CHAPTER THIRTEEN

Intercultural Communication and Health Care

CHAPTER OUTLINE

The Importance of Communication in Health Care
Intercultural Barriers to Effective Health Care
Historical Treatments of Cultural Groups
Prejudicial Ideologies
Religion and Health Care
Cultural Influences on Approaches to Medicine
Power in Communication about Health Care
Imbalances of Power in Health Communication
Health Care as a Business
Intercultural Ethics and Health Issues
Summary
Building Intercultural Skills
Activities
Endnotes

STUDY OBJECTIVES

After reading this chapter, you should be able to:

1. Understand the importance of communication in health care delivery. Describe some of the ways that communication can be overlooked and how this might impact the delivery of medical services.

2. Explain some of the intercultural barriers to effective health care. Explain the ways that some cultural groups have been or continue to be treated in the health care system. Describe how prejudicial attitudes can influence health care delivery.

3. Explain how religious or spiritual beliefs may be important in effective health care delivery. Describe some of the ways that health care professionals can deal with religious and spiritual beliefs. Discuss the ethical implications of some of the ways that health care professionals deal with religious or spiritual beliefs.

4. Explain how power differences can influence health communication.

5. Identify the four frameworks that physicians might use in communicating about a patient’s health.

6. Describe the role of ethics committees. Describe some of the complex issues to be dealt with in making ethical health care decisions.

KEY TERMS

AIDS
alternative medicine
benevolent deception
biologically based practices
complementary medicine
contractual honesty
energy medicine
ethics committees
euthanasia
Fat Acceptance Movement
health care professionals
HIV
manipulative and body-based practices
medical jargon
medical miscommunication
medical terminology
mind-body medicine
prejudicial ideologies
religious freedom
religious history
strict paternalism
Tuskegee Syphilis Project
unmitigated honesty
The longer I stay in the U.S., the more differences I find between American and Chinese health care practices. For instance, some elderly people spend the rest of their lives in nursing homes even if they have children, and that seems to be commonly acceptable. However, in China, children have the responsibility to take care of their elder parents. Sending one’s parents to nursing homes, although not illegal, is considered by the general public as a very bad practice. Another difference I found is that, in the U.S., abortion is a very controversial topic; however, in China, it’s commonly considered just as a medical practice, and is not associated with moral judgments in general.

—Lan

Lan’s experience with cultural differences in health care is instructive in how we think about health care more generally. While we may often think of health care as a scientific or medical issue, health care and communication are also deeply embedded in culture.

What you have learned about intercultural communication has important applications in the health communication context. As the U.S. population ages and new medical technologies are developed, health care will become even more significant in our lives. Health care has also become increasingly controversial as more and more managed care corporations have entered the market. Within this changing context, as the U.S. population becomes increasingly diverse, U.S. Americans are beginning to seek out health care from a variety of sources—from traditional Western practitioners to more “exotic” Eastern practices.

In this chapter, we discuss some of the reasons communication about health has become more important and some of the ways you might navigate this communication context. Not only patients, but health care professionals—including physicians, nurses, physical and occupational therapists, and medical technicians—can come from a variety of cultural backgrounds. Intercultural communication and misunderstandings in health communication arise daily in this context.

THE IMPORTANCE OF COMMUNICATION IN HEALTH CARE

Intercultural communication is increasingly relevant in the health communication context for a number of reasons. First, as our population becomes increasingly diverse, complexities arise in communicating about health issues.
Part IV  Intercultural Communication in Applied Settings

Not only are health care professionals communicating with people from differing cultural backgrounds, but these same patients are communicating with nurses, doctors, and other health care professionals from differing cultural backgrounds. Table 13.1 shows some of the diversity of cultural backgrounds of U.S. physicians. And in some cultures, there may be certain stigmas associated with communicating about health issues, making it difficult to discuss these concerns. For example, in some cultures, subjects such as mental illness, AIDS, bird flu, sexually transmitted diseases, impotence, and abortion are not easily broached.

Second, health care professionals and patients may not realize the importance of communication. This oversight may seem incidental to medical training and treatment, but the reality is, much medical practice, particularly diagnosis, relies heavily on patient communication. In many ways, this shortcoming in health care reflects a Western cultural phenomenon, “due partly to the belief that the biomedical model of health care—the predominant model in Western societies—is based on a range of predominantly physical procedures (physical examination, physical manipulation, injections, etc.) rather than communication between two parties.”¹ In other words, Western physicians tend to rely heavily on physical symptoms to evaluate illness, rather than communicating with patients about what they are experiencing.

However, good communication is crucial to quality health care. Health care providers ask questions to diagnose problems, to help patients understand the treatment, and so on. And patients come to health professionals to seek treatment and ask questions. But even native English speakers complain about the use of medical jargon—potentially confusing or difficult-to-understand medical terminology—by physicians.

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**TABLE 13.1  Home Countries of Foreign Doctors**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>India</td>
<td>19.9%</td>
<td>47,581</td>
</tr>
<tr>
<td>2.</td>
<td>Philippines</td>
<td>8.7%</td>
<td>20,861</td>
</tr>
<tr>
<td>3.</td>
<td>Mexico</td>
<td>5.8%</td>
<td>13,929</td>
</tr>
<tr>
<td>4.</td>
<td>Pakistan</td>
<td>4.8%</td>
<td>11,330</td>
</tr>
<tr>
<td>5.</td>
<td>Dominican Republic</td>
<td>3.3%</td>
<td>7,892</td>
</tr>
<tr>
<td>6.</td>
<td>U.S.S.R.</td>
<td>2.5%</td>
<td>6,039</td>
</tr>
<tr>
<td>7.</td>
<td>Grenada</td>
<td>2.4%</td>
<td>5,708</td>
</tr>
<tr>
<td>8.</td>
<td>Egypt</td>
<td>2.2%</td>
<td>5,202</td>
</tr>
<tr>
<td>9.</td>
<td>Korea</td>
<td>2.1%</td>
<td>4,982</td>
</tr>
<tr>
<td>10.</td>
<td>Italy</td>
<td>2.1%</td>
<td>4,978</td>
</tr>
</tbody>
</table>


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Surf’s Up!

Did you know that you can major in health communication? Health communication covers a variety of issues such as patient–physician communication, health communication in organizations, social support, and health promotion. In a culturally diverse setting, how should we approach these issues?
Kathleen B. Kennedy, dean of the College of Pharmacy at Xavier University in New Orleans, developed a communication model called LEARN to help with interactions with patients.

- Listen to the patient’s perception of the problem.
- Explain your point of view.
- Acknowledge and discuss the differences and disparities in perceptions of the problem.
- Recommend treatment.
- Negotiate treatment.

It is also important to be constantly working on increasing your knowledge about other cultures and their values and beliefs, especially in relation to health issues. There is no easy way to do this, but learning about other cultures is a lifelong, ongoing process.

If English speakers have trouble with common medical terms, health care professionals need to be especially careful using these terms. For those patients who are communicating in a second language, medical terminology—scientific language used by doctors to describe specific medical conditions—can be particularly confusing. And when cultural misunderstandings arise, it can lead to inadequate treatment. This misunderstanding is sometimes called medical miscommunication. This type of miscommunication can result in medical mistakes, problems with patient use of medication, and other problems. A study of medical miscommunication in Japan also show that there can be significant financial costs that result as well. In cases where there was no medical error, 64.4 percent of the problems were due to miscommunication between medical providers and patients (and families).

Third, and probably the most obvious barrier to health services, are language barriers. Some health care providers ask their bilingual employees to serve as interpreters to patients who do not speak English. In a case cited in New York City, for example, when a “Spanish-speaking hospital receptionist refused to interpret during her lunch hour, doctors at St. Vincent’s Staten Island Hospital turned to a 7-year-old child to tell their patient, an injured construction worker, that he needed an emergency amputation.” Language issues can create problems in health care, not only in hospitals, but also in pharmacies. A study done by pediatricians in the Bronx section of New York City found that “pharmacies often used computer programs to translate prescriptions. Only one pharmacy employed a Spanish-speaking pharmacist that could check the translations.” This raises even more issues with language barriers in health care. As the authors of this study noted, “we visited one of the large chain pharmacies, and discovered that the computer could not translate some commonly used terms, such as dropperful, or for thirty days.” Many hospitals rely on their workers or bilingual children of patients to help translate. At one California hospital, “there have often been no Hmong-speaking employees of any kind present in the hospital at
night. . . Sometimes not even a child is available. Doctors on the late shift in the emergency room have often had no way of taking a patient’s medical history. . . . I asked one doctor what he did in such cases. He said, ‘Practice veterinary medicine.’

It is also important to remember that Title VI of the 1964 Civil Rights Acts requires that institutions receiving federal funding make accommodations for those who have limited English proficiency. Because many patients rely on federal assistance (e.g., Medicare, Medicaid, Veterans benefits), accommodation must be made for those with limited English language skills. There are no easy answers to many of these concerns, given the numerous languages spoken in the United States and around the world, but awareness of these issues may lead to innovative ways of dealing with language differences.

Fourth, health care providers and patients alike may operate out of an ethnocentric framework without realizing it. Assumptions about health care often have cultural roots. Consider the following example: Setsuko, a Japanese woman now living in the United States, had to spend several months in the hospital for a chronic illness. She became extremely depressed, to the point of feeling suicidal. Whenever the staff would ask her how she was doing, Setsuko would answer that she was fine. Based on this lack of communication, the nursing and medical staff were unaware of her depression for weeks. It was not until she began to exhibit physical signs of depression that she was offered a psychiatric consultation. The problem was that Setsuko was culturally conditioned to be a good patient by not making a fuss or drawing attention to herself or embarrassing her family with complaints about being depressed, so she always reported that she was fine. Although the psychiatrist tried to explain that in this context a “good patient” was expected to discuss and report any and all problems or symptoms,
Setsuko still had to work to redefine her cultural role as a good patient in order to receive better health care. In this case, both the health care providers and the patient struggled to negotiate a more effective communication framework to ensure better treatment.

Fifth, treating patients is not always a matter of communication between the physician and the patient. While one-to-one communication generally works well in Western cultures, which are more oriented to individualism, other cultures may focus more on the family’s role in health care. Thus, communication between the physician and the patient is only one element in the communication process. Unfortunately, most health communication research has limited itself to the physician–patient relationship. Laurel Northouse, a nursing professor, and Peter Northouse, a communication professor, note: “This lack of systematic study of professional-family interaction is symptomatic of the lack of importance that health professionals have traditionally attributed to this relationship in health care.”

This cultural bias in thinking about the role of the family in health care can lead to problems. Consider the case of the Samoan man hospitalized with a gunshot wound. Throughout the day, more and more family members gathered in the waiting room. Because there were so many extended family members, hospital personnel asked them to wait in the main lobby. The family members became increasingly irate because they wanted to see the patient as a large group, but the hospital had a policy of only three visitors at a time. Tensions between the family and the staff continued to escalate until a hospital administrator, sensitive to cultural differences, made a special exception and allowed large groups of family members to visit the patient.

A similar cultural pattern occurs in Iranian culture, where families may be seen as ignoring or violating hospital visiting hours, which can create conflict with the hospital staff. This cultural pattern emerges from a cultural duty to be there for the patient:

Iranians are very sociable, and hospital visits to friends or relatives are considered a moral duty. Visitors come in large number, bring sweets, flowers, and gifts. It is a time to socialize and to keep the patient company, and most hospitalized Iranians enjoy having large numbers of noisy visitors. In Iranian culture it is considered shameful to leave a loved one alone in the hospital without visitors.

If hospital staff understand this cultural difference in health care, it might help avoid cultural conflicts with the patient’s family. Given the importance of the family in the overall health care of the patient, cultural accommodation might be seen as one way of nursing the patient to better health.

Families, of course, can provide very important support to a patient as she or he recovers. Their role is even more important after the patient returns home. But this means that the family must receive adequate information about the patient’s condition. In turn, this means that health care professionals must be sensitive to cultural differences and must adapt their communication accordingly.
Finally, some work has begun to show the importance of community involvement in health care. In their work on community-based health communication, communication scholars Leigh Arden Ford and Gust Yep found that a community-oriented approach often works much better than a focus on individuals. Part of this effectiveness emerges when community health workers “become catalysts for change. Through their public health and communication network role enactments, they promote community organizing efforts and enable individual empowerment. Significantly, community health workers empower themselves as they become a means to empowerment for individuals, families, neighborhoods, and communities.”¹⁰ This community-based approach seems to work in Haiti, where Dr. Paul Farmer of Partners in Health focused on “community-based solutions to its health problems. That meant, for example, training local residents as doctors, technicians and outreach workers who could diagnose and treat their neighbors.”¹¹ A focus on community as a foundation for health care is quite different from a more traditional focus on the individual, but it seems to work.

INTERCULTURAL BARRIERS TO EFFECTIVE HEALTH CARE

In Chapter 3, we discussed the importance of history in intercultural communication. Let’s look at some of these historical dynamics as they influence health care today. This is important because the history of medicine guides how different cultural communities may relate to health care.

These doctors are vaccinating children against polio, despite rumors in some countries that polio vaccines were a conspiracy to sterilize children. What might have happened in the past to lead to such fears?
Historical Treatments of Cultural Groups

First, historically, widespread ideologies about different cultures have fostered differential treatment for some groups, especially racial and ethnic minorities, by medical professionals. As sociologist Chris Shilling writes, “Historically, the negative construction of black bodies has made them targets for a variety of moral panics surrounding health and disease.”\(^\text{12}\) In the past, medical conclusions about alleged racial difference have justified a number of deplorable social practices, from slavery, to colonization, to immigration restrictions.\(^\text{13}\)

This differential treatment has caused some cultural groups to be justifiably suspicious of contemporary health care. For example, the infamous Tuskegee Syphilis Project, conducted by the U.S. Public Health Service on unsuspecting African Americans in Tuskegee, Alabama, over a 40-year period, spurred some of these concerns.\(^\text{14}\) In this study, Black patients who sought out medical care for syphilis were instead given placebos (sugar pills), but were not told that they were part of a study, simply to establish an experimental control group. The purpose of the study was to explore how syphilis spreads in a patient’s body and how it spreads in a population. Periodic reports were published in medical journals, but the Centers for Disease Control received only one letter from a physician raising ethical concerns. The study was finally halted, not by the medical community, but only after a public denouncement by Senator Edward Kennedy in Congress. Unfortunately, it’s hardly surprising that such a study was not conducted on wealthy White Americans in Beverly Hills.

The Tuskegee Syphilis Project, among other studies and projects, has reinforced suspicion about the medical community from many marginalized communities. This “mistrust of the medical system by some African Americans has been identified as a barrier to optimal health care and participation in clinical trials.”\(^\text{15}\) In a recent study on perceptions of trust in medical care, differences in trust emerged between White and Black respondents. These researchers found that “African Americans have been shown to have greater awareness of the documented history of racial discrimination in the health care system than white Americans, and this greater awareness of historical discrimination has been associated with less trust of clinical and research institutions. This is consistent with our finding of greater concern among African Americans about the potential for harmful experiments being performed in hospitals.”\(^\text{16}\) Given this horrible history, how might health care providers work with African Americans to gain their trust? Given the “alarming inequities in health outcomes between different racial and ethnic groups in the United States,” it is important that we focus on “the development of strategic, adaptive, and sensitive health communication across a range of communication channels and media” to enhance the health of all of us.\(^\text{17}\) In a recent study on life expectancies across race and educational differences in the United States, researchers found that these disparities are continuing to grow. For example, college-educated White men tended to live 14.2 years longer than Black men with less than a high school diploma. The differential life spans are growing, rather than shrinking, which has a tremendous
Part IV  Intercultural Communication in Applied Settings

impact on the very different worlds that we live in. The rise of AIDS (acquired immune deficiency syndrome) and HIV (human immunodeficiency virus) in the late twentieth century provoked new fears among gays and minorities that the medical community would again provide differential treatment. As Jeffrey Levi, an AIDS and health policy consultant, argues:

Homophobia was not introduced into the health-care system with the AIDS epidemic. Rather, its long-standing legacy of discrimination and exclusion has resulted in the creation of a separate health-care system within the gay community, a health-care system that responded to this new crisis immediately, saving countless gay lives—and heterosexual lives as well—while the government-sponsored system floundered, unable to find the will or the funds to operate.

The slow response to the AIDS epidemic by the federal government has been widely discussed and critiqued. In his analysis of public discourses about AIDS, Larry Gross, a communication professor, concludes that “AIDS thus taught two lessons. First, a disease that strikes gay people (and people of color, and drug users, and poor people) will not receive adequate attention. Second, people will begin to pay attention when famous and important people are involved.” Thus, the HIV/AIDS epidemic highlighted the traditional lack of trust between the health care system and minority communities.

Prejudicial Ideologies

Second, prejudicial ideologies—sets of ideas based on stereotypes—about various cultural groups affect both health care professionals and patients. These attitudes can present significant barriers to intercultural communication. Consider the following case: A social worker in one of the nursing units was recording information on a patient’s chart when she overheard staff members discussing a patient who had recently been admitted to the unit. They were not certain if the patient was Chinese, Taiwanese, or Vietnamese. The head nurse called the supervisor of international services, who helped clarify that the patient was Taiwanese and so needed a Taiwanese-speaking interpreter. As they continued to discuss the patient, one staff member said, “So she doesn’t speak any English at all? How does she get along in this country if she can’t speak English?” Another staff member responded, “She doesn’t need to get along here. They are all on welfare.” Given our concern with the kinds of health care received by members of nonmainstream cultural groups, these comments take on even more significance than simply being prejudicial. Such attitudes may influence the quality of health care that patients receive. And health care professionals are hardly immune to prejudice. Attending nursing school or medical school does not purge feelings of homophobia, racism, sexism, and other kinds of prejudice.

Patients, too, often enter the health care system with prejudicial attitudes. Tom’s brother-in-law, for example, a physician in North Carolina, often
encounters patients who prefer not to be treated by doctors who are “Yankees.” He is frequently asked, Where are you from?” which suggests that regional differences remain barriers. Because he is from California, these patients consent to his treatment; after all, he is not a “damn Yankee.” Regional identities can influence whether people trust medical professionals.

Because of this mistrust, many people prefer to obtain a significant amount of their medical information from their own communities. For example, in the case of AIDS, many gay men turned to the gay community for information on the latest experimental drugs and treatments. In the South, some low-income Whites believe that Prozac is addicting despite scientific evidence to the contrary. However, because Prozac is seen as addictive within this community, patients often refuse to take the drug when it is prescribed. The point here is that people may turn to their own communities out of mistrust of medical professionals. Sometimes these communities can provide significant alternative health care, as in the case of gay men and AIDS; other communities, however, can provide misinformation.

Currently, the ongoing effort to wipe out polio continues, but it has encountered a major setback with the belief that polio vaccinations are meant to sterilize children, as well as the spread of polio in areas that are very difficult for health care workers to reach. The earlier success in eliminating polio may be difficult to continue:

The decline from 350,000 new cases in 1988 (when the goal of rapid polio eradication was first declared) to 2,000 cases now (chiefly in Nigeria, India, Pakistan and Afghanistan) looks like a near victory. But the final stretch is the hardest. . . . The fighting in Afghanistan and Pakistan has hampered vaccination programmes there. So have rumours among Muslims in northern Nigeria that the vaccination programme was in fact a conspiracy to sterilise children. That allowed the polio virus to strengthen and spread. The Nigerian strain may have now reached a dozen other countries.22

Because of these fears about the vaccines, polio may spread, rather than face elimination. Yet, why would people be afraid of a conspiracy to sterilize children? What might have happened in the past to lead to such fears?

RELIGION AND HEALTH CARE

Even when they are not facing serious illness or death, many people turn to religion or spirituality to help them try to understand the complexities of life.23 When they are ill, however, some people are driven to seek answers to questions that science cannot always answer. While some people turn to spiritual healing, others prefer to combine their spiritual beliefs with traditional medical care. Sometimes spirituality and/or religion can be helpful in the healing process; other times, it may be helpful in facing death.
The role of religion and spirituality in health care is still a controversial topic, but today “more than half of the med schools in the country” offer courses in religion and spirituality, “up from just three a decade ago.”24 Yet the role of religion and spirituality in health care raises a number of issues about ethical ways to approach the topic of incorporating health practices into existing beliefs and helping patients avoid any pressure they may feel about their beliefs. It is also important for health care professionals to avoid imposing their beliefs on patients. One example of such an error is when a “doctor told his patient that ‘if she was right with God, she wouldn’t be depressed.’”25 Needless to say, health care professionals should not assume that all patients share their beliefs, as people around the world hold a wide range of spiritual views.

Yet, accommodating for religious differences can be an important part of effective health care. Consider the following example:

Dr. Susan Strangl, a family-medicine doctor at UCLA, [had] a Muslim patient who needed medication but was observing Ramadan and couldn’t drink or eat during the day. After taking a religious history—routine for all hospitalized patients at UCLA—Strangl chose a once-a-day medication that could be taken after sundown. “If we hadn’t talked about it, I would have written him a prescription for four times a day and he would not have taken it,” she says.26

While religious and spiritual beliefs vary widely, Drs. Koenig, McCullough, and Larson attempted to survey the studies available in this area and compiled the Handbook of Religion and Health Care. Our understanding of the role of religion and spirituality in health still leaves us with many unanswered questions, but they do recommend seven specific strategies for physicians and other health care professionals in dealing with patients:27

• Take a religious history.
• Support or encourage religious beliefs.
• Ensure access to religious resources.
• Respect visits by clergy.
• View chaplains as part of the health care team.
• Be ready to step in when clergy are unavailable.
• Use advanced spiritual interventions cautiously.

Some of these suggestions may be difficult for health care professionals to follow, particularly when they are followers of different religions, hold different spiritual beliefs, or are atheists or agnostics. Patients also may not want to discuss such topics. One physician, “Dr. Jim Martin, head of the American Academy of Family Physicians, teaches residents to take spiritual histories, but ‘if a patient flinches, we don’t go there.’ And if a patient says faith or spiritual beliefs are not important, ‘we check that box and move on.’”28

Some physicians, however, argue against some of the previously suggested guidelines. For example, Dr. Richard P. Sloan of the Columbia-Presbyterian

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What Do You Think?

Should hospitals provide interpreters for their patients who do not speak English? If so, for all languages or only a few? If you were vacationing in, say, Italy and had to go to the hospital, would you expect someone at the hospital to speak English? What about Mongolia, which gets very few English-speaking tourists?
Medical Center cautions against praying with patients: “It confuses the relationship. It may encourage patients to think a prayer is going to somehow improve their well-being. It certainly will improve their spiritual well-being but there’s no evidence it’s going to improve their health.” His biggest concern about health care professionals engaging in religious issues is “Manipulation of religious freedom. Restriction of religious freedom. Invasion of privacy. And causing harm. It’s bad enough to be sick, it’s worse still to be gravely ill, but to add to that the burden of remorse and guilt for some supposed failure of religious devotion is unconscionable.” While some health care professionals may believe that spiritual beliefs or religious beliefs can help patients be healthier, Dr. Sloan notes, “The question is if religion is demonstrably efficacious, if it really influences longevity, morbidity and mortality, and the quality of life, why don’t the insurance companies get in on it?” The point here is that there is no easy list of ways to deal with cultural differences and religious differences in health care. Issues of ethics, however, should always be at the forefront of considerations. Communication about these issues can be key to unraveling the ethical issues at hand.

Many health care professionals may not be aware of the diversity of religious and spiritual beliefs around the world. How can studying religious and cultural differences be helpful to health care professionals? How can health care professionals communicate respect for others’ religious or spiritual beliefs without compromising their own beliefs? How assertive should patients be about asking health care professionals to accommodate their religious or spiritual beliefs? Health care professionals should also be aware that some patients may fear getting inferior care if they do not share the dominant religious beliefs. How might patients and health care professionals assure each other in this context? All of these questions are at the forefront of the debate about the role of religious or spiritual beliefs in health care.

Cultural Influences on Approaches to Medicine

Different cultures bring different perspectives on our health—how we stay healthy, as well as how we fall ill. You may have heard many cultural stories in your own home about staying healthy or ways to avoid illness. Some people are told that wearing a hat in cold weather is important because the head loses an enormous amount of heat, when in reality, any exposed parts of your body are places where heat is lost. If you wear a swimsuit in cold weather, for example, the exposed parts of your body will release heat at the same rate as the head. Some people are told to eat chicken soup when they are ill, because chicken soup is a cure. For others, boiling citrus in water is a drink to help cure various illnesses.

There are also many cultural differences about what might be considered something that needs medical attention. Increasingly, in the United States, for example, the loss of hair on men is seen as something that may require medicines, such as Rogaine (minoxidil) to help correct this “problem.” The television show, Nip/Tuck, highlights the use of medicine to solve other “problems” that may not be considered health care problems in other cultures. For example, is the need for breast augmentation a cultural issue? Or a health issue? Or both?

What Do You Think?

Currently, obesity is measured according to Body Mass Index (BMI), which is calculated by dividing weight by height in inches squared. What is your BMI? Is this a fair measure or are there other factors that should be considered? Using BMI statistics, the National Center for Health Statistics estimates that of U.S. adults 20 years and older 32.7 percent are overweight, 34.3 percent are obese, and 5.9 percent are extremely obese. What would other cultures think of the use of BMI as a measure of overall health?
Lots of attention has been focused on obesity in the United States. Cultural attitudes about weight have changed over the years in the United States, as well as in cultures around the world. Once seen as a sign of wealth, today obesity is seen as a sign of medical disorder in need of medical treatment. The debates over weight and what should be acceptable have been at the forefront of the Fat Acceptance Movement, a social movement that works to end discrimination against overweight people and the assumption that they are necessarily unhealthy or in need of medical treatment.

In the United States and many other westernized nations, the dominant model of medicine is based on biomedical science. All other approaches fall under the term, alternative medicine. There is no comprehensive list of other ways of thinking about medicine and health, but some of the major approaches to alternative medicine include homeopathy, naturopathy, and traditional Chinese medicine. Acupuncture is one approach used in traditional Chinese medicine, and many patients report that it does work for them. The use of herbs is another aspect of traditional Chinese medicine. There are many other approaches that developed in China and are widely accepted in many Asian cultures.

There are too many other approaches to medicine that would fall under alternative medicine than we can list here, but they are also seen as equally valid approaches to health care. These other approaches are sometimes referred to as “complementary and alternative medicine.” Currently, the National Institute of Health has a unit called the National Center for Complementary and Alternative Medicine that is focused on other approaches to health. There are many different approaches to health that are not considered traditional medicine. They have been categorized into four major approaches: (1) mind-body medicine, (2) biologically based practices, (3) manipulative and body-based practices, and (4) energy medicine.  

Mind-body medicine focuses on using the mind to influence the body. Some of these approaches include patient-support group therapy, meditation, and prayer. Biologically based practices refers to the use of products found in nature as therapy. Some of these approaches include the use of herbal therapies, dietary supplements, and other natural products. Manipulative and body-based practices refers to the use of massage or chiropractic approaches to health. Energy medicine focuses on the use of energy fields to foster health.

When used, in any combination, in conjunction with traditional Western medicine, these alternative approaches are considered to be complementary medicine. Some health care providers accept a complementary approach, while others feel negatively about alternative medicine.

POWER IN COMMUNICATION ABOUT HEALTH CARE

There is often an imbalance of power in health communication situations. We examined the role of power in Chapter 2, but let’s take a look at how it might function in communication in the health care context.
Imbalances of Power in Health Communication

Communication between physician and patient is often marked by an imbalance in power with regard to medical knowledge and access to treatment. Patients, for example, may not have access to drugs without a written prescription from a physician. In order to get that prescription, the patient must rely on the physician, who has the power to prescribe drugs. Physicians in HMOs (health maintenance organizations), which are increasingly common in the United States, can elect to refer or not refer patients to specialists. Physicians have power over patients in other ways as well. For example, they can recommend certain treatments (and not others), order medical tests, and otherwise determine what kind of treatment the patient receives.

This power imbalance is built into the health care structure in the United States, but physician–patient communication also reflects these power differences. For example, if Judith goes to see a physician for the first time, the physician may introduce herself by saying, “Hi Judith, my name is Doctor Tyndall.” What would happen if Judith were to respond, “Hi Lisa, my name is Doctor Martin”? Some physicians would be amused, but others would be irritated by the perceived effort to challenge the power imbalance.

Note also the potential confusion of patients when they meet Dr. Tyndall. Who is Dr. Tyndall? Is she an intern? A staff physician? What role does she play in providing health care? And how many other health care professionals will the patient see today? Because patients may encounter many health care workers in a single day, cultural differences in communication may be exacerbated. The process of negotiating cultural differences may be especially difficult for the patient because each communication interaction may be brief.

What Do You Think?

Before children played “doctor” or “nurse,” perhaps they played “healer.” The ways in which people care for the sick and dying in society have varied across cultures and throughout history. The doctors of Western society today attribute many remedies to the cultural healers of yesterday. So, why is it that contemporary science seems to want to divorce itself from folk or ancient traditions?
Health Care as a Business

It is important to remember that the health care industry in the United States is a huge business. The implications for patients have been the subject of heated public debates over the allocation of health care resources. One controversial issue is whether HMOs ration health care resources; obtaining such resources often is not easy or automatic.

Rising health care costs have had a huge impact on how we think about medical resources and their distribution. In the United States, we have looked at other health care delivery systems around the world. A recent study has shown that from 1999 to 2009, income growth in U.S. families has been offset by increasing costs for health care. At the same time, medical debt is increasing as a factor in decisions to declare personal bankruptcy. Medical debt is often referred to collection agencies far faster than other types of debt.

In response to growing costs and concerns about the U.S. health care system, President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010. Although sometimes derided as “Obamacare,” this act marks a major change in health coverage. It aims to reduce the number of uninsured (or under-insured) Americans and decreasing the rapid rise of health care costs overall. Many of these changes will take place over a number of years, and the U.S. Department of Health and Human Services has set up a website to explain all of the changes: www.healthcare.gov.

Patients from countries where health care is provided by the government may be confused by the private health care system in the United States. U.S. Americans, too, can become lost in the maze of rules and regulations governing the access to specialists and special treatments. Because there is a power imbalance at work here, patients need to recognize that HMOs are businesses. It may not be enough simply to ask for many medical services, particularly higher-priced treatments.

For example, Didier, a French patient who needed extensive occupational therapy after an accident, did not understand why the number of occupational therapy hours was so limited, especially after his physician told him he would need much more therapy before returning to work. It was only after Didier realized that his HMO was a business that he began to pester the HMO for more hours; in France, this service is provided by the government. Eventually, the HMO consented to more therapy. But Didier believes that it was only after the cost associated with his relentless pestering threatened to exceed the cost of the therapy that the HMO consented to the additional therapy. Thus, patients have to realize that they are the objects of a cost–benefit analysis and that they have to insist on getting access to health care resources.

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act. The act introduced enormous reform and complete regulatory overhaul to the American healthcare system. The PPACA is aimed at reducing the number of uninsured Americans and streamlining the overall costs and outcomes of healthcare through mandates, subsidies, and tax credits.
What could unite the American Medical Assn., the lobbying arm of the pharmaceutical industry, Regence BlueCross BlueShield, and the Service Employees International Union (SEIU) in a common cause? Surprisingly, healthcare reform.  

This act has been met with major controversy as it continues to change the way that U.S. Americans view healthcare and its status as a for-profit system.

**Intercultural Ethics and Health Issues**

What are the ethics of health care communication? In the physician–patient relationship, the physician has far more information than the patient, and the ethics are complicated, particularly in intercultural situations. With regard to communication ethics in health care, physicians can give information about the patient's health within four general frameworks: (1) strict paternalism, (2) benevolent deception, (3) contractual honesty, and (4) unmitigated honesty.

**Strict paternalism** reflects a physician's decision to provide misinformation to the patient when the physician believes it is in the best interests of the patient. If a patient has terminal cancer, for example, the physician may not feel it would be helpful to tell the patient that he or she has high blood pressure as well. **Benevolent deception** occurs when the physician chooses to communicate only a part of a patient's diagnosis. For example, a patient might be told that she or he has cancer and that treatments are available, but not be told that the prognosis is very poor. **Contractual honesty** refers to the practice of telling the patient only what she or he wants to hear or to know. For example, if a patient says, “I only want to hear about the treatments available to me, but not my chances of survival,” a physician may choose to follow the patient's wishes. Finally, **unmitigated honesty** refers to when a physician chooses to communicate the entire diagnosis to a patient. Some health care professionals prefer this communication route as a protection against lawsuits. However, some patients are put off by the bluntness of this approach. For instance, if a physician told a patient that some very expensive and painful treatments were available but the patient probably wouldn’t survive anyway, that patient might be justifiably upset.

The fear of malpractice suits guides many decisions related to ethics. Sometimes health care organizations use **ethics committees**—often staffed by health care professionals, religious leaders, and social workers—to help make decisions about ethics. In the intercultural context, these decisions can be complex. In some cultures, the family is intimately involved in the health care and medical treatment of its members. In other cultures, medical information is confidential and is given only to the patient, unless he or she is incapacitated or incapable of understanding. Knowing the appropriate way to communicate with patient and family is not easy. For example, some patients may not want their families involved in their care if they have a miscarriage, are suffering from colon-rectal cancer, or are depressed. And many medical procedures are very controversial, even among members of the same culture.
The birth of octuplets to Nadya Suleman, also known as “octomom,” who already had six children, has raised the issue of ethics in the use of in vitro fertilization. “The American Society for Reproductive Medicine, a leading organization in the field of reproductive medicine, recommends that a woman under the age of 35 should have no more than two embryos implanted by way of in vitro fertilization (IVF).” 37 Since Suleman’s physician implanted more than two embryos, questions about the ethics of this decision have arisen. Also, people have raised ethical questions about her ability to provide for her 14 children. Many people have very strong feelings about her decision to have 14 children. What do you think was the right thing for the physician to do? What should Nadya Suleman have done? Is it anyone else’s business how many children a woman has? What are health care ethics issues in this case?

In some religious systems, euthanasia, which involves ending the life of a terminally ill patient, is seen as suicide and therefore is unacceptable. In other religions, euthanasia is acceptable for terminally ill patients. Key issues include how much control a patient should have in this situation, how much power a physician should have if his or her ethical framework differs from the patient’s, and how much power the state should have in making laws preventing or permitting euthanasia.

SUMMARY

In this chapter, we examined a number of issues relevant to intercultural communication and health care. Intercultural communication is becoming more important in health care as the population becomes more culturally diverse.
Communication is vitally important to the functioning of health services, and this communication is not simply between patient and physician.

We also looked at barriers to effective health care. The history of differential medical treatment and medical studies has created mistrust among some cultural groups. The Tuskegee Syphilis Project and the AIDS epidemic are two examples of how and why groups can come to mistrust the health care system. Many health care providers and patients also hold prejudicial ideologies that can create barriers to effective treatment and to the provision of health care resources. In addition, religious beliefs can also present communication and health care challenges.

Finally, we turned to the issue of power in health communication. There is an imbalance of power between physician and patient, as well as an imbalance of power between patients and the health maintenance organizations. Four ethical approaches to health issues are strict paternalism, benevolent deception, contractual honesty, and unmitigated honesty.

BUILDING INTERCULTURAL SKILLS

1. Reflect on the history of your own family and traditional health care. Do you have many family members who are health care professionals? Did you grow up going to the doctor frequently? How much trust do you have in physicians?

2. Think about how you communicate to others in health care situations. As a patient, do you realize the importance of your communication to the physician or nurse in the diagnosis and treatments you receive? How might you better communicate your health situation to health care professionals? What kinds of cultural attitudes about various health issues do you hold that could be barriers to more effective communication? For example, have you been raised to be ashamed to ask questions about certain parts of your body?

3. Think about how health care professionals communicate with you. If you have a serious illness that may require much interaction with a physician, for example, is this someone whom you can trust?

4. Think about how health care professionals might encourage more open communication from patients so that they can receive better health care.

ACTIVITIES

1. The media and health care: Watch the news media for coverage of health issues as they relate to the most affected cultural groups. For example, is AIDS still framed as a “gay disease”? Is the hanta virus portrayed as a Navajo illness? In what ways does the conflation of the cultural group with the disease create misunderstandings?

2. Communication about health care: Talk to a health care professional about his or her experiences with cultural differences in communication. What were the main problems in the communication process? What suggestions might you make to avoid these problems in the future?
ENDNOTES


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