INTERCULTURAL HEALTHCARE HANDOUT

important concepts in alphabetical order

Assimilation: Assimilation describes the process of social, cultural, and political integration of a minority into a dominant culture and society. This is the *melting pot* theory, when the new group loses its own identity and becomes part of the majority culture. Up until the 1980ies, it was expected of ethnic minorities to 'melt into' the new society and give up their own characteristics. Cultural pluralism is the contrast.

Cultural pluralism Smaller groups within a larger society maintain their unique cultural identities, and their values and practices are accepted by the wider culture provided they are consistent with the laws and values of the wider society. It is not only a fact but a societal goal. Assimilation is not required here, just peaceful co-existence and mutual respect. It is the *mosaic society.* It is the basic idea behind intercultural healthcare. People are entitled to keep their own practices in health care settings as well, as long as nobody is hurt.

Culture The common heritage shared by the people of a society, consisting of customs, values, language, ideas, and objects. Culture is society in you. It is your learnt view of the world. It includes ideas, beliefs, norms and values. It is passed on from one generation to the next but it does change.

Compliance in healthcare, compliance means the patient follows doctor's orders. Non-compliance is a very common problem. Many patients do not do what the doctor told them to do. They don't take the medicine, don't lose weight etc…

Deviance describes an action or behaviour that violates social norms in a society. deviant actions are unacceptable by society's standards. As social norms differ from culture to culture, deviance is relative to culture. Doctors must try to avoid being judgmental about behaviours in intercultural encounters. Something which is morally suspect in one culture might be perfectly acceptable in another. As doctors have great authority, if they label something as deviant, it might have serious consequences for the identity of the patient.

Discrimination The unequal and unfair treatment of individuals or groups on the basis of some irrelevant characteristic, such as race, ethnicity, religion, sex, or social class. A person is treated negatively because he or she belongs to a group.

Ethnic group A group that shares a common cultural tradition, and sense of identity. What we might call a 'people' in lay terms.

Ethnocentrism The tendency to see one's own culture as superior to all others.

Health beliefs: Health related ideas and beliefs of lay (non-medical) people. These ideas might be very different from what is held by medical professionals, but they are logical and make good sense to the lay people believing in them. They depend on culture. People make sense of their symptoms and take action based on their health beliefs.

Health literacy*:* the ability to obtain, read, understand and use healthcare information to make appropriate health decisions and follow instructions for treatment. It is not only whether the patient understands what the doctors say but also the ability to get good information online, being able to decide what information is good, knowing what source to believe and being able to take action to improve one's health. People with higher SES generally have better health literacy.

Intercultural Any interaction between members of different cultures attempting at least to lessen misunderstandings stemming from living together. It can be very difficult. The important thing is the intention. If you want to understand people from other cultures, you will be able to do so.

Illness behaviour- Activities people undertake in trying to make sense of their symptoms, interpret them and seek remedy if necessary

Minority group Any recognizable racial, religious, ethnic, or social group that suffers from some disadvantage resulting from the action of a dominant group with higher social status and greater privileges. It is not necessarily about numbers. There were more black people than white in South Africa during apartheid, but the black people were still a minority as they had less power. There are many studies showing that members of ethnic minorities have worse health status than the majority population (there are some exceptions, for example in the case of dental health.) This is partly due to their lower socioeconomic position. They don't have the resources needed to maintain good health. Their health literacy is lower, too. They have communication problems stemming from language barriers and lower education.

Labelling theory- It is how important fractions of society reacts to deviance that matters not whether or not the act is done. According to this theory deviance is caused by a) the deviant's being labelled as morally inferior, b) the deviant's internalizing the label and c) finally the deviant's acting according to that specific label. Medicine is a strong moral authority. So for

example, if you label a patient as a hypochondriac because he or she expresses pain more dramatically than you think is justified, you will lead to that person feeling like a deviant.

Placebo is a substance or procedure that the patient believes to have the potential to change certain symptoms or external-internal sensations, but which in reality cannot produce the necessary pharmacological or specific effect needed to achieve the change in question.

Prejudice A "prejudged" unfavourable attitude toward the members of a particular group, who are assumed to possess negative traits. This is not action (see discrimination). It is a negative attitude. As members of the helping profession, doctors are expected to control their prejudices (if they have any) and not discriminate.

Race A classification of humans into groups based on distinguishable physical characteristics that may form the basis for significant social identities. Sociologist don't believe that race influences behaviour. Only racism does so.

Racism The institutionalized domination of one racial group by another. It is race based discrimination and prejudice.

Stereotype. It is over-generalized belief about a particular category of people. Stereotypes are generalized because one assumes that the stereotype is true for each individual person in the category. It is based on distortion and is usually negative. In intercultural encounters one of the difficulties is to accept the existence of cultural characteristics without stereotyping members of that culture.

Subculture A group that adopts a way of living that is different from that of the dominant culture. It can be an ethnic minority or any other group that belongs to the majority in some ways but differs in others. See for example punks, football hooligans etc…

The cultural dimension model:

The Hofstede model of national cultures consists of six dimensions. It is a way to compare national cultures along six important dimensions. See this website for details. The website also helps you to learn about cultural characteristics of different nations. It is a good tool to prepare for intercultural encounters. https://www.hofstede-insights.com/models/national-culture/

The six dimensions are scored from 0-100. The model consists of the following dimensions:

power distance index (pdi)

This dimension expresses the degree to which the less powerful members of a society accept and expect that power is distributed unequally. The fundamental issue here is how a society handles inequalities among people. This is relevant in a health care setting as it will influence the doctor patient relationship as well as hospital hierarchy. In low power distance countries patients will want to be treated as partners and your boss will not order you around. In high power-distance countries, patient will accept doctors' authority and the boss orders people around.

individualism versus collectivism (idv)

A society's position on this dimension is reflected in whether people's self-image is defined in terms of "I" or "we." Do people think of themselves as individuals or members of groups? In cultures where individualism is low, there will be huge groups of relatives at the bedside or at consultations and decisions are made in groups, too. In high individualism countries, it is only the patient you will be dealing with, not the family. People from highly individualistic cultures are less likely to be vocal about pain as they don't see the use of complaining while people from collectivist cultures will express pain more fiercely as they rely on group sympathy.

masculinity versus femininity (mas)

The Masculinity side of this dimension represents a preference in society for achievement, assertiveness, and material rewards for success. Society at large is more competitive. Its opposite, Femininity, stands for a preference for cooperation, modesty, caring for the weak and quality of life. Feminine societies are more consensus-oriented. High masculinity cultures are more achievement oriented. They live to work. Low masculinity countries are more care and cooperation oriented. They work to live.

uncertainty avoidance index (uai)

The Uncertainty Avoidance dimension expresses the degree to which the members of a society feel uncomfortable with uncertainty and ambiguity. The fundamental issue here is how a society deals with the fact that the future can never be known: should it try to control uncertainty with a lot of bureaucracy and regulations or just let things happen? Low uncertainty countries are more laid back when it comes to dealing with risks. High uncertainty avoidance countries are very bureaucratic and controlling as this is how they try to reduce uncertainty. It is done through rules and regulations. Defensive medicine (ordering all the possible tests 'just in case') is also more characteristic of high uai countries

long term orientation versus short term normative orientation (lto)

Societies who score low on this dimension prefer to maintain time-honoured traditions and norms while viewing societal change with suspicion.

Those cultures scoring high here take a more pragmatic approach: they encourage thrift and efforts in modern education as a way to prepare for the future. High lto countries are more open to new things and approaches. You can innovate here. Low lto countries do not improvise and are not likely to change protocol. Stick to time honoured ways in these countries.

indulgence versus restraint (ind)

Indulgence stands for a society that allows relatively free gratification of basic and natural human drives related to enjoying life and having fun. Restraint stands for a society that suppresses gratification of needs and regulates it by means of strict social norms. High restraint societies are less verbal about expressing pain and more apt to be able to control their vices in preventive behaviour.

Discussion

The aim of this unit is to help you understand that people's health related norms, values, ideas and beliefs are based on their learnt culture. If you want to understand the way different people behave in health care settings, it is their culture that you must look at in part.

In most countries you are likely to work in, the chance of meeting patients and colleagues from other **ethnic** backgrounds is rather high. This may be the result of migration or the simple fact that more ethnic groups have always lived in the given country. Different ethnic groups often have their own **culture.**

Please do not confuse **ethnicity** with **race**. The concept of race has no sociological significance as we don't think that biology causes differences in behaviour. But unfortunately racism is an important concept as there are still countries where people suffer discrimination based on their race.

Not all members of an ethnic group are the same. We should avoid **stereotyping.** But being aware of cultural characteristics of different ethnic groups can serves as guidelines to understanding each other. Being sensitive to cultural differences can help you deal with situations like the following:

Your Chinese patient is obviously in great pain and he is refusing pain medication. Your Italian patient has a small scratch and he demands pain relief. Your Hungarian colleague seems to be rude. Your Nigerian patient keeps talking about an angry neighbour instead of answering questions about his heart condition. Your Muslim patient seems distressed when you touch her with your left hand. No matter how directly you ask your 22 year old Roma (gipsy) patient about her symptoms she never answers. Instead, it is her mother doing the talking.

To be prepared to deal with situations like this is the reason that intercultural healthcare must be studied.

As illustrated in the lecture by the examples of greeting, it is very easy to misunderstand each other in intercultural situations. A smile, a touch, a look can carry radically different meanings, depending on the culture you call your own. The meaning of time, the level of formality required with people of different positions all vary from culture to culture. The degree to which men and women may interact in public settings is also very different. As members of the multicultural community of Semmelweis, I am sure you have encountered situations like these. As the doctor-patient interaction is a social encounter, the norms governing it might lead to problems if the actors do not share the same cultural background. Misinterpreting verbal and non-verbal communication is one source of intercultural misunderstandings.

Ethnocentrism, prejudice and discrimination may compound the situation. This is a second possible source of problems. Ethnic and racial groups are often **minority groups** who may suffer social disadvantage and negative treatment from the majority society. There is evidence in many countries of institutional discrimination, too, meaning that discrimination occurs in schools, workplaces and health care settings. Doctors must be careful not to label behaviour as **deviant** just because it differs from what is acceptable in their own. To us a simple example, a tone of voice which is deemed too loud in Hungary on a bus might be perfectly ok in some other country. The foreigners speaking loud are not being disrespectful of other passengers, they are just speaking in a voice normal to them in their own environment.

Providing competent intercultural healthcare is important from an ethical and practical aspect as well.

Cultural pluralism denotes a society's acceptance of the coexistence of multiple cultures within itself. In such circumstances, individuals and groups may live according to their own norms and values as long as they do not cause harm to others, and therefore, do not have to conform to any dominant group.

The metaphor of the ‘melting pot’ describes the expectations of assimilation towards immigrants arriving to the great urban centres of the USA in the first half of the 20th century: everyone should give up their previous culture and become American. Assimilation describes the process of social, cultural, and political integration of a minority into a dominant culture and society.

From the 1980ies onwards, the image of the ‘melting pot’ was gradually replaced by the ‘mosaic’ as a sign that today’s immigrants are encouraged to embrace their cultural heritage, to add their minority culture to the shared common culture enriching the society as a whole in the process. Modern developed countries have replaced the “melting pot” approach with the “cultural mosaic” approach, and cultural minorities are not expected to assimilate, or conform; their members may live according to their own norms and customs. In societies embracing cultural pluralism minorities are not required to assimilate but merely to respect the laws of the society they live in.

Healthcare provided without any discrimination, but rather with intercultural sensitivity is not only a moral requirement but also has practical benefits as well. It can increase compliance with therapy, patient satisfaction, health literacy, and helps physicians understand lay health beliefs.

Compliance means that patients cooperate with their doctors, and act upon their advice. The extent to which they do so greatly affects the result of the treatment. If patients are satisfied with their doctor’s explanation, understand it, accept it, and not only endure it, it is more likely that they will cooperate. This is crucial in case of chronic conditions, which may be the basis of lifelong doctor-patient relationships. Although compliance is an important dimension of health care, studies suggests that there is still much room for improvement as a lot of patients do not follow agreements made with their doctors. It is all the more important that doctors’ communication be culturally sensitive. They have to be aware of the type of arguments and ideas that are able to convince someone from a specific culture and most ensure their cooperation.

Another important concept, strongly related to therapy compliance, is **health literacy**. How can one receive reliable information about health? Do individuals understand what they hear or read concerning a given medical topic? Do they understand what their doctors are telling them? Are they able to act upon that information?

Health literacy has various components: cultural and conceptual knowledge, written and oral information processing skills, numeracy, media literacy, medical experience. According to Hungarian and international studies, almost every second person has limited health literacy. What may seem self-explanatory to doctors (e.g. that patients should go to next day’s blood test

on an empty stomach, take two pills a day) may not necessarily be clear to their patients. This is especially true if they belong to ethnic minorities if language is an issue.. It is more difficult to navigate the healthcare system with limited health literacy. They might not know who to turn to and when, and what rights they possess. They might not know which source of information is credible and which is not. They might not fully understand what their doctor is saying due to language difficulties.

Lack of intercultural proficiency may lead not only to patients being unable to understand their doctors, but also to doctors misunderstanding their patient's **communication of complaints**. This may not merely be due to a general language barrier, but also to lack of knowledge concerning some culture-specific concept. If a Roma patient says, "The pills didn't hurt," a culturally adept doctor will understand that the patient believes the pills did not affect the symptoms (it did not hurt the illness); whereas a culturally inept one would wrongly conclude that the patient did not experience negative side-effects.

A fine example of how communication of complaints can be misunderstood concerns the interpretation of pain. The perception, significance, and discourse about pain varies across cultures. While 99% of dentists' patients ask for pain relief in case of drilling or filling procedures in the US, only 1% of patients in China do the same. (Moore et al, 1998). The body part and the procedure is the same, but still, patients with different cultural backgrounds handle the situation in different ways. In some cultures, feeling pain is communicated in a loud and dramatic fashion, while in others, it is done subtly and discretely. The former is more characteristic of Roma people living in Hungary. They do not act so because patients want to manipulate the system. That is simply the way they interpret and express the feeling of pain. In some areas, coping with pain in silence is considered a virtue (for example, in England), in others, its intense and spectacular display is seen in the same light (in Italy). A study – now considered a classic– conducted in a New York hospital examined reactions to pain by Irish, Italian, and Jewish immigrants on the one hand, and at least third generation "Old Americans", on the other, and found fundamental differences between the three ethnic groups. The perception and reporting of pain is also something we have learnt in childhood. A child whose bruises their knee on the playground only to have the parents dismiss it with a simple "That's nothing," or "Big boys don't cry," will react in a different way to pain than one whose injuries elicit a more significant reaction from those in the environment where such injuries are held to be important. Whether someone believes pain to be a part of life, God's way of teaching, a punishment, or an evil to be avoided depends on cultural education. This attitude will then influence how and what information should be divulged to a doctor.

Culturally influenced **health beliefs** play a part in whether a person showing symptoms of an illness will visit a doctor or not, and what that person does with information received from a doctor. A patient always interprets symptoms and personal conditions according to culture-specific norms and knowledge. These interpretations are called health beliefs. In some areas in Hungary, a draft in a room is considered to have serious health consequences. In England, a substantial amount of people imagines viruses and bacteria to be some kind of "bugs". Many Africans believe in curses. If their physicians are unaware of these beliefs, they will have no clue why the patient is carrying on about having left the window open all night, having swallowed a stomach bug, or having a jealous neighbour.

Another important factor to consider is that Western medicine is not the only option people holding themselves ill have to rely on. Professionals who know that Chinese people regard toothaches as symptomatic of a diseased internal organ will be better equipped to convince their patients to receive symptomatic dental treatment until the perceived internal disease can be healed by the method of alternative medicine of their choice.

What is a physician to do with a patient whose belief system does not correspond to the ideas of modern medicine? If the professional believes that belief to be harmful, this must be disclosed to the patient in a clear, culturally sensitive manner. If on the other hand the belief is not harmful and does not disturb the planned treatment, its acceptance might increase the chance of a **placebo** effect.

Placebo is the curing power of the patient's faith in the physician, in God, a charm, a mantra. The effect is a widely known and scientifically proven phenomenon. In other words, if the patient believes prayer or some form of alternative medicine to be effective, it may help the patient even if the perceived procedure is ineffective according to current scientific knowledge.

The application of intercultural sensitivity within treatment recognizes patients' values, norms, worldviews, and medical expectations as well. By doing so, it may increase patient satisfaction. Satisfied patients are more likely to accept treatment plans and cooperate with their doctors.

Patient satisfaction is an important factor of quality assurance. From the viewpoint of quality assurance, the preferred improvement in patients' health is not the only point of significance, but also the positive or negative experiences acquired during treatment. There are various factors influencing patient satisfaction, but one of the most important is their relationship with doctors and nurses. To ensure that the relationship is sound, healthcare professionals must be aware of patients' expectations and culture, and must take these into consideration to the

greatest extent possible. Patient satisfaction is increased if patients of various ethnicities have trust in a given professional because they know they will receive treatment that is culturally relevant to them.

How does one prepare for intercultural encounters?

Being culturally competent when dealing with people from other ethnic groups is part attitude and part knowledge. By attitude I mean accepting cultural pluralism and being open to others. Ethnocentrism must be avoided. for the knowledge part it is worth learning about the culture of the major ethnic groups you are likely to work with.

Finally, the Hofstede **cultural dimension model** can help you prepare for working with patients and colleagues from other nations. It is based on years of research and is regularly updated. It basically looks at whether people from a given national culture accept and expect hierarchical power relationships **(pdi)**, feel more comfortable as members of groups or as individuals **(idv)**, are achievement or quality of life oriented **(mas)** , can live with uncertainty or must have laws and regulations for everything **(uai)** , are willing to innovate or stick to the ways things were always done**(lto)** and finally their willingness to not indulge in pleasurable things for a higher goal **(ind).** These are all aspects that may be important in a medical context.

Check out Hungary in the country comparison tool of the Hofstede insights website https://www.hofstede-insights.com/product/compare-countries/ and see if you agree.

Finally, as the Roma people are the biggest minority in the country in which you now live and study, a few words are in order so that you may know them better.

How many Roma actually live in Hungary? It is a difficult question to answer primarily because, it is not easy to determine who classifies as a Roma person. According to the census of 2011, 316 thousand people described themselves as Roma. The methodology of the census dictates that a Roma person is one who classifies him or herself as such. Consequently, identity is an important factor here.

On the other hand, according to a study conducted by the University of Debrecen between 2010 and 2013, 876 thousand Roma currently live in Hungary (Pénzes, Tátrai, Pásztor, 2018). This survey employed external specialist qualification: they asked municipalities and Roma self-government organizations how many Roma live in a given township. External judgement is an important dimension of a minority's existence, which often speaks more about biases and

prejudices than the self-classification employed by the census, but reveals nothing about identifying with a given culture.

The *Labour Market Overview* published by the Hungarian Central Statistical Office states that as of 2015, 16% of the Roma between ages 15 and 64 in Hungary had not finished their secondary education, and that secondary was the highest level of education for 64%. In case of the non-Roma population, the corresponding numbers are 1% and 19% (KSH, 2016a). According to the study, in 2015, 39% of the age group between 15 and 64 were employed, 16% unemployed, and 45% were inactive. This is largely because more than half of the Roma population live in small villages where it is much more difficult to find employment (KSH, 2016a). The *Living Standards of Households* study of the Hungarian Central Statistical Office asserts that in 2016, the poverty risk rate[1] of Roma people was three times higher than the national average, and 75.6% of them are at risk of falling into poverty or social exclusion. 55.5% of Romani people in Hungary live in severe poverty (KSH, 2016b).

The health of Roma people is also worse than the national average. The Roma Health Report of 2014 published by the European Commission provides an overview of the topic. According to the study, the life expectancy of Roma males at birth is 10 years shorter than non-Roma males', and Roma females' is 18 years shorter than non-Roma females' (European Commission, 2014). Roma people generally start smoking at an earlier age, and a larger proportion of them become smokers in comparison to the non-Roma population. The same is true for alcohol consumption. Although more than half of the Roma never or only rarely rely on healthcare services, they are still more likely to end up in a hospital than the non-Roma (in other words, they go to see a doctor in much more severe conditions, or are taken to the hospital by an ambulance). The report also mentions the 2009 study of the European Union Agency for Fundamental Rights, which states that during the preceding 12 months, 18% of Roma people felt that they were subject to bias and discrimination from health care professionals. A study published in 2018 reported that studies focusing on anti-Roma behaviour describe a permanently high level of prejudice towards the Roma. The study maintains that 30% of the Hungarian population is anti-Roma, 57% are irresolute (dismissive towards Roma in some but not all aspects), and only 13% are accepting.