TB & CULTURAL COMPETENCY
Notes from the Field
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Striving Towards Cultural Competence:

An Outreach Perspective

By Joan M. Crafton, Field Supervisor, Disease Control and Karen Galanowsky, Nurse Consultant

The following case comes from the most densely populated county in a state with a population of 8.5 million (2001 census estimate). There are over 180 different languages spoken by residents from many countries, particularly South and Central America, Mexico, Cuba, India, Pakistan, and Egypt. In 1999, sixty-seven percent (67%) of the TB cases in this county were from countries where TB is endemic. The challenge of providing culturally appropriate public health activities to this diverse patient population is one that staff at this county's chest clinic face daily. How can a TB public health workforce become culturally competent to provide quality outreach services to this diverse population?

The Challenge

Cultural competence may be defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Campinha-Bacote, 1995). There are three components of cultural competence: cultural awareness, cultural knowledge, and cultural skill. The details of the following case illustrate how one outreach worker used all three components to conduct TB control activities and directly observed therapy (DOT).

Meet the Patient:

A 27-year-old woman came to the chest clinic with a medical report. She emigrated to the U.S. from Pakistan one month prior to the clinic visit and spoke no English. A male family member explained that the patient was diagnosed with TB one year ago. With the male family member interpreting, the patient explained that she took 3 different medications daily for 5 months and then stopped taking TB medication on her own because she gained weight and felt better. During this initial visit, her chest x-ray showed left lower lobe consolidation. The patient was diagnosed with pulmonary TB and was placed on the first-line anti-TB drugs. A TB interview and DOT were assigned to an outreach worker (OW).

Cultural Awareness

The OW assigned to the patient arrived at her home and noticed that she lived in a two family house. The door was answered by an older Pakistani woman who spoke no English and made no eye contact. While waiting at the door, the OW noticed that there were dozens of shoes in the hallway, of all different sizes indicating that many people lived there. The OW observed many women

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peeking and then ducking out of the windows. The OW was not invited in. The OW left a business card stating that she would return the next day at 9 am. That night, telephone calls were made to the patient's home in an attempt to find out if anyone in the home spoke English. These calls were answered by non-English speaking women who promptly hung up the telephone. Although this initial visit was unproductive from an outreach perspective, the OW's cultural awareness proved essential for later success in working with this patient.

Cultural Knowledge

The behavior of the women observed on the first visit and the telephone calls to the home in the evening prompted the OW to learn about the Pakistani family structure and status of the women in the family prior to the next encounter. This information was obtained from a trip to the municipal library and through discussions with a colleague from the same culture. In addition to obtaining information about the culture, the OW was aware of the problem of cultural stereotyping. This new information gave the OW confidence in going to the home a second time.

Cultural Sensitivity

The next day, the OW returned punctually, and was greeted by a Pakistani male who spoke fluent English. Using what she learned about the culture the night before, the OW did not attempt to shake hands with the man nor make eye contact, as she usually would do. She learned that this man was the patient's brother-in-law and the spokesman for the head of the family, an older, non-English speaking Pakistani male. The spokesman invited the OW into the house. She asked permission to remove her shoes before entering. Once inside, the OW was culturally sensitive and did not move until cues or directions were received from the spokesman. The OW knew that rapport with the spokesman was critical. He was the key to the TB interview and future treatment of the patient. The TB interview was not conducted at this time. In order to obtain information that was reliable and valid, rapport had to be established first. The OW achieved this by observing behavioral patterns of the women in the house and accommodating her behavior to theirs. The spokesman told the OW where to sit and, although the patient was part of this meeting, she did not speak. The spokesperson answered questions and provided information for the patient during the discussion.

Cultural Skill

The following day, a third visit was made to the home and the OW was allowed to do the TB interview. Open-ended questions were asked about the patient and household

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Six steps YOU can take toward Cultural Competence

1. Involve patients in their own healthcare.
2. Learn more about culture, starting with your own.
3. Speak the language, or use a trained interpreter.
4. Ask the right questions and look for answers.
5. Pay attention to financial issues.
6. Find resources and form partnerships.

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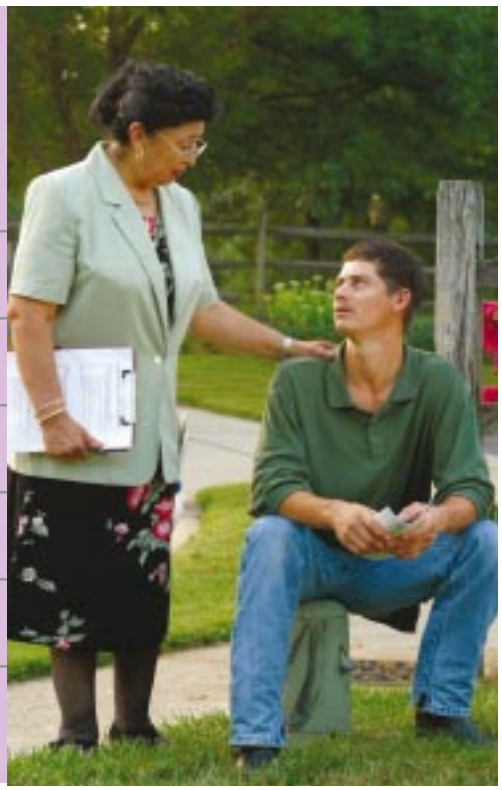

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members. The spokesman was very proud and eager to speak about his family. He provided the information so that the appropriate TB interview forms could be completed. During this interview, the spokesman stated that the patient had been symptomatic with cough, fever, chills, night sweats, weight loss, and loss of appetite for the last eight months.

This information was validated by the patient, who communicated, but only with the spokesman. This contradicted the information given to the nurse and physician during the initial clinic visit, but was important in determining the parameters of the contact investigation. Literature about TB disease was given to the spokesman. It was learned that the spokesman had minimal knowledge of TB and treated it lightly until the nature of the disease and outcome, if not treated, were explained to him. The need to have all household members tested was explained and discussed. The spokesman willingly gave all names and birthdates of household contacts. Two options were then given: he could bring the family members to the clinic or a nurse could come to the home do the tuberculin skin testing. The OW knew that giving options or choices empowers the patient/family and helps establish rapport.

Outcome

The second option was chosen, and a nurse went to the home the next day with the OW to do the testing. There were seventeen people in the household, excluding the patient; ten adults, eight children. Fifteen people were tested; some of whom were previously treated for TB disease. Seven out of the fifteen (47%) were tuberculin skin test positive. The spokesman ensured that all contacts would be brought to the chest clinic for medical evaluation and treatment. At the end of treatment the patient was 100% adherent on DOT.

Lessons Learned

Many lessons were learned from this experience. TB treatment and outreach activities traverse all cultural boundaries. The first step in providing outreach to patients from a culture unlike one's own is to become aware of beliefs and practices that are shared by the people of that culture. Cultural sensitivity and awareness of differences must be sincere. Second, it is essential to conduct the TB interview and contact investigation in the patient's living environment. Multiple visits are usually necessary to gain knowledge and build rapport with patients and their families. Third, healthcare workers must be aware of their own ethnocentrism. An individual's behavior is influenced by many things, not only cultural values and behaviors passed on from generation to generation, but also by religious values and life events just to name a few. Crossing the lines of difference is a journey, not an outcome. Awareness of how one's own culturally-based behavior affects expectations of others is often a good place to begin. Learning should continually occur from observations, discussions, and review of literature. Education about different cultural and religious beliefs and practices will be helpful in providing insight on how to behave and communicate effectively with patient/family members. However, armed with information, one must be careful not to fall into cultural stereotyping.

In conclusion, a TB healthcare worker in a city, county, or region which has culturally diverse populations must be genuinely interested and sensitive to the population in order to establish the rapport that is necessary to permeate the fear and distrust of an unfamiliar TB control system. The common denominator for success in working with any patient from any background is demonstrating sensitivity, respect, and courtesy in a way that is meaningful to the patient.

Communicating Across Cultures

By Helen Osborne, MEd, OTR/L,
President, Health Literacy Consulting

Excerpts from *In Other Words…*
Communicating with People from Other Cultures

Cultural values, beliefs, and assumptions influence healthcare. In every clinical encounter, providers decide what to say and what not to say, who to include in important discussions, how to provide patient teaching, and when to schedule follow-up care. When providers are working with someone from another culture, decisions may be influenced by assumptions and stereotypes about what people from different culture are like. If the assumptions are wrong, a person's health can be seriously jeopardized. When healthcare providers see only stereotypes and not the individuals, the result can have a major impact on treatment and care decisions.

In the hurried clinical environment, healthcare providers may make assumptions about how the cultural values and beliefs of people they treat affect their understanding of health information. These assumptions are often based on a person's birthplace, command of the language, color of skin, age, or appearance. "This tendency is not malicious," says Grace Clark, Coordinator of Diversity Initiatives at the Dana-Farber Cancer Institute in Boston, "but happens unconsciously. Inadvertently, the provider may make assumptions that language and culture will prohibit understanding." But the assumptions are not always right. In fact, Clark adds, "We might be right only about half of the time."

In the box below are 4 tips on how to talk with people who come from various cultures other than your own. Use these tips when you need to communicate important health information to someone whose experiences and understanding of life are likely to be considerably different from your own.

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As president of Health Literacy Consulting, Helen Osborne helps health professionals communicate in ways patients, families, and employees can understand. To learn more, or to read this article in its entirety, please visit the Health Literacy Consulting Web Site at www.healthliteracy.com

1. **Start by Examining Your Own Beliefs** To treat the individual and not the stereotype, you need to understand your own cultural beliefs about health. You need to know your own and your family's rituals, traditions, and biases. "Be aware," Clark says, "that some things you do or recommend may come from your own values." When they do, she adds, they may not match the values of the person you are providing care for. "You can't understand someone else's cultural complexities," she says, "without knowing yourself first."
2. **Learn What You Can About Other Cultures** As you learn about other cultures, however, stay aware of the fact that there are groups within groups. The people you meet from another culture may not match even what you have learned from careful study. Individual differences within a culture can lead to many confusing contradictions. These contradictions can get in the way of effective care unless you make a conscious effort to genuinely understand a patient's background.
3. **Work with the Decision Maker** Remember that the patient may or may not be the primary decision-maker with regard to treatment. Find out whether solely the patient, by the entire family, or by a designated family member, makes decisions. Identify the decision-maker, and include this person when important information is being discussed or when treatment decisions are being made.
4. **Be Creative** Find ways to compromise and work together. Be open to considering, for example, a treatment plan that includes both antibiotics and a spiritual advisor. By working together, providers and patients can find common ground for respectful treatment and care.

To learn more:

- **Diversity RX**
  www.diversityrx.org

Diversity Rx is a clearinghouse of information on how to meet the language and cultural needs of minority, immigrant, refugee, and other populations seeking healthcare.

- **Ethnomed**
  www.Ethnomed.org

Ethnomed is a resource for culture-specific patient education, including cultural profiles of about 10 different populations.

- **TB Education and Training Resources**
  www.findtbresources.org

This site, from the Centers for Disease Control and Prevention, is for healthcare professionals, patients, and the general public. The site can be used to search for TB education and training materials in various languages and to locate TB-related web links.

- **Cultural Diversity in Healthcare**
  www.ggalanti.com

Ms. Galanti's site is designed as an introduction to diversity issues in healthcare settings such as cross-cultural misunderstandings, and cultural competence.

Self-Assessment

This checklist is not intended to be a measure of cultural competence, but a tool for self-reflection. This checklist does not have an answer key with correct responses, but it can aid you in identifying specific areas where you may be able to improve your cultural sensitivity.

Directions:

Please select A, B, or C for each item listed below.
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical Environment, Materials & Resources

_____ I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

_____ I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

_____ For individuals and families who speak languages other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.

_____ I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, or other interventions.

Values & Attitudes

_____ I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

_____ I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

_____ Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

_____ I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

_____ I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially, and linguistically diverse groups.

The items to which you responded "C" indicate areas where there may be room to improve your cultural sensitivity.

Excerpted from a checklist developed by:
Tawara D. Goode, Georgetown University Center for Child and Human Development (June,1989; revised 1993, 1996, 1997, 1999, 2000, and 2002).
Email Wendy Jones at joneswa@georgetown.edu for permission to reprint any part of this checklist.

Suggested Reading:

"How Does Culture Influence Healthcare?" *Physician Assistant*, Volume 26 (4) April 2002, pp. 21-22, 25-37.

Our culture—how we think, perceive, and interact with others—influences how we seek and receive healthcare. Clinicians are advised to develop culturally sensitive approaches to caring. This article discusses how to provide an appropriate cultural assessment.

Please let us know what you think of this newsletter:

1. Did you find this newsletter easy to read? ❑ yes ❑ no

   Why?_____

2. Was the newsletter's length: ❑ too long ❑ too short ❑ just right

3. Will you apply anything from this newsletter to your current practice? ❑ yes ❑ no
   If yes, what specifically _____
   _____
   _____

4. If continuing education contact hours/credits were awarded for future newsletters, would you apply for them? ❑ yes ❑ no
   If yes, what type of contact hours_____

5. What topics would you like to see in future newsletters:
   _____
   _____
   _____
   _____
   _____

Would you be willing to contribute a case study or article? If so, please provide your contact information. Please fax this page to 973-972-1064. Thank you.

New Jersey Medical School
National Tuberculosis Center
A Founding Component of the International Center for Public Health
225 Warren Street, 1st Floor, West Wing • PO Box 1709
Newark, NJ 07101-1709
(973) 972-0979 • www.umdnj.edu/ntbcweb