

## **CULTURAL ADAPTATION: THE AMBIGUITY TOWARD THIS NOTION IN HEALTHCARE<sup>1</sup>**

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During the 1980s, the significant increase in ethnic diversity in major Canadian cities, and in particular Toronto, Vancouver and Montreal, lead public health officials and practitioners to rethink the framework of their interventions. Dominate questions regarding immigrants, which continue to be pertinent today, included: 1) health, 2) beliefs and behaviour regarding prevention, 3) accessibility to health services and utilisation. Such preoccupations also lead to the development of a field of research on the role of culture in this area. In the rethinking of intervention frameworks, culture emerges as the most important key in the understanding of health trajectories of new immigrants, and possibly that of their descendants.

The object of cultural studies in Anthropology, once relegated to the understanding of faraway people, is now transported to Western societies with the arrival of successive waves of diverse immigrant populations. Culture, as an explanatory tool, has taken on a different meaning as it is often used to explain perceived differences between the western world (generally thought of one of science and rationality) and the rest of the world (generally thought of one of beliefs, tradition and irrationality).

Culture, once the object of study in the social sciences, has now been added to the list of social determinants of health, and has spawned a new field of research. Culture can be useful in the understanding of immigrant health representations and practices, and that of their children. However, culture is equally present in health representations and practices of practitioners. In fact culture plays a dynamic role in the clinical encounter, shaping attitudes, beliefs, values and actions of both practitioner and client – as well how each perceives the other. The focus of this presentation will be to illustrate this last point.

### **Cultural Adaptation of Services" or "Culturally Sensitive Care: An Ambiguous Concept**

During the last two decades, Canadian and Quebec public healthcare policy emphasized the need to provide culturally adapted services. Practitioners were strongly encouraged to develop culturally sensitive healthcare practices.

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Formal government documents did not explain these concepts, nor did they provide practical guidance. For example, a Health Canada report published in 2001 stated that healthcare providers had to become culturally sensitive and offered a minimal, not to mention vague, number of steps: 1) Develop awareness of one's self and personal values; 2) Understand the role of culture within the health system; 3) Develop sensitivity to cultural problems of each individual client; 4) Develop the understanding and ability to use specific methods to treat cultural problems.

Who are we talking about? This report does not even distinguish between different professional groups and different immigrant populations, each with their own trajectory and history. Furthermore, it is not clear up to what point must the healthcare system provide culturally adapted services. What are the limits for practitioners in their ability to be culturally sensitive?

The starting point of our reflection on the issue of cultural adaptation in healthcare began with the results of two research studies on two different groups of health professionals:

- 1) *The clinical encounter between patients and doctors within a cultural context of difference* (Guibert, et al., 1997-1999)<sup>2</sup>
- 2) *Homecare workers: training, ethnicity and institutional trajectory* (Meintel et al., 1999-2002)<sup>3</sup>.

Even though, the respective object of these two studies is distinct, they nevertheless shared a common preoccupation: they each questioned intervention practice within an intercultural context.

Both studies took place in the primary health sector in Montreal, in multiethnic neighbourhoods. In the first project we interviewed 25 doctors from private and public practice: 12 men and 13 women; 15 Canadian born; 10 immigrants. The interviews focused on the challenges entailed in an intercultural clinical encounter. In the second study, 40 Homecare workers (from private agencies and the public health sector) participated in semi-structured interviews: Among the participants 28 were women and 12 men, 23 were immigrants and 17 Canadian born. The interviews focused on their practice and relations with client within an intercultural context.

The major finding from comparing results from these two studies is that both professional groups espouse a paradoxical view of culture: they both see culture as having both a positive and a negative impact on the intervention process: In its positive form, culture is perceived as a source of enrichment, openness and learning, and is used as a mediating tool in constructing the relationship with the client/patient, and in establishing the trust necessary in the therapeutic relationship. In other words, culture is seen as an important resource to be exploited.

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<sup>2</sup> - Guibert R., Rosenberg E., Xenocostas S., Meintel D., Sévigny R., Kirmayer L. et Young A., study funded by CRM (Medical Research Council).

<sup>3</sup> - Meintel D., Cognet M., Raigneau L., Fortin, S., Renaud J. et Sévigny R., funded by CQRS (Quebec Council of Social Research).

In its negative form, culture is perceived as the very source of the problem in the patient's/client's inability to take care of themselves or of their children. Culture also serves as an explanatory factor in cases involving a misunderstanding of the healthcare system as well as the norms, values of Canadian society. Culture can also be viewed by practitioners as an instrument of domination (gender relations), discrimination. Culture in this form is seen as an obstacle that must be eliminated.

In both professional groups, we note the presence of certain hierarchical representations of cultures and countries of origin. Cultures and countries of origin associated with the western world were considered modern, and thus valued; whereas non-western cultures and countries of origin, perceived as underdeveloped in terms of knowledge and technology, were seen less favourably.

However, the importance attached to the role and impact of culture in the intervention process differs for these two groups. In general, homecare workers do not accord much importance to cultural differences as long as they are successful in establishing a friendly relationship with the client. Even the presence of a language barrier is not seen as a significant obstacle, since the client's body serves as the locus of communication expressed through the gestures, and actions of the homecare worker.

In contrast, doctors seemed to have more difficulty in situations involving great cultural differences, since they perceive the ability to orally communicate with the patient as a fundamental condition of a successful therapeutic relationship. Language barriers are seen as a major obstacle, of which the presence of language interpreters can only partially resolve.

Finally, we can suggest that two major differences characterise both groups with regard to professional status and roles:

The majority of doctors have a clear sense of their professional identity, role and mission. This strong sense of identity has been acquired through many years of medical training and reinforced by the high social status accorded to their profession. These representations have legitimised the certitude of their expertise in the health system. In other words, they have no self doubt about the way they diagnose and treat their patients. And so, in situations involving cultural differences, where the patient has their own views about health and treatment; culture becomes an obstacle for doctors. In order to overcome this difficulty, doctors believe that the patient must learn to adapt to the values and norms of the Canadian health system.

On the contrary, most homecare workers as a group demonstrate a certain vulnerability with regard to their professional identity. This weak sense of identity can be explained, in part to, their short and rudimentary training (less than one year), and a low social and professional status attached to their profession. In addition, this profession lacks clear conceptual models of reference. These representations do not

allow them to establish a strong professional certitude in defence of their practice. As a result, homecare workers are less rigid in the way they carry out their interventions and are more willing to negotiate with the client. They believe that they as a professional group, as well as the Canadian health system, must adapt to the client.

However, these two professional groups are not strictly homogeneous with regard to whether or not they should adapt to the “patient”/”client”. These intra group differences can be explained to factors other than that of professional status, and in particular, that of personal life history and immigration experience or not. Our findings suggest that individuals with an immigrant experience, more often than not, have a positive outlook of the intercultural encounter and of the immigrant “patient”/”client”.

The polarized nature of these findings invited us to verify the question of cultural adaptation in relation to a different health professional group. What follow is our findings of the third study which focuses on nurses.

#### **The Practice of Nurses : Between Professional and Cultural Models<sup>4</sup>.**

In this study, we interviewed nurses (n=45) in three different sectors of practice in Montreal (Quebec): 1) public sector employees (CLSC); 2) nurses hired by private for profit agencies; and 3) nurses working in private non-profit associations. Our methodology favoured both quantitative and qualitative methods. We first designed a questionnaire (n=260) which we used to determine, among other things, the various nursing profiles (sector of service, level of professional training, personal biography etc.).

The results of this questionnaire helped us determine the dominant sub group profiles. We then randomly selected sample for each sub group to explore the social representations of nurses toward the other in an interethnic encounter. More specifically, we explored their vision of the healthcare system, their perception of immigrants, and the interrelationship between these two factors and the notion cultural adaptation.

#### **Adaptation: A continuum of representations**

Our results show that the notion of adaptation can be interpreted in terms of a continuum within which practitioners position themselves between two extremes. On one end, we find practitioners who think that it is the immigrant who must adapt by changing their behaviour and by learning our healthcare system and its values. In others words becoming "normal" users.

*“ It was necessary (to show her), how to organise herself, how to manage a budget (ugh) how to take care of a newborn, because of the way she was taking care of the baby, let’s just say that it wasn’t normal, it was necessary that she adapt to our way of doing things... Her behaviour was not normal. She was open to learning, open to trying new things, but she needed help. ”*

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<sup>4</sup> - Study directed by Cognet and funded by Canadian Institutes in Health Research, 2002-2005.

On the other end, we find practitioners who believe that they must adapt their practice to accommodate their client's perceptions and needs.

*“One must really understand the perceptions people have of different illnesses. According to their origin, religion, they perceive illness differently and treatment differently too. We have to take this into account, and sometimes we have to adapt a lot ...”*

The way practitioners position themselves depends on many factors according to personal and professional history and it is intricately linked to two representations:

- 1) The way practitioners perceive the healthcare system and its core values
- 2) The way practitioners perceive immigrants

### **The Canadian Health System**

The majority of practitioners interviewed, including nurses, view the Canadian health system as unquestionably the best when compared to others. They attach a superior value to the biomedical model adopted by industrialized societies and promoted by the WHO. The practitioner's perceptions are part of a much larger, dominant social representation found in industrialized societies which equates modernity with science, and in turn, places it in opposition with the rest of the world where the dominant models are influenced by tradition and beliefs.

*“I will adapt, I will try to find another solution, as long as it respects the norms of healthcare and the rules of healthcare in order to assure the quality of care. This is not a question of tolerance. It is a question of being a professional and respecting... We see things like that, false beliefs, and we must work hard since – no – I will not adapt to something like that.”*

However, some practitioners espouse a more relativistic point of view of the biomedical model. They see the value of non western medical system, and at the extreme some accept a pluralistic health models.

*“They have a panoply of knowledge. (...) They first treat themselves according to how they know and when this doesn't work, they come to the clinic. And often both things happen at the same time. They ask for antibiotics and at the same time they use their herbal medicine. I feel this is wonderful. I agree with that: It's functional!”*

### **Portraits of Immigrants**

Similar to the representation of the healthcare system, we note a range of opinions situated between two extreme positions:

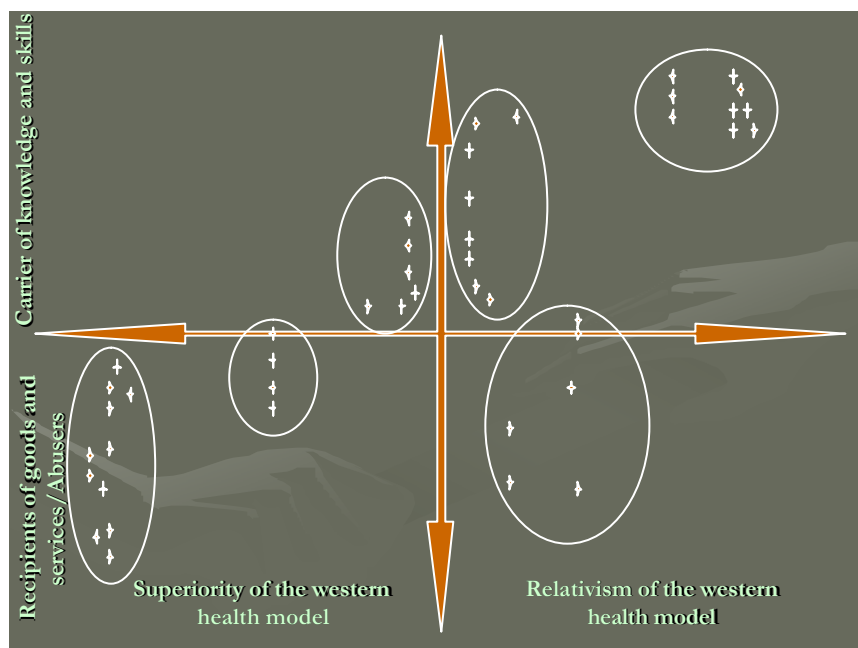
At one end, the immigrant who arrives with nothing, and becomes a recipient of goods and services; at the extreme of this point of view, the immigrant is seen as a taking advantage of the system, an abuser.

*“These people arrive here, over there they don't have anything, okay, you don't work, you don't eat, it's the way things work over there. But they come here; we offer all kinds of services. These people are really well taken care of here. They have here what they never had at home.”*

And on the other extreme, the immigrant arrives as a carrier of knowledge and resources that can be shared with the host society.

*“One must never act as an expert and act as if they know nothing... it is not true, these people have a life behind them, they have experiences that may be different, but they also know a lot of things and we can also learn from others...”*

The various positions of our participants were analyzed and compared according to two dominant social representations placed on an orthogonal diagram: 1) The superiority of the western medical system vs the relativism of the western medical system (horizontal axis); and 2) The immigrant as a receiver of services vs the immigrant as a carrier of resources and knowledge (vertical axis). Six principal clusters were identified:



- 1) At the upper right section, we have what we have called, the « **Critical egalitarians** »: They take into account the strengths and skills of immigrant and minority groups. They can also be highly critical of Canadian society. Their defining feature is that they believe that the Canadian healthcare system can benefit by integrating the knowledge of other medical systems, and in turn, by revising its norms and rules.
- 2) The second cluster is found in the upper right, next to the vertical axis. They have been classified as the “**Critical Conciliators**” since, like the first group, they acknowledge that the immigrant is a carrier of knowledge and skills; therefore deserving respect. The major difference with the first group, that instead of fighting the system, the second group tries to negotiate cultural compromises within the boundaries of the healthcare system.
- 3) The third group, classified as “**Humanitarians**” is situated at the upper left part, near the vertical axis, also see the immigrant as a carrier of experience and knowledge. They see their contact with the immigrant as enriching.

However, they tend to display a great attachment to the values and norms promoted by the Canadian health system, and because they think that it is the best, they will not question it. Their discourse is grounded in terms of respect and value of the human being.

- 4) The fourth cluster is situated in the mid-left, around the bottom half of the horizontal axis. This cluster can be classified as the « **Adaptive Integrationists** ». This group displays an certain interest in immigrant culture; the latter is viewed primarily in folkloric terms and is perceived as being useful in an limited and practical way. In other words, culture can be useful if it facilitates care and the implementation of protocol.
- 5) The fifth group, situated under the left, horizontal axis and on the far left, have been classified as “**Assimilationists**”. The majority of this group espouse a negative view of immigrants. The immigrant is seen as someone who is not only “lucky” to be in Canada and therefore able to receive healthcare, but as someone who is takes unfair advantage of the healthcare system and therefore cannot be trusted. Immigrant values are deemed inferior to Canadian ones and do not merit any consideration. According to this view, the immigrant must comply and conform to the norms and way of doing things within the Canadian Health System.
- 6) The last cluster, situated in the bottom right, has been classified as “**Segregationists**”. They perceive the immigrant as radically different, who should ideally be treated in a parallel culturally adapted system. For the majority, cultural groups are not only different, but can be placed according to a cultural hierarchy, with certain groups perceived as more advanced (therefore on the top) and others as more traditional or backwards and therefore on the bottom. This group of practitioners are strong proponents of the “ethnic match”.

These various positions among practitioners with regard to cultural adaptation cannot be simply explained in terms of differences in levels of training, sector of work, general level of education, gender and age. The only variable which can explain these differences is previous and/or actual experience with immigration, or on a more general level with ethnic difference. For instance, the two groups situated on the upper left represent 80 % of the total number of immigrants in the study. The other members of these two groups are either children of immigrants or spouses of immigrants. A small number include those that have previously travelled to countries which are culturally very different from their own. Finally, 80% of visible minority participants in this study are found in the upper right sector.

## **Conclusion**

In conclusion, in the present day Canadian healthcare system the concept of cultural adaptation is considered as a key element in providing interethnic care. However, as the results from our three studies suggest, a high degree of ambiguity surrounds this notion among practitioners. Also, the way this notion can be successfully applied to

practice is neither clear nor simple, nor is it just a question of receiving intercultural training.

Cultural adaptation among healthcare practitioners (be they doctors, homecare workers or nurses) can be only successfully applied in professional practice if the following two factors are taken into account:

Professional groups are not homogeneous, not even within the same professional group. Individual groups can vary internally, in terms of biographic and personal trajectories – this includes ethnic identity and immigration experience.

Also to be taken into account, is the larger political context which determines interethnic relations in western, industrialized societies, and produces policies and laws that : 1) historically structure healthcare systems and the way services are offered; 2) that govern the way new immigrants settle in the host society; 3) implicitly produce social representations of the health professional and the «immigrant other »; and 4) on a more general level, produce social representations of ethnic groups, some of which are held in high esteem and some of which are discredited. As we have seen, in Montréal, more often than not, the social image of the immigrant tends to be negative rather than positive.

In conclusion, in order for the notion of cultural adaptation to be successfully applied in healthcare and services, priority steps need to be taken that go well beyond providing intercultural training to practitioners. More importantly at the political, decision making level, action is needed to modify the representations of different ethnic groups in society. Of equal importance at the public health level, officials need to develop more precise application strategies with regard to cultural adaptation and must also identify the limits of this approach.