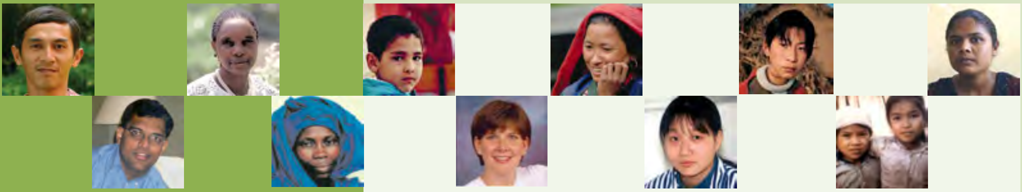
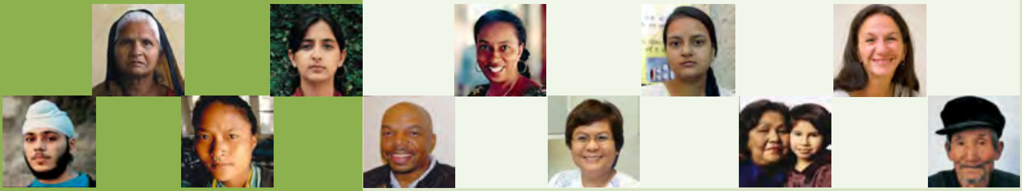


Cultural Competency and Tuberculosis Care

A guide for self-study
and self-assessment

NEW JERSEY
MEDICAL SCHOOL
GLOBAL
TUBERCULOSIS
INSTITUTE



Cultural Competency and Tuberculosis Care

A guide for self-study and self-assessment

The New Jersey Medical School Global Tuberculosis Institute is designated and funded by the Centers for Disease Control and Prevention as a Regional Training and Medical Consultation Center (RTMCC) in the United States.

Acknowledgements

We would like to thank the following individuals and groups who participated in development and review of this material:

Martha Alexander, MHS
Director of Education & Training
Bureau of TB Control
New York City Department of Health and Mental Hygiene
New York, NY

Stephanie Anderton
Refugee Health Field Representative
New York State Department of Health
Syracuse, NY

Maureen Donovan, RN
Nurse Consultant
Division of TB Control
Maryland Department of Health and Mental Hygiene
Baltimore, MD

Xiomara Dorrejo
Community Outreach Coordinator
Bureau of TB Control
New York City Department of Health and Mental Hygiene
New York, NY

April Garcia
Case Manager
East Metro Health District
(Gwinnett, Rockdale and Newton Counties), GA

Andrew Lanum, MPH
Prevention Specialist
Baltimore City Health Department
Baltimore, MD

Sandra Morano, RN
TB Coordinator
City of Stamford
Stamford, CT

Danielle Orcutt, MPH
Epidemiologist II
TB Control Program
Connecticut Department of Public Health
Hartford, CT

Karen Simpson, MSHSE
Director, Education & Training
Southeastern National TB Center
Gainesville, FL

Margaret Tate
Epidemiologist II
TB Control Program
Connecticut Department of Public Health
Hartford, CT

Kay Wallis, MPH
Special Projects Manager
Francis J. Curry National TB Center
San Francisco, CA

Kristina Ottenwess, MPH
Training Specialist
Southeastern National TB Center
Gainesville, FL

Robert Like, MD, MS
Professor and Director
Center for Healthy Families and Cultural Diversity
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, NJ

Anne Williamson, MS
Heartland National Tuberculosis Center
San Antonio, TX

Edward Zuroweste, MD
Chief Medical Officer
Migrant Clinicians Network
Staff Physician
Pennsylvania Department of Health

We would also like to thank the following individuals who contributed case examples to this material:

Bill Bower, MPH
Director of Education and Training
Charles P. Felton National TB Center
New York, NY

Joan Mangan, PhD, MST
Assistant Professor
Department of Medicine
University of Alabama
Birmingham, AL

This guide was developed by:

Lauren Moschetta-Gilbert, MA
Training and Consultation Specialist
New Jersey Medical School Global Tuberculosis Institute
University of Medicine and Dentistry
Newark, New Jersey

The following individuals at the New Jersey Medical School Global Tuberculosis Institute also contributed to the development of this material:

Nisha Ahamed, MPH
Program Director, Education and Training

Rajita Bhavaraju, MPH, CHES
Training and Consultation Specialist

Chris Hayden
Consultant, Evaluation Activities

Anita Khilall, MPH
Training and Consultation Specialist

Eileen Napolitano
Deputy Director

Mark Wolman, MA, MPH
Program Manager, TB Control

Suggested citation: New Jersey Medical School Global Tuberculosis Institute. *Cultural Competency and Tuberculosis Care: A Guide for Self-Study and Self-Assessment.* 2008: (inclusive pages).

This guide is available on our website at:
http://www.umdnj.edu/globaltb/products/tbculturalcompguide.htm

Table of Contents

Preface

Most of us are aware of our natural human tendency to classify and categorize things in our lives. Organizing and structuring information into smaller, more manageable sections helps us to quickly and effectively process the sheer volume of information available to us. Without this internal “filing system” we might be overwhelmed by information. Most of us are also aware that while this works with many types of information, it does not often work with information about people, who can defy easy or clear categorization.

Working in TB prevention and control requires that we develop the skills to work effectively with people from many cultures and backgrounds. In order to do this, it is beneficial to have information about our patients and their communities that will help guide us in these interactions. However, the individual nature and diversity of people makes accurately categorizing groups of people difficult. Further, the human tendency to categorize around race, ethnicity or cultural characteristics may sometimes lead to harmful stereotypes. Yet, the time we have available to accomplish our duties and tasks is often so limited that it may be tempting to use cultural categorical checklists and the like, which may appear to be valuable time management tools. Unfortunately, checklists and shortcuts often fail to recognize the uniqueness of individual people.

Think about your own cultural background and ask yourself how accurately a group of standardized cultural characteristics might apply to you. Diversity within groups and our individuality does not allow for this kind of categorization to work in a way that is helpful to us. So how then does one navigate interactions with people from multiple different backgrounds and cultures, especially when touching on topics that may be sensitive or emotional? In other words, how does one become “culturally competent?” In this self-study guide, we hope to begin to address this question and explore ways in which we can increase our cultural awareness and develop approaches which will promote working effectively with many diverse groups of people.

Introduction

The United States is becoming more and more diverse. There are many contributing factors in this evolution, including immigration, refugee resettlement, and the mobility of once minority and oppressed groups into various facets of our society. As a society we should be better prepared to deal with such positive changes; however, most of us acknowledge a feeling of a lack of preparedness at times.

Government studies around health disparities resulted in the 2002 Institute of Medicine (IOM) Report, *"Unequal Treatment – Confronting Racial and Ethnic Barriers in Health Care."* The report concludes that even with equal income and insurance benefits, racial and ethnic minorities tend to receive *lower* quality health care than non-minorities. This is especially significant for TB care since more than half of TB patients in the United States are non-US born. The report states the factors contributing to unequal treatment include: stereotyping, biases, and uncertainty on the part of health care providers. Thus, the report calls for ongoing cross-cultural training for health care providers.

Standards for Culturally and Linguistically Appropriate Services in Health Care

One of the first steps toward closing the health disparities gap as discussed in 2002 IOM report is the development of the Office of Minority Health's **C**ulturally and **L**inguistically **A**ppropriate **S**ervices in Health Care, or the **CLAS** standards. These national standards cover issues related to culturally competent care, support for organizational cultural competence and the implementation of policies that impact the provision of culturally competent care. The complete description of the standards is included in the Appendix.

Approaches to Cultural Competency Training and Education

Cultural competency training and education often takes one of two approaches: a **culture-specific** focus or a **culture-general** focus. The culture-specific approach focuses on the distinct features of individual cultures. Culture-specific information, some tailored for TB prevention and control, can be found through several resources which are listed in the resources section of this guide. The culture-general approach focuses on gaining awareness of broad cultural issues, more likely to be common to many cultures.

This cultural competency self-study guide will utilize the culture-general approach, providing you with a general overview of cultural competency, its role in health care and more specifically, in TB prevention, control, and care.

Culture-specific, TB-related information is available from several sources, including other Tuberculosis Regional Training and Medical Consultation Centers and the Centers for Disease Control and Prevention (CDC). Information on these products and additional sources of culture-specific information can be found in the resources section of this guide.

About This Guide*:*

This guide is an introduction to cultural competency in the context of TB control activities. We encourage you to seek local cultural competency training opportunities as well as web-based cultural competency training. Possible sources for web-based training are also listed in the resources section of this guide.

Objectives of this guide:

After reading this self-study guide, you should be able to:

- Define cultural competency.
- Describe why standards for cultural competency in health care exist.
- Recognize why cultural competency is important for TB prevention and control.
- Explain the stages of cultural competency development.
- Assess (informally) your own level of cultural competency development.

- Assess (informally) elements of your own communication style.
- Recognize how your own communication style may impact cross-cultural TB patient encounters.
- Describe the attitudes, knowledge, and skills necessary for developing cultural competence.
- Cite at least three resources of cultural competency information.

Throughout this guide, you will see helpful ***Tips*** and ***Quotes*** highlighted in text boxes. The tips are excerpted with permission from *10 Tips for Improving the Caregiver/Patient Relationship Across Cultures* by Suzanne Salimbene and Jacek W. Graczykowski. The quotes in this document are from a cultural competency focus group convened at the 2003 Northeast TB Controllers Meeting with public health nurses and TB program staff and coordinators.

The importance of acknowledging and understanding cultural differences is a critical factor in the provision of TB care that addresses the needs of the diverse and changing population in the United States. We hope that this guide will serve as useful tool in this effort.

Part I – Culture

1. What is Culture?

What do we mean when we refer to culture? The meaning of the word *culture* has been widely debated and broadly defined. Below is the definition that guided the development of the CLAS standards:

> ***"Culture refers to integrated patterns of human behavior that include the language, thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups."***
>
> Source: The National Standards for Culturally and Linguistically Appropriate Services in Health Care, adapted from Cross T, Basron B, Dennis K, Issacs M. 1989.

Or, stated more succinctly:

> ***"Culture is defined as the learned and shared values, beliefs and meanings that form the lens or perspective through which an individual understands and interprets their experience."***
>
> Adapted from: Fitzgerald MH, Mullavey-O'Byrne C, Clemson L. Cultural issues from practice. *Aus Occ Ther J*. 1997; 44: 1-21. and Helman CG. Culture, health and illness. 4th ed. New York: Oxford University Press; 2001.

Culture is shaped by our life experiences and events and contributes to our beliefs, values, attitudes, and behaviors. Culture may also impact the ways in which we communicate, both verbally and non-verbally, as well as how we respond to information. It is impossible to name all the ways culture influences our lives.

Culture should not be considered foreign or about "other" people. It is about all of us because we are all part of multiple cultures. Consider the fact that our ancestors likely came from many other countries, with which we associate our ethnic or cultural background. We also associate and identify with specific religions, professions, and social groups. All of these concepts combined, and more, make up an individual's "culture." "American" culture is influenced by the many cultures that co-exist in this country. Considering culture as belonging only to non-US born individuals only serves to distance ourselves from others rather than connect us to them.

1a. What is Cultural and Linguistic Competence?

> ***"Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations."***
>
> Source: The National Standards for Culturally and Linguistically Appropriate Services in Health Care, adapted from Cross T, Basron B, Dennis K, Issacs M 1989.

On an individual level, the above quote encompasses treating patients in a way that is consistent with and respectful of their unique cultural needs, beliefs, and risk factors. This includes the ability to either speak with limited English-speaking patients in their own language, or to use a qualified interpreter who can do so.

Examples of descriptive terms often used in place of cultural 'competence' include:

- Cultural sensitivity
- Cultural responsiveness
- Cultural awareness
- Cultural effectiveness
- Cultural humility
- Cultural literacy

Cultural competence, however, implies lifelong learning of all these concepts with the added component of *effectively operating* in various cultural contexts.

On an organizational level, this means providing health care professionals the tools and services they need to facilitate culturally competent care. The CLAS standards address specific goals for culturally competent organizations which include ongoing staff education in culturally and linguistically appropriate care, implementing strategies to retain a diverse staff representative of the population it serves, to have available appropriate language assistance services, and to provide written materials in languages spoken and read by those seeking health services through the organization. For a complete list of recommendations specific to organizations please see the Appendix.

1b. The Role of Culture in Health Care

Culture may have a significant influence on our beliefs about health. Our individual perceptions of illness and the severity of symptoms may depend on our beliefs about what it means to be healthy. For example, an individual may believe that in order to be healthy, one must maintain balance and harmony in his or her mind and body. Therefore, if he or she experiences depression, or has aches and pains, he or she may look for reasons that point to an imbalance in this emotional or physical life. This person may attribute the symptoms to working too much, staying out too late, or excessive worrying. These symptoms could also be attributed to a physical or spiritual imbalance that is less familiar in Western concepts of health. This could be an imbalance in essential life forces in the body, such as *chi* (the life force in Taoism or traditional Chinese medicine) or the *doshas* (the three vital energies in traditional Ayurvedic medicine).

Since cultural norms may influence our perception of health and illness, they may also impact the following aspects of our decision to seek care:

- When to seek care
- Where to seek care
- From whom to seek care

Our training as health care professionals provides us with theories and practices that will, at times, be in conflict with the people for whom we provide care. As we educate our patients and negotiate TB treatment, we should keep in mind that information and suggested treatment may be in direct opposition with long standing religious and cultural values, even when patients appear to accept our recommendations. Health beliefs will be discussed again in Section 2 of this guide.

1c. The Role of Culture in TB Control and Prevention

We already know the population affected by TB is very diverse. TB affects a disproportionate number of non-US born individuals, migrants, people who travel extensively to and from TB-endemic countries, racial and ethnic minorities, the elderly, and other distinct groups. Currently, over half of all TB patients in the United States are non-US born. The top three countries of origin for TB patients living in the US are Mexico, Philippines and Vietnam, respectively. As such, our patients often come to us with diverse concepts of illness and health care. Knowing how to *uncover and attend to* these concepts and expectations for care will inform how to effectively work with TB patients.

While local TB epidemiology varies greatly from area to area, these patterns show us that cultural competency is important for TB control work in all geographical locations. For more information on the distribution of TB in your area, contact your state or big city TB control program or review the document *Reported Tuberculosis in the United States* (released each year), on the Centers for Disease Control and Prevention, Division of Tuberculosis Elimination website at: http://www.cdc.gov/tb/surv/default.htm

1d. The Role of the Health Care Professional in the Context of Culture

Quote: *"Don't think you can get a cookbook of whatever culture you're working with, because it just doesn't work. Be open and sensitive to whomever you're dealing with at that point. Be careful of preconceived ideas. You really have to start from scratch right then and there, or in the here and now."*

– Public Health Nurse

The role of the health care professional in the context of culture is to provide the best possible care in a way that is most acceptable to the patient. This involves the application of general cultural information as hypotheses not stereotypes. We are not expected to be culture experts. Treat all "facts" learned about cultural variables as *possibilities*. The best source of cultural information is the patient. Take care not to make assumptions and to try and turn the "facts" into questions.

Tip: Allow the patient to be open and honest. Do not discount beliefs that are not held by Western biomedicine. Often, patients are afraid to tell Western caregivers that they are visiting a folk healer or are taking an alternative medicine concurrently with Western treatment because in the past they have experienced ridicule.

Source: 10 Tips for Improving the Caregiver/Patient Relationship Across Cultures. When Two Cultures Meet: American Medicine and the Cultures of Diverse Patient Populations, Book 1, What Language Does our Patient Hurt In? An 8-Part Series of Practical Guides to the Care and Treatment of Patients from Other Cultures. Salimbene S, Graczykowski, Amherst, Mass: Inter-Face International. Amherst Educational Publishing; 23-25. 1995.

Questions are central to TB control and care, and may play an even more essential role when working with people whose culture differs from ours.

When gathering relevant cultural information that may assist in making TB care and treatment more acceptable to patients, it may be helpful to ask:

- What do you think will help to cure your TB?
- Apart from me, and the [nurses] and [doctors] who *else* do you think can help you get better?
- Are there things that make you feel better, or give you relief, that [nurses] or [doctors] don’t know about?

Adapted from Pfifferlling JH. A cultural prescription for medicocentrism in Eisenberg L, Kleinman A., eds. *The Relevance of Social Science for Medicine.* Dordrecht, Holland: D. Reidel, 1981.

These questions are examples of ways to explore the patient’s ideas about TB treatment. These specific questions may not be relevant in every patient encounter. However, these questions may help elicit information from a patient who may be hesitant to discuss alternative treatment ideas out of respect for the health care professional. When asked with genuine curiosity and warmth, these questions can also demonstrate the health care professional’s interest in obtaining the best possible care for the patient.

It is important to remain open, listen to the patient and respond appropriately. For example, if the patient suggests unfamiliar or unusual tests, procedures, or drugs in answer to the question about what they think will cure their TB, you could ask them to describe more about the tests or treatment and how they will help. We will discuss questions further in the section “Asking Questions” on page 28.

2. Developing Cultural Competence




Cultural competence involves the development and integration of certain **attitudes, knowledge, and skills**. To really be effective, we need to incorporate aspects from all three domains. For instance, even if we have an open, accepting attitude, without certain knowledge and skills, it may not be enough to ensure a productive and satisfactory patient-provider experience. Consider the following four elements necessary for developing cultural competence. Answer the included questions to assess (informally) your level of development.

Awareness of one's own cultural values

- Recognition and understanding of the origins of our own cultural values and how they impact our behavior, particularly during patient interactions
  - **Ask yourself** ⇨ Are you aware of and attentive to your own preconceived notions of other cultural groups?

Awareness and acceptance of cultural differences

- Recognition that people of different cultures have different ways of communicating, behaving, interpreting, and problem-solving
  - **Ask yourself** ⇨ Do you look for opportunities to meet and interact with individuals who are from cultures other than your own?

Development of cultural knowledge

- Recognition that cultural beliefs may impact patient health beliefs and health-seeking behaviors, including interactions with health care professionals, and adherence to prescribed regimens
  - **Ask yourself** ⇨ Are you familiar with the worldviews and health concepts of cultural groups other than your own?

Ability to adapt practice skills to fit the cultural context of the patient

- An ability and willingness to adapt interactions and interventions to more closely fit the patient's cultural expectations for care
  - **Ask yourself** ⇨ Do you have the know-how to navigate cross-cultural patient interactions?

2a. Attitudes

The idea of *attitude* can sometimes seem abstract and subjective. But remember, one's attitude can be conveyed both verbally and non-verbally. It can be communicated through tone of voice, choice of words, eye contact, body posture, hand gestures, etc. As health care professionals, patients' perceptions of our attitudes toward them or their belief systems are important determinants of successful patient interactions and outcomes. As stated by Dr. Amy Blue of the Medical College of South Carolina, if a patient senses that a health care professional discounts, disapproves, or ridicules his or her health beliefs, the patient may withhold important health information and may not return for care. This can have critical implications for TB prevention and control.

> **Quote:** *"I don't know if you can call it a skill, but one thing I find important is just the ability to keep an open mind – also your powers of observation are key."*
>
> *– Outreach Worker*

Our attitudes influence our ability to engage in effective, respectful communication. The following attitudes may facilitate this process:

- **Lifelong commitment to continuous learning**
  Every patient encounter is a learning opportunity. Approaching each encounter with this attitude can transform preconceived attitudes.

- **Open-mindedness and respect for all**
  Having an open mind involves the willingness and ability to listen and acknowledge another person's point of view. Listening to and addressing patient fears, concerns, and challenges is part of *demonstrating* respect for that patient.

- **Humility**
  Although we may have years of education or years of work experience or both, we may not know everything! We can be both confident and humble. These attitudes together convey strength and openness.

- **Curiosity**

  A genuine curiosity about people and culture will help fuel an ongoing development of cultural knowledge.

- **Empathy**

  Attempting to "put yourself in the other person's shoes" helps soften the approach to patients and builds rapport.

Tip: It may not be appropriate to treat the patient in the same manner you would wish to be treated. Culture often determines the roles for polite, caring behavior and will formulate the patient's concept of a satisfactory relationship.

Additional Thoughts on Respect

Respect is a key element in building rapport with a patient. Keep in mind:

- Respect must be *perceived, recognized,* and *felt* by the patient if it is to be effective.
- Communication of respect does *not* necessarily transcend culture.
- A patient's idea of respectful behavior may not be the same as yours.
- Behaviors considered polite and respectful in American or Western culture, such as a handshake, looking someone in the eye, or using a "friendly" first name greeting, may be viewed differently by someone from another culture.
- We cannot know what is considered respectful behavior for every culture, but we can learn these things from our patients.

> ***Quote:*** *"I used to read all the cultural background information I could before going into someone's home. But I often didn't find the information I needed. I want to know what the culture of the family is. How do the members interact? Who has the authority? Who is the person you are supposed to show respect to when you come in the door? Is it the older person, the woman, the man? Those things are really important and can only be learned from the patient or family"*
>
> *– Nurse Case Manager*

The *Values and Attitudes* section of the Self-Assessment Checklist on page 15 provides a good summary of respectful perspectives and approaches to patient care.

2b. Knowledge

i. Self-Awareness

Sensitivity to and awareness of various factors that shape a person's identity is important for developing cultural competence. This sensitivity and awareness facilitates one's ability to meet the health care needs of individuals from diverse cultures. Developing this sensitivity often starts with *self-awareness.*

Self-awareness involves the ability to recognize your own individuality and the elements that make up that individuality. Once familiar with these elements in ourselves, we are better equipped to recognize and appreciate individuality in others.

As we develop self-awareness, we should be mindful of *ethnocentrism* and guard against ethnocentric thinking.

Ethnocentrism: *The assumption that the beliefs, values, norms and behaviors of one's own culture are the correct ones and that those of other cultures are inferior or misguided.*

Source: The California Endowments Principles and Recommended Standards for Culturally Competence Education of Health Care Professionals

Developing Self-Awareness

You may be thinking: "Where do I begin?" It can be helpful to consider such topics as:

- Your family origins; when, how, and why your ancestors or you arrived in this country
- Your values around issues like time, personal space, and communication
- Family roles and relationships

For consideration: How might these variables differ among people from cultures other than your own or among other people in general?

Another component of developing self-awareness involves assessing where you currently stand on the path of developing cultural competence. Use the **Self-Assessment Checklist** to uncover specific areas where you may be able to improve your cultural sensitivity. There is no answer key with correct responses. The checklist is intended to be only a tool for self-reflection. It is not intended to be an actual measure of cultural competence.

ii. Self-Assessment Checklist

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

To the degree that I am able:

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

☐ I ensure that printed educational 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 or dialects 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, home visits, or other interventions.

☐ I attempt to determine any familial colloquialisms (jargon or slang) used by individuals or families that may impact on assessment, treatment or other interventions.

I understand the principles and practices of linguistic competency and:

- ☐ Apply them within my work or program.
- ☐ Advocate for them within my program or agency.

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, god parents).
- ☐ I accept and respect that gender roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, expected social interactions).
- ☐ 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 expectations of children within the family).
- ☐ Even though my professional or moral viewpoints may differ from persons I serve, 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 understand that the information described above should be considered theory rather than fact.

- ☐ I accept that religion and other beliefs may influence how a family responds to illness, disease, disability, and death.
- ☐ I pursue professional development and training opportunities 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.

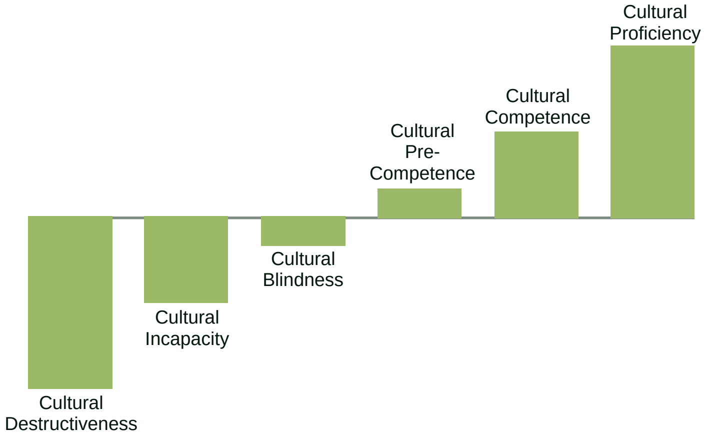
Adapted and reproduced with permission from a checklist developed by: Tawara D. Goode, Georgetown University Center for Child and Human Development – Adapted from Promoting Cultural and Linguistic Competence and Cultural Diversity in Early Intervention and Early Childhood Settings and Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children with Special Health Care Needs and their Families – (June, 1989; revised 1993, 1996, 1997, 1999, 2000, 2001).

iii. Stages of Cultural Competence

As stated earlier, cultural competency is not an ending point. "Competency," despite the finality of the word, is not something one achieves, but rather, something that continually develops through a lifetime of learning.

To help further identify your level of development in this area, consider the following stages of cultural competency. Read through the description of each stage and note the descriptions with which you identify. Keep in mind that we do not often fit neatly within one category, and we can circle back through categories over time, or before moving forward.

- Individuals in the **cultural destructiveness** phase view their own culture as superior, believing other cultures should conform to the mainstream or be eradicated.
- Individuals in the **cultural incapacity** stage lack cultural awareness and skill (often fostered by being raised in a homogenous society, taught to behave in certain ways, and not to question why). In this phase, there is still belief in the superiority of the dominant group and the maintenance of stereotypes.
- Individuals in the **cultural blindness** stage see others in terms of their own culture. These people regard all others as the same and think they should be treated in the same manner.
- **Cultural pre-competence** involves recognition of cultural differences. In this stage, a person begins to seek education about these differences.
- Individuals in the **basic cultural competence** stage accept, appreciate, and accommodate cultural differences, and appreciate the influence their own culture has in relating to others.
- During the **advanced cultural competence** stage, one begins to actively educate less informed individuals about cultural differences, seeks out knowledge about other cultures, and develops skills to interact in diverse environments.



Source: Cross T, Cultural Competence Continuum, *Focal Point*, Fall 1988.

Tip: Begin by being more formal with patients who are from a culture different from your own. In most countries, caregivers maintain a greater distance from patients. Except when treating children or very young adults, it is best to use the patient's last name when addressing him or her.

iv. Beyond Race, Ethnicity, and the Foreign-Born

Often, health care professionals come into contact with people of many races, from many different cultures. This is especially true for those working in TB control and prevention. The nature of TB control work often requires a high level of involvement in patients' lives. Directly observed therapy (DOT) places health care workers in patients' homes several times per week. Contact investigations require patients to share details about their lifestyles, relationships, and work.

In order to effectively engage patients in this process, we need to remember that culture is not simply equal to race. Patients who are of similar ethnicity, skin color, language, or country of origin as the health care worker may still be hesitant to engage in dialogue and care due to issues of trust or fear of being judged.

A short list of groups having their own culture, transcending categories of foreign-born or race might include:

- Religious communities
- Gay and lesbian communities
- The homeless population
- Substance abusers
- The transgender community
- Residents of correctional facilities
- People with disabilities
- Refugees or people with a history of oppression

Quote: *"Some of our patients are refugees who come from places where their lives were in danger. We represent the government to them. I think that was the hardest thing I had to overcome; trying to make people understand that I am here as a friend. It's really hard for someone who has fled their own government to have a government person come and say – I'm your friend, I'm here to help you."*

– Program Manager

v. Health Beliefs

Health beliefs are culturally-based belief systems about what determines a person's good health as well as the cause and treatment of illness and disease.

Patient beliefs about TB may differ from the medical model in which most health care professionals are trained. These beliefs may include:

- Ideas from modern or holistic medicine
- Ideas that have mystical origins
- Ideas that have religious origins
- Ideas that have superstitious origins
- Ideas that are based in astrology

This may include beliefs about how TB is transmitted, how TB is treated, and the significance the disease has for the affected person. The long history of TB has led to various theories about its cause, including beliefs that certain factors, such as smoking, pollution, or hard labor may cause TB and contribute to its progression. Furthermore, remedies for symptom relief and cure of the disease can vary. It is important to respect patient health beliefs while providing information about the rationale for medical TB treatment in a non-judgmental fashion. In order for treatment to be successful, the patient must agree to take TB medicines. Traditional or folk medicine can complement Western medicine, but should be overseen by the treating clinician.

vi. Western and Non-Western Cultural Dynamics

The table below is a summary of some key fundamental differences that may exist between Western and non-Western cultures, including a comparison of core health beliefs and practices. Clearly not all individuals from Western or non-Western cultures will have all of these practices or beliefs, but the table can be a useful starting point.

Cultural Dynamics Influencing the Clinical Encounter

American/Western Cultures	Concepts	Non-Western Cultures
• Health is absence of disease • Seeks medical system to prevent disease and treat illness • Seeks specialty practitioners (e.g., physicians, nurses, psychiatrists, surgeons, etc.) • Foods used to affect biological functioning	**Core Health Beliefs and Practices**	• Health is a state of harmony within body, mind, spirit • Seeks medical system when in acute stage of illness • Seeks herbalists, midwives, santiguadoras, curanderos, priests, shamans, espiritistas, voodoo priests, etc. • Prevention of disease is not a recognized concept • Foods used to restore imbalances (hot/cold, yin/yang)
• Values individualism; focus on self-reliance and autonomy • Values independence and freedom • Values youth over elderly status • Personal control over environment and destiny • Future oriented • Efficiency: time is important; tardiness viewed as impolite	**Cultural Values, Norms, Customs**	• Values collectiveness: reliance on others and group acceptance • Values interdependence with family and community • Values respect for authority and elderly status • Fate controls environment and destiny • Present oriented: here and now • Efficiency: time is flexible

Cultural Dynamics Influencing the Clinical Encounter		
American/Western Cultures	**Concepts**	**Non-Western Cultures**
• Greeting on first-name basis denotes informality and builds rapport • Being direct avoids miscommunication • Eye contact signifies respect and attentiveness • Personal distance denotes professionalism and objectivity • Gestures have universal meaning	**Communication Styles**	• Greeting on first-name basis denotes disrespect • Being direct denotes conflict • Eye contact may be considered disrespectful • Close personal space valued to building rapport • Some gestures have taboo meanings depending on cultural subgroups
• Individual interests are valued and encouraged • Individual is the focus of health care decisions • Reliance on nuclear family bonds	**Family Dynamics**	• Individual interests are subordinate to family needs • Family is the focus of health care decision-making • Reliance on nuclear and extended family networks

Source: Office of Minority Health

Examples of values that may be viewed as reflective of traditional American values are:

- Achievement
- Success
- Independence
- Progress
- Material comfort
- Practicality
- Equality

To each of these traditional “American” values, there are likely to be alternative values in other cultures. Indeed, in many American families there are probably alternatives to these values.

However, Western health care disciplines often reflect these traditional values. As health care professionals, we must guard against proceeding in our daily work without questioning the assumptions that may be derived from these values.

2c. Skills

i. Cross-Cultural Communication

Communication is complex, involving much more than just words. It involves the exchange of information and the creation of meanings. No two people will ever attach the same meaning to the same message which can make effective communication both challenging and interesting!

The success of TB control activities is directly related to the health care professional's ability to develop and sustain positive relationships with TB patients. Communication is the foundation of that relationship.

We also need sharp written and verbal communication skills in order to carry out basic functions of TB control work. Some of these basic functions include, but are not limited to:

- Locating patients
- Interacting with third parties
- Conducting patient interviews
- Assessing patient expectations
- Structuring patient-provider interaction
- Demonstrating respect
- Carrying out DOT
- Providing health education
- Responding to patient concerns

Effective cross-cultural communication involves awareness and sensitivity to:

- Non-verbal cues
- Body language
- Gender roles
- Face-saving needs (which can be viewed as the need to maintain or preserve one's dignity, self-respect, or good reputation)

Differing communication styles, the presence of a foreign accent, or dialect differences can pose communication challenges for both the health care professional and patient. If the patient's ability to speak the language spoken by the health care worker language is limited, then an interpreter is necessary. A good resource for guidelines on using an interpreter is the video: *Making the Connection: An Introduction to Interpretation Skills for TB Control* produced by the Francis J. Curry National TB Center.

General techniques for effective communication are outlined below. These techniques can be particularly useful in cross-cultural patient encounters.

Technique	Reason	Example
Make an attempt to correctly pronounce patient's name.	• This demonstrates respect and assists in building rapport.	"Hello Mr. Smythe." "Am I pronouncing your name correctly?"
Learn a common greeting in patient's language.	• This can ease tension and show sensitivity to patient's culture and language.	Kumusta Ka? (How are you in Tagalog)
Speak slowly and clearly using short sentences.	• English may not be patient's first language. • The patient or health care worker's accent may be hard to understand. • Diagnosis may be stressful and confusing. • Provide an opportunity for increased patient understanding.	"What do you know about TB?" "TB can be cured."

Technique	Reason	Example
Use non-technical words and phrases.	• Some multi-lingual patients may internally translate phrases into the language with which they are most comfortable. • Phrases, particularly “sayings” with figurative meanings will change meaning when translated. • Avoiding local jargon and medical language will ease communication.	Use the words the patient uses. If the patient says “bad stomach” resist the urge to replace the phrase with a medical term.
Check for patient understanding using open-ended questions.	• Absence of questions does not always indicate understanding. • In some cultures it may be considered impolite or disrespectful to ask questions of a health care provider.	“Tell me about how you take your medicine.” “I’d like to hear from you. Tell me what we talked about during our meeting today.”
Use written information.	• Sometimes even if English is not the patient’s primary language, it may be easy for them to write. If not, try to obtain phonetic spellings (spelling it the way it is pronounced) of important information such as names and addresses of contacts based on what the patient states. This can be helpful when asking additional details about certain contacts and when interacting with any named contacts later.	If a patient seems unwilling to share information on contacts with you, say, ”Would you prefer to write the list down on this paper?”
Give explanations and acknowledge the sensitive nature of some questions.	• Modesty is highly valued in some cultures.	“The next few questions I need to ask you are somewhat sensitive. I apologize for this, but the information is important for me to be able to provide you with the best treatment.”

Technique	Reason	Example
Listen to patient stories; the answer to your question may be in there.	• Storytelling can hold special significance in some cultures. • Patients sometimes use stories to convey beliefs or behaviors they think will cause a negative reaction, or to explain something they may not be comfortable saying directly.	Patients may provide examples of family or friends who had "bad things" happen to them because of sheer luck or misdeeds. This may provide insight into what patients are feeling in terms of why they got sick. Patients may also talk about others' who have gotten cured through non-traditional means.

ii. Communication Style Inventory

Assess *Your* Communication Style

In working with a variety of patients, your communication style may at times be incompatible with the expectation the patient has of a good patient-health care worker relationship, or the way they themselves prefer to communicate. The following assessment tool can help you determine your communication style and provides some approaches that may be helpful in addressing or resolving these differing expectations.

This tool looks at how you use words, understand meaning through non-verbal communication, analogies, and stories, and handle information exchange in reaching the objectives of your health care encounter. However, this tool can be equally useful for assessing how your patient is communicating with you based on the same criteria. This is not a scientific assessment. It should be considered a tool in the development of self-awareness. As you review the tool, consider your own communication style and which side of the scale you tend towards.

Continuum of Communication Styles

Degree of Directness

Direct	Indirect
You say what you mean and mean what you say – the truth is more important than sparing someone’s feelings.	You prefer an indirect style. Others may have to read between the lines to understand your meaning. The truth, if it will hurt, should be tempered.

Role of Context

Low Context	High Context
You are comfortable in an individualistic, low-context cultural background where little is assumed, therefore messages are explicit. Words are the primary means of communication. Non-verbal cues are NOT the key to understanding.	You are comfortable in high context cultural backgrounds where there is inherent collective understanding. The spoken word is NOT the primary means of communication. Non-verbal cues and context are key to understanding. What is NOT said is often the intended message.

Importance of Saving/Losing Face

Least Important	Most Important
Face is somewhat important, but the facts are more important than being careful about what you say. Information exchange is the overriding goal of communication. Criticism is straightforward. Saying “no” and confrontation are acceptable.	Face is of utmost importance. Saving face takes precedence over the “truth.” Maintaining harmony is the goal of communication. Confrontation is avoided, saying no is difficult. Criticism is handled very delicately. What is said and what is felt are often not the same.

The Task or the Person

The Task	The Person
The task and the person are separate. Establishing rapport and a good personal relationship is not essential to getting the job done. The goal is accomplishing the task at hand.	The task and the person cannot be separated. A good personal relationship is a prerequisite to getting the job done. Conversation typically begins with small talk and then moves to business. The goal is building the relationship.

Reprinted from *Culture Matters* with permission from the Peace Corps, Washington, DC. 1997

For consideration: What communication challenges may arise when interacting with a patient whose communication style differs from yours on the degree of directness?

In general, if you fall more into the categories on the left side for most variables, you prefer a more direct communication style, and perhaps are more determined to accomplish your health care objectives more quickly. If your patient also falls into the left-sided area, then you may be likely to have smooth interaction. If he or she tends more to the right, then you may need to use more relationship-building approaches and take some additional time to build rapport with the patient. You will need to be observant and derive meaning from among other things, the patient's body language and, perhaps, presence of silence, or hesitation to speak. All this can be done while still preserving the objectives of information exchange and patient care.

iii. Asking Questions

The best source of patient-related cultural information is the patient. As health care professionals, we are accustomed to always having an answer. But in this case, asking questions *is* the answer.

> *"How a question is asked affects its effectiveness."*
> *(Dillon, 1997; Hunkins, 1995)*
>
> *"When questions stimulate a person to think, a deeper level of understanding takes place."*
> *(Jarolimek & Foster, 1989.)*

Asking questions, particularly regarding cultural information, does not reflect poorly on the public health professional. Rather, asked appropriately, questions reflect respect, interest, and care. It is important to use a conversational tone when asking questions. Remember that your efforts are aimed at developing rapport through the demonstration of respect for important cultural variables.

> ***Quote:*** *"…sometimes patients and their families very much enjoy teaching us about the way they do things. So it's a good idea to elicit that by asking: What does this mean in your culture?"*
>
> *– Disease Investigator*

Question Styles

- **Closed-ended questions**

  Questions that can only be answered using "yes," "no," or with a specific piece of information are closed-ended questions. These questions are best used to obtain specific pieces of information and should be avoided during the initial interaction with the patient (except when seeking identifying information). A closed-ended question is quick to answer and easy to document. This type of questioning is good for regaining or maintaining control of an interaction, obtaining clarification, or getting discussion back on track.

- **Open-ended questions**

  For most other situations, it is best to use an open-ended questioning style. Open-ended questions are those that:

  - Cannot be answered with a "yes" or "no"
  - Usually require more than a one-word answer
  - Give us a window into what the patient is thinking and feeling
  - Give the patient an opportunity to tell his or her story
  - Usually begin with "why," "how," or "tell me about ..."

When asking difficult questions, such as questions about HIV status, preface the question by stating your rationale for asking and acknowledge the sensitivity of the subject, if appropriate.

Examples of open-ended questions:

- What do you think would happen if you took your TB medicine everyday?
- In order to develop an appropriate treatment plan, it may be important for me to know how important decisions are made in your family. Can you tell me about that?
- How do you feel about knowing that you have TB?
- While these medicines are doing their job, what else can you do to help yourself feel better or help your body get strong?

Tip: Do not make assumptions about the patient's ideas about ways to maintain health, the cause of [TB], or the means to prevent or cure it. Adopt a line of questioning that will help determine some of the patient's central health beliefs.

Suggestions for asking specific questions for gathering relevant cultural information:

- At first interaction, after referring to the patient by a prefix (e.g., Mr., Ms.) and his or her last name, ask, "How do you prefer to be addressed?"
- "What country were you raised in?" (as opposed to asking about the birth country only. This can provide important cultural information.)
- "So that I can be aware of and respect your cultural beliefs, can you tell me about [your thoughts on taking TB medicines], [upcoming holidays or days of observance], [how medical decisions are made in your family]," etc.?
- "Tell me about any health care procedures or tests which you might be opposed to."
- "Tell me about any cultural considerations that may impact [your TB treatment], [our home visits], [this interview]," etc.?
- "As you complete this course of treatment, what matters most to you?"

Below are useful questions for determining a person's health beliefs and how they interpret their illness.

- What information do you have about TB?
- What do you think causes TB?
- What problems will having TB cause you?
- Why do you think you got sick when you did?
- What does TB do to your body?
- How severe do you think your illness is?
- What treatment do you think you should receive for TB?
- What are the most important results you hope to receive from this treatment?
- What are the main problems having TB has caused for you? What do you fear about TB?
- How do your family members or close friends feel about your having TB?

Adapted from: Cross-Kleinman, Eisenberg, and Good (1978), CDC (1994)

These can be important questions to ask before providing any patient education. Answers to these questions can give you information about what is important to the patient and help identify opportunities for meeting a patient's need. All of this information is useful for knowing how to approach patient education, care, and treatment.

> ***Quote:*** *"Always ask questions. Describe the kinds of questions you will be asking during the interview and ask if the person is willing to answer such questions. Ask if the person might feel more comfortable having someone else present. You can incorporate that question into a question about language: 'Would you prefer to speak with (or without) an interpreter? Do we need to have someone else here?' This gives the person an 'out' if they need to have someone else present during the interview."*
>
> *– Nurse Case Manager*

iv. Patient Education

Patient education is an ongoing part of TB control work. As emphasized throughout this manual, there is no single way to provide culturally competent care. The same is true for patient education. Every patient encounter and interaction is a cross-cultural experience. All patient education efforts should consider the patient's ability to understand written and verbal information. This not only refers to providing written materials or verbal information in the patient's first language, but also ensuring that you are providing information at a level the patient can understand when communicating in English.

Research in the field of health literacy has shown that even people with doctoral degrees prefer simple, easy to understand information, particularly when it comes to health information. So keeping information in simple "plain language" terms is the best approach.

The goals of providing culturally-sensitive TB patient education are to:

- **Increase the patient's TB knowledge** keeping in mind that someone other than the patient may be responsible for care and treatment decisions.
- **Clarify misinformation about TB** while demonstrating respect for differing health beliefs.
- **Engage the patient in treatment for Latent TB Infection (LTBI) to maintain good health** keeping in mind that some cultures do not ascribe to the idea of "preventive treatment."
- **Create a desire in the patient to follow TB treatment regimen** once disease occurs by framing treatment in a way that supports the patient's values.
- **Minimize treatment complications** by gathering information about specific situations that may pose potential conflicts for continuation of care and treatment.

Suggestions for achieving these goals are as follows:

- **Present the context first.**

  The context is what the patient already knows and is familiar with. Begin with this, moving from simple information to more complicated information. In your discussions, incorporate what you already know about the patient's life and values to bring personal meaning to the message.

- **Focus on behaviors and skills.**

  Patients may not need to know a lot of background information on the history of TB or the disease process. Emphasizing desired patient behaviors helps a patient gain a concrete understanding of what is expected to achieve a *mutually agreed upon* goal.

- **Limit the amount of information given at any one time.**

  A patient may not be able to remember the important components of LTBI, TB disease, or TB treatment if too much information is given at one time or if they are not prepared to receive detailed information. For example, the patient may be overwhelmed from attempts to navigate an unfamiliar health care system, or may be experiencing fear or shame over their diagnosis. In addition, illness may make it difficult for the patient to fully participate. Be aware of the limits of the patient's ability to pay attention and to absorb relevant information. Look for and seize opportunities when patients are ready to learn.

- **Provide an overview in the beginning and a summary at the end.**

  People remember information presented at the beginning and at the end of an educational session more easily than the information presented in the middle. Make your most important points toward the beginning of your discussion and summarize these points again at the end.

- **Repeat important information.**

  Some people need to hear new information several times before they remember it. Key messages should be reviewed throughout your patient education discussions. These messages should include the reasons for treatment, the importance of treatment continuation, and information regarding monitoring and side effects.

- **Encourage the patient to ask questions.**

  Patients should feel comfortable asking questions about information they do not understand. After giving instructions or an explanation, pause and ask, “I know we are discussing a lot of information at once. What questions do you have?” This can be more effective than simply asking if the patient has any questions (a closed-ended question) because it demonstrates that you assume the patient has questions.

  Keep in mind patients may be concerned about appearing uneducated, or may be nervous or not feeling well and simply want to end the interaction quickly. For these reasons, it may take courage to ask questions. Patients should be praised for asking questions. For example, you can say:

  – “I’m glad you asked that question.”

  – “Good question.”

  Additionally, in some cultures, asking questions of a health care professional may be considered disrespectful. It may be helpful to let the patient know that you will not be offended by questions; in fact, patient questions will help you to know you are providing the best care possible for the particular patient. Another strategy is to state common questions that other patients have posed around the topics you are discussing. This allows you to cover common areas of confusion without putting the patient on the spot.

- **Use available patient education materials.**

  Printed materials can be helpful in providing patient education. The language used in education materials should match the patient’s level of comprehension and be culturally appropriate. Effective educational materials should generally assume no more than a sixth-grade reading level. For patients below that level, review materials verbally with them or look for alternatives to written materials. See Part III for information on patient education materials.

One of the biggest challenges to providing patient education may be illiteracy. This is not to suggest that patients from cultures other than your own are more likely to be illiterate. Rather, as health care professionals, those who do not read simply represent another distinct group to be mindful of as we work to provide care for TB patients. Illiteracy can be hard to recognize. Below are several recommendations for spotting and working with a patient who does not read:

- Engage front desk staff in efforts to recognize illiteracy.

  Front desk staff can be an organization's biggest asset in recognizing illiteracy. Front desk staff can promote a "shame-free" environment by diligently promoting a helpful attitude. Forms can be used as "screens" for illiteracy. Ideally, forms should be written at a fifth-grade level. When filling out forms, front desk staff should be alert to patient clues. Spending an unusually long time with a form, or incomplete forms may be clues to a patient language or literacy issue. Front desk staff should privately point out these concerns to health care professionals who will be working with patients.

- When working individually with patients, pay attention to visual cues:
  - Does the patient make excuses when asked to read something?
  - Does the patient ask others to read for him or her?
  - Does the patient quickly push aside written information?

- If you suspect a reading problem, but are still not sure, you may want to ask your patient directly about his or her visual and reading abilities.

  Some examples of appropriate questions include:
  - How often do you have someone (a family member, friend, health care worker) help you read health-related materials?
  - How often do you have problems learning about your health because of difficulty understanding written information?
  - How confident are you about filling out medical forms by yourself?

Source: Wallace LS et al. Can screening items identify surgery patients at risk of limited health literacy? J Surg Res 2007; 140 (2):208-213.

Finally, there is the use of open-ended questions to assess comprehension of written information. This technique should already be a part of your patient interaction, so it should flow seamlessly into the discussion. An example of an open-ended question is, “How happy are you with how well you read?”

If you determine that your patient is unable to read, or reading below a sixth-grade level, assure him or her that there are many other ways to learn about TB. Some alternatives to written instructions or patient education material include the use of:

- Pictures
- Videotapes or DVD’s
- Audiotapes

Source: Smith L.S. Help! My patient’s illiterate. *Nursing.* 2003;33:326.

Contact your Regional Training and Medical Consultation Center’s (RTMCC) Education and Training Department for teaching tools that use these methods to educate TB patients. RTMCC contact information appears in Part III.

LEARN Model

The LEARN model is a mnemonic tool representing the communication process of *listening, explaining, acknowledging, recommending,* and *negotiating.* We work with all of these behaviors when providing patient education. This tool can be a useful guide as we juggle these behaviors in our educational approach. An example of how this might be utilized during a patient interaction is provided in Part II, teaching case # 3.

- **L**isten with sympathy and understanding to the patient’s perception of the problem.
    - Try to understand the patient’s point of view without correcting information or implying the patient is wrong. Listen and then demonstrate that you have understood what the patient said by paraphrasing what you have heard.
- **E**xplain your perceptions of the problem.
    - How does Western medicine understand the problem? Use relevant culturally appropriate patient education materials or alternative strategies to reinforce the information.

- **A**cknowledge and discuss the differences and similarities in your perceptions.
    - Find areas of agreement and discuss areas of potential conflicts.
- **R**ecommend a treatment plan.
- **N**egotiate a mutually agreed upon plan for treatment.
    - Consider the patient's cultural norms and lifestyle. There are probably a variety of treatment options outside the biomedical approach that can be incorporated harmlessly. For example, if a patient is concerned about medicines causing "hot" side effects, eating certain foods to counteract this should be encouraged. Search for compromises that will make treatment more acceptable to the patient.

Adapted from: Berlin EA. & Fowkes WC, Jr.: A Teaching Framework for Cross-Cultural Health Care. West J. Med. 1983, 12: 139, 934-938.

Summary:

Development of cultural competence is fueled by an active commitment to critical self-reflection and an ongoing broadening of cultural knowledge, experience, and adaptation of practice. It is a lifelong process of letting go of the personal assumptions that prevent us from seeing the uniqueness of each individual patient. Working in TB care and control provides unique opportunities to meet a wide variety of people and allows for invaluable learning experiences about different cultures, circumstances, and lifestyles. The fact that TB can affect anyone, points to a need to become skilled at working effectively with a variety of people. But the fact that TB affects a disproportionate number of non-US born individuals, migrants, people who travel extensively to and from TB-endemic countries, racial and ethnic minorities, the elderly, and other distinct groups, points to an even greater need for and importance of becoming effective and comfortable working with individuals whose culture or lifestyle is different from our own.

The information in this self-study manual takes a culture-general approach to the development of cultural awareness or cultural competency. Resources for culture-specific information can be found in the Introduction and the Resources section of this manual. *When reviewing culture-specific information, please keep in mind that there is always variation within groups. Culture-specific information applied to a group can sound like a stereotype.* Instead, use culture-specific information to simply familiarize yourself with concepts that may or may not be relevant for the patients you encounter. Patients' treatment preferences should override any how-to guide for a specific group.

A few final thoughts to remember are:

- Use open-ended questions and a conversational questioning style.
- Avoid complicated explanations and medical jargon, instead use plain language.
- Always ask if you are unsure about cultural norms.
- Remember, there is a tremendous amount of diversity within groups.
- Become a skilled observer.
- Take the time to find out what the patient's preferences are and act accordingly.

> *"To be culturally competent doesn't mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept that there are many ways of viewing the world."*
>
> *– Okokon O. Udo, B.D., Ph.D., CPCC*

Part II. Case Examples

Case 1:

Who you are: Outreach Worker with Local TB Program

Goal: Assist patient in completing diagnostic testing for TB

Part 1

Following the diagnosis of a person with infectious pulmonary TB at a local chicken plant, the contact investigation identifies an additional worker with symptoms consistent with TB. Carlos is 43 years old and is originally from a rural area of Honduras. As you talk with him, he readily answers your questions. It becomes apparent that he is somewhat knowledgeable about TB. You express concerns about his symptoms and ask him to come to the clinic the next day for a medical evaluation.

The next day at the clinic, Carlos tells the physician that he had a test on his arm two years ago and had a “big bump for a while” where the needle poked his skin. The physician orders a chest X-ray, which reveals a few infiltrates in the left upper lobe. Because the clinic does not have a negative pressure room, you ask Carlos to follow you outside to collect a sputum sample but he hesitates.

What might Carlos’ hesitation indicate? What should you do?

Potential Explanation

Within many areas of Central America, tuberculosis is a stigmatized disease. It is not uncommon for people to report that those who have TB are unhygienic, live in filthy homes, do not have a good lifestyle, abuse alcohol or drugs, or are HIV positive.

Carlos’ hesitation may stem from a concern that others may see him with a TB staff person and would think he lives in an unhygienic home or engages in unhealthy practices.

How to proceed:

- Explain that the reason you are asking him to step outside to collect a sputum specimen is because, when a person coughs in an enclosed space, bacteria may remain in the air. These bacteria may then be breathed in by other people. Describe how the risk of bacteria remaining in one area and being breathed in by another person is much lower in open-air environments.
- Assure Carlos that the area in which he will provide the sputum specimen is private and not visible to others. Explain that you will not stand next to him as he collects the sputum so people will not know he is being seen in the TB clinic.
- You may offer to give Carlos directions to this area without accompanying him down the hall or you may suggest that he leave in his car, collect the specimen in an area he is comfortable and return to the clinic with the sputum.

Part 2

After Carlos provides a sputum specimen, you tell him that you would like to collect another sample and ask if he will come back to the clinic the next day; he agrees but fails to show up and does not return your phone call.

When you drive over to the chicken plant later that day to follow up, he seems surprised to see you. He promptly provides a sputum sample without objection or excuse. When you explain that you will need to collect a third specimen from him, Carlos pleasantly thanks you for your concern but says, “It is okay – you do not need to make these efforts.”

What might cause Carlos to respond in that way? How might you reply to this comment?

Potential Explanation

In some countries, public health clinics provide medical care for the majority of the citizens. At times, the stock of supplies and/or medications available through these clinics may become very low or may be depleted. Consequently, a provider’s request for multiple sputum samples may be interpreted to mean that the health care providers are “going through the motions” of providing care, but in fact do not have the medications needed to treat a person.

Similarly, some patients may interpret a request for sputum to mean that “good” medical care is not available through the clinic. To these patients “good” medical care requires the use of equipment to examine or diagnose a person. Consequently, the need for an X-ray or a more invasive approach to collecting a specimen for diagnostic testing – such as venipuncture – reflects “good” medical care; while a “simple” urine or sputum sample is reflective of a lack of resources.

How to proceed:

- Reassure Carlos that it is important that you follow-up with him to ensure an accurate diagnosis and to provide TB treatment if it is needed.
- Discuss with Carlos why and how sputum is used to diagnose pulmonary tuberculosis.
- Explain why three specimens are used to make the diagnosis.
- Reiterate the next steps that will be taken, according to the protocols in your jurisdiction.
- Ask Carlos what questions he has.

Case 2:

Who you are: Public Health Nurse in TB Clinic

Goal: Complete patient blood draw for HIV testing

Selea, a 32-year-old woman, is referred to the clinic for evaluation of possible miliary TB. While reviewing her medical history, the patient reveals that she has experienced weight loss, night sweats, and has suffered from the "flu" three times in the past six months. The clinic physician explains to Selea that he would like to run additional tests to determine if she might also be HIV positive.

After the physician provides counseling and obtains the patient's consent to perform the test, you begin to gather the necessary phlebotomy supplies from the cabinets in the exam room. Upon seeing the needle and vacutainer tubes, Selea becomes agitated and protests that you cannot draw her blood because she "cannot become more weak."

Should you interpret the patient's protests to mean that she has withdrawn her consent to HIV testing? How should you proceed?

Potential Explanation

At this point, the patient's protest should not necessarily be interpreted to mean that she has withdrawn her consent to having an HIV test. While a number of people have a fear of needles, this patient specifically referred to becoming "more weak" – within some cultures a loss of blood is associated with the loss of strength or loss of soul. Other patients might be concerned with becoming faint or nauseated as a result of the procedure.

How to proceed:

- The connection between blood and a patient's symptoms or a disease may not always be readily apparent to some patients. Ask the patient, "What happens when you have your blood drawn?"
- Step away from the phlebotomy supplies and explain the importance of the blood test to diagnose the condition. You may also try to explain in simple terms what the test looks at in the blood sample.
- Explain that the vacutainer tubes look big; however, they hold

just a few spoonfuls of blood. You might demonstrate this by filling a tube to the fill-line with water then pour this water out into a tablespoon, spoonful by spoonful.

- If pediatric-size tubes are available, you might show these vacutainer tubes to the patient and ask, “Would it be better if I use these smaller tubes?”
- If the patient’s fear is a loss of soul, inquire what may be done to protect the soul when blood is drawn. If the described actions (such as prayer) can be accommodated, try to make these accommodations.
- If the patient still refuses to have any blood drawn – offer to perform an HIV screening test using a kit that requires a swab from mouth, if this type of test kit is available.
- Document your decision in the patient’s file so that if she is approached again in the future for screening, it will be done in sensitive manner.

Case 3:

Who you are: Public Health Nurse in a TB Clinic

Goal: Gain patient's trust to ensure continuation of care

Santo is a 37-year-old man who emigrated from the Dominican Republic (D.R.) 10 months ago. After initially being treated for pneumonia, Santo was found to have both pulmonary and extra-pulmonary TB. Santo spent one month in airborne isolation, as he had extensive disease and his cultures did not convert. Doctors and DOT staff explained the next phase of his treatment, which will be at the outpatient clinic at a nearby hospital. After improving clinically, he is discharged with a plan to return home to live with his wife and brother – even though his sputum samples are still smear-positive.

Santo is welcomed warmly at the DOT clinic and quickly bonds with the staff there. He comes in for DOT every day; however, while showing steady clinical improvement he remains smear-positive for one month on DOT. Santo makes it clear that it upsets him to wear a surgical mask at the clinic every day.

After two weeks, Santo says he feels much better so he finds it frustrating that he has to keep coming for DOT at the clinic. He is unhappy and unsure at the same time; while he feels better, staff are treating him as if he is still very sick.

He asks "Are you really giving me a strong treatment? Why is the treatment taking so long? Why do I still have to wear a mask when I come to clinic? I don't want to come here anymore."

Potential Explanation

Santo may be wondering why the nurses and doctors do not just use stronger medicine, like injections, which are commonly used by 'good' doctors in his home country. In some countries, injectable medicines have historically been cheaper than the same medicine in pill form, so use of injectable medications is more accepted and valued. Patients remember that those who got well were given injections right away – instead of pills. He wonders if all these pills will accumulate in his stomach or do him harm if he eats certain foods. And he has never seen any other patients wear masks in the waiting area. It makes him feel uncomfortable. This is not the kind of TB treatment he remembers seeing in his home country.

This is an important moment in Santo's relationship with TB program staff. Trust and confidence must be reestablished in order ensure Santo completes treatment.

Consider using the "LEARN" model, discussed on page 36, as a guideline for engaging a patient in communication that fosters trust and builds confidence in the treatment plan.

Listen
Explain
Acknowledge
Recommend
Negotiate

How to proceed:

Listen. Start by asking Santo open-ended questions about his satisfaction with treatment thus far. Listen closely for explanations regarding his concerns and doubts. Paraphrase what you think you have heard to demonstrate understanding and give Santo the opportunity to correct you if you are wrong. You learn that Santo is concerned about:

1) Whether he is getting strong enough treatment
2) Length of treatment
3) Wearing a mask in the clinic

Explain. Address directly the concerns Santo has revealed. Some suggestions:

- Explain that the treatment he is receiving is the standard for excellent TB care and treatment.
- Explain the rationale behind the length of TB treatment.
- Describe situations in which injectable drugs are used in the US, and point out that he does not require the use of injectable drugs.

- Explain again how the treatment for TB is in two phases; how the first two months have several drugs and the last 4-7 months have only two drugs. He may have forgotten this.
- Describe the mask as a precautionary measure to protect other people in the waiting room.

Acknowledge his perception that treatment procedures in his home country may be different. Convey that you understand his desire to have a strong treatment is based on his need to get back to work, pay his bills, and send money back to the Dominican Republic. Explain that it is natural to be frustrated about lengthy treatment for any disease, but assure him that it is the only way to completely cure tuberculosis. Acknowledge that you understand it must be awkward to feel that 'everyone is looking at him' in the clinic waiting room. Discuss the possibility of minimizing his time in the waiting area.

Recommend. Show Santo information that states the recommended treatment for TB disease is exactly the four medications he is taking. Recommend that he continue with this regimen and complete the full course of treatment. Ask Santo if he is willing to continue this treatment. If Santo is hesitant, ask him what would need to happen in order for him to be willing to complete treatment.

Negotiate. With that information, negotiate an agreement that is acceptable to both of you. If, for example, Santo still has concerns about the pills accumulating in his stomach or concerns about his diet while taking the TB medicines, explore possible non-clinical protective measures he can take while taking the medicines. Also, explore with Santo if it may be helpful to include his family in some aspect of his treatment for support.

Case 4:

Who you are: Case Manager in a TB clinic

Goal: Coordinate culturally sensitive post-hospital care for TB patient

Part 1

Jean-Pierre, a 33-year-old Haitian refugee, is about to be released from the hospital with a diagnosis of pulmonary TB. You are charged with coordinating care for Jean-Pierre. He is described as a “difficult patient” who utters “voodoo curses” at hospital staff. A staff nurse tells you Jean-Pierre appears frightened, but has not been able to discuss his possible fears because he will not talk with the nurses or doctors caring for him. The nurse also tells you he repeatedly states he wants to go home “to die” with his family. When he does speak, he uses English with a mix of French-Creole.

What should you do?

Potential Explanation

The United Nations (refugee act of 1980) definition of “refugee” describes a person who has a well-founded fear of, or experienced persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion, and because of this, is unable or unwilling to avail himself of the protection of that country. Jean-Pierre’s possible experience with oppression or persecution may be relevant to his current behavior. A first step in arranging his post-hospital care and treatment might be to gather information about Haitian culture and the history of Haitian refugees and discuss this information with the health care worker who will be visiting the patient. Also, inform the health care worker that knowing the year of Jean-Pierre’s entry into the United States may be helpful, as it may point to relevant historical events (war, disaster) Jean-Pierre may have experienced.

Many Haitians come to the United States as legal or illegal immigrants or refugees. Their history of mistreatment in Haiti has led some to distrust the government or the police. These refugees may have experienced long delays in detention centers while awaiting the determination of their asylum status in the US.

Others have been returned to Haiti before reaching US shores. Given these historical circumstances, Jean-Pierre may be hesitant to talk due to fear of being returned to Haiti or detained in a jail setting. Regarding his TB diagnosis, many Haitians consider illness a form of punishment from God. Generally speaking, TB is regarded as the worst possible diagnosis, since the sick person must be isolated from family, and it is believed by many to lead to certain death. While most Haitians are Catholic, many also believe to some extent in voodoo.

How to proceed:

Since the patient may be hesitant to talk with a health care worker, it may be important to familiarize yourself with some information that may assist a health care worker in gaining Jean-Pierre's trust.

- Familiarize yourself with historical circumstances of Haitian refugees.
- Gather information about the role of voodoo in Haitian culture. Why might Jean-Pierre be reciting voodoo curses?
- Gather information regarding Haitian health beliefs about TB. Why might Jean-Pierre believe that he will die?
- Share and discuss this information with the public health worker who will be visiting Jean-Pierre, or suggest the health care worker gather some of this information in preparation for meeting with Jean-Pierre.

Becoming familiar with this type of information will allow future (anticipated) discussions with Jean-Pierre to occur in a context of cultural understanding.

Additionally, since it appears the patient may have many fears and was hesitant to talk to hospital staff, trust may be the most important factor here. Another suggestion for fostering trust with this patient is to have an interpreter present for the first visit. Hospital staff reported the patient spoke a mix of English and French-Creole, but the extent of his English language knowledge is unknown. Also, the patient may feel more comfortable speaking with a third party in a language that may be more familiar to him.

Patient trust can also be facilitated by:

- Being consistent
- Acknowledging any concerns about legal status and/or fears about deportation
- Assuring the patient of privacy in health care matters
- Taking time to recognize and acknowledge the patient's feelings
- Genuinely caring about the patient's health

Note: A good resource for succinct cultural information on refugee populations is: *Refugee and Immigrant Health – A Handbook for Health Professionals* by Charles Kemp and Lance Rasbridge, 2004. A summary of information contained in the book including a profile of the people of Haiti, appears on Charles Kemp's website: http://www3.baylor.edu/~Charles_Kemp/refugees.htm

Part III. Resources

Regional Training and Medical Consultation Centers (RTMCCs) Contact Information:

Francis J. Curry National Tuberculosis Center (Western United States)

3180 18th Street, Suite 101 San Francisco, CA 94110-2028
(415) 502-4600 (Phone)
(415) 502-4620 (Fax)
http://www.nationaltbcenter.edu

Heartland National TB Center (Central United States)

2303 SE Military Drive
San Antonio, TX 78223-3542
(800) 839-5864 (800-TEX-LUNG) (Phone)
(210) 531-4500 (Fax)
http://www.heartlandntbc.org

New Jersey Medical School Global Tuberculosis Institute (Northeastern United States)

225 Warren Street
Newark, NJ 07103
(973) 972-3270 (Phone)
(800) 482-3627 (Toll Free)
(973) 972-0979 (Education and Training Department)
http://www.umdnj.edu/globaltb

Southeastern National Tuberculosis Center (Southeastern United States)

1329 SW 16th Street, Room 5187
Gainesville, FL 32608
(352) 265-7682 (Phone)
(352) 265-7683 (Fax)
http://sntc.medicine.ufl.edu

Culture-Specific Information

Southeastern National TB Center – Specific Guides for Health Professionals Working with Foreign-born TB Clients*

The aim of the Country Specific Guides is to help health care professionals become better acquainted with the attitudes, beliefs and practices surrounding tuberculosis and HIV/AIDS that exist within the birth countries of foreign-born clients.

This knowledge will help facilitate communication and improve staff relationships with patients and families. Each Country Guide contains the following information: 1) Country Background; 2) TB and HIV Epidemiology; 3) Common Misperceptions, Beliefs, Attitudes, and Stigmatizing Practices Related to TB; 4) Common Misperceptions, Beliefs, Attitudes, and Stigmatizing Practices Related to HIV/AIDS; 5) Cultural Courtesies to observe when interacting with patients and families; 6) Website links to translated patient education materials; and 7) References. Individual country guides will be created for a total of 31 countries. Available at: The University of Florida, Southeastern National Tuberculosis Center Website: http://sntc.medicine.ufl.edu/Products.aspx

* Mangan, JM, Ottenwess K, Wegener D, Simpson K. Gerald LB, Lauzardo M. Cultural Competency and Tuberculosis Control: Country Specific Guides for Health Professionals Working with Foreign-born TB Clients; 2008.

CDC Ethnographic Guides: Promoting Cultural Sensitivity Series

Developed by the Division of Tuberculosis Elimination, these guides are intended for health care providers, community-based workers, program planners, and health educators, and aim to increase knowledge and understanding about TB program clients born in countries other than the Unites States. The series includes information on working with clients from Mexico, Somalia, China, Vietnam, and Laos (specifically Hmong ethnicity). The series will be available online at: http://www.cdc.gov/tb

Cultural Competency Newsletters from the New Jersey Medical School Global Tuberculosis Institute

Available at: http://www.umdnj.edu/globaltb/products/newsletter.htm

Web Resources

All websites active as of May 2008

Center for Cross Cultural Health

http://www.crosshealth.com

Based in Minnesota, this organization provides education, consultation, assessment, and training of providers, educators, and organizations. Also provides information and resources through publications, referrals, newsletters and networking opportunities.

Cultured Med

http://culturedmed.sunyit.edu

This website promotes culturally competent health care for refugees and immigrants. Site also maintains databases on refugee and immigrant health issues and statistics, resettlement agencies, foreign language materials, and cultural profiles of many distinct groups of people.

Diversity RX

http://www.diversityrx.org

Diversity Rx is a clearinghouse of information on how to meet the language and cultural needs of minorities, immigrants, refugees and other diverse populations seeking health care. Website covers such topics as: appropriate use of interpreters, communication basics, state and federal laws, expert testimonies, bibliographies, glossaries, and statistics.

Ethnomed

http://ethnomed.org

From the Harborview Medical Center in Seattle, the Ethnomed website contains information about cultural health beliefs, medical issues, and other related issues concerning the health care of recent immigrants to Seattle and the US.

Health Literacy Consulting

http://www.healthliteracy.com

This site provides the training and support needed to clearly communicate health messages to a number of different audiences.

Making the Connection: An Introduction to Interpretation Skills for TB Control

http://www.nationaltbcenter.edu

This video and viewer's guide, from the Francis J. Curry National TB Center, serve as an introduction to the use of interpreters in the TB setting. The materials address skills that facilitate an interpreted session. Skills include:

- Conducting pre-sessions
- Employing three styles of interpreting
- Using a variety of tools to promote accuracy and completeness
- Demonstrating telephone interpreting in the field

National Center for Cultural Competence

http://www.gucchd.georgetown.edu/nccc

This website contains information to help individuals and organizations design, implement, and evaluate culturally and linguistically competent service delivery systems. Contains helpful planning guides and maintains a database of a wide range of resources on cultural and linguistic competence (e.g., demographic information, policies, practices, articles, books, research initiatives and findings, curricula, multimedia materials and websites, etc.). Also contains a teaching module series covering topics such as the cultural competency self assessment.

National Council on Interpreting in Health care

http://www.ncihc.org

This website promotes culturally-competent professional health care interpreting as a means to support equal access to health care for individuals with limited English proficiency. The site covers a range of topics including: the role of the health care interpreter, interpreter qualifications, the terminology of health care interpreting, and models for the provision of health care interpreter training.

Office of Minority Health

http://www.omhrc.gov

The Office of Minority Health (OMH) was established in 1985 by the US Department of Health and Human Services (HHS). The organization advises the Secretary and the Office of Public Health and Science on public health program activities affecting American Indians and Alaska Natives, Asian Americans, Blacks/African Americans, Hispanics/Latinos, Native Hawaiians, and other Pacific Islanders. OMH operates the OMH Resource Center (OMHRC), which serves as an information and referral service on minority health issues for professionals, community groups, consumers, and students. OMHRC maintains a minority health knowledge center and database, distributes publications, manage exhibits, publishes funding opportunities, maintains a list of volunteer resource experts available to the public, and conducts literature searches.

Provider's Guide to Quality and Culture, from the Manager's Electronic Resource Center

http://erc.msh.org

This website is a clearinghouse of valuable resources that includes information on specific cultural groups, health disparities, patient-provider interaction, and organizational cultural competency.

Transcultural Nursing Society

http://www.tcns.org

Contains links to current and past issues of the Journal of Transcultural Nursing as well as information on courses and lectures.

Part IV. References

Abrums ME. Leppa C. Beyond cultural competence: Teaching about race, gender, class, and sexual orientation. *J Nurs Educ*. 2001;270–275.

American Medical Student Association. Cultural competency in medicine. Available at: http://www.amsa.org/programs/gpit/cultural.cfm. Accessed March 31, 2005.

Association of Asian Pacific Community Organizations. *Cross Cultural Tuberculosis Guide.* Oakland, CA; 2000.

Bacote C. Transcultural Care Associates. The process of cultural competence in the delivery of health care services: A culturally competence model of care. Available at: http://www.transculturalcare.net/. Accessed June 19, 2003.

Bayles AK, Tomoeda CK. Cultivating cultural competence in the workplace, classroom and clinic. ASHAleaderOnline. Available at: http://www.asha.org/about/publications/leader-online/archives/2002/. Accessed February 9, 2004.

Berlin EA, Fowkes WC. A teaching framework for cross cultural health care: application in family practice. *West J Med*. 1983;139:934–938.

Betancourt JR, Carrillo JE, Green AR. Cross-cultural primary care: A patient-based approach. *Ann Intern Med*. 1999;130:829–834.

Betancourt JR, Carillo JE, & Green. *Cultural competence in health care: Emerging frameworks and practical approaches.* Field Report. New York, NY: The Commonwealth Fund; 2002.

Betancourt JR, Carillo JE, & Green, AR. Why the disease-based model of medicine fails our patients. *West J Med*. 2002;176:141–143.

Blue AV. The provision of culturally competent health care: Available at: http://www.musc.edu/fm_ruralclerkship/culture.html

Bodley, J. *Victims of Progress.* 4th Edition. Mountain View, CA. Mayfield Publishing Co. 1999.

Burg MA, Lieberman LS, Stoller EP. Patient education and compliance. *J Florida Med Ass*. 1997;84:371–373.

Chachkes E, Christ G. Cross cultural issues in patient education. *Patient Educ Couns*. 1996;27:13–21.

Chin JL. Cultural Competence in a Multicultural Society. Cultural competence: A checklist. Available at: http://www.selfhelpmagazine.com/articles/cultural. Accessed November 14, 2005.

Cole P. When medicine and culture intersect. Changing patient demographics mean traditional approaches are inadequate. *Postgrad Med*. 2002;112:1–6.

Cole P. Cultural competence now mainstream medicine. Responding to increasing and changing demographics. *Postgrad Med*. 2004;116:1-7.

Cross T, Cultural Competence Continuum, *Focal Point*, Fall 1988. Available at: http://www.nysccc.org/T-Rarts/Articles/CultCompCont.html

Dimou N. Illness and culture: learning differences. *Patient Educ Couns*. 1995;26:153–157.

Fitzgerald MH, Mullavey-O’Byrne C, Clemson L. Cultural issues from practice. *Aus Occ Ther J.* 1997;44:1–21.

Galanti GA. *Caring for patients from different cultures.* Philadelphia, Pennsylvania: University of Pennsylvania Press; 2004.

Gilbert MJ. *The Principles and recommended standards for cultural competence education of health care professionals and related documents*. California: The California Endowment A Partner for Healthier Communities; 2002.

Helman CG. *Culture, health and illness*. 4th ed. New York: Oxford University Press; 2001.

Hunt LM. Beyond cultural competence; applying humility to clinical settings. *Park Ridge Center Bulletin.* 2001;24:3–4.

Kennedy J, Everest A. Developing multicultural interviewing skills: Interviewing candidates from diverse backgrounds. *Cult Div at Work J*. 1991;3:1–3.

Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. PLoS Med 2006;3(10)e294 doi:10.371/journal.pmed.0030294

Lakhani A, Mackenzie G, Pannekoek H, Parkinson M. Issues that influence patient/physician discussion of complementary therapies. *Patient Educ Couns*. 1999;38:155–159.

Leavitt RL. CEU: Developing cultural competence in a multicultural world (part 1). *PT-Mag Phys Ther.* 2002;10:36–48.

Leavitt RL. CEU Developing cultural competence in a multicultural world (part II). *PT-Mag Phys Ther.* 2003;11:56–70.

Like RC, Steiner RP, Rubel AJ. Recommended core curriculum guidelines on culturally sensitive and competent health care. *Fam Med*. 1996;28:291–7.

Maranto G. Overcoming cultural barriers for better care. Available at: http://www.nytimes.com. Accessed October 1, 2002.

Minnesota Department of Human Services. Cultural competency-organization and administration. Available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_016415. Accessed February 2, 2005.

National Center for Cultural Competence. Rationale for Cultural Competency in Primary Care, Policy Brief 1. Available at: http://www11.georgetown.edu/research/gucchd/nccc/documents/Policy_Brief_1_2003.pdf. Accessed August 1, 2005.

National Center for Cultural Competence, Georgetown University. Curricula Enhancement Module Series Available at: http://www.nccccurricula.info. Accessed February 4, 2005.

Osborne, H. Health literacy consulting. In Other Words...Helping Patients Ask Questions Available at: http://www.healthliteracy.com/article.asp. Accessed January 10, 2007.

Pfifferlling JH. A cultural prescription for medicocentrism. From: Eisenberg L, Kleinman A., eds. *The Relevance of Social Science for Medicine.* Dordrecht, Holland: D. Reidel, 1981, 207.

Salimbene S, Graczykowski JW. *10 Tips for Improving the Caregiver/Patient Relationship Across Cultures. When Two Cultures Meet: American Medicine and the Cultures of Diverse Patient Populations, Book 1, What Language Does our Patient Hurt In? An 8-Part Series of Practical Guides to the Care and Treatment of Patients from Other Cultures.* Amherst, Mass: Inter-Face International. Amherst Educational Publishing; 1995:23–25.

Smedley BD, Stith AY, Nelson AR, eds. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press, 2003.

Smith L.S. Help! My patient's illiterate. *Nursing.* 2003;33:326–328.

Storti C, Bennhold-Samaan L. *Culture Matters: The Peace Corps Cross Cultural Workbook*. Washington, DC: Peace Corps Information Collection and Exchange; 1997.

US Department of Health and Human Services Office of Community Programs *Physician toolkit and curriculum: Resources to implement cross-cultural clinical practice guidelines for Medicaid practitioners* (Contract Number: 02TO2502701D). Massachusetts: University of Massachusetts Medical School Office of Community Programs; 2004.

US Department of Health and Human Services, BHPR – Other definitions of cultural competence. Available at: http://bhpr.hrsa.gov/diversity/cultcomp.htm Accessed March 16, 2006.

US Department of Health and Human Services, Information for health professionals and your patients-cultural competency. Available at: http://www.4woman.gov/healthpro/cultural. Accessed March 13, 2006.

University of Michigan Health System, Programs for multicultural health: Basic concepts and definitions. Available at: http://www.med.umich.edu/multicultural/ccp/basic.htmc. Accessed August 1, 2005.

University of Michigan Health System, Program for multicultural health: Questions to ask your patients. Available at: http://www.med.umich.edu/multicultural/ccp/questions.html. Accessed August 24, 2005.

Wallace LS et al. Can screening items identify surgery patients at risk of limited health literacy? *J Surg Res* 2007;140 (2):208–213.

Welch M. *Culturally Competent Care*. *Concept Paper* National Advisory Committee Office of Minority Health/Office of Public Health and Sciences: Department of Health and Human Services; 2002.

Appendix

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Office of Minority Health

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The topics of the fourteen culturally and linguistically appropriate standards for care are:

- Understandable and Respectful Care
- Diverse Staff and Leadership
- Ongoing Education and Training
- Language Assistance Services
- Right to Receive Language Assistance Services
- Competence of Language Assistance
- Patient-Related Materials
- Written Strategic Plan
- Organizational Self-Assessments
- Patient/Consumer Data
- Community Profile
- Community Partnerships
- Conflict/Grievance Processes
- Implementation

The standards are organized by themes: Culturally Competent Care (Standards 1–3), Language Access Services (Standards 4–7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS **mandates** are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS **guidelines** are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient’s/consumer’s race, ethnicity, and spoken and written language are collected in health records, integrated into the organization’s management information systems, and periodically updated.

Standard 11
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

NEW JERSEY
MEDICAL SCHOOL
GLOBAL
TUBERCULOSIS
INSTITUTE

225 Warren Street, 1st Floor, West Wing
PO Box 1709, Newark, NJ 07101-1709
973-972-3270
www.umdnj.edu/globaltb