Culture, Identity and Health[1]

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It is worth noticing, in most recent years, the increasing relevance of the concept of culture in health communication. With the increasing number of multicultural population and the global flows, health communicators have called for more work which should engage with the concept of culture (Airhihenbuwa 1995). Generally, culture is treated as a static set of values, beliefs and practices. Unlike this view, the culture-centered approach refers to culture as dynamic and transformative, made up of the voices of its cultural members. Health care services increasingly face patient populations with high levels of ethnic and cultural diversity. Thus cultures are also associated with distinctive ways of life, concepts of personhood, value systems, help seeking and clinical decision making. Likewise, cultural differences may impede access to health care, accurate diagnosis and effective treatment. The clinical encounter, therefore, must recognize relevant cultural differences, negotiate common ground in terms of problem definition and potential solutions, accommodate differences that are associated with good clinical outcomes. Attention to culture, both in the clinical encounter, and in the structure of health care institutions, can contribute to building a pluralistic civil society. Clinical attention and respect for cultural difference can provide experiences of recognition that increase trust in and commitment to the dominant society, can help to sustain a cultural community through recognition of its distinct language, knowledge, values, and healing practices, and to the extent it is institutionalized and constitutes a pluralism in itself.

Medicine is an important context in which to consider the issues of pluralism and diversity in civil society for several reasons. Medicine focuses on specific cases that demand we translate abstract or general principles, procedures, values and intuitions into explicit choices and actions. In so doing, we are forced to address basic areas of difference or disagreement between value systems and negotiate some common understanding and course of action. Through the expression of attentiveness, concern and commitment to appropriate and effective helpful action, the clinical encounter provides a site of recognition of the other. This recognition can promote experiences of trust and learning that transform the participants'

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perspectives on the world. This transformative possibility works on both the patient and the clinician, as well as on the larger communities to which they belong. Health care involves a hierarchy of levels of interaction ranging from the bodily physiology of illness and treatment, through the interpersonal dynamics of the clinical encounter, to the social, institutional, and governmental policies and practices that define and regulate the health care system. At the center of health care is the clinical encounter which has its own unique exigencies that include: the dynamics of the relationship between the doctor and the patient, the highlightened vulnerability of the suffering individual, the necessity for clinical responsibility, the need to translate general or generic knowledge into individualized or personalized intervention; and on the ways in which the patient and the clinician are connected to larger social and cultural domains of family community, institutional national and transnational networks. Although the health care system is focused on diagnosis, treating and ideally preventing disease, the clinical encounter has other functions as well. Among these other functions is the creation of special type of relationship between the patient and the clinician. The most basic elements of this clinical relationship center on the connection between two individuals when one is suffering and afflicted and one is in the position to help.

People come to the doctor because of the fundamental human needs for making sense of affliction and relieving pain and suffering (Kleinman 1998). They thus face the clinician with a highlightened vulnerability in a situation of asymmetrical power that calls for empathic responsiveness and responsibility on the part of the healer or helper. The clinical encounter allows the possibility for recognition of the other not only in his or her essential humanity, but also with a specificity that reflects each individual's unique experience and predicament. Beyond this encounter between individuals, there are larger social contexts of meaning that shape the clinical encounter: for doctors these social contexts include the technical system of medicine with its knowledge, ideologies, institutions and practices, as well as their own personal ethno-cultural background and communities of identification and participation. The scientific and technical basis of contemporary medicine creates a cultural divide between the doctor and the patient in that, while many patients respect the authority of scientific medicine, most lack detailed familiarity with its theory, making it difficult to follow medical explanations couched in technical language. In a sense, medicine constitutes a subculture with its own background and, therefore, every clinical encounter is intercultural. Clinicians who strive to engage patients as active agents in their own care must work to communicate their medical knowledge in ways that enable patients to think through the consequences of different choices of action. In situations where the cultural difference forms the distance between the perspectives of the patient and of the clinician, effective communication demands attention to broader aspects of the personal history and social world of the patient (Kirmayer 2008). To the extent that there are important differences in the perspective of the patient and of the clinician, the negotiation of a mutually intelligible and acceptable course of action can create a shared purpose and mutual understanding (Taylor 2002).

Recognition of culture involves recognition of collective identity of groups, but also recognition of individuals within such groups, who may have identities or

aspirations that may be in conflict with those of the groups or communities to which they belong. The clinical encounter can work against the silencing of the individuals – when it recognizes the suffering of some individuals that arises from contradictions or injustices coming from a particular cultural arrangement. More generally, the encounter with other cultures in pluralistic societies provides an opportunity for members of a community to become aware of these inequities that might otherwise be invisible, taken for granted or viewed as inevitable (Phillips 2007).

Identity refers to the way in which we see ourselves, and it is intrinsically connected to our understanding of health and illness, our relationship with the others in health care settings (Shilling 1993). Identities are culturally situated, as the culture provides the contextual space within which individuals develop a sense of the self, come to value certain aspects of the self, and come to enact this self-action through their day to day actions. Cultural values and beliefs are played out in the realm of identity as they come to influence the ways in which the individual sees himself/ herself, develops relationships with others and engages in day-to-day practices. Identity refers to the construction of the self that is evoked in day-to day interactions of cultural participants, and provides the scripts for the ways in which participants construct meanings of health. Therefore the identity of cultural members is related to the meanings they construct, the ways in which they communicate with others, and the way in which they experience health and illness. Likewise, identity is central to the response of cultural participants to health messages, their adoption of preventive behaviors, the treatments they seek out, and the experiences they have with the healthcare systems. The identity of cultural members is responsive to the context and is dynamic in nature. In other words, different aspects of a patient's identity are evoked in different relationships and in different cultural contexts. How an individual sees himself/herself in the world also influences the ways in which he/ she interacts with others, the expectations he/she has from these relationships, and the role of these relationships in further shaping the individual's identity. In other words, identity is played out in the realm of relationships individuals participate in. It is after all based upon a sense of identity that individuals come to interact in the world. Cultural values, beliefs and contexts influence the ways in which individuals perceive themselves and others in a relationship, and the ways in which they communicate with these others in relationships. Identity influences health choices by being intertwined with the meanings and relationships individuals form with others. How an individual sees himself/herself is essential to the ways in which he/she approaches health.

As a dynamic setting within which individuals experience health and illness, culture provides the backdrop against which identity is realized. It sets up a dynamic context within which meanings are negotiated in the articulation of identities. Cultural members construct their identities and act on the basis of these identities through their interpretations of what it means to be a member of the culture.

Thus relationships are built upon the identities of the individual participants and their perceptions of the identity of the other. Therefore, in the area of doctor-patient relationship, the identities of the patient and of the clinician are integral to the ways in which the relationship is negotiated, expectations are laid out and communicated, and health outcomes are managed. Furthermore, the constructions of

identity and expectations around identity are located within the broader contextual spaces of cultures. In other words, cultural contexts, values, and meaning systems are constructed and negotiated. Identity not only influences how health meanings and relationships are negotiated, but also the ways in which cultural participants negotiate their health choices. Health and medical choices are culturally situated practices and as symbols of the culture, they offer cultural members with opportunities for enacting their identities and relationships.

The pluralism we are confronted with nowadays requires social space for alternatives and this is obviously extended to the health care system. Doctors usually cannot (and should not) deliver treatments that they do not believe are effective or endorse cultural practices for which the evidence of harm is unbalanced by any comparable benefit (Shweder 2002). Indeed, health professionals are expected to contest or oppose patient choices they believe are harmful, but, in order to be effective, they must do this in ways that respect the autonomy and perspective of the patient and not foreclose the possibility of continued dialogue. The need to recognize culture in the clinical encounter follows from the diversity of ethno-cultural communities in a multicultural society. Because cultural systems provide alternative definitions of health and pathways of healing, this recognition supports a broader pluralism. Participation in a pluralistic society requires a moral and political education that is itself transformative of cultures (Curtis 2007). Even where the dominant society is hostile to pluralism, the clinical encounter, with its commitment to respond to individuals in their distinct identities (which reflect their cultural background) can provide a site of resistance and a place from which a more pluralistic civil society can grow.

In conclusion we may say that cultural differences may become a major social determinant of health. Recognizing culture therefore is part of accurately identifying the origins and location of health disparities. Moreover, we may say that these health disparities are not necessarily the result of economic or educational differences, but rather the effect of the failure to recognize cultural differences in the delivery of clinical services. Undoubtedly these would lead to poor communication, misdiagnosis and inappropriate treatment. Therefore, recognizing and responding to culture can improve these clinical outcomes directly.

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Abstract

The aim of this paper is to study the role of identity in communication about health and, at the same time, to explore the relationship between culture and identity. Identity refers to the ways in which we see ourselves, and is intrinsically connected to our understanding of health and illness, our relationship with others in healthcare settings, and the actions we engage in the context of health and illness. Identities are culturally situated, as the culture provides the contextual space within which individuals develop a sense of the self and come to value certain aspects of the self. Cultural values and beliefs are played out in the realm of identity as they come to influence the ways in which the individual sees himself/herself, develops relationships with others and engages in day-to-day practices.

The goal of this paper is to provide an understanding of what identity is and the ways in which it is tied with the health experiences of cultural members. The relationship between identity and health is also going to be discussed. Likewise, attention will be paid to the way in which identity is tied to the meanings of health understood by cultural members and the health-related actions they engage in.