The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission
Cultural Competence and Ethical Practice

Introduction
Over time, the concepts related to culture have evolved. Today, there is a continuum of concepts and terminology that address cultural concerns and the implications on occupational therapy education and practice. Researchers and program developers in medical education face the challenge of implementing and evaluating curricula that teach health care students how to effectively and respectfully deliver care to increasingly diverse populations. Inherent in this challenge is clearly defining educational and training outcomes consistent with this imperative.

The traditional notion of competence as mastery of a theoretical body of knowledge and demonstrated application of skills may not be appropriate to the area of cultural sensitivity, cultural competence, and cultural proficiency. Cultural humility and cultural effectiveness are proposed as more suitable goals in multicultural education and application of attitudes and interactions during the clinical practice of occupational therapy (see Appendix A for definitions of these terms).

Ethical considerations dictate that cultural competence should be considered in activities such as hiring practices, teaching, evaluation, and supervision of staff and students. There is an equally important need for all occupational therapists and occupational therapy assistants to continually improve their level of cultural humility and to establish a mechanism for the evaluation of competence-based practice. Guided by the Occupational Therapy Code of Ethics (American Occupational Therapy Association [AOTA], 2015), occupational therapy practitioners should take a leadership role not only in disseminating knowledge about diverse client groups but also in actively advocating for fair, equitable, and culturally appropriate treatment of all clients served. This role should extend within and outside the profession. In the Principles and Standards of the Code, occupational therapy practitioners have a framework to guide their decisions when cultural conflicts arise.

Vignette 1
Joan, a pediatric occupational therapist, is asked to make a visit to the home of a recently immigrated Southeast Asian family whose child was referred to the Birth-to-Three Early Intervention Program. On examination of the child, she notes red, round, coin-sized marks over the child’s back. She never asks the mother about the marks. After leaving the home, Joan wondered whether the mother is using a traditional healing treatment. She asked herself, “How can I give this child ethical and quality care while allowing the mother to continue with this harmful practice?”

Application to the Code of Ethics—Principles and Standards of Conduct
- **Principle 3, Autonomy**, states that individuals have a right to make determinations regarding care decisions and **Principle 2, Nonmaleficence**, states that occupational therapy practitioners shall
refrain from actions that cause harm. **Principle 4, Justice**, relates to treating individuals in a “respectful, fair, and impartial manner” (AOTA, 2015, p. 5)

- **Standard 2B** says occupational therapy practitioners must “avoid abandoning service recipients” (AOTA, 2015, p. 3) which Joan would be violating if she discontinued intervention for this child in light of the family’s actions.

- **Standard 3A** tells occupational therapy practitioners to “respect and honor the expressed wishes of recipients of service” (AOTA, 2015, p. 4) and **Standard 3D** tells us to “establish a collaborative relationship with the service recipients” (AOTA, 2015, p. 4) Telling a family that occupational therapy will not be provided unless they cease one of their customary practices is not establishing a collaborative relationship or respecting the family’s wishes.

- Joan’s failure to inquire about the practice and become educated about cultural preferences of the family violates **Standard 3J**, which tells occupational therapy practitioners to address barriers to communication, including the culture of the service recipients or their families (AOTA, 2015)

**Discussion**

Every day, people face problems, dilemmas, and issues with ethical significance that necessitate action or inaction. Doing the right thing in practice is always a challenge. In an increasingly pluralistic society, health care providers find themselves confronting choices that may depend more on moral and ethical values than on medical knowledge.

Joan’s dilemma in Vignette 1 is a question not of what intervention method she should use but of whether she can provide quality ethical care. After researching, Joan would find that cupping has been an accepted practice for many years, and this traditional practice would not be considered abusive or harmful and would not affect occupational therapy intervention. Culturally competent practitioners realize that behaviors are shaped and defined differently by every culture. Rather than being distressed by another culture’s health practice, a culturally competent practitioner welcomes collaboration and cooperation in making sound ethical decisions.

Cultural competence exists on a continuum (Black, 2016); it is a journey rather than an end. It refers to the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different people (AOTA, 1995). It is a set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals to enable effective work in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competence entails understanding the importance of social and cultural influences on patients’ health beliefs and behaviors, considering how these factors interact at multiple levels of the health care delivery system and, finally, devising interventions that take these issues into account to ensure quality health care delivery to diverse patient populations (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003).

In a clinical setting, **cultural competence** means having the self-awareness, knowledge, skills, and framework to make sound, ethical, and culturally appropriate decisions. It is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis & Donald, 1997). A culturally competent practitioner is not afraid to ask the client culturally pertinent questions up front.

**Cultural effectiveness** “is working successfully with people whose cultural background differs from yours in a manner that embodies respect, sensitivity, and recognition of difference”
Elements of cultural effectiveness can include the following:

- Awareness of one’s own cultural values;
- Development of cultural knowledge;
- Awareness, acceptance, and understanding of the dynamics of difference; and
- Adapting practice to a client’s cultural context (Clowes, n.d., as cited in Wells et al., 2016).

Cultural competence is key to effective therapeutic interactions and outcomes. It implies a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities in a larger social context. It enhances the occupational therapy provider’s knowledge of the relationship between sociocultural factors and health beliefs and behaviors. It equips providers with the tools and skills to manage these factors appropriately, with quality occupational therapy delivery as the gold standard.

**Vignette 2**

Mrs. Sanchez is in her mid-60s and of Hispanic ethnicity. She is dependent for her existence on food stamps and Supplemental Security Income benefits. Somewhat hard of hearing, she has a slight tremor in her voice and arthritis in her hands. The three-bedroom house in which she lives is in poor condition and unkempt. For meals, she relies on her neighbors and junk food.

Mrs. Sanchez is admitted to the rehabilitation unit after experiencing a mild stroke that leaves her impaired on the right side. Her treatment sessions consisted of transfer training, education in one-handed cooking, and dressing with adaptive equipment. A variety of equipment and devices were recommended and ordered for her. At the discharge planning session, the occupational therapist stated in her report, “Mrs. Sanchez refuses all the equipment she needs, even though she is able to use it safely and properly.”

**Application to the Code of Ethics—Principles and Standards of Conduct**

- While **Principle 1, Beneficence**, states that occupational therapy personnel shall “demonstrate a concern for the well-being and safety of the recipients of their services” (AOTA, 2015, p. 2).

**Principle 3, Autonomy**, tells us that service recipients have a right to “self-determination, privacy, confidentiality, and consent” (AOTA, 2015, p. 4). [While the occupational therapy practitioner may know that the use of this adaptive equipment could lead to improvements in Mrs. Sanchez’ ability to dress herself and prepare healthy meals, Mrs. Sanchez needs to want that as well. In assuming that all people have the same wants, needs, and priorities, the occupational therapy practitioner violates **Principle 4, Justice**, which says that occupational therapy personnel should relate to individuals and groups in a “respectful, fair, and impartial manner” (AOTA, 2015, p. 5).

When the occupational therapy practitioner made the apparently unilateral decision to order adaptive equipment for Mrs. Sanchez without discussing this plan or considering the financial, cultural, or environmental contexts of the client and family, the occupational therapy practitioner violated the following ethical standards:

- **Standard 3J**, “Facilitate comprehension and address barriers to communication,” which can include differences in “language, literacy, and culture” (AOTA, 2015, p. 5). Was there a discussion with
Mrs. Sanchez about ordering equipment that would need to be paid for? If so, was she able to hear the discussion, and was she able to understand the discussion? When necessary, occupational therapy personnel must use the services of a translator or family member. Does Mrs. Sanchez’ culture value autonomy over getting help? Is there a stigma attached to admitting a need for help? Or is there a cultural expectation that family and caregivers will take care of a person, therefore eliminating the need to focus on increasing independence? (Wells, 2005).

- **Standard 3A**, “Respect and honor the expressed wishes of the recipients of service” (AOTA, 2015, p. 4) Was there an occupational profile and discussion of Mrs. Sanchez’ values and preferred occupations? She didn’t cook before her stroke; does she want to cook with one hand now?

- **Standard 3D**, “Establish a collaborative relationship with recipients of service...to promote shared decision making” (AOTA, 2015, p. 4) Did the occupational therapy practitioner work together with Mrs. Sanchez to determine goals for intervention and discharge planning? Did they discuss Mrs. Sanchez’ current environment and whether the equipment would fit in the home and relate to valued occupations?

- **Standard 3E**, “Respect the client’s right to refuse occupational therapy...” (AOTA, 2015, p. 4) Was Mrs. Sanchez given the opportunity to decline the equipment? Does Mrs. Sanchez’ cultural background make it difficult for her to say no to an authority figure?

**Discussion**

Several Western bioethical principles and concepts may be in opposition to certain values and beliefs of other cultures, which presents ethical conflicts and dilemmas. Culture affects many therapist–client interactions, but the participants may not perceive the interactions as culturally or ethically related. Western bioethics leans toward placing the self at the center of all decision making (autonomy). However, many cultures place the family, community, or society above the rights of the individual. The disclosing (truth telling) of a diagnosis of serious illness or disability to the client is not universally accepted. Many believe that the family, not the client, should make important health care decisions. Some people believe that health is maintained and restored through positive language. When disclosing risks of a treatment or approach, health care providers speak in a negative way (informed consent). Questions of race, ethnicity, and cultural beliefs are part of the equation when resources are finite or scarce (justice).

Ethical dilemmas can be further complicated by the unequal distribution of power in the relationship between the client and therapist. Clients and families faced with medical decisions are often subject to being over- or under-influenced by the health care system and providers. In the therapist–client relationship, the therapist has the ultimate responsibility for developing conclusions and proposing treatment. These issues can lead to dilemmas in which the practitioner must either accede to the family’s wishes or withdraw care. Respect for autonomy grants clients, who have been properly informed in a manner appropriate to their beliefs and understanding, the right to refuse a proposed treatment (Wells, 2017).

Without cultural humility, one can easily imagine the possible adverse consequences that can result when distrust, miscommunication, and misunderstanding interfere with the therapeutic relationship. The outcomes can range from frustration, confusion, or shame to anger in the client, family, and practitioner. Cultural ineffectiveness can result in compromised quality of care and client noncompliance with an intervention (Wells et al., 2016). Alternatively, cultural competence can produce a positive outcome for the client and a feeling of professional satisfaction in the practitioner from knowing that he or she helped a client at a time of need.
**Vignettes 3A and 3B**

**Vignette 3A.** The faculty in an OTD program were very impressed with Arthur during his interview and offered him a position. Charles remembered that a former classmate of his worked at the same university as Arthur had previously and asked her about him and his research on seniors aging in place. She said she did not remember anyone named Arthur, but there used to be a faculty member named Annette with the same surname who did research on that topic.

Arthur was assigned to colead a research course with Charles, but Charles said he had a scheduling conflict and switched sections. When both faculty members were assigned to the same committee to prepare for reaccreditation, Charles traded assignments with another faculty member. He often commented on Arthur’s clothes, saying “cute shirt” or “nice shoes” and brought him a birthday card with a pink unicorn on it. Arthur complained to the program director, who said Charles just had a strange sense of humor.

During a dressing skills lab focusing on one-handed techniques, a male student was struggling with the bra. Charles pointed to his colleague and said, “Dr. Wilson’s the expert.” The student laughed, saying “oh, he’s a real ladies man, huh?” “No,” replied Charles. “He’s a real lady, man.” When the student looked confused, Charles said to Arthur, “Tell him, Annette.” Arthur resigned from the faculty that day.

**Vignette 3B.** For two years Helene, an OTA pediatrics instructor, has identified on her professional development plan the need to strengthen her skills with intervention techniques for school-aged children on the autism spectrum. Jackie, a pediatric fieldwork educator, tells Helene that she and one of her coworkers were supposed to attend a great course next month in a state 1,000 miles away. The coworker is now unable to attend. If Helene can pay for the registration and airfare, she can share Jackie’s hotel.

The cost exceeds the budget, but the director received approval for those expenses. When Helene returned, she submits expenses for 3 nights in another hotel. When questioned about the extra expenses, Helene said, “I couldn’t stay with her. She’s, uh, you know, she’s a…lesbian. She really is a great pediatric treater, but I don’t know if we should send our students there for fieldwork anymore.”

**Application to the Code—Principles and Standards of Conduct**

- **Principle 6, Fidelity,** Tells occupational therapy personnel to “treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity” (AOTA, 2015, p. 7). There were multiple violations of this principle in both vignettes.

- **Standard 6A,** “Preserve, respect, and safeguard private information about employees, colleagues and students” (AOTA, 2015, p. 7). Both Charles and Helene violated this when they disclosed personal information about Arthur’s gender identity and Jackie’s sexual orientation.

- **Standard 6E,** “Be diligent stewards of human, financial, and material resources of their employers” (AOTA, 2015, p. 7). Helene exceeded her approved travel budget and did not inform anyone of the additional expenses until after the fact.

- **Standard 6F,** “Refrain from verbal, physical, emotional, or sexual harassment of peers or colleagues” (AOTA, 2015, p. 7). Charles may or may not have been joking when he made remarks to and about Arthur, but the comments were not funny to Arthur. Harassment is determined by the discomfort of the recipient, not the intent of the person who said or did it. Comments or actions
alluding to a person’s sexual orientation or gender identity can be perceived as verbal, emotional, or sexual harassment.

- **Standard 6G**, “Refrain from communication that is derogatory, intimidating, or disrespectful and that unduly discourages others from participating in professional dialogue” (AOTA, 2015, p. 7). No code of ethics can mandate that one has to agree with other people’s life choices, opinions, or behaviors. Ethical behavior does entail avoiding negative communication about those choices, opinions, or behaviors. Suggesting that the school stop sending fieldwork students to Jackie because of her sexual orientation is discriminatory against people in the LGBT (lesbian, gay, bisexual, transgender) community and shows disrespect for Jackie’s clinical expertise and her previous service to the school and its students.

- **Standard 6J**, “Use conflict resolution and internal and alternative dispute resolution resources as needed to resolve organizational and interpersonal conflicts” (AOTA, 2015, p. 7). The OTD program director violated this principle due to failure to act on Arthur’s complaints about Charles’s behavior. The director brushed it off and did not investigate or put a stop to the harassment. As a result, the program and its students lost a valuable faculty member and opened itself up to a potential lawsuit.

**Discussion**

Clinicians, students, and clients who identify as LGBT experience discrimination in school, the workplace, the health care arena, and the community. In many states throughout the United States, it is still legal for people who are LGBT to be denied service in restaurants or stores, and most states do not have legislated protection in the workplace against discrimination on the basis of sexual orientation or gender identity (Copti, Shahriari, Wanek, & Fitzsimmons, 2016). Types of workplace discrimination include termination of employment, denial of employment or promotion, negative performance evaluations, unequal pay or benefits, and verbal or physical abuse (Badgett, Lau, Sears, & Ho, 2007). Offering mandatory training or instituting nondiscrimination policies is a start, but the goal should be cultural competence and proficiency, not just “competent enough” (Rossi & Lopez, 2017).

Cultural competence in the workplace includes the language used in both verbal and written form, beginning with using a person’s preferred pronoun. Imagine not being able to talk with your classmates or colleagues about your family, your interests, or your travels because you are afraid to share that you have a same-gender spouse. Using gender-neutral language such as *spouse* instead of *husband* or *wife* can serve to help individuals feel more comfortable with their peers. Including scenarios in the classroom or in the workplace that involve same-gender partners or transgender individuals can help to destigmatize the LGBT population and facilitate cultural competence.

In this digital age, most people are plugged into some sort of social media. They are used to expressing their thoughts and opinions whenever they want and expect others to be interested in what they have to say. However, this spills over into interpersonal interactions that are not modified by emoji winks and LOLs (laugh out louds) or into written or transmitted interaction that, once seen by others, can never again be unseen. Personal information about such details about someone’s sexual partners, financial status, leisure interests, and religious or political beliefs are not for public knowledge unless the person himself or herself wants to share. This is true of all people but may be seen even more true in the LGBT community when people may fear being judged or when they have not yet “come out.” It is not the responsibility of anyone else to decide for them when and what to share with others.
Vignette 4

An occupational therapy practitioner working in an acute care hospital setting requests a day off work for observing a religious holiday. When a coworker hears about the upcoming day off, the coworker complains at a staff meeting in front of the manager, the practitioner who requested time off, and the other health care practitioners, stating, “Why should they get off an extra day? When do the rest of us get an extra day off so that we can play, eat, and spend time with our families?”

Application to the Code—Principles and Standards of Conduct

The Principle that specifically addresses relationships with colleagues in the Code is Principle 6, Fidelity, which states, “Occupational therapy personnel shall treat clients, colleagues, and other professionals with respect, fairness, discretion, and integrity” (AOTA, 2015, p. 7). The following Standards relate directly to the situation of insensitive colleagues:

- **Standard 6B** tells occupational therapy practitioners to “address incompetent, disruptive, unethical, illegal, or impaired practice that jeopardizes the safety or well-being of others and team effectiveness” (AOTA, 2015, p. 7) Complaining about coworkers and challenging the manager’s decision (which in fact had no bearing on the individual complaining) in front of all the staff does not set the tone for an effective team.

- **Standard 6G**, “Refrain from communication that is derogatory, intimidating, or disrespectful and that unduly discourages others from participating in professional dialogue” (AOTA, 2015, p. 7). Insinuating that a colleague gets preferential treatment is not only disruptive, it is disrespectful to the management who made the decision. Comments about another person’s religious beliefs or expression can be seen as derogatory and may serve to intimidate others from speaking up.

- **Standard 6M**, “Self-identify when personal, cultural, or religious values preclude, or are anticipated to negatively affect, the professional relationship or provision of services” (AOTA, 2015, p. 8). An individual who holds beliefs that have the potential to negatively affect the team dynamic or a supervisor–supervisee relationship needs to disclose that and use conflict resolution techniques and use the services of an unbiased third party.

Discussion

The occupational therapy practitioner in the scenario above has the right to be treated impartially regardless of religious affiliation. Although days off are not guaranteed by law, Title VII of the Civil Rights Act of 1964 “requires employers to reasonably accommodate the religious beliefs and practices of applicants and employees” (U.S. Equal Employment Opportunity Commission, n.d.). Although the manager in this vignette has accommodated the needs of the employee, the employee is harassed by a colleague in front of the team. The issues include how the practitioner should respond to the colleague, how the manager should diffuse the hostile situation, and how colleagues should approach cultural differences in the workplace.

Creating a diverse workforce of occupational therapy practitioners was one goal of the AOTA Centennial Vision (AOTA, 2007). As the U.S. workforce becomes more diverse, occupational therapy practitioners and students should be proactive in educating themselves regarding the cultural differences they will encounter and how to best respond sensitively to the cultural needs of colleagues and clients alike. This step in self-education is consistent with AOTA Core Values of Equality, Justice, and Dignity, and the AOTA Code of Ethics Principle of Fidelity (AOTA, 2015). According to the Occupational Therapy Practice Framework: Domain
and Process (3rd ed.; AOTA, 2014a), occupational therapy practitioners concern themselves with the meaning assigned by an individual’s culture to occupations and rituals that one values.

Just as clients are affected by their cultural backgrounds, practitioners view their contexts through their own cultural lenses. The practitioners in Vignette 4 are each approaching the situation with their own cultural biases. Unfortunately, the cultural bias of one employee is creating an environment of discomfort by singling out the employee who requested time off. A lack of cultural competence regarding one’s own religious practices among coworkers can create moral distress (Berlinger & Berlinger, 2017). Although an employee is under no obligation to educate colleagues about his or her cultural background, the practitioner who requested time off can consider whether it would be helpful to educate colleagues about one’s own religious or cultural practices to avoid misunderstanding in the future. Such education, whether completed informally in the break room or formally through an in-service, could assist one’s colleagues in staying true to ethical and professional obligations as outlined by the Code of Ethics (AOTA, 2015) and the OTPF–3 (AOTA, 2014a).

Employers have an obligation to their employees to create a work atmosphere that is inclusive and nonhostile (Lahiri, 2008). Managers can contribute to this inclusive atmosphere through requiring regular education to aid in developing competence in recognizing the value and importance of cultural diversity and the need to value employee relationships through a lens of cultural sensitivity (Lahiri, 2008). Education has proven effective in professional programs (Black & Purnell, 2002; Ghaddar, Ronnau, Saladin, & Martinez, 2013); the efficacy of educational programming for cultural competence in the health care workforce warrants further investigation. Moreover, managers have an obligation to correct and reprimand employees who are creating a hostile environment through insensitive comments.

Occupational therapy practitioners work as colleagues alongside individuals with a variety of cultural backgrounds. Occupational therapy practitioners have an obligation to educate themselves in regard to their own biases and cultural sensitivity, to treat other practitioners with respect, and to create a workplace culture of inclusion. If a practitioner such as the one in Vignette 4 recognizes the voice of intolerance in oneself, he or she is obliged to change his or her approach to interactions with colleagues based on the Code of Ethics (AOTA, 2015). Opportunities for reflection on one’s own culture and its impact on worldview provide an excellent place to start (Garran & Rozas, 2013; Berlinger & Berlinger, 2017). Sensitizing oneself to a variety of cultural backgrounds can assist a practitioner in becoming more aware of situations in which culture plays a role and ways in which the practitioner can diffuse cultural tensions and reach across cultural divides (Black & Purnell, 2002). Occupational therapy practitioners must learn to move beyond tolerance of diversity and “accept, respect, appreciate, and value it” (Black & Purnell, 2002, p. 9).

Conclusion

Occupational therapy practitioners must become culturally effective professionals. Direct service providers, educators, supervisors, researchers, and professional leaders must be mindful of the impact of cultural diversity in interactions with clients, families, students, and colleagues. The Code of Ethics recognizes that culture may influence how individuals cope with problems and interact with one another. Cultural competence builds on the profession’s ethical Principles of
Beneficence, Nonmaleficence, Autonomy, Confidentiality, Justice, Veracity, and Fidelity, as well as core values of Equality, Justice, and Dignity (AOTA, 2015).

Cultural humility is a basic reminder to all occupational therapy practitioners of their responsibility in protecting the rights of clients, their families, and colleagues and in acting as their advocates. Being culturally effective can help practitioners develop intervention approaches, health delivery systems, health policies, and workplaces that fully recognize and include the effects of culture on the ethics of health decisions (AOTA, 2014b). Sound ethical decision making will build trust, aid practitioners in integrating fair and equitable services, and ensure that services are holistic, contextual, and need-centered.

Cultural competence involves successful negotiation of cross-cultural differences through awareness, attitude, knowledge, and skills. (DTUI.com, n.d.). Cultural competence requires occupational therapy practitioners to enter into the therapeutic relationship with an awareness of their own culture and cultural biases, knowledge about other cultures, and skills in cross-cultural communication and intervention (Wells et al., 2016). Practitioners tend to make assumptions and judgments about individuals on the basis of their own particular culture, ethnicity, race, religion, sexual orientation, language, disability, or life experiences, and such assumptions and judgments can lead to improper intervention. When two values present themselves and a participant chooses one rather than another, that participant is saying, on the basis of his or her own cultural context and beliefs, that one value is more valuable than another (Iwama, 2003).

As individuals and professionals, occupational therapists and occupational therapy assistants take a particular action on the basis their own sense of right and wrong, values, knowledge, and skills. One’s values and beliefs can lead to emotional reactions when faced with cultural differences; therefore, an “attitude adjustment” is often necessary when striving to achieve cultural proficiency. Knowledge about different cultures helps practitioners avoid cultural gaffes and facilitates problem solving and ethical action. However, awareness, attitude, knowledge, and skills alone may bring practitioners only to the level of cultural precompetence, when one may have a sense that he or she is “competent enough.”

The interaction of clients and practitioners embodies a form of multiculturalism in which several cultures—including the health care profession, institution, family, community, and traditional culture—are all merged (Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003). It is necessary for occupational therapy practitioners, educators, and students to develop the skills needed to effectively manage differences, avoid discrimination, and foster inclusion, fairness, respect, and collaboration. Only then can a practitioner say he or she is culturally proficient.

References


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