

CULTURE, INTERCULTURAL COMMUNICATION, AND HEALTH CARE

On January 21, 2013, Dr. Margaret Chan, director general of the World Health Organization (WHO), in a speech to the WHO Executive Board in Geneva, Switzerland, asserted this:

The climate is changing. Antibiotics are failing. The world population keeps getting bigger, and older. The rise of chronic noncommunicable diseases is relentless. The microbial world continues to deliver surprises. Public expectations for health care are rising. Budgets are shrinking. Costs are soaring at a time of nearly universal austerity. Social inequalities are at the worst levels seen in half a century. Conflicts are rife. The health consequences, also for civilians, are severe. The will to relieve human misery is strong but gets blunted by too few resources, too little capacity, and too much uncoordinated aid.³⁶

Although advances in health care over the past century have been monumental, the status of the world's health remains in flux. Reflecting on the words of Chan, consider the following four health care scenarios in four cultures:

Researchers in Switzerland have developed a new medical device that identifies irregularities in heart rate and can, within seconds, alert doctors and patients via their smartphones. The device consists of four noninvasive electrode sensors attached to the skin and linked to a radio module and computer chip, which clips to the patient's belt. Heart data are then sent to the patient's smartphone, where they can be viewed in real time.³⁷

Cao gio, also known as coining or coin rubbing, is a dermabrasive (i.e., skin) therapy thought to alleviate symptoms from a number of illnesses (e.g., headache, body aches and pains). Coining is used by a number of ethnic groups from Southeast Asia. During coining, the skin on the patient's chest and back is lubricated with oils or balms and then rubbed firmly with the edge of a coin. The procedure often generates considerable skin damage (e.g., burning and scarring). In some cases, the oils and balms used are toxic and, if absorbed, lead to camphor intoxication. In these cases, the patient can suffer nausea, vomiting, confusion, tremors, and even convulsions.³⁸

The majority of African American women (i.e., more than 80%) are either overweight or obese. These women are at significant risk for a range of serious health issues, including high blood pressure, high cholesterol, arthritis, stroke, gall bladder disease, heart disease, diabetes, and some cancers. The high obesity rates among these women are often attributed to cultural factors, such as a preference for high-fat and high-calorie foods, a distorted frame of reference for normal and healthy body weight, and a lack of physical activity. Societal and environmental factors also contribute, including poverty (e.g., high-calorie foods

are less expensive) and limited opportunities for recreational physical activity (e.g., unsafe neighborhoods).³⁹

Rural Dominicans often combine folk and professional medicine to manage their health care. One rural Dominican woman took modern antibiotics for a vaginal infection yet taped garlic to her palm to cure an infection in her hand and relied on prayer to heal an infection in her infant son. In another case, a local faith healer dissolved modern antibiotics in tea, then rubbed the potion on a sick child in a prayer ritual to eliminate the child's fever.⁴⁰

As the previous four scenarios suggest, people from diverse cultural backgrounds face different health issues and carry vastly different assumptions about their health. Recall from Chapter 1 that culture is defined as *an accumulated pattern of values, beliefs, and behaviors shared by an identifiable group of people with a common history and verbal and non-verbal symbol systems*. Different cultural groups have different beliefs, values, and behaviors associated with their health and health care. These different belief and value systems translate into diverse theories and practices about the causes and treatments of illness. As Hope Landrine and Elizabeth Klonoff note, "The health beliefs of professionals and laypersons alike are structured and informed by a cultural context from which they cannot be separated and without which they cannot be fully understood."⁴¹

Lay Theories of Illness

In his classic text on culture, health, and illness, Cecil Helman suggests that people from different cultures generally attribute illness to one of four causes: (1) factors within the individual, such as bad eating and exercise habits; (2) factors within the natural environment, such as air and water pollution; (3) societal factors, such as intergroup conflict, poor health care facilities, and the like; or (4) supernatural factors, including religious beliefs, fate, and indigenous beliefs.⁴² Helman notes that these attributions for health and illness reflect the particular culture's general value orientations. For example, persons in Western cultures such as the United States, which are often individualistic, generally believe that the origins of illness are rooted in the individual patient. As Helman explains, the responsibility for one's health generally, though not exclusively, rests with the individual. So ill health is often considered to be the result of the individual's bad habits, such as poor diet, lack of exercise, damaging lifestyle choices, poor personal hygiene, alcoholism, drug abuse, or other deviant behavior. Thus, from this perspective, one should feel guilty when faced with ill health. Persons in this orientation do understand that other factors contribute to illness, such as heredity (e.g., cancer, diabetes) and environmental conditions (e.g., pollution, allergens, poisons, food additives, weather).⁴³ Typically, these cultures rely on a biomedical model of health care, in which the fundamental assumption is that diagnosis and treatment of illness should be based on scientific data. Helman observes that in many non-Western cultures, illness is often attributed to societal and/or supernatural conditions. Societal attributions are based on intergroup or interpersonal conflict within the culture. Here, according to Helman, one of the most common causes of illness is thought to be witchcraft. According to a 2010 Gallup poll, belief in witchcraft is widespread throughout sub-Saharan Africa and affects how believers in witchcraft see

their lives and their health. For example, 95% of persons surveyed in Ivory Coast, 80% of those in Senegal, 77% of those in Mali, and 75% of those in Niger believe in witchcraft. On average, 55% of persons in the 18 African countries surveyed believe in witchcraft. The study found that believers in witchcraft rate their general well-being lower than do those who do not believe in witchcraft.⁴⁴ Helman notes that among believers in witchcraft, certain persons, often women, are thought to have mystical powers that can harm others. So conflicting families or groups may call on a witch to put a curse (e.g., illness) on their opposition.⁴⁵

Supernatural conditions, such as religion, pure fate, and indigenous belief systems, are also thought among certain cultures to be the origin of illness. Here, one's ill health is believed to be caused by the intervention of a supernatural being. This is also referred to as the *personalistic* approach. Helman explains that persons in such cultures may believe that their illness is God's punishment for their misdeeds, such as not attending church regularly or not saying their prayers. In Western cultures, such as the United States, persons might attribute their illness to bad luck; that is, they believe their illness is the work of fate.⁴⁶

Helman is careful to point out that persons in many cultures make multicausal attributions for illness. So while persons in Western cultures may rely on the biomedical approach for their health, they may also believe that a supernatural force is responsible in some way.

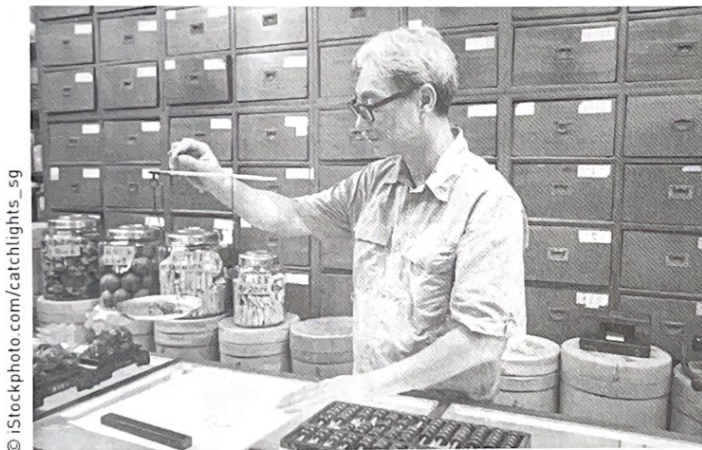


PHOTO 11.2

Medicinal treatments vary considerably across cultures.

health

communication

The study and use of communication strategies to inform and influence individual decisions that enhance health.

Health Care and Resources Across Cultures

Health care is clearly one of the dominant forces that people in all cultures must manage. But the available resources to manage health care differ considerably across cultures. One of the biggest challenges facing the world's countries is the monumental cost associated with health care. U.S. health care spending grew nearly 4% in 2017, reaching \$3.5 trillion (i.e., \$3,500,000,000,000), or

\$10,739 per person. As a share of the nation's gross domestic product, health spending accounted for almost 18%.⁴⁷ Government expenditures on health care as a percentage of total expenditures vary considerably across the world, as does the number of physicians available to treat patients (see Table 11.3).

In addition to the disparities in terms of cost, number of physicians, and life expectancy, to name only a few, the differences in how cultures address health issues are also significant. It is in these contexts that communication plays a key role.

Health Communication

The study of **health communication** is relatively young compared with other areas of communication study. Kevin Bradley-Wright and his colleagues point out that the study

TABLE 11.3 ■ Government Expenditures on Health Care Across Cultures

	Government Expenditure on Health Care as a Percentage of Total Government Expenditures	Physicians per 10,000 People
Afghanistan	8.5%	2.7
Brazil	9.5%	18.9
Canada	10.9%	20.7
Central Africa Republic	3.8%	0.5
Chad	3.6%	—
China	5.4%	14.9
Cuba	8.6%	67.2
France	11.6%	31.9
Germany	11.3%	38.9
Iraq	4.8%	6.1
Kuwait	2.6%	17.9
Mexico	6.1%	21.0
Nigeria	3.4%	4.1
Pakistan	2.8%	8.3
Saudi Arabia	3.8%	24.9
United Kingdom	9.3%	28.1
United States	17.0%	24.5

Source: World Health Organization. (2015). *World Health Statistics 2015*. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland.

of health communication began in the mid-1970s. At about that time in U.S. history, professional and social attitudes about health and health care transitioned. Bradley-Wright and his colleagues note that physicians and other health care providers historically have addressed health care issues via a biomedical model of medicine that focuses on the scientific method and procedures for treating disease. This approach uses physical evidence such as laboratory results, X-rays, MRIs (magnetic resonance imaging), and surgery to diagnose and treat illness. Since about 1970, health care workers have begun to include a psychosocial approach to illness. This approach does not ignore the scientific

patient-provider communication
Face-to-face interaction between the patient and his or her individual health care provider.

component of health care but expands it to include other variables that affect health, such as a patient's culture, ethnicity, coping abilities, and other socially oriented events. The study of health communication typically focuses on this latter approach to health care.⁴⁸

The Centers for Disease Control and Prevention and the National Cancer Institute define health communication as "the study and use of communication strategies to inform and influence individual decisions that enhance health."⁴⁹ The study of health communication covers a vast array of topics, far too many to address in this chapter. But one area in particular that has direct relevance for intercultural communication is **patient-provider communication**. The focus here is on the face-to-face interaction between the patient and his or her individual health care provider, which includes physicians, nurses, psychiatrists, psychologists, and counselors, among others.

STUDENT VOICES ACROSS CULTURES

HEALTH CARE IN THE FAROE ISLANDS



Vivian Filisþóttir Hansen

Vivian Filisþóttir Hansen

I was born and raised on the Faroe Islands, located in the North Atlantic. I am 31 years old and graduated from St. Norbert College in 2013.

Because the Faroe Islands is such a small country, everyone knows one another in some way; so the doctor-patient relationship is much more personal than formal. Physicians are approachable but at the same time keep a professional environment. The

majority of physicians practicing medicine on the Faroe Islands are schooled in surrounding Scandinavian countries, but in the past 5 to 10 years, many of our physicians have been educated in Poland because the programs there have a very good reputation.

In the Faroe Islands, we pay an annual fee of about \$550 for health care. This covers as many doctor and hospital visits as we need. We start paying this annual fee when we are 16 years old. Before that, we are on our parents' health insurance (the \$550 fee does not change).

When making an appointment, we call the doctor's office and get an appointment within 2 days, depending on the seriousness of our situation. We always meet with doctors directly, and they give a diagnosis and send the patient to a specialist if needed. The quality of care is good, but the wait to see the doctor can be a little long (about an hour but, again, depending on the severity of the illness). Doctors treat patients with respect and take their opinions into consideration; however, they ultimately give patients the treatment they think fits best.

Dr. Julian Wohl, professor emeritus of psychology and former director of the Clinical Psychology Training Program at the University of Toledo, wrote that just about all psychotherapy (and by extension, health care) is intercultural. Wohl asserted that health care

is intercultural whenever cultural differences are present within the four elements of any health care communication context—that is, the health care provider, the patient, the locale or setting, and the method to be employed. He explains that to ignore the cultural differences in any of these elements is to court disaster.⁵⁰ Likewise, Tina Carmichael, a registered nurse and respiratory therapist at Boston Children's Hospital, writes: "To become successful practitioners as a body of nurses, we must address the challenges of a nonhomogenous client-centered practice as well as a nonhomogenous work place."⁵¹

Patient-Provider Communication

Dr. Debra Roter, a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health, points out that, historically, the relationship between the provider and patient in medical contexts has been asymmetrical. Because of their advanced education and experience, providers (e.g., physicians) hold more power than patients and are responsible for managing the interaction with patients, while the patients are generally passive. This approach, which was dominant throughout the 20th century, is called *paternalism*. In contrast, an approach labeled *consumerism* or *mutual participation* has been the popular model in the 21st century, in which the patient sets the agenda and shares responsibility for decision-making. As Roter describes, in this model the provider accommodates patient requests for information and services.⁵²

The degree to which paternalism and consumerism are practiced across cultures has been the focus of a number of studies. Theoretically, we would expect that in large power distance and collectivistic cultures, a paternalistic approach might continue to dominate patient-provider communication. But several studies have shown that this is not the case. In an oft-cited study, Bennett, Smith, and Irwin examined patient preferences for participation in medical decisions across several cultural groups, including Hong Kong, Australia, the United States, and China.⁵³ Their results revealed several interesting and countertheoretical findings. They found that (a) Hong Kong patients prefer to participate in medical decision-making with their physicians instead of deciding for themselves or delegating such decisions to their doctors; (b) students from Australia, China, and the United States overwhelmingly prefer joint decision-making with their doctors; and adult participants in three cities in mainland China do not prefer to delegate decisions to doctors when given the opportunity to participate in such decisions. Bennett and his colleagues conclude the following:

The outcome is singular, strong, and consistent. Regardless of age, culture, and nationality, patients prefer to take part in joint decision making with their doctors. The convergence of findings on this issue is remarkable. Patients prefer to discuss and participate in decisions regarding their medical care. Chinese participants do not differ from those in Australia, the United States, or the United Kingdom in regard to the part they want to play. What we have found on this matter is cultural similarity, not cultural difference.⁵⁴

Alden, Merz, and Akashi studied preferences for physician decision-making styles among young adult Japanese and U.S. patients. Recall that Japan is generally considered a collectivistic culture, while the United States is considered individualistic. In their

study, patients were asked to respond to a treatment scenario that described one of three physician decision-making styles, including a passive approach in which the physician makes the decision, a shared decision-making approach in which the patient and physician decide together, or an autonomous style in which the patient decides from a set of medically appropriate alternatives. Their results showed that Japanese respondents evaluated the autonomous interaction most positively. U.S. respondents evaluated the shared decision-making scenario most positively. Alden and his colleagues argue that despite cultural differences, both Japanese and U.S. respondents preferred higher participation in decision-making. Consistent with the findings of Bennett and his colleagues cited earlier, these findings suggest that passive patient approaches (i.e., paternalism) are falling out of favor as patient-centered care expectations (i.e., consumerism) become normative, even in traditionally large power distant cultures.⁵⁵

But in Malaysia, a collectivistic large power distance culture, shared decision-making among physicians and patients is rarely studied or practiced. Medical researchers, including faculty in the School of Medicine at the University of Malaya, conducted a comprehensive review of literature on the subject and interviewed medical education researchers, key opinion leaders, governmental officials, and patient support groups. Their goal was to study the extent to which patient participation was incorporated into the medical curriculum, health care policies, and legislation in Malaysia. Their results showed few studies on patient participation in decision-making in Malaysia. They also found that while physicians were aware of informed consent, few practiced shared decision-making with their patients. Moreover, they discovered limited instruction about shared decision-making in both undergraduate and postgraduate curricula and a dearth of accessible health care information for patients. They also found that while professional medical organizations endorsed patient involvement in decision-making, there was no implementation plan.⁵⁶

Kim, Smith, and Yueguo investigated the influence of patients' individualism (i.e., independent self-construal) and collectivism (i.e., interdependent self-construal) on preferences for medical decision-making among patients in Hong Kong and Beijing, China. In their study, they asked patients to rank four medical decision-making choices: joint decision-making, delegation of decision to physicians, deciding alone, and family decision-making.⁵⁷ Their findings showed that participants from both Hong Kong and Beijing preferred joint decision-making. However, the patients' level of collectivism and/or individualism affected their ranking of choices. The patients' level of collectivism was predictive of doctor decision-making and family decision-making. The patients' individualism was not. Individualism was predictive of joint decision-making and patient decision-making but not of decision-making by the family or doctor alone.

Within the United States and internationally, racial and ethnic disparities in health care are widely documented. In one study, Sleath, Rubin, and Arrey-Wastavino examined the extent to which physicians expressed empathy and positiveness to Hispanic and non-Hispanic White patients during primary-care visits. Their results showed that physicians expressed empathy at equal rates to Hispanic and non-Hispanic White patients. However, when examining only Hispanic patients, physicians were significantly more likely to express empathy to patients whom they knew better. Also, physicians expressed positiveness to non-Hispanic White patients more often than to Hispanic patients.⁵⁸ Lin and Kressin found that Black Americans and Hispanic/Latino Americans received less information from their doctors about the rationale for their treatment recommendations.

Both Black Americans' and Hispanics/Latinos' doctors less often cited their own experiences or scientific research as a reason for treatment recommendations.⁵⁹

Researchers in Australia sought to identify communication factors affecting health care for Aboriginal patients from the Yolngu language group of northeast Arnhem Land. In this study, interactions between Aboriginal patients and health care workers (non-Aboriginals) were videotaped, and in-depth interviews about perceptions of the interaction were conducted with all participants in their first language. The authors report that a shared understanding of key health-related concepts was rarely achieved. Moreover, they report that miscommunication between the health care staff and Aboriginal patients often went unrecognized. Sources of problematic communication included a lack of patient understanding of the language, a lack of medical knowledge by the Aboriginals, and marginalization of the Aboriginals by the health care workers. The authors concluded that communication problems were so pervasive that even trained interpreters provided only a marginal solution.⁶⁰

As we saw in Chapter 8 on nonverbal communication, a person's accent plays a role in how that person is perceived by others, especially if the person speaks with a nonnative accent. In one study by Rubin and colleagues, participants were exposed to recordings of a physician speaking in an Asian accent and in a standard English accent. Participants then rated the physician's superiority, interpersonal attractiveness, dynamism, professional competence, their (the participants') intent to comply with the physician's instructions, and recall of the physician's instructions. Interestingly, the English-accented physician was rated higher than the Asian-accented speaker on only one of the variables—interpersonal attractiveness.⁶¹

In an intracultural study conducted in the United States, physician Rachel Johnson and her colleagues sought to determine whether the quality of communication during medical visits differed among African American and White patients in terms of the duration of the visit and average speech speed, patient-centered orientation (i.e., physician verbal dominance and physician patient-centeredness), and overall emotional tone (i.e., patient and physician positive affect). Data were collected from 30 White, 21 African American, 9 Asian or Indian American, and 1 "other" race/ethnicity physicians. The results showed that physicians were more verbally dominant and engaged in less patient-centered communication with African American patients than with White patients. Both African American patients and their physicians exhibited lower levels of positive affect than did White patients and their physicians.⁶²

In another similar study, Johnson and several of her colleagues compared patient-physician communication in same-race and different-race doctor-patient visits and examined whether communication behaviors could explain differences in patient ratings of satisfaction and participatory decision-making with their physicians. In the



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PHOTO 11.3
Physician and patient communication and decision-making vary across cultures.

study, African American and White patients received care from 31 physicians (of whom 18 were African American and 13 were White). Patients completed scales designed to measure their perceptions of physician patient-centeredness, physician participatory decision-making styles, and overall satisfaction with their physician. The results showed that same-race patient–doctor visits were longer and had higher ratings of patient positive affect compared with different-race doctor–patient visits. Patients in same-race doctor–patient visits were more satisfied and rated their physicians as more participatory in health care decision-making than did those in different-race doctor–patient visits.⁶³

While this is not an exhaustive account of the research done on intercultural communication in health care settings, it does allow us to draw some (tentative) conclusions about health care communication that seem rather countertheoretical when it comes to culture. For example, theoretically, we might expect that patients in collectivistic, large power distance cultures might defer to their health care providers when making decisions about health care treatment options. But the research cited earlier suggests that patients in these cultures prefer to participate in such decision-making. Of course, while these patients indicate that they would like to participate in such decision-making, we do not know for sure if they actually do. Decades of research on accents has shown that persons with nonnative accents are perceived differently (i.e., negatively). Yet the study suggests that in health care settings, the provider's nonnative accent has only a minimal effect on patient perceptions of him or her. The one area of research cited earlier that seems consistent with many of the theories discussed in this text is patient–provider communication within the United States, particularly with microcultural groups and health care providers. The research in this area suggests that microcultural group status does affect health care communication between patient and provider.

INTERCULTURAL COMMUNICATION AND EDUCATIONAL SETTINGS

One type of relationship that exists in every culture is the student–teacher relationship. And in all cultures, students learn and teachers teach. Students learn by seeing, hearing, reflecting, experiencing, reasoning, memorizing, and even intuiting. Teachers teach by lecturing, demonstrating, discussing, questioning, and applying principles. But *how* students go about learning and teachers go about teaching may vary considerably across cultures. And as in the health care context, virtually all interactions in an educational/classroom setting are face to face (online courses notwithstanding—although, in the United States the majority of prospective students prefer the in-class experience over online courses).⁶⁴

In the United States and abroad, grade school and high school teachers, as well as college professors, are finding their classrooms filled with students from various cultures. According to the Institute of International Education, in the 2017–2018 academic year, over 1 million international students attended U.S. colleges and universities. The United States hosts more of the world's international students than any other country. Just over 5% of college and university students in the United States are international exchange students. Students from China represent the largest percentage of international students