AM
Rivista della Società italiana di antropologia medica / 11-12, ottobre 2001, pp. 243-253

Cultural competence in Medicine

Xavier Allué

MD, PhD (Anthrop.) Hospital Universitari de Tarragona Joan XXIII, Tarragona (Spain)

It is only recently that the biomedical universe has become concerned with cultural diversity as a factor in health and disease. The growing tide of immigration from Third World countries into the First World has brought the subject to the attention of medical institutions such as the American Medical Association and the American Academy of Pediatrics (1998, 1999).

Various factors play a role in this subject. Just as health care is understood as a right and, in European countries, is regulated as universal and paid for by taxes, the concern about the peculiarities of minorities, how they gain access to care and how these peculiarities affect the management of disease processes becomes important. Across the ocean, in the managed care system of the US, the proper use of resources calls for a continuous concern for efficiency. Curiously enough for a country built on successive waves of immigrations throughout the 20th century, the United States of America has only recently begun to consider cultural diversity. Even more, most references on the subject are related to the questions arising from Hispanic, Latin-American, immigrants (*Committee on Pediatric Workforce*, 1999, Fox, 2000). All the other immigrants in the past, mostly of European extraction, did not have distinctive cultural backgrounds of significant influence in their health, and health histories.

Recently, the *American Government Office for Minority Health* made an effort to assure cultural competence in health care through a well-researched set of recommendations and guidelines (OMH, 2000) known as the standards for *Culturally and Linguistically Appropriate Services* (CLAS). These standards deal with the following points, among others: providing care that is respectful and compatible with cultural beliefs and given in the preferred language; recruiting staff representative of the demographic characteristics of the area; educating and training staff in cultural diversity; employ-

ing bilingual staff and interpreters; using a preferred (secondary) language in communications and written statements and reports; creating easily understood health care materials and leaflets; implementing policies and operational plans to provide CLAS; incorporating CLAS into internal audits; including data about individual patient's race, ethnicity, and spoken and written language in the medical records (and keeping it up to date); facilitating consumer involvement in management, and identifying, preventing and solving cross-cultural conflicts.

Obviously the impact of Latin-American immigration, with its baggage of illegality, plus the probable common reluctance of the newcomers to adapt themselves rapidly to American culture, unlike their predecessors from central and eastern Europe in the 1940's and 50's, is noticeably different and the cultural diversity becomes more evident.

In Spain the immigration phenomenon is fairly new. Migration in Spain has had two distinct aspects. Up until the fourth quarter of the last century Spain had been a net emigrant country. Galicians and Asturians have traditionally emigrated to South America in such large numbers that Buenos Aires, Argentina, houses far more Galicians that any Galician city. During the 1950's and 60's up to 3 million Spaniards flooded the train stations of Germany, the Netherlands, France and Switzerland in search of better-paid jobs, while Spain lingered in the gloom of the last years of Franco's dictatorship. Most of these emigrants returned to Spain in the 70's and 80's. On the other hand throughout these years, more than 4 million Spaniards migrated from the rural areas into the industrial cities of Northern Spain.

These migration phenomena have had little repercussion on matters related to health, disease, and health management. They took place over a period of time when the gradual industrialisation and urbanisation of the country, along with the development of a state-regulated National Health Service, contributed to a homogenisation of health beliefs and health care demand in Spain.

It is the recently growing immigration from African and Central and South American countries that has been attracting the attention of doctors and health administrators, along with the public exposure of immigration as a problem when certain social events have hit the news media [(1)].

However, being a quite recent phenomenon, the pressure on the health system has not been felt or, shall we say the pressure is limited only to certain areas of the country, and concern about cultural diversity is yet to be considered.

Even though the theoretical aspects of the cultural significance of health and disease have been widely studied by anthropologists and some medical practitioners, (noticeably psychiatrists) in Europe, and in Spain, there is a lack of medical literature on the subject.

Cultural diversity in a district hospital

Since the summer of 2000, we have been collecting observations on behaviours, opinions and practices in relation to cultural diversity in a district hospital. This is part of an informal data collection for a larger project on the subject of the theory of hospitals.

Immigration being, as stated above, a relatively recent phenomenon, there is no evidence that the activities of the hospital reflect on the existence of cultural diversity in its midst. Signs, indicators, posters and the like are usually written in Catalan, the official local language. Occasionally some might be written in Spanish, also an official language as in the rest of Spain. I recall the signs and indicators in The Montreal Children's Hospital in the early seventies. They were trilingual – in English, French and modern Greek – as the hospital was located in a predominantly Greek community in downtown Montreal.

However the perception of the hospital personnel is that "there are many immigrants nowadays" [(2)].

The hospital does not list patients by race or ethnic origin. In the admitting procedure there is no place to register any such information. The only related data could be the place of birth and whatever interpretations can be made from the names.

The place of birth is not universally registered and since, as mentioned above, many Spaniards have themselves been immigrants in the past, the records could well be misleading.

Some administrative and managerial meetings in the recent past have considered including racial or ethnic origin on patients' records. It was decided not to on the grounds that it may be unconstitutional (*sic*!), that it may invade patients' privacy or that it may generate problems with other patients if they are informed that they have to share rooms or other facilities with people from ethnic minorities. Curiously enough there are no records of any incident related to either the presence of foreigners or immigrants in the hospital, or complaints of having to share rooms or other facilities. Occasionally the nursing personnel have made arrangements so

that people of different ethnic origin do not have to share the same room but no more than when this type of arrangements have to be made for differences in age or the behaviour of patients or families.

When the nursing personnel are questioned on these matters they may make vague references to problems, always minor, related to the presence of gypsy families in the wards. They usually refer to the common custom of Spanish gypsy families of coming to visit hospitalised relatives in large crowds. It may be mentioned that *«... gypsies are camping on the wards ...»* or *«... well, gypsies tend to do that ...»*. The author's experience is that, even though gypsies do tend to "invade" the hospital whenever they have a relative admitted, particularly if he or she is going to undergo a surgical procedure, the only annoyance is the sheer presence of large numbers of people in often closed quarters. Mostly they are just there, quiet and respectful of the hospital norms and policies [3].

A question was put to the personnel involved in the maternity service. Supposedly a growing number of immigrant mothers are having babies. The public hospital is state owned and all health care is covered by the National Health System – in Spain universal, free and paid for by taxes – it should take a greater load of foreign mothers. When the professionals were asked how many immigrant mothers had their babies in the hospital most answers were "quite a few", "many", "more than a few years back", and the like. When asked to volunteer a percentage figure the answers varied considerably, the vast majority exaggerating the actual figures. Tables 1 and 2 show the answers and the real figures.

The professionals directly in charge of the care of the delivering mothers sensed that the actual presence of immigrant mothers was far larger than the reality.

Table 1. Supposed percentage of mothers of non-Spanish ethnic origin delivering babies in hospital Joan XXIII, year 2000, according to health personnel

Midwives	Staff obstetricians	Obstetric residents	Anaesthetists
5-10%	10-15%	10-15%	Less than 5%

Table 2. Ethnic origin of mothers delivering babies in the Joan XXIII hospital in 2000

TOTAL	Mahgrebi	Sub-Saharan	Other non-EU	EU non-Spanish
1411	50 (3.54%)	9 (0.63%)	13 (0.92%)	20 (1.41%)

Percentage of non-Spanish 6.52%

When confronted with the actual figures the comments vary. But most were ready to accept that immigrants were more "visible". Some related the erroneous appreciation to language difficulties, as many African women speak no Spanish at all. Having to deliver a baby, they say, requires the co-operation of the mother in following certain instructions. Language barriers, right in the middle of a rather hectic situation such as a baby's birth, are perceived as added difficulties and thus more easily remembered.

These difficulties are extended to having to explain to the father or the family the results of the situation: whether everything had gone all right, whether the newborn is a boy or a girl and the like. Even though most male immigrants have a better knowledge of Spanish (or Catalan, for that matter) the more or less dramatic circumstances of childbirth may increase language distances. An anxious father may misinterpret instructions and information given at the door of the delivery room by a harried midwife or obstetrician, particularly if he does not fully master the language.

In fact the midwives had the closest guess, according to the tables, not the anaesthetists explained by the others as «they do not have to talk to the patients» (4) and, thus, they are not influenced by the language difficulties.

A few members of the personnel, including the anaesthetists, commented on matters related to religious beliefs and Islamic integrationist exigencies for the mother to be treated only by female personnel. This situation has taken place in a few cases. There is no written hospital policy to deal with these matters. Occasionally the Obstetrics service has tried to comply with the patients' requests as all midwifes the majority of the Obstetrics residents and half the anaesthetists are female. Otherwise the family has been informed that no female personnel was available, all the senior obstetricians typically being male, and the procedures have been eventually carried out without much of a problem.

In no case did anyone verbalise that there could be "cultural" barriers or differences as such. Foreign immigrants are viewed as "different", actually "strangers", mostly as the words for foreign and extraneous are very close in Spanish (*extranjero* and *extraño*) and in Catalan, the official language of Catalonia (*estranger* and *estrany*). At the same time (see Allué, 2000) cultural factors among our health personnel are more commonly referred to as differences in behaviours, habits, daily or weekly schedules, diet and, also, religion, but hardly ever as illness or disease explanatory models, health beliefs or creeds. "Culture" is equated, then, to "knowledge" or education. Thus the differences present in foreign immigrants are usually dismissed as caused by poor or little education, "*incultura*", sheer igno-

rance, in the same line that many health problems of both immigrants and Spanish citizens are due to lack of health education ("*educación sanitaria*") [5].

This aspect of "lack of culture", or ignorance, is also commented on over the treatment of other foreign nationals as well. The hospital receives a considerable number of tourists, particularly during the summer months as several million holidaymakers stay in the tourist resorts of the *Costa Dorada* or just drive towards the Mediterranean coast further south.

The hospital administration provides interpreters during the summer season to help tourists and doctors to understand each other. In the recent past the interpreters spoke mostly English, French, German and Dutch. In the past three years a large contingent of Russian and Ukrainian tourists have flooded the hotels on the coast but Russian interpreters were only enlisted this past summer. No interpreters for African languages (Arabic, Chelja o Swahili) have been provided nor even considered. These differences in the consideration of foreigners have only one explanation: money talks.

However, as difficulties arise with hospitalised tourists, once the language barriers have been set aside, the hospital personnel often mention that the tourists that come to our area, as tourist travel keeps getting cheaper and cheaper, belong to the uneducated lower classes, ignorant and unable to understand what they are told and undisciplined. Once again, culture is equated to "education". Peculiarly enough and in relation to tourists coming from European countries, the hospital personnel may say: "... they do not *even* speak English ..." as the English language is becoming more and more the *lingua franca* in the tourist and travel world [6] and in medical environments as well.

Doctors' culture/patients' culture

Most physicians at the hospital would place cultural issues in a quantitative fashion: more culture-less culture, more knowledge-less knowledge. The reality of a qualitative distance is hardly considered. It is generally assumed that the patients belong to the same culture and, the specifics of medical knowledge aside, what is considered "common sense" should suffice to reach a common ground of discussion when interrogating the patients, taking the medical history, or giving information during the hospital stay or with the discharge summary.

This last element, the discharge summary, called in Spanish "*informe de alta*" or "*alta*" for short, has been compulsory in all patients' discharges since the late eighties, when the Spanish General Health Law was passed.

Even though the philosophy of the law was that every patient had the right to a written statement on whatever resulted from a hospital stay, the discharge summary had its origins in the documents issued by doctors to enable or disable a worker to carry on his duties when the Spanish Health system was dependent on the Department of Labour back in Franco's days [7]. Therefore, the document style is rather medical and usually contains a lot of medical jargon, the laboratory results are given in numerals and units, the diagnoses are explained in the terms contemplated in the ICD-9 WHO code and the recommendations are limited to a short sentence or one line, usually including a return appointment date and hardly anything other than the dose and name of the medicines to be taken.

Most doctors admit that the vast majority of their patients hardly ever understand any of what is written in the discharge summary. Many would argue that the discharge summary is meant for the family physician and also to be a typewritten summary of the history and progress notes so they can be read easily, a task that is usually quite difficult because of the proverbial indecipherable handwriting of many doctors. Other considerations include the legal value of the document since it may be used in litigation cases as the basic proof of the care given. At any rate, it is given to the patient on discharge from the hospital but is not "meant" for the patient.

Thus, the final medical act, the discharge after a hospital stay, consolidates and very often increases the cultural distance between patients and doctors. To my knowledge nobody has ever considered including any of the patients' opinions or views regarding their ailment in the summary. Only occasionally may one find such information in psychiatric discharge summaries, but this is also meant for the family physician, particularly if there are discrepancies between what doctors feel is wrong with the patient and the patient's own view. The information is thus included as a warning.

Having defined the concept of explanatory models of disease, Arthur Kleinman (1980, 1997) expressed his frustration over the use of such a term by the residents at his hospital. After the idea had been extended amongst the junior physicians while in Medical School, and the concept had been clearly explained in all its meanings, he found that when students presented a patient's case on the rounds, they would thoroughly relate that the patient may have such and such symptoms; such and such complaints; such and such physical signs; such and such biological test results or X-rays AND such and such "explanatory model" of his/her disease, as if the explanatory model was one more clinical feature to be collected with the rest of the clinical data, to be considered and analysed and eventually weighed against all the others but, obviously, well within the

understanding of biomedical culture. The explanatory model had no more status than another bodily peculiarity such as the blood pressure, a skin rash or an X-ray image which, in any case, would rate as more objective, the explanatory model merely being the patient's subjective opinion.

Culture is the result of a combination of such factors as the language, history, learned knowledge and experiences of any social group. In the physician/patient intercourse each factor carries its own load of cultural values and norms, uses the vocabulary, syntax and semantics learned and evaluates every new experience on the basis of previous lived or learned experiences. Their personal histories are inseparable from the concepts of something as intimate as their own bodies and their own sense of health and illness, once it is framed in the grid of their social relationships. No patient, particularly no conscious patient, can be separated from his/her culture and understanding. But even the poor victims of an emergency in cardio-respiratory arrest reaching the Trauma Room deserve their cultural background, beliefs, religious or personal feelings to be taken into account while their medical care, resuscitation included, is carried out. Otherwise these victims will eventually be victims of the imposition of cultural values that may not be theirs.

The professionals have their own cultural conditionings. The medical jargon, learned in Medical School, is eventually incorporated as a language and many doctors, especially the young, have difficulties translating the medical vocabulary to lay people's language. In their information interviews with patients, many residents state whatever they have written in the charts or discussed with their seniors and then spend some more time putting the information in common terms if they happen to know them. Occasionally they may borrow some vocabulary from their interlocutor but more often impose their own (medical terms) in the dialogue.[8] What is more, some doctors, easily identified as rather conservative, resent the patients' use of medical terminology as if patients were taking something away from them.

It is in this setting that the idea of the need for a certain cultural sensibility or cultural competence finds its space.

The idea is to foster physicians' interest in the cultural peculiarities of immigrant ethnic minorities in order to understand and eventually treat their health problems.

The proposals go about including ethnic minorities' cultural beliefs, vocabulary, myths and popular knowledge in educational programmes in medical schools, residency programs and postgraduate continuing education programmes.

All those laudable efforts, however, miss one major point: they fail to consider the cultural distance between doctors and patients as they are. It is not a matter of doctors and all health personnel learning how to deal with the cultural differences of immigrant minorities but, rather, how to deal with the cultural determinants in *all* patients. Cultural competency means bridging the cultural distance between the increasingly growing ensconcement of medical and health personnel in hyper-technified, complex biomedical knowledge and all lay people, not just some marginal minorities.

In this sense, all our patients can be considered to be "immigrants" in the biomedical culture. It would not make sense to offer the minorities what we are outrightly denying the prevailing majority.

Cultural competence has been defined by health care providers and health care organisations as the ability to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter.

Well, cultural competence is also a professional commitment to bridge the gap that advancing science is creating with the people who are to benefit from it.

Medical Anthropology has the responsibility to make cultural diversity feel at ease with biomedical progress, and vice versa. *Clinically Applied Anthropology* has yet to be introduced as a practice for anthropologists in Spain as they hardly get a chance of intervention in most biomedical settings, being limited to research projects or the occasional participation in programmes related to admittedly social subjects such as mental health or AIDS.

Perhaps the need to develop cultural competence will bring about a common ground of interrelations for anthropologists and physicians, and will lead to a better understanding of health, disease and improvements in care.

Notes

(1) During 2000 a new immigration law was passed by the Spanish Parliament. The Government party, the Popular Party, which won the new elections and proceeded to change the law, making it more restrictive, contested the law. This situation created trouble with the illegal immigrants and probably increased the illegal influx of North-African immigrants through the Gibraltar straits with the increasing incidence of the sinking of small boats ("*pateras*") and drowning victims. Immigration has become the single most important issue in the news in the past few months in Spain.

(2) The figures for immigration in Catalonia are readily available through the *Institut Català d'Estadística* webpage (www.idescat.es) in English. The latest figure on foreign residents is 1.9% of the population, a rather meagre quantity by the standards of any other European country.

(3) An entirely different matter is whenever the admitted gypsy patient is involved in illegal activities, mostly drug addiction. Unfortunately the Spanish gypsy community has acquired a heavy load of drug dealing and drug addiction and the related problems of crime and AIDS. Whatever problems may arise are more likely to be related to crime, marginality or mental derangement rather than racial or ethnic issues.

(4) Actually anaesthetists do talk to patients in the pre-op procedures, but in many emergency situations such as a caesarean section, they may deal with patients in a wakeful state for only a very few instants.

(5) However, no one ever dares to say who is responsible or how health education should be imparted.

(6) For instance, indications and signs in the metropolitan underground trains in Barcelona are bilingual: in Catalan and English.

(7) The document still exists as such: the "*baja*" paper is issued by the family doctor assigned to the worker and presented to his/her employer. When the patient recovers a new paper is issued, the "*alta*". This nomenclature originated in the 19th Century and is common to many registries in Spain. When someone is "active" in the registry he is "*alta*" and when he becomes inactive "*es dado de baja*". "*Alta*" and "*baja*" in Spanish have spatial connotations (up and down, or high and low). Also casualties at war in Spanish are called "*bajas*".

(8) To use the term "virus" to refer to common febrile illnesses of childhood is relatively new in Spanish. Commonly mothers would use medical diagnoses such as tonsillitis, pharyngitis, etc. due to the prestige of the medical jargon and what has been termed the "loving dictatorship" (de Miguel, 1984) acted by paediatricians upon Spanish mothers during many years of Franco's era. As a mother put it, «... my child has a pharyngitis, but these mad doctors call it a *virus* ...»

References

Allué, X. (1999) "La relación asistencial. Factores socioculturales". *Trabajo social y salud,* num. 32, p. 437-451.

Allué, X. (2000) "De qué hablamos cuando hablamos de factores culturales desde la asistencia pediátrica". In Perdiguero, E. and J. M. Comelles (eds.) *Medicina y Cultura. Estudios entre la antropología y la medicina*. Barcelona: Ed. Bellaterra. p. 54-70.

Comelles, J. M.; Bardají, F.; Mascarella, L. and X. Allué. (2001) *International migrations and health care in Spain*. In press.

Comelles, J. M; Mascarella, L.; Bardají, F. and X. Allué (2001) "Some health care experiences for foreign migrants in Spain". In Vulpiani, P.; Comelles, J. M and Van Dongen, E. *Health For All, All In Health. European Experiences On Health Care For Immigrants*. Roma: Cidis/Alisei. p. 144-173.

Committee on Pediatric Research (2000) "Race/Ethnicity, Gender, Socioeconomic Status-Research Exploring their Effects on Child Health". *Pediatrics*, num. 49, p. 1349-1351.

Committee on Pediatric Worforce (1999) "The culturally efective pediatric care". *Pediatrics*, num. 83, p. 65-73.

De Miguel, J. (1984) *La amorosa dictadura.* Barcelona: Anagrama.

Flores, G. (2000) "Culture and the patient-physician relationship: achieving cultural competency in health care". *J Pediatr*, num. 136, p. 14-23

Flores, G.; Abreu, M.; Schwartz, I. and M. Hill. (2000) "The importance of language and culture in pediatric care: case studies from the latino community". *J. Pediatr*., num. 137, p. 842-848

Fox, K. (2000) "Cultural issues in pediatric care". In Berhman, R. E. [*et al*.] *Nelson's Textbook of Pediatrics*. 16th ed. Philadephia: WB Saunders. p. 8-10.

KLEINMAN, A. (1980) *Patients and healers in the context of culture*. Berkeley: University of California Press.

KLEINMAN, A. (1997) "'Everything that really matters': Social suffering, subjectivity and the remaking of human experience in a disordering world". *Harvard Divinity Bulletin*, vol. 26, num. 4, p. 11-17. William James Lecture Series.

OFFICE OF MINORITY HEALTH, PHS, US Dept. of Health and Human Services, Federal Register, Dec. 22, 2000, 65:80865-80879 (available also at http://www.omhrc.gov/clas/finalcultural1a.htm)

PACHER, L. M. (1994) "Culture and clinical care: folk illness belief and behaviour and their implications for health care delivery". *JAMA*, num. 271, p. 690-694.