CULTURE MATTERS – DELIVERING INTERCULTURALLY COMPETENT HEALTH CARE

By: Dorli Kahr-Gottlieb and Martin McKee

Summary: The growing diversity of Europe demands that both incoming and host populations understand each other’s cultural origins and values. This is particularly the case for the health care workforce, whose members are asked increasingly to deliver culturally sensitive care to patient groups with diverse backgrounds. This requires an open discussion about the cultural impact on health and a deliberate addressing of their own cultural imprints by both groups. These issues will be addressed throughout the European Health Forum Gastein 2016 programme, with topics such as values, diversity, migration and refugee health and the responses of health systems being discussed in the Opening Plenary and in parallel sessions such as “Desperate migration and health”, organised by the International Peace Institute and “Refugee health” organised by DG SANTE.

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People on the move
Not for the first time, the population of Europe is changing. Throughout history, people have been moving to, through and from Europe and have been bringing their genes, their customs, and their ideas to Europe. Movement within Europe has been on a similarly large scale, most often in the aftermath of conflict. However, today, the actual migration numbers are greater than ever, reflecting the urgent need for non-European populations to flee their war-ridden territories, the growth in the world’s population and the relative ease of transportation.

It is not, however, only contemporary migration that has shaped the complex cultural landscape of Europe. Ethnic and religious minorities have lived among the majority populations for centuries. Some of these groups, such as Roma and certain religious minorities, have, to varying degrees, retained distinctive cultures. Events in the 20th century, especially during one of the darkest periods of Europe’s history, but also in the post-war period, have powerfully influenced the distribution of different groups across the continent. Movement on this scale and over so many years has had profound implications for the composition of European populations.

Implications for health care
As health facilities reflect the populations they serve, health systems increasingly
provide care for patients from many different ethnic and religious groups and cultures. The growing diversity of European populations, bringing with them an array of cultural values, challenges health care providers to adapt their services to more culturally sensitive care and communication. Anand and Lahiri point out the importance of health care choices and outcomes being understandable not only regarding language but also in terms of other cultural frameworks and experiences. On the other hand, the health workforce also derives from many different cultural backgrounds as Europe has underinvested in training health professionals for decades. This has caused many national health services to depend on migrants, in all aspects of the delivery of care. In the United Kingdom, for example, about 11% of health workers are migrants. In some areas, such as mental health and care of older people, the figures are much higher. Indeed, contrary to what has been alleged by some of Europe’s populist politicians, migrants in hospitals are much more likely to be providing treatment than receiving it.

Both aspects are important. The way that both patient and carer understand many of the things that happen in health care facilities is shaped by their culture. Amongst other cultural dimensions, Hofstede distinguishes collectivistic and individualistic approaches to health. Individualism dominates in societies in which the ties between individuals are loose, who mainly take care of themselves and their immediate family (which tends to be seen in many European countries); while collectivism is seen in societies in which a person is integrated into strong and cohesive groups from birth onward, which continue to protect them with unquestioning loyalty. An understanding of these and other cultural dimensions, like masculinity versus femininity or cultural differences in power-distance/hierarchy, could overcome problems that can arise in many everyday health care situations.

Nowhere are cultural values more important than at the extremes of life, in birth and death. How do we welcome a new life into the world and how do we ensure the best possible departure from this earth? Who should be present at these events? Patients from a collectivistic society will expect a large extended family to be present, with implications for the functioning of the facility. Even after death there may be strongly held beliefs about who can touch the body and what can be done with it. But there is much more. Is it deemed acceptable for someone of the opposite sex to see us naked? Does our understanding of the concept of asymptomatic illness, such as hypertension, requiring long-term treatment, especially when that treatment may be causing side effects? Different cultural groups may fail to respond to treatment, simply because they are not taking it for varying reasons. These examples affect the relationship between the individual patient and the health worker, but there are times when belief systems also impact on others, as when fundamentalist Christians prevent their children from being immunised or Jehovah’s Witnesses refuse a life-saving blood transfusion.

Language and cultural barriers

The situation is complicated further by differences in language. Recent migrants, and especially the extended family of those who move first, may have limited ability to communicate in the working language of the country concerned. Sometimes this can be overcome but in many cases there will be a need for interpretation. This, itself, creates many challenges. Are there sufficient adequately trained interpreters, are their costs covered by the health care system, especially when the language involved is spoken by few people in the country concerned? Also, how well do the concepts of modern medicine translate into such languages? Frequently family members are requested to help, but this raises issues of confidentiality and also, in some cases, control, especially where women depend on male relatives. The challenges are even greater in some areas, such as mental health, where additional barriers and questions of stigmas and taboos may influence the care process.

It is well recognised that language barriers matter; where health professionals and patients do not share a common language there is greater use of diagnostic investigations, poorer uptake of preventive services, worse adherence to self-monitoring, and lower patient satisfaction. In contrast, training health professionals to work with qualified interpreters improves quality of care and patient satisfaction.

Language and culture come together in communication.Hall coined the terms high-context and low-context cultures. A patient from a low-context culture tends to communicate directly and explicitly with the goal of receiving and giving information. High-context communication is generally more context-oriented, less explicit, with those involved tending to “beat around the bush”, with gestures and tone of voice supporting the message. A failure to appreciate these differences can have important consequences for diagnosis and the success or failure of treatment. Nor should we forget that the relationship between the health worker and the patient is bi-directional. Given the dependence of health systems on migrant workers, there may also be cultural misunderstandings when a health worker with a different cultural background is treating a native patient.

Finally, we cannot ignore the uncomfortable fact that, on rare occasions, health workers not only fail to act in the best interests of their patients but even abuse them. This is most likely to occur when patients are disempowered and vulnerable, as is often the case with migrants and other minorities. Such abuse can take many forms, starting from an active disregard for the cultural needs of the patient concerned.

Language is, however, one area where much has been achieved, with the Netherlands and Sweden developing
systems of “community interpreting” since the 1980s, while in several countries a right to have an interpreter is recognised in law. However, in others, such services are simply unavailable. This is an area where technological advances offer considerable potential, whether through the involvement of interpreters located remotely, using applications such as Skype, or if no interpreting is available even automated translation, such as Google Translate, though not optimal, can offer support in an acute care situation.

It is for these reasons that the focus of the European Health Forum Gastein 2016 will be on diversity, offering once again an unparalleled opportunity for sharing ideas and experiences.

References