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Multiculturalism, Medicine and Health Part I: Multicultural Health Care

SUMMARY

Culturally sensitive health care is not a matter of simple formulas or prescriptions that provide a single definitive answer: rather, it requires understanding of the principles on which health care is based and the manner in which culture may influence those principles. This series of six articles will examine influences that ethnic and cultural background may have on health and health care. Part I outlines the development, importance and relevance of multicultural health care. The author stresses the importance of understanding community needs, cultures and beliefs; the active interest and participation of the patient in his or her own health care; the importance of a good physician-patient relationship; and the benefit of an open-minded approach by physicians and other health-care workers to the delivery of health-care services. (*Can Fam Physician* 1988; 34:2173–2178.)

RÉSUMÉ

Culturellement, on ne peut réduire les soins de santé à un simple livret de formules ou de prescriptions capables d'apporter une solution facile et définitive; il faut plutôt comprendre les principes sur lesquels repose la santé et l'influence de la culture sur ces principes. Cette série de six articles examinera les influences exercées par l'histoire culturelle et ethnique sur la santé et les soins. Cette première partie décrit le développement, l'importance et la pertinence des soins multiculturels. L'auteur insiste sur l'importance d'une bonne compréhension des besoins de la communauté, de sa culture et de ses croyances; l'importance pour le patient de s'intéresser et de participer activement à ses propres soins; l'importance d'une bonne relation médecin-patient; et les avantages d'une ouverture d'esprit de la part des médecins et des autres professionnels de la santé dans la dispensation des soins.

Key words: multicultural health care, physician effectiveness

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> Observe the nature of each country; diet; customs; the age of the patient; speech; manners; fashion; even his silence...one has to study all these signs and analyse what they portend. *Hippocrates*[1]

IN HIPPOCRATIC TIMES physicians were itinerant, moving from town to town and country to country to care for the ill[2]. It was important for physicians of that era to be aware of the effects that cultures and customs had on health care.

In modern times the patient is more likely than the physician to have done the travelling. Given that there is such diversity in the cultural backgrounds of people who present themselves at a physicians' office, it is as important now that physicians be aware of the influences that culture has on health care as it was in the time of Hippocrates.

Culturally sensitive health care is not a matter of simple formulas or prescriptions for care that provide *the* answer; rather, it requires understanding of the principles on which health care is based, and the manner in which culture may influence those principles. That influence may affect or bias physicians, patients, and institutions serving the community. Hence there is a need for health-care providers, including physicians, to provide multicultural health care.

This series of six articles, of which this is the first, will examine influences that ethnic and cultural

background may have on health and health care. It deals both with health concepts or beliefs and with the practical implementation of health care.

Part I outlines the development, importance and relevance of multicultural health care. What is multicultural health care, and why is there a need for it? How have the changing demographics of Canadian society affected the health-care system? And what developments have taken place in response to those needs?

Part II will begin an examination of cultural beliefs relating to health and illness and their effect on health care. We shall begin by examining health-related beliefs based on natural causation. For example, what are some of the characteristics of the health concepts or beliefs that many cultures have in common? How does a physician begin to understand the many dietary beliefs to which patients adhere?

Part III will continue the examination of cultural health beliefs, focusing on the beliefs based on self-and supernatural causation. It will conclude with a brief discussion of how ethnocultural background and beliefs about health and illness may affect a patient's choice of treatment. We shall consider such questions as: How can a physician accept or acknowledge spiritual beliefs that are unfamiliar to him or her? What changes have been made within our health-care system that may serve as models for acceptance of other belief systems? How do belief models affect treatment and the sources to which patients may turn for assistance when ill?

Part IV will examine how the ethnocultural background of an individual may influence his or her health and so should be taken into account in the doctor-patient interaction. What are some of the areas of interest or concern in the physician-patient interaction that are specifically affected by ethnocultural background?

Part V will examine health care from a community perspective, focusing on some of those areas or situations in which the ethnocultural composition of the community may play an important part in the delivery of health-care services. How does a physician acknowledge and work with the cultural norms of a community? What is the importance of developing working relationships with community groups, as well as with individuals?

Part VI will summarize some of the existing multicultural health needs that have been advanced in this series and will conclude with suggestions for a simple but effective approach to cross-cultural care. Is there a practical approach to cross-cultural care that can be used in a variety of circumstances, regardless of the cultural background of the physician, patient or community?

Definitions and Qualifications

Before proceeding, it is important that we agree on the definitions and qualifications or limitations which should be kept in mind throughout the six parts of this series.

Definitions

In the scope of this article the following definitions will be used:

- *Multicultural health care* is health care that is culturally sensitive and culturally responsive.
- *Culture* refers to patterns or standards of behaviour that one acquires as a member of a particular group. These standards may include language, behaviour, concepts, beliefs, and values. A person's culture may or may not be the same as his or her ethnic origin or identity. In a complex pluralistic world and in Canadian society, a person may have encountered a variety of cultural influences or, perhaps, be the product of a mixed marriage.
- An *ethnic group* is a group of people who share a common ancestry or history, and who have distinctive patterns of family life, language, values, and social norms. A person's *ethnic origin*, therefore identifies him or her as having come from a particular group background; however, as I have indicated, he or she may have a somewhat different, or an entirely different, cultural identity as a result of having acquired other cultural patterns.
- The term *ethnocultural community* or simply *community* will be used in the following articles to identify a group of individuals who share cultural or ethnic characteristics.

Qualifications

Three important qualifications should be noted:

- References to ethnocultural groups such as "Chinese" are intended to identify an ethnocultural background, not citizenship. It must constantly be remembered that there is as much or more variation within a cultural group as there is among groups or communities. Identity is complex. Within Canada we refer not only to ethnic groups but also to linguistic groups such as "the Spanish-speaking people", or to racial groups, such as "the Black community". A member of either collective could come from anywhere in the world and have a complex identity. Similarly, a collective group such as the South-East Asians are diverse not only culturally but also linguistically.
- To allow for the discussion of issues, generalizations must be made. Generalizations should not be interpreted as representing characteristics applicable to all or, in some instances, even most of the individuals within a community. Generalizations may, in fact, be completely inappropriate when applied to any specific individuals or circumstances without regard to the individual or the circumstance. The application of generalizations in this manner constitutes stereotyping.
- There may be more similarities between the health beliefs or practices of different ethnocultural groups at the same socioeconomic level than there are within the same ethnocultural group at different socioeconomic levels. Although socioeconomic factors contribute significantly to health beliefs and practices, they are outside the scope of this article.

As physicians it is important for us to remember the uniqueness of each person or case, as well as the generalities.

Let us examine part of the background of multicultural health.

Multicultural Health Care

Background and development of multicultural health care

In 1974, under the then Minister of Health Marc Lalonde, the Government of Canada produced a report entitled *A New Perspective on The Health of Canadians*. In the report his

Ministry examined methods of improving the health of Canadians; it concluded:

> The Government of Canada, in co-operation with others, will pursue two broad objectives:
> 1) To reduce mental and physical health hazards for those parts of the Canadian population whose risks are high.
> 2) To improve the accessibility of good mental and physical health care for those whose present access is unsatisfactory.[3]

Accessibility of health care was thus identified as an area of importance. Accessibility of health-care services is not only a Canadian concern: reducing health inequalities is the primary target in the *Health For All* report of the World Health Organization(WHO).[4] The report points out that inequality is not simply a concern in developing countries: there are still marked differences between the more and less privileged groups within many industrialized countries.

Jong, writing in *Migration and Health* noted that a "free access" health-care system, supposedly available in Western countries, is less than a complete reality. Apart from the fact that many immigrants tend to live in lower socioeconomic areas, which are often underserviced, they are also faced with a number of other barriers relating to language competence and culture. There are also groups, including ethnocultural groups, who may face very real barriers of discrimination. "As long as these barriers are not removed, one cannot say that access is equitable for ethnic minorities".[5]

To respond to the needs of the entire Canadian population in this decade, physicians must be aware of the influences of culture on diagnosis, treatment, and the delivery of health-care services. One of the challenges faced by Canadian family physicians is that of responding to the needs of people with diverse backgrounds in our multicultural society.

As front-line health-care providers, family physicians play an important part in the community, providing access both to health services and to education. An understanding of cultural factors affecting health can help to simplify health care and make it more effective. A general examination of the multicultural composition of Canada is the first step in the provision of multicultural health care; it is the first step in understanding that pluralism is relevant to every physician in all parts of Canada.

Canadian society is composed of individuals and groups of many cultural, racial, and linguistic backgrounds. The 1981 census figures provide evidence that a significant percentage of persons in all provinces have a mother tongue other than English or French (Table 1). A majority of those individuals whose mother tongue is not English or French have immigrated to Canada (Table 2). In many cities individuals identifying themselves as being of other than English or French background comprise a large percentage of the population; in Toronto, Winnipeg, and Vancouver they comprise the majority.[6] Pluralism, however, is not just an urban phenomenon. In some provinces people of non-British origin comprise a considerable percentage of the population: Almost half the residents of Ontario fall into this category, and their origins are quite diverse.

Moreover, these figures do not reflect accurately the needs of francophones and Native Canadians. These groups have specific health needs within their respective communities that may differ from the needs provided for in the general community. Their needs, too, must be interpreted within the context of official bilingualism and aboriginal or historical Native rights.

It is also important for us to realize that Canada's cultural diversity is not simply a temporary phenomenon. Demographers indicate that if Canada is to maintain its current economic position, increased immigration will be required in future to offset the declining birth rate.

Like many countries around the world, Canada faces a challenge to respond to the needs of a variety of cultural groups. Given the increasing mobility of people, many, if not most countries have populations who are multilingual or multicultural. The only thing unique about Canada's population is the particular mix of ethnic and cultural groups from diverse origins. Canada has established a multicultural policy to acknowledge its multiracial, multilingual, and culturally plural society.

In view of the acceptance of multicultural policy, it is surprising to find a relative lack of Canadian studies on the relationships between culture and health. There has been some development in Native health studies: courses in this area exist at a small number of post-secondary institutions, one of which is the University of Regina. In general, however, there has been a paucity of interest and response in Canada. One must often

Table 1
Total Number of Individuals Who Identify a Non-Official Language as Their Mother Tongue

Canada	3 175 625
Ontario	1 470 735
British Columbia	449 590
Quebec	425 280
Alberta	365 035
Manitoba	237 760
Saskatchewan	171 955
Northwest Territories	19 745
Nova Scotia	18 250
New Brunswick	9 060
Newfoundland	4 560
Yukon	2 325
Prince Edward Island	1 380

Source: Statistics Canada, 1981.

Table 2
Ontario, Non-English-, Non-French-Speaking Population

Ethnic Group	Mother Tongue	Born Outside of Canada
Italian	338 975	247 065
Portuguese	114 280	93 135
Chinese	89 355	77 040
Indo-Pakistani	48 525	42 520
Spanish	32 330	27 890
Total who identify a non-English, non-French mother tongue[a]	1 470 735	1 111 420

Source: Statistics Canada. Ethnocultural Data Materials Series II, 1981.
a. Includes other groups.

turn to the United States for research or studies. The need to turn to the American experience is, in one sense, all the more puzzling because of the continuing American philosophy of the "melting pot" as compared to the Canadian policy of multiculturalism.

In 1985, the Ontario Human Rights Commission commissioned a report on visible minority health-care workers. The report pointed to a number of inadequacies within the health-care field that need to be examined if we are to respond to the needs of communities in Canada. In one recommendation (#6), the authors stated:

> The evidence of this study suggests that many hospitals and other health systems do not fully recognize and act on the fact that Canada has become a multicultural and multiracial society.[7]

More recently a report examining access to health care and social services for members of diverse cultural and racial groups has again pointed to the difficulties or barriers facing some ethnocultural groups in gaining access to mainstream health and social systems.[8] These reports demonstrate that we must not address only ourselves as physicians, but we must also examine the cultural bias in the institutions and systems in which we work.

Despite the previous lack of sensitivity or response by mainstream health systems or organizations, in the past several years an increasing number of efforts have been made in the health-care field to respond to ethnocultural community concerns or needs. For example, some health organizations have developed multicultural committees, while others have sponsored multicultural awareness programs. Some hospitals, such as the Regina General Hospital, have started programs to examine and respond to specific community needs.[9] Other examples of positive action in initiating programs have been provided by the Mount Sinai, Doctors, and Central Hospitals in Toronto.

The nursing profession is responding: a post-graduate transcultural nursing program exists in Toronto. Memorial University in Newfoundland has formally incorporated cultural awareness as part of the undergraduate curriculum; in several programs sessions on nursing and cultural awareness are taught. The Transcultural Nursing Society was formed in 1974 and has promoted cultural sensitivity and transcultural nursing techniques.[10]

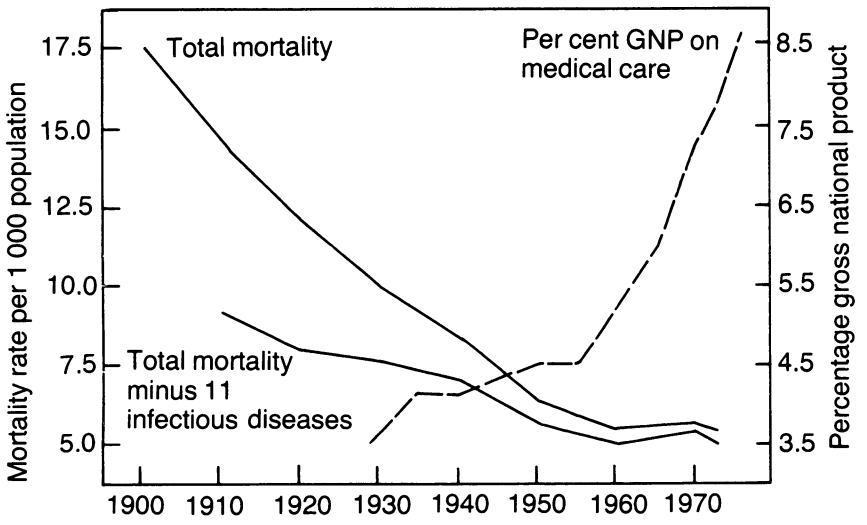
Other recent developments include conferences and workshops in which multicultural health care is examined. One of the first Canadian conferences, "Health is a Cultural Affair", was held in 1984. The conference was co-sponsored by the City of Toronto, Department of Public Health and Ryerson Polytechnical Institute. Since then, there have been several other events, including a provincial symposium in Ontario on multicultural health which was co-sponsored by the Multicultural Health Coalition and the University of Toronto, Faculty of Education ("Partnerships in Health in a Multicultural Society").

The Multicultural Health Coalition is a provincial organization incorporated in Ontario in 1983. It is composed of individuals and organizations interested or active in the provision of health care to ethnocultural community groups. Similar organizational developments have occurred in other provinces and a national body, the Canadian Council on Multicultural Health, was incorporated in April 1988.

In November 1987, the Canadian Public Health Association sponsored a national workshop on "Ethnicity and Aging". In April 1988, the Hon. Elinor Caplan, the Ontario Minister of Health, announced the formation of an Advisory Committee on Multicultural Health. This Committee is to advise her on means of increasing the sensitivity and awareness of health-care providers.

All these initiatives have represented steps in improving the awareness of cultural influences on health care (multicultural health).

Figure 1
Mortality Rates, United States, shown in Contrast to GNP.
Source: See reference 15.



The Relevance of Multicultural Health Care

To be effective and responsive to community needs, health-care systems and physicians will need to be aware of, and sensitive to, the needs of ethnocultural community groups. The response to these needs, con-

cludes a recent report of the World Health Organization, should be integrated within the mainstream systems. The report states in its conclusions that:

> Provisions for ethnic minorities in host countries should be integrated into the existing health care programmes provided for the indigenous population [11]

Giving insufficient consideration to community needs or beliefs may lead to misunderstandings and possibly to isolation or rejection of physicians by an individual or a community. From the most practical point of view, an understanding and a sensitivity to community needs, cultures, and beliefs can only help the physician to practice medicine more effectively. Understanding will improve co-operation and communication between community groups and physicians, and perhaps enhance the profession's profile in the community.

Our health-care system is generally biased towards technology and treatment of illness. What this bias may overlook is that in the long run, good health care is not simply a reflection of technology or the expenditure of health care dollars per capita.

One needs only to reflect on the rising cost of health care which is unaccompanied by a corresponding decrease in mortality rates to appreciate the point (Figure 1). Good health involves the active interest and participation of the individual in his/her own health care.

Our Western bias may also encourage us to overlook the importance of the physician-patient relationship in the healing process, in favour of technological investigations or scientific treatments. We may give insufficient attention to the effect of the physician's communication skills in the successful outcome of a medical intervention. The danger of this bias is that beneficial effects from a doctor-patient relationship may be dismissed as a placebo effect. As one writer has stated:

> Placebos...have been shown to be dramatically effective, especially when the relationship between the doctor and patient is characterized by deep trust and open communication, leading to the belief by some researchers that the doctor-patient relationship itself is the most powerful placebo of all.[12]

Unfortunately it is exactly this doctor-patient relationship that does not lend itself to scientific analysis and consequently may be understated or understudied.

Finally, failure to involve the community can lead to poor community health, despite modern health services.[13] Failure to communicate effectively with a patient may have similar consequences. To work effectively with patients and communities we, as physicians, must be willing to examine other, perhaps complementary, approaches to community medicine.[14] At a minimum we must be aware of our own cultural bias or beliefs and the cultural bias in the health-care systems and institutions. We shall then be in a position to take further steps.

In the next two articles of this series, therefore, I shall examine the impact that health beliefs and practices may have in the provision for the acceptance of health care. While there are many cultural beliefs, they are often conceptually related. Beliefs will be categorized and examined under three classifications: natural, self, and supernatural. In the next articles I shall examine health beliefs based on natural causation, and the effect that beliefs and practices may have on treatments and in clinical practice. ■

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