Physical Assessment: Performing – Cultural Considerations

What Are Cultural Considerations in the Context of the Physical Assessment?

› A physical assessment is the systematic process of evaluating a patient’s physical, mental, and emotional status. Consideration of each patient’s cultural beliefs, values, and practices is important to the appropriate performance of the procedure for physical assessment

• What: The purpose of the assessment is to identify abnormal findings that signal the presence of an underlying disease or a change in patient status. Understanding and integrating the patient’s cultural background in the physical assessment is important to the delivery of optimal and individualized patient care

• How: A face-to-face interview with the patient and/or family is conducted to initiate the physical assessment, and cultural assessment should be performed as part of the initial patient assessment. Certain assessment techniques (e.g., inspection, auscultation, palpation, and percussion) and equipment are subsequently used to assess for physiologic abnormalities. For patients who have been admitted to an inpatient healthcare facility, physical assessment is performed by nursing staff members once each shift, as needed when a patient’s condition changes, and as appropriate to assess the effect of therapeutic interventions. Although an initial patient assessment can take more time, typically the physical assessment is performed at the bedside in the inpatient setting and under most circumstances requires approximately 10 minutes

• Where: Physical assessment can be performed in any healthcare setting, including an inpatient facility, outpatient clinician office, and in the community in cases where in-home care is being provided or emergency medical care is needed

• Who: Physical assessment is performed by nurses, physicians, and emergency medical staff, and should not be delegated to assistive staff members. Depending on the patient’s preference and the need to promote patient privacy, it is appropriate for family members to be present during physical assessment of the patient

What is the Desired Outcome of Considering Cultural Factors When Performing a Physical Assessment?

› The desired outcomes of considering cultural factors when performing a physical assessment are to optimize communication between the patient and clinician and promote patient comfort and satisfaction with care. Optimal communication will enable the clinician to elicit patient cooperation and obtain more accurate information from the patient

Why Is Consideration of Cultural Factors When Performing a Physical Assessment Important?

› It is important that clinicians adapt their care to the patient’s unique cultural needs because individualized patient care is more likely to facilitate achievement of the patient’s goals and lead to better patient outcomes

› Showing respect for the patient’s cultural history, practices, and beliefs helps build rapport and trust between the clinician and the patient, and allows the patient to be open and receptive to members of the healthcare team
Gaining knowledge about the patient’s cultural history, practices, and belief systems will not only improve performance of the physical assessment, but will be beneficial in understanding how culture can affect the provision of other healthcare services (e.g., diet, activity level, pain management).

**Facts and Figures**

Cultural background can affect the patient’s level of cooperation with certain aspects of the physical assessment. Investigators in a large population survey determined that the propensity to consent to measuring certain physical characteristics (e.g., height, weight) among older Hispanic adults was affected by the ethnicity of the interviewer and the respondent. Patients who were interviewed by a bilingual Spanish-speaking clinician were more likely to consent to having their physical characteristics measured. Patients who were interviewed by Black non-Spanish speaking interviewers were least likely to consent (Sakshaug et al., 2010).

The population of the United States is becoming increasingly ethnically diverse. In the 2010 Census, Whites accounted for 72% of persons living in the U.S., Blacks accounted for 13%, Asians accounted for 5%, Native Americans/Alaska Natives accounted for 1%, and Native Hawaiian/Other Pacific Islanders accounted for 0.2%; 6% of respondents were classified as “some other race” and 3% reported having more than one race. More than 16% of respondents identified as Hispanic or Latino. The vast majority of the population growth during the period 2000–2010 (27.3 million persons) came from persons who identified as some race other than White alone or persons who reported their ethnicity as Hispanic or Latino (U.S. Census Bureau, 2011).

Health assessment educational tools typically reflect the dominant culture. Researchers who evaluated the nursing curricula of nursing schools in Canada found that for education about the cultural aspects of health assessment, 67% of schools relied on publisher-produced audiovisual (AV) tools as an adjunct to the assigned textbook information regarding physical assessment, and that these AV tools focused on a Eurocentric bias, were superficial in content, and lacked culturally specific illustrations or role modeling. Topics that were poorly addressed included negotiating the use of an interpreter, modesty, and the inclusion of support persons in the health assessment procedure (Chircop et al., 2013).

**What You Need to Know Before Considering How Culture Will Affect the Physical Assessment**

The diversity of the U.S. population indicates an increased need for culturally competent health care, or health care that is provided with an understanding of the patient’s cultural needs. To deliver care that is culturally competent, clinicians must

• understand and appreciate differences between patient and clinician health practices and beliefs
• be aware of how organizational and personal practices can be biased against individuals of other cultures
• initiate efforts to eliminate organizational and personal bias
• adjust clinical practice to maintain the dignity of persons of all cultural groups

Knowledge of normal anatomy and physiology, and knowledge that variations in anatomy can be present in individuals of various ethnic backgrounds, are important

• Ethnic variations in vital signs should be acknowledged. Although the average pulse does not change with ethnicity, racial and sex differences in blood pressure exist. On average, younger Black men who are 18–34 years of age have lower systolic blood pressure readings than White men of the same age group. This difference is reversed for Black and White men who are 35–64 years of age, and after 65 years of age no difference in systolic blood pressure readings exists. White women typically have a lower systolic blood pressure reading than Black women at every age (Andrews, 2008).
• The body mass index (BMI), which is an estimation of body composition based on height and weight, may be less accurate in Black females. Some experts suggest that clinicians should use body fat percentage and weight distribution instead of BMI to classify individuals in weight categories (Bennett et al., 2011).
• Racial/ethnic background can influence skin color; amount, texture, and dispersion of body hair; and average patient height, weight, and BMI (Andrews, 2008).
  – Skin: Normal skin color varies widely according to the amount and distribution of melanin in the skin
  - Hyperpigmentation (i.e., darker areas of the skin that are caused by hormones or irregular melanin distribution) can be present. Use caution when assessing areas of hyperpigmentation to avoid overlooking a rash or erythema that can be masked by the darker color
  - Mongolian spots (i.e., irregular areas of deep blue pigmentation that are usually located on the sacrum and gluteus, but can also be present on the arms, shoulders, abdomen, and thighs) are a normal skin color variation in children of Hispanic, Asian, and African ethnicity
  - Vitiligo (i.e., areas of the skin where melanocytes [i.e., melanin-producing cells] have become nonfunctional and the skin is unpigmented) is more common in dark-skinned persons
Jaundice (i.e., a term used to describe a yellowish color in the skin, sclera, and other mucous membranes due to elevated levels of bilirubin) is best observed in the sclera due to the wide variety of skin pigmentation.

Cyanosis (i.e., a bluish or purplish tinge to the skin and mucous membranes due to decreased levels of Hgb) is difficult to assess in patients with darkly pigmented skin. The circumoral region in persons of Mediterranean descent is often dark blue.

Hair distribution: Widespread hair distribution can be normal in patients of Mediterranean descent, but might indicate an endocrine disturbance in other patients.

Height: In the U.S., average height is as much as 3.8 cm/1.5 in taller in persons of higher socioeconomic status. First-generation immigrants in the U.S. on average have an additional 3.8 cm/1.5 in in height compared with their counterparts in the country of origin. On average, White males are 1.27 cm/0.5 in taller than Black males and are 7.6 cm/2.9 in taller than Asian males. White and Black females are on average the same height.

Weight: Although socioeconomic class has a significant effect on body fat (i.e., as a general rule, the higher the socioeconomic class, the lower the weight), on average Black men weigh less than White men, and White women weigh less than Black women.

Depending on a patient’s cultural history or belief system, he or she
• might be strongly dependent on family members to make decisions and/or refuse to cooperate with the assessment without the permission of the head of household
• might not exhibit signs of pain, even when pain is severe
• might react strongly to mild physical symptoms and/or display a strong emotional response to medical information or treatment
• might be resistant to or refuse certain aspects of the assessment (e.g., genital examination)
• might use terminology that is not readily understood by the clinician. For example, in the Chinese culture it is typically more acceptable to somaticize emotional pain and a Chinese patient might characterize and speak of depression as having “heaviness of the heart.” This statement could prompt many clinicians who are unfamiliar with the Chinese culture to assess for cardiovascular disease with unnecessary, invasive, and costly tests.

Demonstrated competence in physical assessment skills is important
• Demonstrated competence in the use of assessment techniques (e.g., inspection, auscultation, palpation, and percussion) to identify physiologic abnormalities is important
• Pain assessment is a key part of the physical assessment. Knowledge that patients of various cultural backgrounds often display signs and symptoms of pain in different ways can help the clinician to assess pain level more accurately. The clinician should utilize a facility-approved, culturally-relevant pain assessment tool to assess the patient’s level of pain and should not focus solely on the patient’s facial expressions or body language
• For details regarding how to perform a head-to-toe physical assessment, see Nursing Practice & Skill ... Physical Assessment: Head-to-Toe --Performing

The clinician should be familiar with cultural factors that can affect how the patient responds to the physical assessment, including the following:
• Ethnicity or race (e.g., degree of comfort with the assessment can depend on the clinician’s ethnicity or race)
• Religion and/or spirituality
• Level of acculturation (i.e., adoption of the dominant culture’s way of life)
• Family structure, family dynamics, and the degree of family participation in patient care
• Issues related to sex (e.g., discomfort with communication with and/or examination by a clinician of the opposite sex)
• Primary language and communication style
• Attitude toward illness (e.g., cultural belief that illness results from spiritual unrest instead of physiologic abnormalities)
• Attitude regarding medical treatment in general or attitude regarding the biomedical model of health care (e.g., conventional Western medicine)

Preliminary steps that should be performed before initiating a physical assessment include the following:
• Review the facility/unit protocol for physical assessment, if one is available
  – Note guidelines for the frequency of the physical assessment and how to notify the treating clinician of abnormalities
  – Review information regarding providing culturally competent care for the patient’s ethnic group
• Verify completion of facility informed consent documents
  – Typically, the general consent for treatment that is executed by patients at admission to a healthcare facility includes standard provisions that encompass physical assessment
• Review the patient’s medical history/medical record for information about allergies (e.g., to latex, medications, or other substances); use alternative materials, as appropriate
Gather supplies and equipment necessary to complete the physical assessment, including
• nonsterile gloves; additional personal protective equipment (PPE; e.g., gown, mask) can be necessary depending on the patient’s infection status and likelihood of exposure to body fluids
• a facility-approved, age-appropriate pain scale
• prescribed analgesic medication and means for its administration (e.g., a glass of water for oral analgesic medication)
• stethoscope
• blood pressure cuff
• thermometer
• penlight
• bedside scale
• tape measure

How to Consider Cultural Factors When Performing a Physical Assessment

› Perform hand hygiene
› Identify the patient according to facility protocol
› Establish privacy by closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed. If in the outpatient setting, close the door to the examination room
› Introduce yourself to the patient and family member(s), if present, and explain your clinical role
  • Determine if the patient/family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, or deafness); make arrangements to meet these needs if they are present
    – Use professional certified medical interpreters, either in person or by telephone, when language barriers exist
  • Identify the appropriate person to address during the assessment. If the designated spokesperson is someone other than the patient (e.g., the head of the family), communicate directly with the appropriate person throughout the assessment
› Be aware of your personal style of communication. Evaluate
  • the comfort level of the patient/spokesperson regarding personal space
  • the appropriate level of eye contact (e.g., does the patient’s culture value direct eye contact or is it considered to be rude?)
  • the patient’s response to touch
› Perform a brief cultural assessment or integrate questions throughout the examination
  • Ask the patient how he or she prefers to be addressed
  • Ask the patient whether or not there are cultural beliefs that will affect the assessment or affect medical care in general (e.g., diet, use of medication, worship practices, or personal care rituals); inquire how you can best assist the patient in adhering to these practices and beliefs during the physical assessment
  • Ask if the patient would like a religious leader to be contacted in order to visit during the patient’s hospitalization
  • Inquire about how the patient normally responds to illness, pain, anxiety, and fear
  • Ask about the patient’s level of comfort receiving care from a clinician of the opposite sex or of a different race or ethnicity
  • Ask if there are any practices that clinicians perform or have performed that he or she considers to be awkward or offensive
› Express your intent to complete a physical assessment. Explain that the assessment will begin with an interview and conclude with a head-to-toe physical examination
  • Assess the patient and family, if present, for knowledge deficits and anxiety regarding the physical assessment
  • Explain the procedure, answer questions, and provide emotional support as needed
  • Ask for the patient’s verbal consent before proceeding with the physical assessment
› Encourage the patient/family to determine who will remain in the room for the patient interview
› Begin the patient interview. Ask a few general questions and after good rapport has been established, proceed with asking more intimate questions. Observe the patient’s verbal responses, facial expression, and body language to determine his or her comfort level
  • General questions can help patients feel more comfortable about sharing information. For example, if the patient has been hospitalized for abdominal pain, initial general questions can include, “What brought you to the hospital?,” “How do you feel?,” or “Are you feeling any discomfort now?” If the patient seems to be comfortable, proceed with more intimate questions such as, “Have you had any change in appetite or bowel habits?”
  • When inquiring about patient history regarding medication and treatment, ask about use of herbs, teas, ointments, and other nonconventional and alternative therapies
› Provide the patient with privacy and ask the patient to determine who will remain during the physical examination
› Request that the patient put on a patient gown if necessary, but consider the patient’s personal and cultural sense of modesty before asking
› Assist the patient to a bed or gurney, as appropriate, and position and drape the patient for privacy and accessibility
› Raise the bed or gurney to a height that is optimal for access to the patient and place the head of the bed as flat as the patient can tolerate easily
› Ask the patient for permission to proceed with the physical examination. Do not touch the patient without first obtaining permission
› Perform hand hygiene and don PPE as appropriate
› Take the patient’s vital signs, including temperature, pulse, respiration, and blood pressure. Explain each procedure before initiating it, and advise the patient of the information you obtain
› Assess for pain using a facility-approved pain scale that is appropriate to the patient’s age and culture. If language or reading barriers exist, utilize a picture scale (called a pictograph) such as the Faces Pain Scale
  • Be aware that the patient’s demeanor or body language may not correspond to the level of pain he or she selects on the pain scale or the pictograph
  • Provide analgesic medication, if prescribed, if the patient reports or is assessed to be in pain
› If the patient is amenable, assess height, weight, and waist circumference
› Complete a head-to-toe physical examination, examining the least intrusive body areas first
  • Continually observe the patient’s response to the physical examination in order to determine his/her comfort level
  • Consider the patient’s ethnic/racial background when completing the physical examination
    – Genetic manifestations, disease processes, skin coloring, body hair distribution and texture, and body weight and shape vary among ethnic groups
    – Consider the patient’s ethnicity when distinguishing normal physiologic variations from abnormalities
› After the examination, assist the patient to a comfortable position in a bed or chair
› Dispose of used materials in proper receptacles and perform hand hygiene
› Update the patient’s plan of care as appropriate and allow adequate time to document detailed information about the physical assessment and identified cultural considerations in the patient’s medical record. Document assessment results in the patient’s medical record, including the following information:
  • Date and time the physical assessment was completed
  • Any physical abnormalities that were identified, as appropriate
  • Information regarding cultural assessment, including specific requests or concerns of the patient
  • Patient’s response to the physical assessment, particularly the presence of pain, other discomfort, and anxiety that were observed
  • Any identified barriers to communication and techniques that promoted successful communication
  • All patient/family member education that was provided, including topics presented, response to education, and plan for follow-up education

Other Tests, Treatments, or Procedures That May be Necessary Before or After the Cultural and Physical Assessment is Performed
› The treating clinician should be notified of abnormal findings and/or significant changes from the previous physical assessment so that the treatment plan can be established or modified
› A reassessment will be conducted at regular intervals (e.g., every 4–12 hours) depending on the facility protocol and the patient’s condition
› After a diagnosis is made and a treatment plan is established, it might be necessary to perform another patient interview to assess
  • the patient’s/family’s understanding of the health issue and its cause
  • the degree of patient/family understanding about the treatment plan
  • the existence of cultural or religious beliefs or practices that conflict with the prescribed treatment

What to Expect After Performing the Cultural and Physical Assessment
› Information from the cultural and physical assessment will be used to formulate an individualized plan of care for the patient that is culturally and medically appropriate
Red Flags
› Document the existence of conflict between the patient’s cultural or religious beliefs and the prescribed medical treatment, and notify the treating clinician. Show respect for the patient’s healthcare choices, and do not attempt to coerce a patient to accept a medical intervention or treatment

What Do I Need to Tell the Patient/Patient’s Family?
› Reassure patients and their families that their cultural values will be communicated and respected by all members of the healthcare team
› Explain that it is important to share information related to cultural beliefs and practices so that the information can be documented and shared with all healthcare clinicians who are involved in the patient’s care

References