Providing Culturally-Sensitive Health Care and Eliminating Disparities Using Spanish Language and Cultural Studies

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There are many variables that influence the issue of the ability to provide culturally-sensitive healthcare with the goal of minimizing the disparities that are products of the cultural insensitivities. This research is being conducted from the perspective of a pre-medical student attempting to utilize Spanish language and cultural studies to construct the ambition to preserve understanding of foreign customs as a future physician. The term cultural studies, in this setting, may be defined as "an innovative interdisciplinary field of research and teaching that investigates the ways in which 'culture' creates and transforms individual experiences, everyday life, social relations and power" ("What Is Cultural Studies?"). Comparing cultures and customs, especially those in the ever-changing environment of a medical setting, can be difficult to evaluate definitive causes of disparities and the consequent effects. To explore and evaluate the relationship between what cultural factors cause medical disparities and how those disparities affect health outcomes and healthcare, this research is divided into two approaches: quantitative and qualitative. The quantitative approach delves into the measurable variables that are pertinent to "health status, access to care, and use of health services in children" (Flores 419), including statistics and sociodemographics, that have been derived in order to make conclusions about the impacts of medical disparities. The latter is explored in this analysis through the use of interviews conducted through surveys and pinpointing specific examples of cultural differences and exploring the importance of those differences and their significance within medical disparities. Opinions of these professionals suggested methods to obtain cultural competence and how these methods could be implemented in the future as a physician, or any profession for that matter. There is an important focus on the perspective of patients belonging to a Spanish-speaking heritage. The objective of this research is to evaluate the variables of cultural disparities in health care, determine the effects of said

variables, and propose a method for future implications of eliminating the disparities to provide culturally sensitive healthcare.

Pursuing a medical career within a system like the one here in the United States takes an even stronger ambition to learn about people. It takes dedication and discipline to learn about a body, but it takes grit and commitment to learn about people. America is a mixing pot, continually enriched by the people that season this country with distant cultures and customs. People are different and said to be equal, yet are not equal. People are already equal, yet it's the opportunities where equality falters. History is chocked full of people dedicating their lives, giving up their lives, and their families' lives for a better chance at opportunity. For a solution, there must be a problem. For a problem to have a solution, there needs to be a population in which the issue is prevalent and pressing. In this case, the investigation to be executed is how can Spanish (encompassing all Spanish-speaking countries) culture and language studies acquired be translated to cultural competence that can then be implemented in the process of training medical professionals, and throughout healthcare administration to prevent issues from being at the root of the problem. Just like any other platform for a pervasive issue, the issue must be clearly defined and without bias. The misunderstanding or lack of effort to understand differences in cultures, customs, and beliefs translate into disproportionate health care opportunities, standards of health, and access to healthcare, among other general topics of concerns involving cultural barriers. Thus, almost as pertinent as defining the problem, is defining measurement standards. This in itself is an entire project, but is essential to evaluate for research of this nature. Due to its relatively new recognition, there are several ways of defining the concept, depending on the context in which it is being used. First, the term "culture" should be clarified. "La cultura puede ser definida como un conjunto de elementos que median y califican

cualquier actividad física o mental que no sea determinada por la biología y que sea compartida por diferentes miembros de un grupo social." ("Culture could be defined as a set of elements that mediate and qualify any physical or mental activity that is not determined by biology and that is shared by different members of a social group"); (Langdon and Wiik 179). In this case, it is best coined "cultural competence," whereas it has elsewhere been understood as cultural "responsiveness, effectiveness, or humility." (Betancourt 294) For the purpose of this research, having been conducted by a Pre-med student with additional studies in Spanish language and culture, this study will be focused on the general Spanish-speaking population of the United States, though literary reviews encompassing other languages are cited. This analysis, though with added specificity to certain aspects of culture, addresses a general foundation of research and approaches that are observed throughout the overall or more general study of cultural competence.

Cultural competence is a two-sided issue. There is the perspective of the foreign culture, then the perspective of the native culture of the health care provider attempting to coordinate with that of the foreign. It is important to keep in mind all perspectives when attempting to explore a difference in cultures. A study such as this, comparing and contrasting cultures and customs, may become controversial and offensive even without malicious intent. Nomenclature, ethnicities, races, customs, beliefs, traditions and preferences are all variables that have to be considered for these said "native" and "foreign" perspectives. Additionally, it is very easy to unintentionally imply a bias to the native perspective in which the research is being conducted. Therefore, the foreign perspective must stay in the forefront when ideals of cultural barriers are investigated, especially in this example, for the relationship to medical disparities in health and health care. When a barrier—of language, culture, etc.— exists between people, regardless of

the relationship, there will be miscommunications, misunderstandings, and complications that inevitably arise. This study is based in the medical environment, where communication between care-giver and patient is the foundation of function. According to "Latino Access to Health Care: The Role of Insurance, Managed Care, and Institutional Barriers," an article written in 2001 featuring Marshall University's Dr. Alberto Coustasse, the United States provides the most expensive healthcare system meanwhile is the least cost effective healthcare system in the (developed) world (Carrillo 1). This statement alone is evidence to demonstrate the intimidation that is presented to not only those not natively from America, but as well to Americans themselves. The process of acquiring health care, whether someone seeks preventative, emergency, or long-term care, is an area that is applicable to any person. Disparities are infinitely-factorial, because the title of being "at a socio-economically disadvantage" first leads to members of minority communities "having less access to insurance, have lower-paying jobs, lower levels of education, work in jobs with higher risks of damaging health effects, or to even reside in areas with lower health-standards" (Betancourt 294). Ironically, this then increases their need for healthcare. The following statistic, included within Betancourt's research, states that in the United States Census Bureau in 2003, minorities are overrepresented among the rolls of the uninsured, with Latinos, for example, representing 13% of the U.S. population but 25% of those Americans are without health insurance" (Betancourt 294). Spanish speakers have a culture which is wide and diverse, but as one of the defining characteristics of the culture, is the dedication to tradition. Thus, coming from a native (Spanish-speaking) country into the unfamiliar systems of United States as a minority is the initial disadvantage that then leads a to a path of disparities. Additionally, the "Spanish-speaking" population that is referred to in this study is not one of specific origin. This

encompasses people of Spanish heritage from any of the numerous origins of a Spanish heritage. The word *Castellano* (Castilian) has, in the past, been used to refer to the Spanish language after having originated from the province of Spain, Castilla. The language has, since then, spread all over the world changing dialect, adapting culture, and varying customs. Although Spanish has many variations and pronunciations, there is a common thread and that remains at the root of the language and culture, unifying members of the Spanish-speaking ancestry—this is why someone from Spain will be able to understand someone from Mexico, but the accent may sound entirely different. This is similar to the way that Americans may understand British-English-speakers, but are able to recognize where they are from (or at least that the English is not the same that is spoken in the United States). Then to further dissect, English varies greatly even within the country with accents commonly known for originated from the "deep south" as well as "northern" accents. This applies to Spanish as well, where someone in Cuba may be able to understand someone from Argentina, there will be distinguishing characteristics that differentiate the two regions of origin.

An important aspect of this research, concerning perceptions of cultural factors, is the importance of understanding that in order to minimize disparities in health care, there must be a cultural flexibility to eliminate barriers causing the disparities (Nápoles-Springer 5). Just to make some distinctions, there is a significant difference between the terms "bilingual" and "bicultural." That difference between them is essentially the concept of "cultural competence". The area and study of "competence," although its issue has been demanding for a long time, is newly-defined and just recently studied with definitive boundaries and definition. The awareness that behind that language barrier that may be eliminated, there are layers of culture, customs, and traditions that further prevent that essential trust between a caregiver and patient, *confianza*, which

simply means trust. A "culturally competent" health care system has been defined as one that acknowledges and incorporates—at all levels—the importance of culture, "assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (Betancourt 294). Competence in general can be implemented as awareness. Regardless of the circumstances, raising awareness of the issue at hand is the beginning and the basis of bettering any problem.

There is no way to pinpoint the exact causes and effects of medical disparities in minorities. It is possible, however, to link distinct cause-and-effect trends. Minority populations, such those from Spanish-speaking backgrounds, are immediately at a disadvantage when they enter this country for reasons that pertain to those people simply not being accustomed to a new environment. Inevitably, this population of people is default to socio-economic disadvantages. From here, the disparities can be extrapolated. In the medical world, there is extensive evidence and data linking socio-economic disadvantages to a general disproportionate suffering from "cardiovascular disease, diabetes, asthma, and cancer among other conditions" (Betancourt 294). The prolonged duration of this problem has caused, by unintentional result, trends of habitual neglect of circumstances. There are many foundational causes of disparities, but many of them begin with the patient. When a patient, referred to in this manner as a member of a Spanish-speaking minority in this case, immigrates as a first-generation family member to the United States, certain trends are adopted inadvertently. The healthcare system is avoided; therefore, never learned or understood. This can be due to the patient's preferences, fears, language, values, or beliefs. This in turn, translates into the inability to self-recognize symptoms, inability to communicate symptoms, threshold for availability for care, inability to understand medications or implications, or even the

overall expectation of care (Betancourt 294). Then as natural progression occurs, the same sentiments of the healthcare system is continually passed down through generations, as well as shared throughout communities of minorities, allowing the disparities to maintain their negative impact.

Spanish language and culture, regardless of the origin or specific heritage, is deeply-rooted so far into tradition, some even dating back to the Incas, Aztecs, and even Mayans. Especially in Mexican culture, due to the profound importance of these historical backgrounds, the traditions are still being practiced to this day, one of which being the traditional medicine. These may include something called a *hierberías,* or herb shop. It is often an important health resource in the lives of certain Spanish-derived ethnicities, just as a pharmacy of Americans. "Hierberías offer a variety of dried medicinal plants, and there are often patent mixtures for the most common ailments. Many of these herbs form the basis for modern prescription medicines and over-the-counter remedies", where some may include *eucalipto* (eucalyptus, used for upper respiratory infections); *yerba buena* (peppermint, used for digestion); *acíbar* (aloe, used for burns and abrasions); and even *manzanilla* (chamomile, for issues of the stomach) (Kearon and DiLorenzo-Kearon 88). Folklore medicinal beliefs and practices stay relevant within these cultures. As an example, the transition from curing someone of an *empacho* (reasoned by these people to be a ball of food stuck to the inside of your stomach causing pain and cramps) by massaging the stomach and some spinal manipulation most likely by a loved one or the village "healer" is normal for them, whereas in the setting of an American hospital or doctor's office, can be immensely intimidating and probably avoided for the reason that they presume that the issue can be taken care of at home and by their own means (Kearon and DiLorenzo-Kearon 104). This also causes issues of self-evaluation, where the symptoms of stomach pains and

cramps can be assumed to be an empacho, whereas just as likely something much more severe and requires more treatment than a stomach massage and spinal manipulation. Similarly, Spanish-speaking natives originating from the Caribbean Islands have "strong beliefs in folk remedies or folk medicine for typical or common ailments where treatments may include herbs, teas, potions, poultices and other homemade remedies," where normally someone seeking a remedy would look to the woman of the house or family, usually elderly, for treatment (Kearon and DiLorenzo-Kearon 124). It is also noted that patients, having been cultivated from such a long line of this kind of culture, will probably continue treating themselves in this way after seeing a physician. They may even become skeptical of the medical practices or medications they have been given if results are not seen soon enough or in the ways that have been promised, only to return back to their traditional practices.

That being said, it is important to understand and educate ourselves in those specific aspects of the varying culture so that we are able to answer the question of "why" people think, act, and live the way they do in addition to "why" they refuse trips to the doctor or feel that it is unnecessary to learn about a proper healthcare system. It is often noted that Spanish is much more outwardly polite than English. For example, there is a verb conjugation specific for addressing someone formally, either singular or plural. In English, when someone is addressed as "you" in speaking, there have to be supplementary words to acknowledge formality such as "sir" or "ma'am." Without these, the use of polite manners and a mild tone of voice usually suffices. This would not be the case for Spanish. There is even an entire tense of a verb that is used for "softening requests" or "speaking diplomatically," in addition to many more ways to say "excuse me" due to the specific verb conjugations and specific attention to formalities (Kearon and DiLorenzo-Kearon 8). Seemingly trivial, this trait of the

Spanish language may explain a great deal as to why a native Spanish-speaker may feel weary of holding a conversation with a non-Spanish-speaker. The attribution of language itself undeniably shapes the way that we think. In the phrase “he broke the plate,” to English-speakers, the named person who broke the plate is at fault, accident or not. In Spanish, the language syntax doesn’t function in this way. When the equivalent of this phrase is spoken in Spanish, the focus is not on who broke the plate, but that the plate broke accidentally. Another example is if someone said, “I broke my arm.” If a Spanish-speaker were to hear this sentence, the significance that the sentence carries is that someone intentionally broke his own arm, whereas in Spanish it would be phrased “my arm accidentally broke,” with no importance as to who did it. Again, such a simple property of the language carries such weight of perception of the way that even events and perspectives are derived (Boroditsky).

In the articles "Limited English proficiency, primary language at home, and disparities in children's health care: how language barriers are measured matters" by Glenn Flores and co-investigators and “Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care” conducted by Joseph Betancourt, several approaches to defining disparities and their causes are proposed. The demand for cultural competence, not only in the healthcare setting, is known to have been relevant for some time. Only recently has this concept been acknowledged as a definitive area of study or research. Additionally, it is difficult to outline all boundaries in which research is being conducted unless it is within the context of a single study with a specific outcome or goal explicitly defined. To reiterate, this analysis acknowledges the general foundation that can be seen throughout the overall study of competence. Again, to reference the article by Flores, instead of inquiring which primary languages spoken at home correlated with which disparities

and further to investigate the specific effects of those disparities relative to the language, the study determined that by following a framework of English proficiency, or lack thereof, enabled the study to have the most clear results. Though this study encountered 12 languages in addition to English, the results showed that the primary language spoken at home (within this study) was Spanish, deriving over half of the homes surveyed. The second most-frequent was a combination of English and Spanish homes (Flores 420).

Additionally the research performed by Joseph Betancourt breaks down the approaches for acknowledging the problem and section strategies for implementing competence into these three categories: organizational, structural, and clinical competence interventions. Similarly, the foundation of this research was conducted, in addition to many other barriers, on the premises of English proficiency. Though, in contrast to the previously-mentioned article, English proficiency in this case was used to identify in what scenarios or levels of healthcare administration the enforcement of competence is not being utilized and then how that has impacted health outcomes. Where there was lack of sufficient quantitative data, observations of the structural levels at which disparities are occurring, allowed for more-specific investigations that were then able identify underlying issues such as the lack of diversity within the systems (health care administration, medical education, etc.). This is an additional factor contributing to the difficulty in overcoming these barriers. Additionally, within the survey interviews, there was one question in particular that held a certain significance for this analysis that asked the interviewees, from their perspectives, to suggest the best method of obtaining cultural competence. The interviews consisted of open-ended questions to refrain from obstructing any original ideas or thoughts. From that specific question, the most common response either entailed the idea of immersion within the

culture of interest, or education. It appears too simple, but that is essentially the idea of competence. This is exactly what is explained in the studies and journals cited as the modest indication of acknowledging deeper thinking and the consideration of others. Realization of these concepts allows the roots of medical disparities, or any other cultural or language obstruction, to be evaluated and furthermore eliminated from their origin.

It is commonly known how the population of America is diverse. Also, it is commonly known how diverse the population of the world is. America is fortunate to be the way that it is, so full of colors and people and ethnicities and religion and traditions and customs all so different from one another. Yet, the unfortunate truth is that the distribution of the opportunities that come with the "American Dream" are a bit patchy. This may include aspects of safety of residential areas, a job that provides not only an income but proper benefits, including access to healthcare or clean air. The blessings of diversity are still followed by the curse of disproportionate opportunity, and this is not necessarily intentional. Whenever there is something that separates people from one another, including differences in language, cultures, understandings, or even as simple as a preferences that don't coincide, misunderstanding and miscommunications are unavoidable. This is human nature and at the fault of no one. But what fingers can be pointed at is the lack of effort to minimize those differences with acquiring knowledge. And it just so happens that those misunderstandings and miscommunications are directly translating into higher frequencies of harmful diseases and ailments for minority populations and overall lower standards of health due to a lack of entire healthcare systems being culturally incompetent to some of the most prevalent minority populations in the United States. Within this analysis, several aspects specific to Spanish culture and language are acknowledged that may explain the thinking behind

the actions of avoidance or sentiments of intimidation that are defaulted to minority populations. The term “minority” immediately opens that door for inequality.

Therefore, by studying the multifaceted culture behind the language that is the initial barrier between caregivers and patients and dissecting the foreign culture to learn how they think, their reasoning, traditions, preferences, and beliefs, a common understanding can be reached. The entirety of this analysis is based of the concept of cultural competence. The idea is very simple, actually, exhibiting the mentality that all aspects of culture create human beings and the ways of life that create the diversity. Diversity encompasses different mindsets, forming the way that people think and believe and realizing that overcoming a language is not the endgame for learning about people. To study how to obtain such an understanding, conclusions about cultural aspects and strategies for applying cultural competence were made from literary analyses of similar studies as well as through personal survey interviews. What was found is that there are infinite ways to measure a study like this, there are infinite ways to become culturally competent, and even more aspects of culture that deserve to be learned. The most common, though, is the following: education. The continual accumulation of knowledge of another culture demolishes barriers among people. Not only knowing a language but acknowledging the history, traditions, ways of life, customs, or any of the characteristics that make that language and the people who and what they are—is cultural competence.

In reality, all of this is important and indisputably essential, yet, all it takes is a shift in mindset. The process of acquiring health care, whether someone seeks preventative or emergency or long-term care, is an area that is applicable to any person. Spanish culture is wide and diverse, meaning there is a lot to understand. By changing the way that the “outlying” culture or language is perceived, to understanding it as a

complimentary characteristic of what makes living amongst such widespread diversity making it the divinity that it is, opens up the possibility that the change in mindset could undoubtedly change the health status of an entire minority population.

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