, 2004). The next large-scale immigration of Russians to the U.S. did not occur until late into the 19th century, when immigrants began to arrive in waves. Following the Revolution of 1917, the biggest immigration wave began in 1987 and established an annual total of 700,000 new entries per year (Liberovsky, 2006). Non-ethnic Russians in this group included Jews, Ukrainians, and any other person born and raised in Russia or the FSU.

Acculturation is a process by which one cultural group implements the beliefs and traditions of a host culture (Mills & Henretta, 2001). Acculturation is multidimensional and includes physical, psychological, financial, social, language, and relational adjustment. It is widely recognized in the literature that the process of acculturation can be very stressful for elderly immigrants in the United States because they often lack the financial and educational resources and English language proficiency required for successful adaptation (Benisovich & King, 2003; Lai, 2004; Suurmond, Uiters, de Bruijne, Stronks, & Essink-Bot, 2011).

Culturally Competent Care

Cultural competence can be defined in many different ways, as this term constantly evolves with the rapidly changing diversity in society. The general definition is a tradition of similar behaviors, approaches, and regulations that come together in a system, agency, or among professionals to allow them to work effectively in cross-cultural situations (Cross et al., 1989).

The first element of this concept, *culture*, “implies the integrated patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values, as well as institutions of racial, ethnic, religious, or social groups” (U.S. Department of Health & Human Services, 2001). Culture is developed through different social standards, values, and various economic factors. The progress of culture can be different for every individual; however, in order to develop a bond with other people and build social relationships, the dynamic of culture must be shared. Understanding values of diverse cultures builds mutual respect and understanding (Betancourt, Green, & Carrillo, 2002).

Cultural differences impact the healthcare community and, most importantly, influence the delivery of healthcare services (Jezewski & Sotnik, 2001). Culture plays a central role in the way individuals perceive health, symptoms of illness, and healing methods; for example, where one culture believes in using heat to treat a certain ailment, another culture could strongly advise against it. On the other hand, modern healthcare was developed on the concept of ethnocentrism and is strongly focused on the incorporation of technology and science for the treatment of ailments; alternative healing methods are often disregarded as obsolete. The modern healthcare environment is often perceived by patients to be very complex, intimidating, and unfamiliar. This is why it is important to develop a healthcare environment organized around the needs of the patients to be served (White, 2000).

Competence refers to the ability to function within the context of culturally integrated patterns of human behavior defined by a group (Betancourt et al., 2002). *Cultural competence* is defined as “a process that requires individuals and systems to develop and expand their ability and to have respect for cultural diversity” (Haden, Catalanotto, Alexander, Bailit, Battrell, Broussard, & Buchanan et al., 2003, p. 564). Developing cultural competence should increase consciousness, acceptance, and aptitude to learn from and about other health-related cultural beliefs. A key element of developing cultural competency is realizing the importance of effective communication, which requires the disposition to listen and learn from people of other cultures and the establishment of a healthcare environment that provides services in multiple languages (California Cultural Competency Task Force, 1994).

Prejudice is any negative attitude about another person based on his or her group membership. *Stereotyping* can be defined as the process by which people acquire and recall information about others based on race, sex, religion, etc. (IOM, 2002). Prejudice often associated with stereotyping was defined in psychology as an unjustified negative attitude based on a person's group membership. Stereotyping includes having an attitude, conception, opinion, or belief about a person or group (Giger et al., 2007).

Most healthcare providers find prejudice morally abhorrent and at odds with their professional values (Vaiani, 2009). However, like other members of society, they may not recognize manifestations of prejudice in their own behavior. While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that their diagnostic and treatment decisions, as well as their feelings about patients, can be influenced by patients' race or ethnicity (Bobo, 2001). In one experimental design, Abreu (1999) found that mental health professionals were more likely to negatively evaluate a hypothetical patient of unidentified race when subliminally primed with African American stereotype-laden words than when primed with neutral words. And in a study based on actual clinical encounters, van Ryn and Burke (2000) found that doctors rated Black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, and more unlikely to comply with medical advice.

Stereotypes can also influence interpersonal interactions between providers and patients and contribute to disparities in healthcare (IOM, 2002). Although providers may not recognize manifestations of prejudice in their own behaviors, patients could react to providers' behaviors in a way that contributes to disparities. One such instance is of a healthcare provider who fails to recognize individuality within a group, causing the

patient to believe the provider is jumping to conclusions about the patient and his or her family (Giger et al., 2007).

Conceptual Framework

Leininger's cultural care theory provided the organizing framework for this study. Together with the Sunrise Model, this theory is perhaps the most well-known in nursing literature on culture and health (Leininger & McFarland, 2006). It draws from anthropological observations and studies of culture, cultural values, beliefs and practices. The theory of transcultural nursing promotes better understanding of the universally held and common understandings of care among humans as well as the culture-specific caring beliefs and behaviors that define any particular caring context or interaction. Leininger argued that the theory of cultural care diversity and universality is holistic and that culture is the specific pattern of behavior that distinguishes any society from another and gives meaning to human expressions of care (Leininger, 1981).

Leininger recognized the comparative aspects of caring within and between cultures, hence the acknowledgement of both similarities and differences in caring in diverse cultures. The model has implications for how healthcare professionals assess, plan, implement, and evaluate care of people from diverse cultural backgrounds. It has been used in a wide range of nursing specialties and across cultural groups.

The aim of the cultural care theory was to enable nurses to provide care that confirms patients' cultural perceptions of what care should be. Leininger emphasized the significance and position of culture in describing a person's health and manners (Leininger & McFarland, 2006). The roots of her theory are in clinical nursing practice; Leininger discovered that patients from different cultures appreciated care more than the

nurses did. Progressively, Leininger became convinced of the need for a theoretical framework to determine, describe, and calculate measurements of care and developed the cultural care theory after analyzing numerous studies of Western and non-Western cultures (Leininger & McFarland, 2006).

Leininger (2001, 2006) outlines several theoretical expectations and descriptions to guide nurses in their encounter of culture care phenomena. The following expectations regarding care and caring were significant when explaining the essence of caring for elderly, non-English-speaking Russian-American patients:

- care (caring) is crucial to treating and healing; there can be no healing without caring;
- each human culture has lay (ethnic, universal, or traditional) care knowledge and practices and usually some professional care knowledge and practices, which vary transculturally;
- cultural care values, beliefs, and practices are influenced by and tend to be rooted in the language, philosophy, religion, relationship, social, political, illegal, educational, economic, and environmental backgrounds of cultures; and
- a patient who faces nursing care that misses the mark of his or her beliefs and values will show signs of cultural conflict, noncompliance, depression, and ethical or moral concern. (Leininger, 2001, p. 189)

CHAPTER THREE

Methods

The purpose of this phenomenological qualitative study was to explore the experience of Russian-speaking nurses caring for elderly, non-English-speaking Russian patients. This study was based on the experience of Russian-American nurses providing care to this type of patient. The goal of this study was to assist nurses and other healthcare professionals in providing specific care to meet the needs of elderly, non-English-speaking Russian patients.

This study utilized Edmund Husserl's phenomenological approach to focus on the participants' experiences of caring rather than on the nature of caring as perceived by participants. A qualitative research design was used to allow the experience of caring to be discovered inductively within the cultural context (Morse & Field, 1998).

Participants

The participants for this study were seven male and female Russian-speaking registered nurses (RNs; Appendix A) with at least five years of experience providing direct, hands-on adult patient care at the general or intermediate care levels of hospitals, adult healthcare centers, and/or outpatient health services of San Diego, California and Tampa, Florida. Participants were renamed with pseudonyms (N1-N7) to ensure confidentiality.

Data Collection

Participants were informed of the purpose of the study and invited to participate in interviews (Appendix B). Participants were informed at the beginning of the interview

of their rights to withdraw any time. They were allowed to choose a quiet, safe environment in which they could freely articulate responses.

The data were collected in Russian through one semi-structured tape-recorded interview and one web conference interview via Skype with open-ended questions (Appendix C). Approval for the study was obtained from the Point Loma Nazarene University Institutional Review Board (Appendix D). Fieldnotes were used to document observations relevant to the interview, such as observations about participants' expressions and behaviors, that could not be captured by voice recordings.

Participation in this research study was entirely voluntary and participants could refuse to participate or withdraw any time during the study. All data were collected anonymously so that there was not any way of linking the data with the participants. Participants were asked to fill out demographic data form prior to interviews. Interviews were 45-60 minutes in length. All interviews were then transcribed verbatim into English.

Data Analysis

The data were analyzed, interpreted, and synthesized using Colaizzi's (1978) methodological interpretations. Colaizzi's analysis was chosen as it allowed analysis to occur simultaneously with data collection (Omery, 1983), the stages were flexible and non-linear (Holloway & Wheeler, 1996), and participants validated their transcripts, thereby enhancing the rigor of the study.

After the transcripts of the interview were read and reread, the interview responses were categorized. This allowed for identification of significant statements and meanings of specific cultural care for elderly non-English-speaking Russian patients. Following this step, the researcher's personal notes were compared with the interview

data, and the meanings were organized into theme clusters. The researcher referred back to the original translated transcripts for validation., noting any discrepancies. Then, results were integrated into complete descriptions of the phenomenon of specific care; the process was concluded when all participants had validated the findings.

CHAPTER FOUR

Results

Three main themes emerged from participant interviews on the healthcare of elderly, non-English-speaking Russian patients: *family connections*, *period of time living in America* (phase of adaptation process), and *compliance with treatment*.

Theme 1: Family Connection

Family involvement and a strong family bond were described as essential to the experience of caring for elderly, non-English-speaking Russian patients. The interaction between the nurse, the patient, and his or her family was best described thus by Russian-speaking nurses surveyed for this research: “*Involving the patient’s family is a must*” (N3). Consequently, for all the participants, the family served as the primary decision-maker in the care of the elderly patients. This description of family involvement appeared throughout the interviews, and participants recommended a family-centered approach for conveying medical information:

...the family makes all the decisions regarding the patient’s healthcare and it is important to build good rapport with them in order to provide high quality care (N4).

Most of the times the family will make a decision on the final treatment plan. The patient won’t make any decisions on their own, so it will be counterproductive if the family is excluded (N5).

In addition, the presence of the family during the discussion of patient's condition and plan of care was an important factor:

If their family is not here, the patient will ask me to wait to go over the specific treatment options so their family is there to listen, ask questions and make the ultimate decision about the healthcare plan (N1).

Participants noted that care and reassurance from the family also played a large role in patient care:

The support that the elderly receive from their family is the best medicine (N7).

The family also played an important role in helping nurses communicate with the patient and facilitate the patient's care and healing:

[I]t is very important to get the family involved, since dealing directly with the patient could be very difficult (N5).

In cases where the patient refused care, the nurse would work with the family to make the patient comfortable with the treatment plan:

Sometimes I am not able to convince the patient one way or another, but I know family can definitely help in such situations (N2).

Finally, participants pointed out the importance of developing trust in the nurse-family relationship. One participant said, *"Always make sure to involve the family during the process. This will make your life easier and the patient will be very happy"* (N6).

Theme 2: Period Of Time Living In America (Adaptation Process)

Participants drew attention to the differences in perceptions of medical care between patients who were new arrivers to the U.S. and patients who had lived in the country for some time. One participant stated, *"...the longer the patient has been in the United States, the more they will comfortable with communicating with me and they are more confident in the quality of health care that they will receive"* (N4). Another noted,

“... patients who have been lived in America for a long time felt more at ease with asking specific healthcare questions and were less apprehensive about the healthcare provided” (N7).

The participants also reported observing that elderly patients who were new immigrant displayed a distrustful attitude, appeared suspicious of healthcare professionals, and were very guarded:

...[they] tend to be suspicious of younger nurses, especially if the nurse is smiling. This type of scenario usually occurs for patients that are new to the United States, as they are not used to people being friendly. Initially, this type of patient believes that the nurse wants something from them or is being unprofessional by smiling at them. As these patients grow more accustomed to the American culture, they begin to understand the friendly demeanor of the nursing staff and become more informed about the hospital rules (N3).

Participants also noted that in the beginning, the elderly patients demonstrated a strong connection to their native cultural practices and health beliefs; however, as time progressed, they became more accustomed to American healthcare beliefs and practices. One nurse described her experience thus:

It is very interesting how I am perceived as a Russian-speaking nurse by the elderly Russian patients who are new to this country. For example, if I were a nurse in Russia, they would all think that I was not smart enough to become a doctor or that I have a bad husband and that's why I am only a nurse and not a doctor. Then afterwards, I would see the same patient come back and they have completely changed their mind on their own. They begin to look at me as their

primary health caretaker. This occurs as these patients assimilate into the new American culture (N5).

The nurses also reported that patients who had lived in America for a long time were easier to talk to and were much more receptive to suggestions made by healthcare professionals:

...they are much easier to talk to because they are willing to listen and they try very hard to understand the given situation. For elderly people who have lived here for an extended period of time I just have to remind them of what they have forgotten (N1).

When asked about differences in behavior of patients that have lived in the U.S. longer, one participant noted,

Patients who have lived here for awhile and know the system know there is a big difference between personal and professional relationships. For newcomers it is hard to understand and differentiate the two. It definitely takes some time of getting used to so it is my responsibility to help the patient and the family to understand the laws and professional conduct in the healthcare system” (N6).

Overall, as patients became more accustomed to life in the U.S., they felt more confident, were less afraid to ask questions, and became more familiar with patient healthcare rights.

Theme 3: Compliance With Treatment

Based on participants’ responses, many elderly patients who were new immigrants did not seek formal medical care except for complicated cases. Rather, patients took a proactive role in maintaining their own health and often used home

remedies or self-treatment for any symptoms identified before seeking physician care. Historically, Russians have greatly respected forms of alternative medicine (e.g., herbal teas, alcoholic tinctures, and other methods to treat disease and promote a healthy lifestyle) and used them often for traditional care. Participants reported patients' use of traditional herbal remedies in conjunction with standard Western medical treatments.

Participants reported that although the patients appeared enormously interested in learning the details of their initial treatment plans and indicated their desire to take a proactive role in their healthcare, they were very suspicious of any medicine prescribed for them and appeared reluctant to take medication even after receiving very detailed explanations from healthcare staff:

[they] are very suspicious of everything. They will double and triple check everything that is given to them. They will contact their relatives and friends in the United States and Russia to seek additional opinions and possible care options and involve everyone around them in their healthcare treatment. They will take medication only if it agrees with their understanding of [the] healthcare treatment (N4).

Some patients simply refused to take any prescribed medication, while others believed that pills were only needed when they experienced symptoms:

I had an elderly man who hid his medication in his cheek because he did not trust American medicine and did not want to tell us anything (N2).

...they refuse to take their blood pressure medicine. I continually hear the same type of response for these patients, such as “Why do I need to take this medicine for blood pressure if I feel normal today?” (N3).

On the other hand, participants believed patients remained very cognizant of their healthcare plans and were more likely to gather information on experimental treatments and more inclined to consider such treatments, especially if they had already obtained previous information about them.

One participant observed, “*Most [elderly, non-English-speaking Russian patients] are very highly educated individuals*” (N6). Thus, it was noted that healthcare professionals must treat these individuals with respect and understanding: “*...know what you are talking about and don’t dismiss these patients as ‘old and dumb’ just because they do not speak English. They will ask intelligent questions and will be able to determine if your answers are not based on actual knowledge*” (N5).

Participants also believed these patients had a very high tolerance for pain and were thus more likely to misstate their actual state of health. One participant reported, “*...they can tolerate pain very well and even if they don’t, they have been taught not to complain. They tend to say that they are fine, when in reality the pain level could be extremely high*” (N7).

CHAPTER FIVE

Discussion

In this study, Russian-speaking nurses provided insight on healthcare beliefs, culturally appropriate methods of care, and interpersonal interaction challenges specific to elderly, non-English-speaking Russian patients. The nurses reported that caring for these patients allowed them to share their cultural knowledge and experiences with their peers. Overall, the participants felt that even a limited knowledge of Russian cultural customs and attitudes could help to greatly improve patient interactions and patient-nurse relationships. This is validated in the literature suggesting that patient-nurse trust relations are often influenced by cultural norms and that patient interactions are also impacted by nurses' cultural backgrounds (Takeshita & Ahmed, 2004).

Theme 1: Family Connection

The theme of family connection and involvement emerged in all participant interviews. Based on participants' observations, it was apparent the process of taking care of the elderly patients was a significant responsibility for Russian families. The families treated the patients with respect, went to great lengths to ensure that someone was always available to listen to their concerns and questions, and usually stayed with patients around the clock to make sure they were not alone. In this study, family involvement in patient care was described as a culturally normative behavior. Family was recognized as a very important factor with a significant influence on the patients' emotional, social, and psychological health.

Participants emphasized that getting the family involved and developing a trust in the nurse-family relationship should be a priority for healthcare staff. Similarly, Shpilko

(2006) advises nurses caring for elderly Russian patients to determine the role of the patients' families and highlights that communicating effectively with patients and families is the foundation of providing quality healthcare. Leininger (1981) also argued that including the patient's family in care planning is essential to the delivery of culturally competent care.

Participants reported a tendency for family members to shield patients from their healthcare concerns and worries. As Shpilko (2006) explained, it is the family's "obligation to take on the burden of the truth" (p. 332); such belief demonstrates the intensely familial nature of the Russian community and the importance of their internal support networks. Similarly, Milshteyn and Petrov (2004) found that the problems of the patient were considered family problems and discussed by the entire family. Further, news about the patient's health was delivered to the family, who passed it along to the patient at a later time (Cichocki, 2008). This allows the patient to be surrounded by close family and friends who can provide the support necessary to cope with the news of the illness (Milshteyn & Petrov, 2004). This study corroborates existing research suggesting that the way a healthcare provider communicates information to a patient can be as important as the information being conveyed and that recognizing the role of the patient's family is vital in caring for elderly, non-English-speaking Russian patients.

Theme 2: Period Of Time Living In America (Adaptation Process)

Participants also saw a direct correlation between the length of time patients had lived in America and their perceptions of the overall quality of their medical care. Patients who had lived in the U.S. longer were more confident in navigating the healthcare system than patients who had recently begun their lives in the country.

Participants noted that elderly patients who had newly arrived to the U.S. demonstrated a strong connection to their native cultural practices and health beliefs, but as time progressed, they became more accustomed to American healthcare beliefs and practices. This observation of adaptation was supported in the literature; Polyakova and Pacquiao (2006) posited that elderly Russians who left the Soviet Union to live in the United States experience the twin challenges of aging and acculturation: “Older members often left their homeland for the sake of their children and subsequently face issues of acculturation and aging at the same time” (p. 44). Some studies suggest that low adaptation acts as a barrier to these individuals’ use of health services (Scheppers et al., 2006; Morrison & James, 2009).

Another challenge of adaptation was cultural disconnect between Russian immigrant elders and their assimilated children, who tended to identify more with the modern American culture and lifestyle than with their Russian heritage and traditions (Polyakova & Pacquiao, 2006). This disconnect also magnified the importance of involving patients’ families in the healthcare process. As the children become assimilated and adapt to the new life more quickly than their elderly parents, they are more likely to collaborate with healthcare providers in executing their parents’ treatment plans. As caretakers, they are more likely to accept the health problems presented, understand the treatment options, and encourage their parents to adhere to medical instructions and follow the prescribed treatment plan (Kasatkina, 2011).

The process of immigration adaptation has been a topic of several studies, and increased familiarity with the subject may allow healthcare providers to recognize some of the unique needs elderly immigrant patients have and identify potential limitations to

their access of healthcare services (Kasatkina, 2011; Pumariega, Rothe, & Pumariega, 2005). Part of developing adaptation skills for elderly Russian immigrants was expressed through help-seeking patterns in their approach to American healthcare. These patterns are characterized largely by a cultural preference for informal medical care and distrust of formal medicine. When in need of physical or psychological assistance, many Russian-Americans turn first to home- or community-based practices rooted in their tradition rather than American pharmaceutical approaches. Russians hold these practices in high esteem, often turning to alternative therapies such as reflexology, massage, oil rubs or steam baths, homeopathy, chiropractic care, or other options before considering typical American medicine (Shpilko, 2006; Grabbe, 2000).

Some elderly Russian-speaking immigrants may be distrustful of physicians and reject health recommendations such as prescribed medication or may choose to combine medically-prescribed treatment with home remedies and treatments (Resick, 2008). There was an underlying distrust of formal medical treatment, especially drugs or anything of a chemical nature, which was seen as more harmful than helpful; as an old Russian proverb reads, “Too much of any medicine is dangerous” (Shpilko, 2006, p. 338). Caretakers can greatly benefit being aware of these cultural differences when providing care.

Serving the healthcare needs of elderly immigrant Russian patients can present special challenges. One such challenge, based on the phases of the adaption process discussed above, is the variety of overall perceptions of the new culture among elderly immigrants patients. Thus, caregivers are not only faced with providing different healthcare needs but also with the need to adjust their approach depending on the patient. Awareness of the obstacles these patients face with social integration can allow

healthcare organizations and providers to serve a more diverse population (Campinha-Bacote, 2008). Currently, few healthcare studies have focused on the immigrant adaptation process. Such research examining the typical traits of immigrant patients in each phase, could help the medical community identify leading healthcare practices for diverse patients.

Theme 3: Compliance With Treatment

Differences in healthcare beliefs between the patient and provider (e.g., the explanatory model of health, illness and healing methods) can act as a barrier for and serve to further disadvantage ethnic minority patients (Scheppers et al., 2006). For Russians, these healthcare beliefs are reflected in their active practice of some form of holistic self-care; for example, many use homeopathic remedies or a variety of drugs brought from Russia to treat headaches, indigestion, bacterial infections, and other general ailments (Milshteyn & Petrov, 2004; Kasatkina, 2011; Wheat, Brownstein, & Kvitash, 1983). Generally, these practices are unrelated to what the patient is doing under the direction of American physicians (Wheat et al., 1983). Therefore, it is very important that medical providers respectfully seek to understand what types of self-treatment their elderly Russian immigrant patients may practice. Mutual respect, trust, and joint decision-making will result in the greater likelihood of a positive outcome (Scheppers et al., 2006).

Participants' comments also revealed that patient compliance with treatment is related to their different perceptions of the healthcare system. Because the primary goal of Russian healthcare is to find the root causes of a particular disease or condition (Grabbe, 2000; Benisovich & King, 2003), many Russian immigrants feel that American

doctors place too much emphasis on treating the symptoms of the disease rather than trying to understand its cause from a more holistic perspective (Dohan & Levintova, 2007; Borovoy & Hine, 2008). Most Russian patients will want to have active discussions with their care provider about what caused the ailment, how it can be cured or treated, and what specifically will be involved in the process (Borovoy & Hine, 2008).

Patients' perceptions of the quality and volume of information received from their providers can have a profound effect on their reception to the information and their willingness to use it. Nurses should remember that patients can sense when communication is lacking, and this can lead to patients feeling increased anxiety, vulnerability, and powerlessness. Overall, participants in this study agreed that patients who understand their providers are more likely to accept providers' explanations of their health problems, understand their treatment options, modify their behavior, and adhere to follow-up instructions.

Considering these observations, the results of this study appear to emphasize that effective communication is at the core of providing patient-centered care. Unfortunately, even when providers know what messages to communicate to patients, they do not always have the interpersonal skills to do so effectively. Thus, experience working with diverse cultural groups can improve care providers' interpersonal skills, leading to better patient outcomes and extended provider-patient dialogue that enables patients to disclose critical information about their health problems so that providers can make more accurate diagnoses. Good communication also develops healthcare education and counseling, resulting in more appropriate treatment regimens and better patient compliance. Effective interpersonal communication makes healthcare more efficient and cost effective; thus,

patients, providers, administrators, and policy makers all have a stake in improved provider-patient interactions.

Study Limitations and Areas for Future Research

The findings of this study contribute to the understanding of how the actions of healthcare professionals can influence the health of their elderly Russian patients. Small sample size and the qualitative design provided an efficient way to gather information on major cultural differences between these patients and their providers, outline patients' general views on medicine and its purpose, and develop recommendations for healthcare providers and nurses when treating an elderly Russian immigrant patient. However, the small sample size is more likely to limit the generalizations that can be made from this study and to neglect other important aspects of providing care for this population.

Another limitation is that qualitative methods produce data based on individual experience; therefore the findings might not be applicable to all people in the identified group. Moreover, because most of the participants (more than 85%) were situated in the same geographical area (San Diego, CA), the results might differ in other areas of the country.

Finally, because methodological analysis is open to interpretations, future research targeting a much larger sample of Russian-speaking nurses in a different region of the country is necessary to replicate and expand on the relevance and accuracy of findings outlined in this study.

Currently, there is little research on the immigrant adaptation process as it relates to healthcare. A study examining the typical traits of immigrants in each phase could help the medical community identify leading practices for diverse patients.

Conclusion

The theoretical framework for this study was Leininger's theory of cultural care diversity and universality, which holds care as the essence and unifying focus of nursing because care is embedded in social structure, worldview, language, and environmental contexts (Leininger, 1981, 2001). Cultural diversities and universalities of care exist in all cultures worldwide, and knowledge of them can guide nursing care decisions and actions to benefit patient health (Leininger 2001, Leininger & McFarland, 2006). Understanding a patient's practice of cultural norms can help providers build rapport and ensure effective communication with patients (Betancourt, Green, & Carrillo, 2002).

Russian patients bring their own cultural perspectives and values to healthcare, and many of their health beliefs and practices differ from those traditional to American healthcare. 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 hold culture-specific ideas and values about health and illness, reporting of symptoms, expectations for healthcare delivery, and the role of medication and treatments. Unfortunately, the expectation of many healthcare professionals has been that patients will conform to American values, which creates barriers to care that are compounded by differences in language and education between patients and providers.

This study presented findings relevant to overcoming these barriers to care. First, it was noted that family plays an important role in the diagnosis of illness, treatment, and care of elderly Russian immigrant patients. Therefore, a family-centered health treatment approach was recommended to enhance the overall experience of the patient and the

nurse and increase the likelihood of a successful outcome. Family members are equal contributors in the problem-solving process, working with care providers to identify the goals of treatment and to plan realistic strategies to achieve these goals. Additionally, family members played a key role in implementing these strategies to ensure that treatment goals were met. Therefore, it is critically important for the nurses to inform patients and their families of their rights and adhere to the guidelines outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Some healthcare organizations ask patients to sign written consent forms before doctors discuss medical information with family caregivers; this is not part of HIPAA provisions, but may be part of the organization's procedural policy.

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