Advancing Cultural Competence

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In the Public Health & Health Care Workforce

School of Public Health
University at Albany

Center for Public Health Continuing Education

New York State of Opportunity. Department of Health

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- This webinar is being presented live on March 30, 2015. It is being recorded and archived for future viewing.
- You can find responses to Frequently Asked Questions on structural competency and additional readings and resources at: www.advancingcc.org

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School of Public Health, University at Albany, State University of New York
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Learning Objectives

After today's webinar, you will be able to:

- Recognize the pitfalls of a traditional cultural competency to health care education.
- Explain the potential benefits of a structural competency approach to health.
- Apply narrative techniques to identify your own frames of listening.
- Identify community partners and resources to help connect your own clinical work with broader social justice advocacy.

Evaluations

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Today's Producer

This webinar is produced by the Center for Public Health Continuing Education at the University at Albany's School of Public Health

Today's producer is Elizabeth Campisi, Ph.D., project coordinator for the Advancing Cultural Competency in the Public Health and Healthcare workforce series

Today's Presenter

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Today's presenter is Sayantani DasGupta, MD MPH.

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Columbia University Medical Center
Program in Narrative Medicine
College of Physicians and Surgeons

From Cultural to Structural Competency: A Narrative Humility Approach

Dr. Sayantani DasGupta

Introducing the Advancing Cultural Competence Series

- Expanding the notion of cultural competence
- Introducing the ideas of structural competence and narrative humility
- Framing the talks to come: Native American, Latino/a, African American, Asian American/Asian Pacific Islander communities

4 "Beats" or Frames of Focus

- Historical Frames of Oppression
- Present Day Sociopolitical Barriers and Challenges to Health
- Activism and Advocacy within the Community around Health
- Clinical Cases

Who am I? Program in Narrative Medicine

(Image Courtesy oprah.com)

Narrative, Health and Social Justice

(Image Courtesy UCSD School of Social Justice)

What is Cultural Competency?

- **A.** A way to train clinicians to serve diverse populations
- **B.** A way to decrease medical errors
- **C.** Behaviors, attitudes and policies that an organization can adopt to work effectively in cross-cultural situations
- **D.** All of the above

(image courtesy downstate.edu)

What is Cultural Competency?

D. All of the Above

A Narrative Medicine Exercise

- "Immigrant Blues" by Li-Young Lee
- http://www.poetryfoundation.org/poem/182923 (hear Li-Young Lee read this poem)

Writing Exercise

- Think about a story told to you by a family elder
- What title/name would your elder have given this story?
- What would you call this story?
- What would your children/younger people in the family call this story?

Thinking Exercise

- In what language was your story told? Could it be told in another? What would it lose/gain?
- How was this story impacted by/reflective of your family's ethnicity and nationality? Socioeconomic situation? Geographic location? Employment status? Religious Views? Other beliefs?

Clinical Aside

- When treating a patient or client who speaks another language, do you:
- **A.** Ask them to bring a family or friend to interpret
- **B.** Ask the cleaning staff who speaks the same language to interpret
- **C.** Wing it
- **D.** Realize you are legally obligated to obtain a professional interpreter and do so!

Interpreter Services

- **D.** Under Title VI of the Civil Rights Act, health care providers are obligated to provide, and pay for language interpreter services. Under the ADA, such services must also be provided for those who are deaf or hard of hearing.
- Under the Native American Language Act (1990), centuries of cultural and linguistic erasure were addressed and the rights of First Peoples to "use, practice and develop" their own languages was at least legally protected.

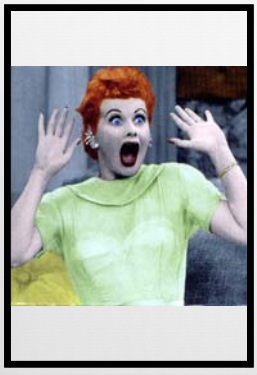
(image courtesy excellentlanguageservices.com)

Clinical Case 1

- A Dominican immigrant to New York is HIV positive. Her infant son is also HIV positive, and her husband died recently of AIDS. She is failing to bring her child in for his pediatric visits, and has not filled a recent prescription for his antiretrovirals.
- The pediatric clinic is ready to call child protection, but one compassionate social worker urges that this is undoubtedly due to the woman's cultural beliefs, and some cultural competency should be used.

Why is this mother being negligent?

- **A.** No one has explained to her that HIV is a virus and requires antiretrovirals.
- **B.** She does not trust the medical establishment in the U.S. and believes they are experimenting on her son.
- **C.** The woman doesn't believe in biomedicine but is assured her son will improve through increasing her Santería worship practices.
- **D.** None of the above



(image courtesy litstack.com)

Why is this mother being negligent?

D. None of the above
(and maybe our framing of this as negligence is inaccurate!)

Clinical Case: "Local World" Approach

- This immigrant mother is perfectly aware that HIV is a virus and needs antiretrovirals. She completed some nursing training in the Dominican Republic and has great faith in biomedicine. Since immigrating, she has been working 2 jobs as a home aid and domestic worker, including many night shifts, and has not had time to take her son to his appointments. She is in between insurance coverage, and must wait for her new card before filling her son's expensive prescription.

Presente! Latin@ AIDS Activism

(image courtesy nypl.org)

What are the Problems of a Cultural Competency Approach?

- It is based on the idea that culture can be reduced to a technical skill for which clinicians can be trained to develop expertise
- Culture is often made synonymous with ethnicity, nationality and language
- It assumes that cultures are homogenous and static – not making room for intersectionality/multiple identities and heterogeneity in communities
- It usually focuses on the client/other ignoring the cultural beliefs and background of the clinician/practitioner

(Kleinman and Bensen, 2006)

Traits List Approach

- Japanese American believe ______
- Dominican Immigrants use ______ herbal supplement
- Muslims believe _________
- South East Asians practice _________

(image courtesy [illegible])

Explanatory Model/Ethnography Approach

(Kleinman 1998)

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment?

(image courtesy guidingchange.com)

Clinical Case 2

- A morbidly obese African American man in his 30's has diabetes, high blood pressure and evidence of coronary artery disease. His primary care nurse practitioner is deeply worried about his future health and, along with his medication, writes a 'prescription' for increasing healthy fruits and vegetables in his diet and walking in the park for 20 minutes a day. On his next visit, the man admits he has not filled either of these non-medication 'prescriptions.' The NP, who was an undergraduate anthropology major, asks him Arthur Kleinman's Explanatory Model questions.

Answers to Ethnographic Approach Questions

- What do you call this problem? *Sugar in the blood, pressure*
- What do you believe is the cause of this problem? *Genes, bad food*
- What course do you expect it to take? How serious is it? *I could have a stroke, lose a limb, go blind – serious stuff!*
- What do you think this problem does inside your body? *Bad things*
- How does it affect your body and your mind? *I can't play sports*
- What do you most fear about this condition? *Dying*
- What do you most fear about the treatment? *Needle sticks*

Why is the man 'noncompliant'?

- **A.** He hates his clinician
- **B.** He does not understand the connection between food, exercise and health
- **C.** He has a death wish
- **D.** None of the above

(image courtesy baycitizen.org)

Why is the man 'noncompliant'?

- **D.** None of the above

(image courtesy riverviewmarket.com)

Structural Competency Approach: Clinical Case 2

- The man lives in a 'food desert' in an impoverished part of his city.
- Local stores don't carry fresh fruit and vegetables. There are no local parks.
- He has no car, and public transport will take him over an hour to get to the closest grocery store.
- Even if he gets there, fresh fruit and vegetables are far more expensive, and quickly perishable, than canned or processed foods.

Structural Competency

- "People's morbidity and mortality is as connected to their zip code as their genetic code."
- "We define structural competency as the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health"

--- J. Metzl and H. Hansen

What Structures/Structural Oppressions Impact Health?

- **A.** Work Hours/Flexibility, Labor Equality
- **B.** Transportation Access/Affordability/Safety
- **C.** Housing Access/Affordability/Safety
- **D.** Childcare Access/Affordability/Safety
- **E.** Food distribution networks
- **F.** Immigration Policies
- **G.** Health Insurance Status
- **H.** Racism/Sexism/Able-ism/Homophobia/Transphobia/Classism
- **I.** All of the above

What Structures/Structural Oppressions Impact Health?

- **I.** All of the above

(image courtesy tnsglobal.com)

What do we do next?

- **A.** rewrite the 'prescription' for diet and exercise in bigger letters
- **B.** organize a fresh food van that travels the neighborhood
- **C.** organize clinic 'trips' to local farmer's markets
- **D.** have a resource desk in your clinic waiting room which addresses structural 'prescriptions' like food assistance, heating fuel subsidies, housing issues
- **E.** work with an urban gardens group to create a community vegetable garden/outdoor exercise space
- **F.** B,C, D or E

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Structural Problems Need Structural Solutions

- Roger Doiron (TEDxDirigio): "Gardening is a subversive activity. Food is a source of energy, but it is also a source of power. When we encourage people to grow their own food, we are encouraging them to take power into their own hands; power over their diet, power over their health…
- Ron Finley (TED) "Gardening is the most therapeutic and defiant act you can do… especially in the inner city. Plus you get strawberries."

(image courtesy communitcation4health.wordpress.com)

Structural Racism

Image courtesy huffington post

Imperialism as Cure for Race, Dirt and Primitivity

"The first step in easing the white man's burden is through teaching the virtues of cleanliness" (Another Soap Ad)

- "The people of India seem to be very much the condition of children. They must be made to clean by compunction until they arrive at that degree of moral education where dirt shall become hateful to them" - 1882 British Report "Indian Habits"
- Filipinos described by another colonialist as "promiscuous defecators."

(Image courtesy Jezebel.com)

Saartjie Baartman (Hottentot Venus; 1789-1815)

What else are we 'diagnosing' when we diagnose obesity?

Health at Every Size Movement

Clinical Case 3

- A Pakistani American woman is having worsening anxiety attacks, to the degree they are interfering with her job as a local school teacher. She is very tearful on her visit to the mental health clinic; reports being on probation at work, and "having trouble at home as well."

Various Approaches

- Trait Based (Traditional Cultural Competency) Approach: Investigate Pakistani Belief Systems, herbal practices, and cultural stigmas around mental health
- Explanatory Model Approach: Investigate this woman's own understanding of what is happening to her – why does she think she is missing so much work?
- Structural Competency Approach: Might investigate possible unstated stressors such as immigration status, unfair labor practices at work or domestic violence at home

Clinical Case 3: "Aren't They pretty sexist?"

- During a meeting of clinicians and case workers, one mental health specialist, with a background in structural competency, suggests that this must be a situation of domestic violence since Pakistani immigrant communities are "pretty sexist" due to "their backward beliefs" and "you know, Islam."
- Which of our previously discussed models might help address what is happening here?

Suffering Women

Activist women

Narrative Humility

- Humility toward that which we do not know, but to which we are responsible
- Expansion of Melanie Tervalon and Jann-Murray Garcia's notion of cultural humility – a practice dedicated to not just learning about "them" but an inward looking and self-reflection about "us"
- Examines clinician biases, attitudes, frames of listening, expectations and gaps in knowledge

Narrative Humility

- Acknowledges that elements of the unknowable and unfamiliar may be present in any patient/client story, not just the experiences of 'Others' (whatever that means to us)
- "Try to understand, realize that you will never understand, try anyway."

Clinical Case 3

- Pakistani American woman was experiencing anxiety due to prevalent anti-Islamic sentiments in her neighborhood and particularly at work.
- While this is **a structural competency** issue, and it could be discovered by asking for this woman's **explanatory model** ("what do you think is causing the problem?") it requires **narrative humility** to uncover practitioner attitudes and biases.

'Saving Muslim Women' as a Justification for War

What Next?

A Combination of Approaches

- 1. Learn about belief systems while making room for ethnographic models; i.e. ask someone what they think is wrong with them.
- 2. Think about histories of oppression, sociopolitical barriers to health, structures and power
- 3. Examine our own biases, frames of listening, and expectations

Seek Community Allies over False 'Competency'

- What sorts of community allies could you call upon to help increase Structurally Competent care at your institution/organization?

(image courtesy socialmediaexaminer.com)

Community Allies

- Translation Banks
- Community-specific Women's Groups
- Community-based labor organizations or food justice organizations
- Cultural and Religious institutions
- **No one group can represent an entire ethnic community**

We all have culture, we all have stories

- Some stories have more power
- Some stories are more frequently marginalized or silenced
- Hearing the individual story is to both listen for particularity **(ethnographic approach)**, while placing the story in sociopolitical context **(structural competency)** and paying attention to our own frames of listening **(narrative humility)**

Won't You Celebrate with Me by Lucille Clifton

- (begin 0.26): https://www.youtube.com/watch?v=XM7q_DUk5wU

Sources

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- Tervalon, M., Murray-Garcia, J. "Cultural Humility versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." Journal of Health Care for the Poor and Undeserved Vol. 9 (2): 117–125, 1998.

Questions?

Evaluation

- Whether or not you are applying for continuing education credit, we would appreciate it if you would take a few minutes to fill out the evaluation. We value your feedback highly and will use it in developing the rest of this series.
- Take the evaluation here: http://www.albany.edu/sph/cphce/advancing_cc_webinar_mar15.shtml