UNDERSTANDING CULTURAL DIVERSITY IN HEALTH CARE

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Abstract

Over the last 25 years there has been considerable pressure from professional medical bodies throughout the world to improve training and evaluation of doctors with regard to communication skills. Skill in communication is essential in establishing a good relationship between doctors and patients. Therefore communication should be a systematic part of all medical education. The idea of this research came witnessing the increasing number of Romanian physicians who choose to carry out their medical profession in English speaking environments. Once these graduates find themselves in the foreign medical system, they are confronted both with the linguistic and cultural barriers. A medical doctor needs to be able to fully understand and communicate with his / her patient. Therefore, our main goal is to create the possibilities to develop the language and interpersonal skills essential to the establishment and maintenance of rapport between doctors and their patients.

Keywords: cultural diversity, health communication, transcultural communication

Introduction: The Concept of Culture

The role of culture in heath communication started to receive increasing attention in the 1980s with the emerging understanding that health communication efforts needed to respond to the shifting cultural landscape in order to be effective. This created the climate for multicultural health communication efforts. The emphasis on multicultural population emphasized the necessity to develop an understanding of culture in international health communication efforts. Culture is one of the most debated concepts found in social sciences and humanities. According to a classic definition formulated by Edwards Tylor in 1871, "culture … taken in its wide ethnographic sense is that complex whole which includes knowledge, belief, art, morals, laws, custom, and any other capabilities and habits acquired by man as a member of society (Tylor, 1871). In 1995, C. Airhihenbuwa noted: "It has become common practice in the field of public health and in the social and behavioral sciences to pay lip service to the importance of culture in the study and understanding of health behaviors, but culture has yet to be inscribed at the root of health promotion and disease prevention programs, at least in the manner that legitimates its centrality in public health praxis" (Airhihenbuwa 1995: 12). In the decade following this observation, health communication theorizing and practice has taken a turn towards incorporating culture in health communication. Therefore scholars have increasingly stressed upon the necessity to develop communication frameworks rooted in the culture and context of those who are at the heart of health promotion efforts. The above mentioned specialist in health communication, Airhihenbuwa, writes that health is a cultural construct and health theory and practice must be rooted in cultural codes and meanings. These values are notions of community rules, traditions, health beliefs, socio-economic ability, societal power structures, education, religion, spirituality, gender roles and exposure (Airhihenbuwa 1995: 12). C. Helman adds that in every human society beliefs and practices related to health are a central feature of

culture: “both the presentation of illness, and others’ response to it, are largely determined by socio-cultural factors” (Helman 1986: 71). This growing awareness of cultural differences globally is based on the understanding that there are many different ways of perceiving and interpreting health across different cultural groups, and, in order to become effective, health communicators need to become aware of these cultural differences (Hammerschlag 1988: 146). Cultural differences were conceptualized as barriers to effective health communication efforts.

For medical students this topic is particularly important because the world nowadays is becoming increasingly globalized and doctors, wherever they may practice, they will have culturally diverse populations. Thus culture can be an important influencing factor in doctor-patient communication. Patients may not share the same perspective upon the world as their doctor and there may be different expectations of the doctor-patient relationship.

During our EFL seminars at the “Gr. T. Popa” University of Medicine and Pharmacy, we noticed that virtually every student whom we encountered during classes and discussions admitted incidents of social unease that they attributed to diversity. They were also aware of the fact that nowadays doctors travel a lot and, furthermore, within a few yeas, by the time they graduate, they might think about this possibility of seeking for a job outside the Romanian cultural context. We also realized that few students felt confident that they had adequate knowledge and skills for intervention in those complex interactive situations. The students were, in other words, more aware and sensitive that knowledgeable and skillful, though, probably, for the majority of them, language skills were not a problem. Their lack of confidence was displayed in their communication patterns, which tended to change when topics that they considered “sensitive” arose. Students were sensitive, but few were prepared for situations that involved diversity. Most had learned to tolerate diversity, but not how to live with it in a manner that let them appreciate and value it. They did not know how to effectively manage themselves in a diverse environment. Due to the fact that the number of Romanian doctors that try to find a job in the medical field abroad increases every year, one of the purposes during the ESP seminars (English for Specific Purposes, in our case, Medical English) should be that of preparing our students to confront the great amount of differences they are likely to experience in the doctor-patient encounter that would take place in an English-speaking environment. However this is not an easy goal to meet. We try to present a framework for understanding social processes underlying the significance that is attached to differences, and a set of strategies for communication and intervention to bridge the gasps formed by those differences. The promotion of diversity moves beyond tolerance, generosity and “good deeds”, and even beyond common decency, to confronting differences and developing awareness, sensitivity, knowledge and skills that encourage authentic, effective interaction, that is, interaction that is enhanced rather than hindered by differences.

Health Beliefs and Practices

Every society has a culture, and every cultural group has a system of beliefs and practices that reflect its general worldview but also relates specifically to health and illness (Helman 1990: 31). When talking about health care, communication is frequently the first challenge that involves diversity. Recognition of care alternatives, development of confidence in cross-cultural communication skills, and the ability to analyze situations in specific terms,

require practice. In order to become comfortable with the skills required for effective interaction in situations involving diversity, practice of those skills is of primary importance. Therefore we do believe that our goal as teachers of ESP (Medical English) is to make our students aware of the necessity to master all these skills and, at the same time, create the necessary background in our seminars and courses to make them familiar with everything that may require the possession of such skills. "Case studies, questions, discussions of myths, simulation, role play and visuals encourage participants to examine their own and others' beliefs and values as a basis for understanding and respecting diversity" (Gorrie 1989: 78).

Thus many patients bring to the clinical encounter models of health and illness that are quite distinct from those of the doctor. Language differences and different understandings of the meaning of symptoms and illnesses can make communication between patients and health care providers very difficult. Cultural understandings of morality, health and illness have important implications during the medical encounter. For example some patients may refuse a particular kind of treatment or insist upon a specific form of care. All these may raise questions about reasoning abilities or decision-making capacity. Therefore, in order to understand such patients, doctors and nurses need to learn how patients interpret their illnesses and comprehend the diagnostic, the prognostic of the disease and the information regarding the treatment.

Cultural explanations of health and illness, along with understandings of the appropriate social roles of family members and health care providers, are mingled with interpretations of what constitutes thoughtful moral conduct. These various ways of thinking about illness, health care, patient-physician relations suggest this cultural diversity that demands explicit recognition in the field of medicine.

Cultural and Social Diversity

The communication skills needed for exploring multicultural issues are a special case of the core skills used to understand the patient's perspective (both in gathering information and in explanation and planning) and build the relationship. In the present day world, one of continuous fluctuation and of people's migration, our doctors have to become aware of the fact that we are reversing the process and exploring how the core skills of discovering the patient's perspective apply to the specific difficulties of multicultural situations where the doctor and the patient often hold differing perspectives. T.M. Johnson says that "each culture is a textured pattern of beliefs and practices, some of which are coherent and consistent and others contested and contradictory" (Johnson 1995: 95). Johnson suggests that doctors must explore a patient's health beliefs and views of their symptoms and illness in every medical interview. If doctors ignore this advice, they risk making assumptions or value judgments or stereotyping patients. This can lead not only to conflict, but also to inaccuracy. In multicultural contexts – indeed in all cases of diversity between physician and patient – discrimination is a potential problem. Johnson makes the following points which doctors may find useful when consulting with a patient who comes from a culture different from his / her own. A person's culture provides him or her with ideas about heath and illness, notions about casualty, beliefs about who controls healthcare decisions and notions about how steps in seeking healthcare are made. Johnson along with other colleagues has also developed a useful explanatory model which sets out common differences between Western-trained physicians

and traditional ethnic patients. Their main finding was that there were a number of barriers to patient satisfaction, to doctors giving a diagnosis and treatment and the patients receiving it. These barriers were related to the patient's cultural experiences, ideas, beliefs, and expectations as well as language difficulties.

P.R. Myerscough (1992) and Z. Eleftheriadou (1996) have also provided useful information about a number of problems related to culture that are commonly encountered by Western physicians. Examples given include the importance of the family structure and lifestyle, women's role, attitudes towards women and their children, dress, religion, food and fasting, and life and death. W.J. Ferguson and L.M. Candib (2002), in their review of culture, language and doctor-patient relationship, mentioned that ethnic minority patients with insufficient English were less likely to engender emphatic responses from their physicians, were more likely to receive less information generally, and were unlikely to be encouraged to develop partnership in decision making. Here is a list of potential points of difference or barriers to effective interaction that require special attention when the cultural and social backgrounds of the physician and the patient are different. In terms of language, the physician must communicate in a language in which he / she is not fluent, he / she is exposed and has to understand the patient's use of slang, accent or dialect etc. In terms of non verbal communication there are some other problems that may come along and function as barriers in establishing a coherent dialogue between the doctor and the patient: physical touch, body language, proximity (closeness / distance), eye contact. In the category of sensitive issues, probable mention should be made of the following: sexuality – including sexual orientation, sexual practices and birth control, uneasiness about some physical examinations, use and abuse of alcohol and other substances, domestic violence and abuse and sharing bad news. But, since we speak about performing a doctor's job in a different cultural environment, the most important category is, nonetheless, that in which we include the cultural beliefs. Here mention should be made of the interpretation of symptoms (what is considered normal and abnormal), beliefs about efficacy of treatment alternatives, attitudes towards illness and disease, use of complementary or alternative sources of healthcare, gender and age expectations about roles and relationships and the role of the doctor and the social interactions related to power and ways of showing respect. Last but not least, there is another category that may function as a barrier as well in establishing the coherent dialog between the doctor and the patient. This is the category of medical practice issues / barriers in which we may include the extent of doctor-patient partnership, the extent of family involvement, meaning personal and family responsibility for healthcare and treatment, doctor's assumptions, stereotyping or prejudices and the concurrent consulting with a practitioner of complementary or alternative medicine.

Such knowledge of different ethnic or cultural contexts in which a physician practises is useful and, in some cases, vital. It can give the doctor confidence and may allow some "short cuts" to be made. However, the core skills of understanding each individual patient and their particular health beliefs, no matter the culture they may come from, remain essential. Labelling the patient with the attitudes and outlook of a whole race or culture may be just as damaging as not being sensitive to cultural issues at all. The doctor's objective must be to find out each individual patient's unique perspective and experience of illness. This is equally important when both doctor and patient share the same culture. There are therefore two

conflicting communication issues to be faced by the clinician, namely how to avoid making assumptions about a patient based on their ethnicity, and how at the same time to value and be willing to explore and understand cultural differences that might make a considerable difference to how you care for the patient. It is not surprising that the development of mutual understanding and trust between a patient and a doctor from different cultural backgrounds often takes time and effort on the part of both parties.

Conclusions

Medicine is an important context in which to consider the issues of pluralism and diversity for several reasons. Like other domains of practical knowledge, medicine focuses on specific cases that demand we translate abstract or general principles, procedures, values, and intuitions into explicit choices and actions. Doctors have to negotiate a common understanding and course of action with their patients. Moreover, health care involves some levels of interaction starting 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 the health care system. At the center of health care is the clinical encounter which has its own exigencies that include: the relationship between the healer and the sufferer, the vulnerability of the suffering individual, the necessity for clinical responsibility and the ways in which the patient and the clinician are connected to larger social and cultural backgrounds.

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