Intercultural Competence in Health Care

Embracing Diversity in Patient-centered Care

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Foreword and Acknowledgements

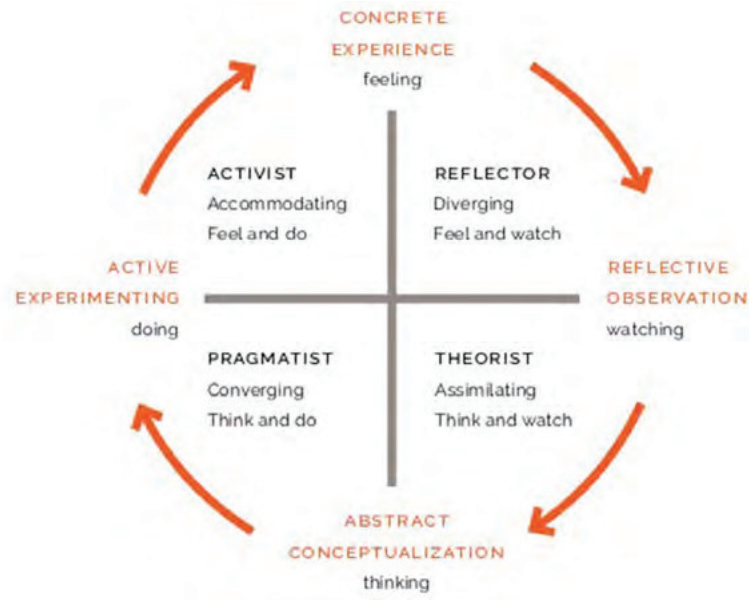
The book you are holding in your hands was born from the many experiences that our colleagues and we have had over many years. The number of cases kept growing: about cultural differences hindering instead of complementing the interaction between healthcare professionals and patients.

Research (Paternotte, 2016) shows a strong discrepancy between healthcare professionals' perception of their own intercultural competence and the reality of the situation. This convinced us to write this textbook, applying renowned models and theories from cultural anthropology, medical anthropology and communication sciences to day-to-day cases in healthcare.
This book will give you insights in what you can do to improve intercultural communication. Better communication contributes to a good relationship with the patient, more satisfaction with the care provided, and better health outcomes. In short: good communication leads to excellent quality of care.

The unique characteristics of our team of authors are our collaboration and diversity. We come from highly diverse professional backgrounds: a doctor and an educator, a nursing lecturer with a background in medical anthropology, a cultural anthropologist, an engineer, a psychologist, and trainers in intercultural communication. We brought our diverse expertise and a broad palette of experiences to bear. We challenged each other to avoid assumptions and to get out of our comfort zones. The fact that our authors come from four different continents – Africa, Asia, Europe and South America – and have extensive international work experience in diverse cultures was highly effective and led to many different angles and dialogues that could not have been explored from a monocultural perspective. Without these discussions, and the insights that came from them, this book would have been very different.

We wrote this book, first and foremost, for healthcare professionals in training (e.g. nursing, medical and similar occupations). However, it also offers eye-openers to professionals with many years of experience. Additionally, educators, executives and

managers who take diversity and inclusiveness in healthcare seriously will find within these pages insights into the characteristics of intercultural sensitivity and diversity in teams.
In short: this book is aimed at healthcare professionals who want to provide excellent care to all patients, regardless of their cultural background.



Kolb's learning cycle
(Source: Brouwer et al, 2015 in: http://www.managingforimpact.org/tool/kolbs-learning-cycle-and-learning-styles)

We are aware that our readers too are highly diverse in age, practical experience, occupation and frames of reference, and that they have diverse learning styles. Therefore, we made this book accessible for all learning styles, in accordance with Kolb's Learning Styles and Experiential Learning Cycle:
case studies for readers looking for concrete experiences;

- reflection questions for readers who learn best by watching and through reflective observation;
- models and theories for readers who prefer to put observations into a conceptual framework;
- examples in the application of theory and models for the practical application-oriented reader; and
- images for the visual reader.

We hope this book will be a useful instrument for all healthcare professionals.

The development of this book was made possible with the help of many healthcare professionals and lecturers, whom we would like to thank by name. We are very thankful for the time, dedication and feedback of our beta readers Gusta Boland, Duco Steenbeek, Carolien Vos, Tarek Karramass, Ann Callewaert, Nicole Janmaat, Marian Harink, Ulrike Mahdi, Francis Burgersdijk, Patricia Mooibroek, Bieke Jongejan, Sophie Uljee, Mathilde Bos, Bas Steunenberg, Kate Clarke, Sinéad Clarke, Kirsty Marshall, Lieke Braadbaart, Joy Obihara, and our most constructive, critical reader Ndidi Obihara.

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1 Culture, Self-Awareness and Intercultural Communication

People often confuse the term culture with country. Culture is so much more encompassing than a geographical space. Culture is learned, and we learn it while socializing in all the groups that we belong to. The way we think, feel and behave has been learned. Our cultural lenses help us with our perception, but they can also limit our perception and distort our judgment of others. We are not aware of that, because a large part of culture is invisible.

The aim of this chapter is to make us aware of all the facets of our culture, which we frequently take for granted. And to realize how our culture influences our judgment of others and our communication. Cultural awareness is the first step towards intercultural competence. This insight will help us communicate more effectively as healthcare professionals in a diverse environment.

1.1 Definitions of Culture

Many definitions of culture originate from cultural anthropology and social psychology. We will not be referring to Culture with a capital C, such as literature, art, music, the theater, museums, architecture or science, but to culture with a small c: the patterns of thinking, feeling, and behaving that we have learned, that we are familiar with and that we share with others in our community. As authors, we chose the following three definitions, which share similarities.

Three Definitions of Culture

1. The British anthropologist **Edward B. Tylor** (1871) was the first to define culture as: "... that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society." (Tylor, 1871)
"*That complex whole...*" makes Tylor's definition of culture inclusive (meaning everyone has culture, and not just a select group of people.) And from "*...acquired ... as a member of society*", we can conclude:

- Culture belongs to a society or a group.
- Culture is something that we learn.

2. The American social psychologist **Edgar Schein** defines culture as:
"a pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration. A product of joint learning." (Schein, 2004)
From this we can conclude:

- Culture belongs to a certain group.
- Culture is a product of learning.

3. The third definition of culture is by the Dutch engineer and organizational psychologist **Geert Hofstede**:
"the collective programming of the mind which distinguishes the members of one group or category of people from another." (Hofstede, 1991)
From this we can conclude:

- Culture belongs to a group.
- Culture is learned. We learn it through upbringing, socialization, norms and values, and perception.

We will be working with Hofstede's definition because it is concise and reflects the essence of culture: culture belongs to a group, and we learn culture as we interact with our group(s). This "enculturation" makes us see through our cultural lenses or cultural glasses.

1.2 Culture: The Hidden Dimension

There are a lot of visible and tangible aspects of culture – such as food, clothing, or home decoration. On this level, cultural differences are obvious. However, the most important cultural differences are on a less visible level. The American anthropologist Edward Hall refers to this as *The Hidden Dimension*.

In every culture, and in every group, Hall distinguishes three levels of culture: tertiary, secondary and primary. (Hall, 1984, p. 230)

On the **tertiary level**, culture is tangible, explicit, and visible or known to the outsider. Traditional dress, local cuisine, or body art such as henna decorations and tattoos are examples of tertiary level culture. Do doctors and nurses wear white uniforms? That is also an expression of tertiary level tangible culture.
On the **secondary level** we find the norms or rules of behavior, which the members of the group know and can even name, although they very seldom explain these norms to outsiders. For example: visiting someone in hospital? Two visitors are fine, don't come with a crowd. What to bring for the patient? Flowers? Yes. Fried rice with fermented shrimp paste? No.
On the **primary level** the members of the group know the rules, they abide by these rules, but they are actually unable to name them. The rules are so implicit, so taken for granted, so outside their awareness. And it is here, on this primary level, that the most dramatic, but unintentional cultural misunderstandings occur - also in the field of healthcare. This is what this book is about: the primary level of culture. We will give concrete examples in Chapters 2, 3 and 4, by making these hidden dimensions visible, using the cultural models set out by Hall, Kluckhohn-Strodtbeck and Hofstede. The subsequent chapters provide new insights and tools on how to benefit from diversity in health care.

Like the submerged part of an iceberg, the hidden dimensions of culture are in fact its largest part, on which the visible culture rests and stays afloat. Every aspect of culture has meaning which can be interpreted in one way by an insider, but in a different way by outsiders.

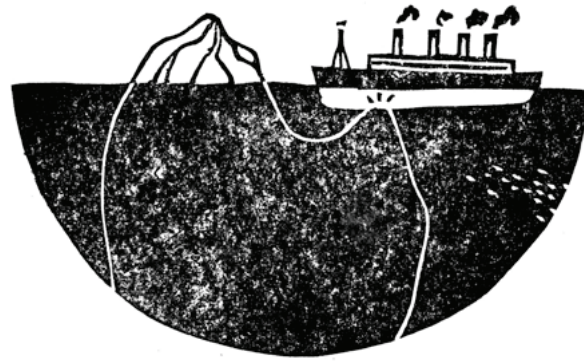

Figure 1.1 The cultural iceberg and the Titanic as metaphor for cultural clashes on the hidden dimension level. (Nunez, Nunez Mahdi and Popma, 2017)

The social psychologist **Edgar Schein** compares the three cultural levels with the layers of an onion, and identifies them from the outer layer to the inner layer as artifacts, norms and values, and basic assumptions.

Figure 1.2 Schein's layers of culture
1. Artifacts
2. Norms and values
3. Basic assumptions
(Edgar Schein, 2004)