Care Planning

[Name of the Writer]

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**Introduction**

There are a more than 7 billion people living on the planet Earth currently. All these human do not belong to the same area, or class, or region, or religion. All of them belong to different back ground, culture, religion, nation and class. Al these humans have been categorized and classified in different classes or groups, for example nations, religion, castes, color, creed, nationality (Thistlethwaite, & Spencer, 2018). The concept of diversity is extremely important in the case of medical practice, where the medical practitioners have to keep the factors of cultural back ground in mind while planning and designing the medical treatment of any patient.

**Discussion**

Culture is the norms, values, practices and traditions being followed at a particular place at a particular time. It is not a thing that can be chosen by a person; in fact it comes naturally with a person’s birth. A person has to accept these values, norms, customs and traditions as it is and they are rarely changed. Personal choices are individual and change frequently. They are optional, unless they are life-threatening or life-sustaining (as diet can be, or stress-free environments). Culture is an over-arching principle, not an individual option (Jha, Mclean, Gibbs, & Sandars, 2015). Hence, sub-cultures, which are elective life ways, do not exhibit the same degree of cohesion, linguistic evolution, influence or perseverance as formal cultures do. If the culture of one requires certain roles, then each of you should adopt the complimentary role and do it justice. The problems arise when one party has acceptance of their culture and the other doesn't. That's a compromise that subjugates one to the other (Griffin, & Hu, 2015). So, first off, make sure both parties at the table are willing to reciprocate or it will be an uphill struggle and a long way down from the middle.
 Depending on cultural ideology, most people are collectivist or individualist in perspective and pursuits: they are ego-anchored or  nonego-anchored in language, behavior and schema (active worldview).  But, what happens is, invariably, one culture or the other has a set of values, taboos, behaviors and pursuits that are incompatible with the others. In that case, respectfully part ways if you want a harmonious relationship that supports the potential of both parties involved, together(Fisher-Borne, Cain, & Martin, 2015). Either both win, or no one wins. If you prefer separate but equal, then, "respect but don't participate" is the usual scenario, but the reality is, unless both can be maintained fully in a partnership, as a team effort, neither is truly accepted.

The concept of accepting and respecting diversity in the medical terms is must thing and it is essential for every medical practitioner to follow these patterns of diversity. In the terms of Anthropology, this concept is known as “Cultural relativism” and its acceptance is general or total in the whole medical field or among all the medical practitioners. Field researchers are supposed to be unbiased, neutral, non-participatory observers, however, and the research is vicarious, at best, as a result.

Most of the times, the medical practitioners do not just accept this diversity but also employ the values of tolerance and the mutual agreement to the agreement or disagreement compromises. There should be an equal participation of all the cultures while designing the medical care and schedule of the patients. Instead of keeping the ratio of this participation as 40:60 or 20:80, this percentage or ratio should be 50:50, every culture should give and take something out of this practice (Hart, & Mareno, 2014). Technically, 50/50 is half of each individual culture at any given time being expressed, or  representative cultures only being enacted half of the time as partners "take turns" at participating in their respective cultures separately while together ("separate but equal")

**Conclusion**

In short, it can be concluded that diversity plays a great role while deciding the type of care a patient should get. The factor of diversity should be kept in mind by the all the medical practitioners, whether it’s a doctor or a nurse or even a ward boy while planning and providing medical care so that appropriate level of medical care can be provided.

**References**

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165-181.

Griffin, B., & Hu, W. (2015). The interaction of socio‐economic status and gender in widening participation in medicine. *Medical education*, *49*(1), 103-113.

Hart, P. L., & Mareno, N. (2014). Cultural challenges and barriers through the voices of nurses. *Journal of clinical nursing*, *23*(15-16), 2223-2233.

Jha, V., Mclean, M., Gibbs, T. J., & Sandars, J. (2015). Medical professionalism across cultures: A challenge for medicine and medical education. *Medical teacher*, *37*(1), 74-80.

Thistlethwaite, J., & Spencer, J. (2018). *Professionalism in medicine*. CRC Press.