

# The Implications of Cultural Diversity for Health Care Practice: an anthropological perspective

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## Introduction

As Britain's Asian and West Indian population has steadily grown in size, many doctors and nurses, and especially those working in inner city areas, have found that an increasing proportion of their patients belong to one or the other of the ethnic minorities. Reactions vary, but many are finding it difficult to provide effective health care to such patients, and there is much perplexity about what form an appropriate response might be. Little in their training will have prepared them to cope with cultural diversity, and few will have had any expectation or experience of diversity on its current scale. Nationally about 8% of all births are now to mothers of non-European descent, but in many urban areas the figures are much higher. In many parts of London and the West Midlands, as well as in the textile towns on both sides of the Pennines, one third or more of all births are of this kind. Hence it is obstetricians and paediatricians who are currently most aware of the scale of these issues. But as the present demographic imbalance evens itself out over the years, all other specialties will encounter an increasing number of minority patients. Moreover an increasing number of General Practitioners, and especially those working in inner-city areas, may soon find that a majority of their patients are of Asian or Afro-Caribbean origin.

Most doctors and nurses working in such situations readily acknowledge that they have problems, and that these problems lie largely at a behavioural – that is linguistic, social and cultural – rather than a biological level. I write here as a social anthropologist, that is as someone who is interested in the significance of culture in human behaviour. My aim is to offer an anthropological perspective on some of the difficulties which health care staff regularly encounter in their dealings with minority patients, and on that basis to make some suggestions about how they might begin to overcome them, and consequently to improve the quality of their clinical practice

It is obvious that I cannot deal here with all the problems which doctors and nurses might encounter in such contexts. I shall therefore concentrate firstly on the kinds of perceptions which most health care staff have of their current problems, and then go on to set out an anthropological critique of these perceptions, and to make some alternative proposals. My interest is in identifying the most appropriate *principles* for good practice in conditions of ethnic diversity. Although I shall illustrate my argument as concretely as possible, my invitation to readers is to try to apply the same kind of approach to the particular problems they may face in their own context and specialty.

## Presenting Problems

Let us begin by considering the difficulties which doctors and nurses encounter in their dealings with minority patients and as they themselves experience them. Though varied, they can be summed up under three broad heads. Firstly there are communication problems. Older people, and those newly arrived from overseas may have very limited English, but even where they have acquired a reasonable degree of fluency all sorts of problems often persist. In consequence, examinations become more time consuming, accurate diagnosis is delayed, and treatment is hampered. Secondly there are problems arising from differences in lifestyle.

The logic behind many aspects of minority patients' personal behaviour – their names, their dress, their diet, and their ideas about disease, modesty, personal hygiene and so forth – is unknown. Because they remain essentially mysterious, they get in the way of the smooth operations of clinics, wards and treatment procedures. This gives rise to strong feelings of irritation and frustration amongst hard pressed staff. Finally there are problems of compliance. As one might expect given problems of both communication and understanding, minority patients often fail to follow instructions, however much care may be taken in explanation. In the light of all this it is small wonder that minority patients are widely regarded as 'problem patients'.

### **Morbidity and Mortality**

Data on patients' ethnicity has, as yet, rarely been systematically collected, so the epidemiological evidence on differences in morbidity and mortality between minority and majority populations is very patchy. Nevertheless it is now well established that amongst the problems more frequently encountered amongst Asians than the remainder of the population are Vitamin D deficiencies (DHSS 1980, Dunnigan et al 1981) and peri-natal mortality and congenital abnormality (Niell 1980, Robinson et al 1982, McFadyen and McVicar 1982). With more extensive and systematic data collection, it is certain that raised and lowered incidences of many other conditions would also be identified.

### **Cultural Pathology?**

The interpretation of epidemiological data is always a complex task. Aetiologies are invariably multi-factorial, so the possible influence of genetic, behavioural, cultural, social and environmental factors, as well as the more familiar medical ones, must all be explored. But faced with a body of people who in many ways present as problems, whose cultures and lifestyles are unfamiliar and mysterious, and for whom there is evidence of raised levels of morbidity and mortality, it is easy and tempting to jump to the apparently obvious conclusion – that it is 'cultural factors' which are at the centre of the aetiology of all these problems.

As an anthropologist, I am constantly struck by the strong tendency to regard minority cultural practices – or at least those aspects of them which impinge on their own work – as essentially pathological. So, for instance, *purdah*, vegetarian diets, the use of traditional medicines and cosmetics, and a preference for marriage with close consanguines have all been variously identified as the prime causes of the raised levels of morbidity and mortality mentioned earlier. Once such a causal link is assumed, a specific remedy appears to be very clearly indicated. Minority patients should be persuaded to abandon those aspects of their cultural traditions, and behave more 'normally'. The minorities, in other words, must be encouraged to assimilate, and be taught more appropriate lifestyles. Only thus, it seems, can minority health be improved.

### **The adequacy of conventional understandings**

Yet just how adequate are these currently conventional understandings? Are they analytically sound? And above all, do they offer a useful guide as to how medical practice might be improved? It is my view as an anthropologist that they do not. Worse still, they may well lead doctors and nurses to adopt absolutely contrary remedies to those which are most likely to be effective and appropriate. Let me explain why.

In the first place, it is worth reiterating that establishing correlation, to whatever degree of statistical significance, is not the same as demonstrating causation. Ethnic minorities are, by

definition, culturally distinctive. But they also differ from the majority across a wide range of other indices, many of which are known to have an impact on health. They are, for instance, much more likely to be low waged, to work in a hazardous environment, to reside in concentrated inner-city areas, and are consequently exposed to specific environmental hazards. Not the least of these is lead – in paintwork, piping and from exhaust fumes. The possible impact of genetic differences must also be borne in mind. The distribution of Thallassaemia and Sickle Cell Anaemia genotypes is well known, but others, such as the tendency of people of African descent to have lowered salt excretion rates, so exacerbating problems of hypertension (Langford, 1961) much less so. Doubtless other differences await identification, for it could be that the lower mean birthweight of Asian babies, as well as that population's problems with Vitamin D metabolism are partly genetic in origin.

It is also worth remembering that some of these differences work in the other direction. European populations, for instance, seem to be characterized by a high incidence of the genotype for cystic fibrosis. Moreover there is much that is clearly positive in minority cultural traditions. So, for instance, the Asian tendency to prefer unrefined foods with a high fibre content must stand them in good stead as compared with their indigenous peers, with their substantial consumption of highly refined convenience foods. It is only when the full range of potential aetiological factors has been taken into account that it is safe to begin to test out hypotheses of causation.

### **Anthropological understandings of cultural processes**

There are stronger reasons yet for scepticism about 'cultural pathology' hypotheses. Anthropologists have clearly established that whenever members of an alien and unfamiliar group are encountered, the most usual response is to regard their lifestyles as misguided, unnatural, backward, and in a broad sense pathogenic. Such ethnocentric fallacies are generated wherever observers use their own unacknowledged and taken, for granted cultural criteria to interpret, and to judge, behaviour ordered according to differing cultural precepts. Others' behaviour is inevitably found wanting. Members of dominant and powerful groups are particularly prone to making such ethnocentric judgments.

The anthropologists' viewpoint is quite different. It assumes that all groups have distinctive cultures, and also that on logical grounds which turn out to be quite unassailable, that there is no way of making an objective rank order of cultural systems. Each system makes logical sense in its own terms, and is sustained by those who use it because the members of that group find it useful, and positively adaptive, to do so. Individual items of culturally sanctioned behaviour – such as the inhalation of tobacco smoke, and the consumption of excessive quantities of alcohol – may, of course, have pathological effects. Each system has its own weaknesses – and strengths. But to adjudge an entire cultural system as pathological, though commonplace, is nothing more than a manifestation of ill-informed ethnocentrism.

Though every system must be understood in its own terms, it is equally important to recognise that each is also constantly changing, and for all sorts of reasons. However there is nothing straightforward about such processes of change. It is widely assumed, for instance, that whenever the carriers of two cultural traditions encounter each other the two will gradually merge. Anthropological findings suggest otherwise. If one group occupies a superior social position to the other, and if members of the dominant group assume that their ways are superior (on the grounds just outlined quite the reverse may occur. Subject to constant external pressure members of the minority will tend to close ranks and look to each other for mutual support. In doing so they are most likely to elaborate their cultural distinctiveness, to enhance their sense of identity and self-worth, to organize a network of

reciprocities with which to make the best of limited opportunities, and generally to resist and to challenge those they face. Pluralism, not assimilation, is the more likely outcome of unequal ethnic encounters.

This is, indeed, precisely what is taking place in contemporary Britain. South Asian, Afro-Caribbean and many other minority groups are sustaining and sometimes elaborating their distinctiveness. They also argue that attacks on their right to do so are nothing less than racism. In these circumstances it is clearly unrealistic for health care staff to expect that their problems will eventually be solved by assimilation. Suggestions that minority cultures are somehow pathological are also likely to precipitate little more than angry abuse. Is there any way out of this impasse?

### **The cultural groundings of medical practice**

If conventional assumptions are untenable, on both analytical and practical grounds, what can be put in their place? I believe that there is a way out of this impasse, but it can only be found if we go right back to basics. Moreover the lessons to be learned by doing so are relevant to all medical practice, not just that with respect to minority patients. Medical and nursing practice, of necessity, has two components. On the one hand it involves 'scientific' skills in physiology, pharmacology, surgery and so forth, and on the other it demands social and cultural skills. Patients are people, not just mobile bio-chemical assemblies. Yet one of the most striking aspects of modern medicine is not just its rapidly increasing technological sophistication, but the way in which all those involved in the delivery of health care have come to evaluate themselves, and to define their activities, primarily in technical terms.

Yet however prestigious 'scientific medicine' may have become, everyday medical practice is, of necessity, quite as much a social as a technical procedure. If doctors and nurses' social and cultural skills do not match their technical skills, their therapeutic effectiveness will surely be impaired. This is, I would suggest, the central reason why medical staff find themselves in such acute difficulties with their minority patients.

My central argument here is not that doctors and nurses tend to be a-cultural in their dealings with patients, but rather that they are unaware of just how far a specific set of cultural assumptions underpins their own everyday practice. That lack of awareness arises for two reasons. Firstly the whole of the current medical ethos, with its emphasis on technical sophistication, means that they will not have been alerted to the extent of the impact of culture on human behaviour, including their own. Secondly (and because of this they tend to take for granted the normality and universality of their own cultural assumptions, so falling into all the ethnocentric traps outlined earlier. If this is so, one would *expect* grave mistakes to be made when health care workers encounter patients who differ in their cultural assumptions.

These mistakes are not just a matter of intellectual nicety. It is obvious enough, for instance, that communication is central to medical practice. Patients are asked questions and given instructions throughout the process of diagnosis, treatment and rehabilitation, and their responses and complaints are carefully monitored. Doing this is relatively straightforward when doctors and nurses and patients share the same set of cultural assumptions. But where they differ communication will necessarily be impaired and therapeutic effectiveness impeded.

This will occur not just in a G.P.'s surgery, but also, very often, in hi-tech medicine. Since such treatments often have severe, if temporary, side effects, they can only be successful in a context of close cooperation between doctor and patient. In the absence of a means of

effective communication that cooperation will not be achieved, and the chances of success necessarily be impaired. Indeed this could well be a contributory factor to the raised rates of morbidity and mortality amongst minority patients which were noted earlier.

However, my purpose here is not just to write critically. It is instead, to try to suggest how the adoption of a more anthropologically informed perspective might be used by clinicians to improve their practice. This can be done, I believe, by examining carefully the cultural underpinnings of doctor-patient interactions, and in order to identify why some are less successful than others. The essence of my argument is firstly that doctors and nurses tend to be unaware of the extent to which they rely on folk concepts to achieve communication with their patients. Secondly they take for granted the normality of the folk concepts that they use to communicate with patients like themselves. Thirdly they are unaware that they might utilize an alternative set of folk concepts with patients who differ from themselves. Finally the miscommunication which inevitably occurs in such circumstances tends to drive them inexorably to the conclusion that difference is to be equated with deviance, and deviance with pathology.

In my view it is on just this kind of basis that the 'cultural pathology' hypothesis has been generated. But there are alternatives. Just what they are, and what their consequence might be, is best approached in exemplary terms, and so I will discuss at length here a single concrete illustration – the ways in which doctors and nurses go about explaining the linked questions of personal hygiene and disease aetiology to their patients. It is, I think, particularly illuminating, but the same kind of argument could be presented with respect to most other areas of medical practice.

### **The use of folk concepts in medical practice**

In discussing personal hygiene and disease aetiology with their patients, health care staff very rarely utilize a technical terminology. Bacteria, Viruses and Fungi go unmentioned. Instead they have recourse to folk concepts, and most especially to those ever-useful creatures, 'bugs' and 'germs'. It is 'bugs going around' which cause disease, and 'germs' one must avoid if one is not to fall ill. Advice about personal hygiene is offered in the same terms. Soap and disinfectant are used to 'kill germs', and sometimes 'all known germs' Children are urged to blow their noses into their handkerchiefs, and to place their hands in front of their mouths when they cough or sneeze, 'to stop germs spreading'. Similar advice is offered about the preparation cooking and serving of food: here too 'germs' must be kept in their place.

Yet all these 'germs' are of course a fiction. The microscopic creepy crawlies of popular imagination do not exist, as the biologically informed are well aware. Nevertheless doctors and nurses regularly refer to these imaginary notions, above all because of their utility. Because they are believed in by patients; consequent they provide a convincing means of communication, so persuading them to act. Health care staff regularly, and indeed necessarily, use folk concepts which are culturally rather than technically grounded to communicate with their patients. And they do so not just with respect to hygiene and disease, but in most other spheres. Yet it is likely that most will be largely unaware of doing so. If they have never sought, in analytical terms, to separate the technical aspects of their practice from its cultural dimensions, and if they use these self-same concepts to order their personal lives and to socialize their children, they will take the normality of the folk based germ theory of disease for granted. Consequent they will be largely unaware of the extent to which, and the frequency with which, they switch between using medical and folk terminologies in the course of their practice.

All this would be no more than a valid, but arcane, point in communications theory if we lived in a culturally homogeneous society. But we do not, and so the argument has immediate practical consequences. Above all it illuminates one reason why health care staff often get into difficulty with their Asian patients. They may not believe in germs! In consequence the arguments which work so well with English patients lose all their force. Why should anyone take action to kill or avoid germs if they do not acknowledge their existence? No wonder there is extensive miscommunication and non-compliance.

### **Purity and Pollution**

Just because 'germs' play no part in the cultural repertoire of a particular group, it should not be assumed that they consequently lack a conceptual structure around which to organize personal cleanliness. Quite the contrary. They will simply utilize a different conceptual order – and in this context Britain's Hindu and Sikh populations can provide a convenient example. For most older members of these groups, the crucial organizing concept is *achhut*, impurity. Such impurity arises as a necessary consequence of all biological processes. Not only are all dead things impure, but so too are all the waste products of natural processes. Excrement, urine and menstrual blood are all impure as are sweat, phlegm, and hair and nail clippings. To maintain one's body in a clean and healthy state, these waste products must be removed and disposed of, using running water, the ultimate purifier.

Much follows from this. Showers are strongly preferred to baths, for English style bathing involves lying in a solution of one's own waste products. Having cleared one's throat one should spit out the phlegm, otherwise one eats filth. And having opened one's bowels one must use water; not paper to clean oneself. The fact that Hindus and Sikhs aim to protect themselves against *achhut* rather than germs leads them to behave in ways which differ quite significantly from English norms. But in purely biological terms the result of their following these rules is very positive, and it is certainly arguable that devout Hindus and Sikhs maintain a higher standard of personal cleanliness than do most English people.

Yet the fact that they use a different and unfamiliar conceptual order regularly causes problems when such patients come into hospital. Staff become irritated when their Asian patients prove reluctant to take baths, and grow concerned when they noisily clear their throats and then wish to spit out the resultant phlegm. But it is around the lavatories that the biggest battles usually take place. Patients are condemned for their 'dirty' habit of trying to take water into the lavatory, and criticism becomes even fiercer when they are still discovered shyly trying to sneak bottles in with them, despite clear explanations that the practice is totally unhygienic: Of course it is not the case that Asian patients are dirtier than English patients. Quite the contrary. But where patients employ rules of personal cleanliness which differ from those in terms of the institution in which they are being treated, those patients will feel themselves dirty because the system works against them, while their efforts to restore themselves to a state of cleanliness will result in their being seen as 'dirty'. Such a state of affairs is not helpful to anyone.

Confusion of this kind can also have quite direct clinical implications. Take the case of the sterilization of babies' feeding bottles. In an English context, sterilization by leaving bottles soaking in chlorinated water for a lengthy period makes good sense, for the fluid can be plausibly represented as having germ-killing powers. But what does the same procedure look like from an Asian perspective? Not only may germs not be believed in, but standing water is stagnant water – and so necessarily a

pollutant. So no wonder many Asian mothers carefully rinse out their babies' bottles once they have had their ritual bath in Milton.

Once such an account of the logic of Asian conceptions of hygiene is available, the inadequacy of conventional conclusions about such patients' unexpected and uncooperative ways becomes very apparent. It is not that Asians lack an understanding of the importance of personal hygiene, but that their concepts differ. Rather than embarking on the wholly unnecessary task of seeking to replace one set of folk concepts with an alternative set with which health care professionals are more familiar as a result of using themselves in the course of their personal lives, it would appear to make a great deal more *professional* sense to work with and through – rather than simply to ride rough-shod over – patients' own folk-concepts, whatever format they might happen to have.

### **A key to good practice?**

Although I have only had the space to discuss a limited area of behaviour in the case of a single specific group of people, I would suggest that essentially similar issues to those which I have sketched out here arise across the length and breadth of medical practice. Culture affects all aspects of human behaviour – how we name ourselves, organize our families, dress, eat, take leisure and present ourselves when ill – and all these have a salient impact on health, health care and thus on medical practice. Doctors and patients, as well as all the other participants in the health care process, all bring with them their own assumptions about how these various aspects of behaviour should be organized. Those assumptions: are all necessarily culturally grounded, and where everyone relies on the same code interactions can proceed straightforwardly – though not a-culturally.

It is when participants use *differing* codes that problems arise. Without a key to the logic of alternative conceptual systems, communication will be exceedingly difficult to achieve. If, worse still, there is no awareness that such systems might exist, ethnocentric conclusions will almost inevitably be drawn. Once they are, and once they become well entrenched, it becomes exceedingly difficult to perceive that the apparent problem actually contains the seeds of a solution. Failure to do so will certainly make minority patients appear 'difficult'. But an attempt to overcome this difficulty by eradicating difference is bound to be counter-productive. Subject to such pressure – in many other fields besides that of health care – many members of the minorities are becoming ever more determined to be 'difficult': their distinctiveness is becoming more and more overt. This situation also raises a more general philosophical argument, to which the Association's Patron, Prince Charles, referred on taking up office. Should patients be expected to fit themselves to the requirements of the Health Service – or the Health Service seek to equip itself to respond to patients? If the latter, the case which I have presented here is surely unchallengeable.

### **Conclusion**

What might that actually mean in practice? The core of my argument is quite simple. It is, essentially, that doctors and nurses need to be as competent and sophisticated in their approach to the anthropological components of their task as they are to its bio-technical dimensions. This must involve a recognition of the extent to which *all* medical practice must have cultural groundings of one kind or another, and also that from this perspective therapeutic effectiveness can only be maximized when health care staff seek to use their patients' cultural assumptions as a resource. Certainly every effort should be made to avoid reducing them to an obstacle.

How might this be achieved? The first step, quite clearly, is to stand current commonplace assumptions on their head. It is not, by and large, minority patients who are the problem. Rather it is health care staff who lack the capacity to respond adequately to their distinctive lifestyles, and so lack the ability to distinguish between what is truly pathological and what is merely incomprehensible. Increasing comprehension will not necessarily be achieved by exposing doctors or students to packages of information on 'minority cultures'. What counts here is not just the information, but how it is used. Hence the first step that doctors need to take is to make themselves aware of how culturally grounded their own professional behaviour already is. Their problems arise not so much because their minority patients' behaviour is culturally distinctive, but because doctor and patient differ culturally. The difference is a two way process.

As Prince Charles implied, it is surely inappropriate to require patients to conform to the doctors' cultural assumptions or indeed those of the dominant majority – before they have access to adequate health care. Any other approach will necessarily set those who differ at a disadvantage, and quite rightly precipitate complaints of bias. Where those who differ only comprise a tiny minority in the population, there would be practical grounds for making an exception to this argument of principle. But now that the scale of the minority presence has reached the substantial levels indicated earlier, especially in inner-urban areas, such arguments would seem to be irresistible.

What shape, then, might a more culturally-sensitive system of service provision entail? Clearly a massive training programme would be required to alert staff at all levels to the issues in this area, and to begin to equip them with the necessary cultural competence to enable them to provide a more effective service to those who differ from themselves. By cultural competence I do not mean anything very elaborate. It amounts to little more than an ability, and a commitment to communicate with patients in their own terms, and to offer them advice, assistance and support in terms which make sense to them.

Paradoxical though it may seem, this will not necessarily entail the absorption of vast amounts of information about unfamiliar cultural practices. Some information is essential of course, but even more important is a perception of what the issues are, and a commitment to start from the patient's own perception of the world, responding to his or her own cultural categories, rather than trying to impose one's own. There is no need to be sceptical of my argument on the grounds that doctors could never know enough. Of course they could not know everything about everybody, especially since all cultural systems are constantly changing. Indeed it is worth emphasising that it is certainly not the case that all members of Britain's South Asian population will *necessarily* use the conceptual framework outlined earlier to organize their own personal hygiene. What doctors and nurses need is not a stereotyped set of rules of thumb along the lines 'this is how the *x*'s behave', for all such stereotypes are necessarily inaccurate. What is far more important is the development of a commitment to accept the legitimacy, adaptiveness and resourcefulness of patient's lifestyles, whatever they may be. In developing such sensitivities a certain degree of knowledge is essential, but information itself is not the issue. It is the perspective adopted towards diversity which matters most of all.

And here lies the rub. In so far as medicine has increasingly been defined as a technical activity, so doctors have not just ignored the significance of cultural factors, but taken the normality of their own cultural assumptions for granted. Thus it is clear that in most medical settings, conformity to English middle class cultural styles is expected, and indeed enforced. Challenging and changing deeply entrenched and taken for granted social conventions is never easy.

Even more importantly, we touch here on a much more general social issue. As the minority presence in Britain has grown, so hostility towards them has become increasingly overt. 'Immigrants', as members of the non-European minorities are conventionally labelled, even when British-born, are consequently perceived as alien and as having a lesser right to scarce resources than their indigenous peers. Hostility is not only focussed on their distinctive colour, but also on their cultural distinctiveness. Non-European cultures are widely assumed, amongst the white majority, to be inferior. The minorities' tendency to sustain their distinctiveness is seen as both unreasonable and illegitimate. Hence it is widely assumed that it is quite unnecessary to make positive responses to diversity in the way which has been outlined here.

Responding to cultural diversity necessarily raises political and ideological, as well as technical issues. These have not been discussed here, on the grounds that doctors and nurses' central professional objective is to provide the most effective possible level of health care to their patients, regardless of the political circumstances. But health care staff are social beings too: they will want to discuss the political implications of various strategies. Where training courses are contemplated, these issues have, of necessity, to be confronted.

Nevertheless the *medical* issues are clear. If doctors, and indeed the health service as a whole, is to maximize the therapeutic potentialities made available by massive recent technological advances, much fuller account will have to be taken of the fact that health care necessarily has cultural and social, as well as biological dimensions. Doing so does not necessarily require the appointment of more social workers, interpreters and the like, but rather a thoroughgoing shift in *medical* priorities. A failure to match technical skills with the relevant degree of cultural competence will necessarily impair therapeutic effectiveness.

Finally it is worth emphasising that the issues raised here do not apply solely to minority patients, but run across the board. There are many dimensions of diversity in British society which run parallel to those of ethnicity – not least those of class, region and gender. Were similar strategies employed with respect to these differences, at least some of the inequalities highlighted in the Black Report might well be diminished. All this might mean 'less sleep for medical students', as a recent B.M.J. editorial suggested. But it should make them much better doctors.