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INTERCULTURAL HEALTH COMMUNICATION

Rethinking Culture in Health Communication

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Culture is an essential factor in shaping individuals' understanding and behaviors in healthcare settings. Traditionally, health communication has been heavily influenced by Western scholarship and has treated culture as an important caveat, noting that many of the findings may not be valid or applicable to individuals and organizations from non-Western cultures. How can culture be an important contextual factor yet function as a "caveat," an outlier that creates noise in observed patterns? More importantly, such an approach to culture in health communication also fails to account for the roles, functions, and impacts of culture in the West. This is reflected in the lack of systematic discussion and conceptualization about how culture, as a contextual factor, (a) serves as a resource and a product of individuals' health behaviors, (b) influences communities' responses in offering support for some while silencing suffering for others, and (c) shapes institutional structures and policies that reinforce disparities or minimize injustice. In other words, culture in the WEIRD-based literature (i.e., studies relying on participants who are overwhelming Western, Educated, and from Industrialized, Rich, and Democratic countries; Henrich et al., 2010) becomes invisible. If Western, modern, and/or industrialized societies are under the influence of culture, how can we theorize culture to explain our understanding and behaviors of health and illness—not just as a caveat or a contextual factor for non-Western people but for *all* people?

Conceptualizing Culture in Health Contexts

Scholars from different disciplines have different ways to think and talk about culture. Some see culture as a relatively fixed or stable set of beliefs, values, and behavior patterns, often demarcated by national or ethnic boundaries. Others see culture as a continual process of renewal and of integrating new information from external environments and indigenous experiences. In this chapter, I will review four of the primary ways culture has been conceptualized: (a) culture as group, (b) culture as speech community, (c) culture as worldview, and (d) culture as a living process. By conceptualizing social interactions as intercultural encounters, I will explore the new frontiers expanded by diverse and fluid approaches to conceptualizing culture in health communication and the transformed landscape of intercultural health communication.

Culture as Group

Conceptualizing culture as groups assumes that the group identified has unique characteristics common to all group members. The literature is dominated by studies that conceptualize intercultural

communication through social interactions between racial and/or ethnic groups. Individuals' gender or minority/at-risk status (e.g., LGBTQ+ populations and the homeless) can also be conceptualized as social groups, shaping individuals' experiences of health and illness.

Demographic Concordance

Some studies have suggested that demographic concordance between physicians and patients has a positive effect on provider-patient interactions and quality of care. For example, African American, Asian American, and Hispanic patients rated their physicians, their medical care, and overall satisfaction higher when they shared the same race with their physicians (LaVeist & Nuru-Jeter, 2002). Compared to racially discordant patients, patients in racially concordant provider-patient interactions were found to receive more information and to be more active in provider-patient communication (Gordon et al., 2006). Although only 10% of patients in a survey reported a preference for a physician of their own race, in practice, minority patients appear to actively seek care from a racially concordant physician: A quarter of Blacks and Hispanics and nearly one-half of Asians reported sharing the same race/ethnicity with their physicians (Saha et al., 2003). Gender concordance between patients and their providers also has a positive impact on cancer screening (Malhotra et al., 2017). A review of the effect of gender concordance in medical encounters found that the effects were real but typically "small in magnitude" (Street, 2002, p. 205).

Despite the positive effects of demographic concordance between patients and physicians, researchers have also found that patient-centered communication style has a significant effect in mitigating racial and cultural differences between providers and patients: "all immigrant racial/ethnic groups preferred providers who listened, spent enough time, and explained things well" (Chu et al., 2019, p. 5). Saha et al. (2003) found that patient health literacy positively contributed to the quality of provider-patient interaction, patient satisfaction, and use of health services; in contrast, "patient-physician race concordance was not associated with better patient-physician interactions or with greater physician cultural sensitivity" (p. 1716). However, a review of a large-scale national survey between 2003 and 2010 identified a disconcerting finding: Hispanic patients seen by Hispanic providers received breast and colorectal cancer screening at significantly lower rates than Hispanic patients seen by non-Hispanic providers (Malhotra et al., 2017). Recognizing that influences of gender are situated in sociocultural and interpersonal contexts, Street (2002) argued, "gender may influence provider-patient interaction to the extent that it can be linked to the interactants' goals, skills, perceptions, emotions, and the way the participants adapt to their partner's communication" (p. 201). In short, the effect of demographic concordance can be mitigated by various factors, including participants' communicative skills and goals.

Providers as Cultural Beings

Historically, the medical literature presumes that clinicians are neutral professionals who are trained to follow guidelines based on objective, evidence-based biomedicine and are unaffected by their own personal variables and prejudice. The conceptualization of cross-cultural medical encounters generally centers on patients as the cultural Other. However, *one in four* physicians in the United States and Canada are international medical graduates (IMG; i.e., physicians who received their medical school education outside of the United States or Canada; Ranasinghe, 2015). The leading source countries for IMGs include India, the Philippines, Pakistan, and Mexico. This does not include U.S. citizens who received their medical education abroad. More than 20 million Americans live in areas where at least half of the physicians are IMGs (American Immigration Council, 2018).

The literature suggests that a physician's race and ethnicity can contribute to different clinical practices and communicative behaviors. Physicians' practices regarding end-of-life care mirror the

preferences of the ethnic or racial group with which they identify (Mebane et al., 1999). Asian American primary care residents are least likely to address cervical cancer, whereas African American residents are most likely to do so (Arredondo et al., 2003). A national survey of primary care physicians found that physicians' race/ethnicity contributed to significant variation in treatment recommendations for depression, anxiety, and medically unexplained symptoms (Lawrence et al., 2015).

Several studies also have identified gender as a factor impacting physicians' communicative styles. A study of Japanese primary care physicians found that female physicians substantially modified their communication behaviors based on patient gender, whereas male physicians did not (Noro et al., 2018). A meta-analysis found that compared to male physicians, female physicians adopt more patient-centered communication, including more partnership behaviors, psychosocial counseling, and emotion-focused talk (Roter et al., 2002). Another meta-analysis found that patients interact with male and female physicians differently (Hall & Roter, 2002). Specifically, patients speak more to female physicians (e.g., disclosing more biomedical and psychosocial information), are more assertive with female physicians, and are more likely to interrupt them.

Culture as Speech Community

Gumperz (1968/2009) argued that a speech community is defined by "the speech varieties employed within [the community] because they are related to a set of social norms" (p. 67). In other words, conceptualizing culture as speech communities means that a cultural group can be classified according to their communicative practices: "their usage, their origins, and the relationship between speech and social action that they reflect" (Gumperz, 1968/2009, p. 67).

Language Barriers

When conceptualizing cultural differences as variations in speech communities, the literature has traditionally relied on provider-patient language discordance (i.e., providers and patients do not share the same language) to illustrate the challenges to cross-cultural care. Compared to the general population, language-discordant patients are at risk of low health literacy. For example, a U.S. survey found that whereas 44.9% patients with limited English proficiency reported low health literacy, only 13.8% of English speakers did so (Sentell & Braun, 2012). Sentell and Braun (2012) found that the impacts of language barriers supersede the impacts of low health literacy for poor health outcomes. In an extensive review, Terui (2017) explained that language discordance can contribute to patients' experience of health disparities through direct and indirect pathways that impact their *access* to care, *process* of provider-patient interactions, and *outcomes* of healthcare services. For example, language discordance may motivate patients to delay help/care-seeking behaviors (Karliner et al., 2012). Patients may also feel less satisfied with the quality of their care and interactions with providers (Harmsen et al., 2008). They are also more likely to experience problematic outcomes, such as having unplanned emergency department (ED) visits within 72 hours after being discharged from the ED (Ngai et al., 2016).

Many medical schools now require training in cultural competence to ensure that providers have sufficient cultural and linguistic proficiency (Vela et al., 2015). With only ten weeks of medical Spanish, providers were able to reduce their use of interpreters, but data indicated an increase in patient satisfaction (Mazor et al., 2002). Such training, however, tends to adopt a biomedical perspective, emphasize physicians' informational needs, and focus on information gathering for clinical decision-making. When there is poor mutual understanding, language-discordant patients are likely to be silenced by providers' increased control over the content and process of communication (Meeuwesen et al., 2007). Compared to providers in language-concordant interactions, providers in language-discordant interactions are likely to spend more time directly advising the patients and

less time engaging them in the decision-making process (Butow et al., 2011). As a result, although providers may feel satisfied because their informational needs have been met, they may fail to address their patients' informational and emotional needs. Diamond and Jacobs (2010) concluded, "teaching 'Medical Spanish' or related courses may actually contribute to healthcare disparities if clinicians begin using these non-English language skills inappropriately with patients" (p. s189). Although many studies have noted that language-concordant care results in higher ratings for patient satisfaction, patient compliance, and perceived quality of care, such effects may be a function of rapport rather than an indicator of quality care (Hsieh, 2016).

Interpreters have traditionally been viewed as the solution for language and cultural barriers in healthcare settings. A comprehensive review by Diamond et al. (2019) found that when patients with limited English proficiency were provided with interpreters, including professional and untrained interpreters, they were likely to have better health outcomes in patient-reported measures (e.g., satisfaction and understanding of diagnosis) and objective health measures (e.g., glycemic control and blood pressure). In the model of bilingual health communication, Hsieh (2016) proposed that interpreter-mediated medical encounters are goal-oriented communicative activities, requiring providers, patients, and interpreters to actively negotiate their task, identity, and relational goals to achieve quality and equality of care. To develop mutually agreeable and effective strategies to achieve their collaborative goal of optimal care, providers, patients, and interpreters co-evolve with one another: They learn to recognize each other's strengths and weaknesses, negotiate their individual perspectives, and adapt to others' needs. For example, Guntzviller et al. (2017) found that when bilingual children serve as interpreters for their Spanish-speaking parents, they adopt a *team-effort model*, working together as a team to utilize both parties' strengths, compensate for partner limitations, and achieve mutually desirable outcomes. Bilingual children actively intervened in order to enhance their parents' self-efficacy, while their parents assisted in enhancing their children's health literacy. When their children believed that the parent-child dyads share the task and responsibility of interpreting, Spanish-speaking mothers reported less frequent depressive symptoms even when they were ambivalent about whether the interpreting activity was a shared task/responsibility (Kam et al., 2017). In fact, Spanish-speaking mothers' support for their children's role as a family interpreter is a protective factor against these low-income, bilingual adolescents' depression (Guntzviller & Wang, 2019). The parents and children thrived *together* when they coordinated and collaborated with one another to achieve mutually shared goals.

Finally, experiences of language barriers are situated in sociocultural contexts. Hsieh (2018) argued that (a) language discordance is a social phenomenon that may entail diverging meanings and experiences in different countries, (b) patients in language-discordant interactions may not share similar experiences even if they are in the same country, and (c) disparities in language concordance may be confounded with other disparities and cultural particulars that are unique to a host society. For example, in the United States, discordant language healthcare generally means that the patient has limited English proficiency (rather than the provider using a second language); in contrast, in Japan, discordant language healthcare may mean that both patients and their physicians communicate in their second language (e.g., English; Terui, 2017). In addition, depending on patients' ethnicity and/or country of origin, patients in language-discordant interactions may experience preferential treatment (e.g., an English-speaking, white patient from France) or potential discrimination (e.g., a Bantu-speaking, Black patient from Zimbabwe) in a host society even though both would be participating in language-discordant communication.

Preferences for Information Management

A comprehensive review found that physicians from Anglo-Saxon cultures mostly believed that patients should be informed about their advanced life-limiting illnesses; in contrast, most physicians

from non-Anglo-Saxon countries were less likely to explicitly offer a poor prognosis (Hancock et al., 2007). Parsons et al. (2007) identified significant cultural differences: Whereas 65% of U.S. physicians reported that they always tell children about their cancer diagnoses, only 9.5% of Japanese physicians reported the same. In fact, less than 1% of U.S. physicians reported rarely or never telling children about their cancer diagnoses; in contrast, 34.5% of Japanese physicians reported doing so. When asked to find a way to balance the family's desire to shield the patient from bad news and telling the truth to the dying patient, an American physician responded, "When I was in medical school, it was driven home to us that autonomy was the lynchpin concept. You're destroying my moral compass" (Solomon, 1997, p. 90). For the physician, information disclosure becomes not just about patient autonomy but a claim of the physicians' moral character.

In Spain, Italy, Greece, and many other collective cultures (e.g., Saudi Arabia, Egypt, Japan, and China), physicians often disclose a poor prognosis to family members before informing the patient, following the family's requests for information management rather than disclosing bad news directly to the patient (Mystakidou et al., 2004). Even when patients wish to know about their diagnosis, cultural backgrounds may lead patients to prefer obtaining only basic (rather than extensive) information, receiving euphemistic messages (to soften the blow), hearing the news from specific persons (e.g., physician, nurse, or family members), and maintaining hope (Mystakidou et al., 2004). In other words, the information management of illness disclosure is dependent on the cultural considerations of appropriate place, time, process (e.g., who should disclose), and purpose (e.g., maintaining hope or respecting patient autonomy).

It is important to note that these communicative patterns are culturally situated and are driven by system norms, reflecting corresponding beliefs, ethics, and values. It is also important to remember that parents and physicians in the United States do not always subscribe to such disclosure practices. Prior to 1960, both parents and physicians in the United States believed that children should not be informed about their cancer diagnoses (Chesler et al., 1986). The shift in U.S. physicians' and parents' attitudes further highlights the socially constructed nature of provider-patient interactions. In other words, what appears to be a universal value within Western biomedicine (e.g., patients' right to information) is, in fact, a recently emerged social construct of the U.S. culture.

Speech Community-Based Normative Beliefs

Language barriers and cultural differences are some of the most observable challenges in cross-cultural care. However, health disparities due to differences in speech communities need not be about people who speak different languages. For example, gender stereotypes and gender role expectations about how men and women communicate differently can lead to disparities in the diagnosis and treatment of illness that compromise women's quality of care.

For example, even though women are more likely than men to die from a heart attack, physicians are less likely to attribute symptoms to possible cardiac causes when female patients report stressful life events than when male patients report stressful life events. In other words, when patients reported stress, only female (but not male) patients' cardiac symptoms were misinterpreted or discounted, shifting from a diagnosis of coronary heart disease to a psychogenic disorder (Chiaromonte & Friend, 2006). As men's report of pain is situated in their gender stereotype (e.g., "stoic men" and "brave men"), men's report of their pain is taken seriously and more likely to result in additional lab tests (Samulowitz et al., 2018). When men appear frustrated or angry about their pain management, they must be in serious pain; if they appear stoic, their complaint is equally real because that's just the way they talk (Dusenbery, 2018). In contrast, women's reports of their pain are interpreted through gender stereotypes and social norms (e.g., "emotional" or "hysterical" women who are crybabies). As a result, if they appear emotional (e.g., crying or expressing anger/frustration), they are just being feminine and are not perceived to be experiencing a high level of pain; but if they calmly discuss

their pain in an objective manner, they must not be experiencing that much pain after all (Dusenbery, 2018; Samulowitz et al., 2018). The gender bias is so pervasive and normative that adults are more likely to believe that a child suffered a higher level of pain when the child was described as a boy instead of a girl—despite identical behaviors and circumstances (Earp et al., 2019).

Because women's reports of their illness are more likely to be attributed to psychological problems and providers do not perceive their report of symptoms as reliable as men's, women also face disparities in diagnosis and treatment. For example, Lyratzopoulos et al. (2013) found that being a woman significantly doubled the likelihood of requiring three or more pre-referral visits with their primary physicians before being diagnosed with bladder cancer by a specialist. For renal cancer, women's odds of requiring three or more pre-referral visits is nearly double that of men's as well. Compared to men, women experience delayed diagnosis (i.e., longer duration from the first presentation of symptoms to the official diagnosis) in a wide range of illnesses (Dusenbery, 2018).

Traditionally, research on cross-cultural care often centers on the experiences of health disparities as a result of the unique characteristics and conditions of specific groups. However, this line of research demonstrates that addressing health disparities is not limited to fixing what is "wrong" with the specific groups (e.g., low health literacy or limited English proficiency). Rather, society's normative beliefs can result in bias and discrimination that contribute to individuals' unnecessary and avoidable suffering.

Culture as Worldview

Worldviews are more than speech practices or social actions. Worldviews are the "fundamental cognitive, affective, and evaluative presuppositions a group of people makes about the nature of things, and which they use to order their lives"; in other words, worldviews are "what people in a community take as given realities, the maps they have of reality that they use for living" (Hiebert, 2008, p. 15). Worldviews allow cultural participants to orient to their social worlds and to comprehend events taking place in their realities (Note et al., 2008). That is, worldviews function as a compass, creating boundaries of what is right, true, real, ethical, and moral. These guiding posts function as beacons, allowing cultural participants to make sense of their experiences in their everyday life.

Medicine as Culture

Some researchers have argued that provider-patient communication should be considered intercultural encounters because providers as medical experts and patients as laypersons do not share the same worldviews (Ruben, 2016). In the theory of communicative action, Habermas (1981/1985) proposed that individuals' understandings of the world are not grounded in instrumental or objectivistic terms but are structured through communicative acts. By highlighting the tension between human communications in the *lifeworld* and the *system*, Habermas noted that the two communication modalities are motivated by different types of rationality. For Habermas, communication in the lifeworld is communicative actions that are sensitive to contexts, orient to mutual understanding, and result in coordinated actions through consensus. The system, in contrast, imposes a calculated, impersonal, purposeful rationality that is devoid of sentimentality or morality. The world of the system involves a purposeful, instrumental understanding of the social world.

Mishler (1984) drew on Habermas's concepts and applied them to the field of medicine, proposing the concepts of the *voice of the lifeworld* and the *voice of medicine*. The voice of the lifeworld recognizes how a patient's experiences of health and illness are always situated in their everyday life, encompassing their unique perspectives and understandings (Lo & Bahar, 2013). Their lifeworld is infused with their cultural beliefs, social experiences, and folk ideologies. In contrast, the voice of medicine is oriented to and framed by the biomedical framework. The voice of medicine involves a

technical understanding of health and illness that defines and controls the scope of a provider's work. Physicians actively frame and reframe a patient's illness narratives and subjective experiences through the voice of medicine.

Physicians' training often socializes them to become the enforcer of the system, speaking as the voice of medicine. For example, when medical students present their cases during the morning reports, they are socialized to display a professional identity. When students deviate from the biomedical framework to include the voice of the lifeworld, faculty members often respond by reinforcing the voice of medicine, telling students to "consider the diagnosis purely from technical evidence rather than from information contributed by the patient" (Apker & Eggly, 2004, p. 422). Medical specialists in certain areas have basically no patient contacts (e.g., radiology and pathology) or only brief patient contact (e.g., surgery, anesthesiology, and emergency medicine). In other words, the patient's lifeworld may have little impact on these medical specialists' practice. Fadiman (1997) observed an emergency care physician who worked on a patient with life-threatening conditions for more than 12 hours straight without realizing that the patient was a girl. Fadiman concluded, "Here was American medicine at its worst and its best: the patient was reduced from a girl to an analyzable collection of symptoms, and the physician, thereby able to husband his energies, succeeded in keeping her alive" (p. 147).

Religion as Worldview

Although normally not thought of as intercultural health communication, religion and spirituality can exert significant influences on individuals' health beliefs and health behaviors, impacting the process and quality of care (Pitaloka & Hsieh, 2015). Tensions and conflicts can arise when people's religious worldviews collide, resulting in diverging process and quality of care.

Conscientious refusal is defined by healthcare providers' refusal to provide medical services or goods, including medication and information, due to their religious, moral, philosophical, or ethical beliefs. In end-of-life care, physicians who report being nonreligious "were more likely than others to report having given continuous deep sedation until death, having taken decisions they expected or partly intended to end life, and to have discussed these decisions with patients judged to have the capacity to participate in discussions" (Seale, 2010, p. 677). In contrast, compared to physicians with low religiosity, highly religious physicians are 4.2 times more likely to object to physician-assisted suicide and 2.6 times more likely to object to terminal sedation (Curlin et al., 2008). Compared to physicians of other religions, Catholic physicians are 2.8 times more likely to object to withdrawing life support, which may reflect the Catholic doctrine of prohibiting actions intended to shorten life (Curlin et al., 2008). Religious intensity is the strongest predictor for whether a physician believes that they are never obligated to do what they personally believe to be wrong, with Catholic and Orthodox physicians most likely to hold such beliefs (Lawrence & Curlin, 2009). The most religious physicians were more likely than the least religious physicians to support refusing to accommodate a patient's request (Brauer et al., 2016). In fact, physicians' religious intensity was a stronger predictor for treatment recommendations for advanced cancer care than patient disposition (e.g., age and preferences; Frush et al., 2018).

Religion as a worldview can prevail at the institutional and even national levels, impacting the general public's access to and process of care. Religious freedom is of such importance to the identity and culture of the United States that it is incorporated into its constitution. The desire to protect individuals' religious freedom is so intense that 44 states and Washington D.C. also instituted religious exemptions to the mandatory vaccination requirements for children despite the potential to jeopardize the health of local communities (National Conference of State Legislatures, 2021; the exceptions are California, Connecticut, Maine, Mississippi, New York, and West Virginia). As religious and philosophical (i.e., nonmedical) exemptions have drastically increased since the early 2000s,

researchers have found an increase in outbreaks of preventable diseases in areas with high exemption rates (Bradford & Mandich, 2015). More recently, employers have relied on religious exemptions to deny employees certain health insurance coverage (e.g., birth control; Gasper, 2015). In July 2020, the Trump administration proposed to allow homeless shelters to turn away transgender people from single-sex facilities to better accommodate the “religious beliefs of shelter providers” (Cameron, 2020). A study found that whereas none of the 30 non-Catholic hospitals surveyed prohibited staff from discussing emergency contraception with rape victims, 12 of the 28 Catholic hospitals in the study had such a policy and seven of the Catholic hospitals also prohibited physicians from prescribing emergency contraception even if patients asked for it (Smugar & Spina, 2000). Patients may not realize they received limited care due to the hospitals’ religious affiliation (Takahashi et al., 2019).

Hostile Lived Environments

Finally, individuals’ lived experiences may lead them to hold specific worldviews, shaping their normative beliefs and health behaviors. Minority stress theory proposes that members of minority groups experience health disparities because they are subject to perpetual and/or unique stressors in everyday life as a result of stigma, prejudice, and discrimination in the larger society (Meyer, 2003). Miller et al. (2007) explained, “From early in childhood to late in adulthood, chronic stress is accompanied by worse health, and the magnitude of this effect is substantial: In some cases, exposure to chronic stress triples or quadruples the chances of an adverse medical outcome” (p. 25). Repeated exposure to and witnessing of aggressive policing that results in fatal injuries of Black men and the injustice of the legal system can trigger traumatic reactions for many Black people, with cumulative, collective effects that can be passed across generations (Bryant-Davis et al., 2017). Such experiences lead minorities to hold unique worldviews about their lived realities that contribute to their health disparities.

Relatedly, medical mistrust (i.e., distrust of medical personnel and organizations) is a known contributor to health disparities, resulting in reduced use of preventive care, poor treatment adherence, and lower patient satisfaction (Williamson & Bigman, 2018). In a national survey, researchers found that African Americans, Hispanics, and Asians are more likely than whites to perceive that (a) they would receive better medical care if they belonged to a different race/ethnic group and (b) medical staff judges them unfairly or treats them with disrespect based on race/ethnicity and how well they speak English (Johnson et al., 2004). Minorities’ distrust of government and healthcare providers not only reflects their marginalized status in society but also often reflects the chronic struggle and tumultuous histories they share with the dominant groups (e.g., Tuskegee Syphilis Study during 1932–1972 and forced sterilization laws from the early 1900s to 1980s in the United States; Hsieh & Kramer, 2021).

In contrast to whites’ expectations of the presumed trustworthiness of a governmental health campaign or healthcare providers, minorities and immigrants have *learned* from past experiences that health interventions and government-sanctioned medical projects may pose serious threats to their interests and well-being. For the victims from these minority and/or marginalized populations, their surviving relatives, and even the community at large, these events are not simply forgotten and forgiven when a president apologizes or court settlements are reached. Schembri and Ghaddar (2018) explained,

Hispanic consumers are highly dependent on trust relationships with friends and family, with a strong familial network interwoven throughout the community. Hispanic professionals within the Hispanic community are trusted professionals and especially so with many local professionals being friends and family.

(p. 150)

To a certain degree, the uneasy histories of minority groups' experiences with healthcare authorities and the government help explain their preferences for different sources of information for health decision-making.

Culture as a Living Process

Increasingly, researchers have recognized that culture is neither a static nor a fixed "thing" attached to a specific group of people. Rather, culture is a living process, entailing varied meanings and perspectives that are situated in contexts and co-evolve with the larger communities. As such, cultures and cultural perspectives are constantly being performed, negotiated, contested, and reconciled through the dynamic interactions and pan-evolutions—changes in one aspect/element/member can lead to changes in all others that are connected in the system.

Informed Consent

An example of culture as a living process is informed consent. Informed consent is an essential element in Western medicine. By operationalizing informed consent as individuals' exercise of patient autonomy and self-determinism, Western medicine has embedded individualism in its vision of best practices (Hsieh & Kramer, 2021). The practice of informed consent has become increasingly rigid as it embodies the philosophy of medical ethics, practice guidelines of healthcare delivery, and legal actions of malpractice claims (Maclean, 2009). Nevertheless, informed consent as a cultural practice can be exploited, contested, and resisted.

For example, informed consent can be exploited in a way that reinforces medical paternalism and creates a direct threat to patient autonomy. A provider may purposefully increase disclosure about surgical risks to manipulate a patient's decision-making (Hsieh et al., 2016). Similarly, the recent rise in states' regulations on provider disclosure for patients seeking abortions is couched under the concept of informed consent. For example, South Dakota now requires physicians to state that abortion will "terminate the life of a whole, separate, unique, living human being" (S.D. Codified Laws, 2019). Oklahoma law prohibits a medical provider from performing an abortion unless he or she first performs an ultrasound, "display[ing] the ultrasound images so that the pregnant woman may view them," and provides a verbal description thereof (Okla. Stat. tit. 63, 2019). The Pennsylvania Abortion Control Act (1982/1989) requires a physician to obtain informed consent at least 24 hours prior to performing an abortion. In addition to informing the patient about "the nature of the procedure, the health risks of the abortion and of childbirth, and the 'probable gestational age of the unborn child,'" the physician must also disclose

the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion.

(Planned Parenthood of Southeastern Pennsylvania v. Casey, 1992, p. 881)

Although these compelled disclosure statutes claim their legitimacy through the process of informed consent, many researchers, providers, and legal professionals have raised concerns about the coercive nature of the disclosure. In his concurring opinion, Supreme Court Justice Blackmun analogized such requirements to compelling "a visual preview of an operation to remove an appendix," which he argued "plays no part in a physician's securing informed consent to an appendectomy" and "does not constructively inform" medical decision-making (*Planned Parenthood of Southeastern Pennsylvania v. Casey, 1992, p. 937*).

In response, providers may develop creative strategies to resist organizational policies regarding information disclosure. As discussed earlier, due to the cultural preference for (or deference to) religious exemptions in the United States, some Catholic hospitals circumvent the practice of informed consent by explicitly prohibiting physicians from discussing or prescribing emergency contraception for rape victims (Smugar & Spina, 2000). However, in these hospitals, physicians “tell victims that they have a policy prohibiting discussion of emergency contraception,” refer the victims to another provider where the information would be provided, invite rape counselors to the emergency department to provide such information, or just discuss the information despite hospital policy (Smugar & Spina, 2000, p. 1373). From this perspective, healthcare providers actively interpret and reconcile the tensions between different cultural perspectives (i.e., their professional responsibility as a healthcare provider, their personal beliefs regarding patient autonomy, and the institutional policy of prohibiting certain disclosure) through strategic actions.

Cultural Fusion and Dialogic Space

Kramer’s (2013) theory of dimensional accrual and dissociation argues that as individuals encounter different cultures, they accumulate diverse repertoires, allowing them to create innovative blends of cultural perspectives—an *integral fusion* worldview. Hsieh and Kramer (2021) argued that an integral fusion approach is a commitment to maintaining a dialogic space that protects, promotes, negotiates, and reconciles different ideas and perspectives. A dialogic space is where people with different perspectives and interests engage with one another—with *the goal to understand the Other* and a *willingness to change*. Essential to the process is the openness to hear, and be influenced by, the Other—to risk one’s hermeneutic horizon so that we may evolve together—emotionally, rhetorically, and cognitively (Kramer, 2000). Using the LGBTQ+ movement as an example, Hsieh and Kramer explored how LGBTQ+ groups do not passively accept stigmatizing labels but actively redefine in-group and out-group boundaries that challenge the existing framework imposed by the larger society. Rather than focusing on their stigmatized status, the LGBTQ+ community focused on efforts to facilitate the *pan-evolution* of the larger society. By embracing opportunities for cultural fusion and securing allies, LGBTQ+ groups secured equal rights for themselves (*Obergefell v. Hodges*, 2015), lent voices to others (e.g., Black Lives Matter), and transformed the larger community to support and even celebrate their uniqueness (e.g., Pride Month and Pride Parades).

From this perspective, an integral fusion approach is consistent with the concept of justice as fairness proposed by Rawls (2001). Reflecting on the process through which a society with different cultural groups and values can create and maintain sustainable justice from one generation to the next, Rawls argued that when community members can believe that institutional structures and social practices are just and fair because the agreed-upon principles are established with their voices incorporated, they would be ready and willing to do their part to follow those arrangements if they can reasonably expect others to do the same.

Similarly, Dutta (2008) proposed the culture-centered approach (CCA) to address health disparities in marginalized populations. Members of these marginalized groups are more likely to belong to different speech communities and experience hostile lived environments than are members of dominant groups. CCA is a commitment to listen to and include marginalized populations’ voices while critically and reflexively interrogating one’s biases and presumptions. CCA has been widely applied in community-based interventions (see Sastry et al., 2019). CCA invites members of marginalized communities, practitioners, and the larger society to engage in dialogues that challenge existing social structure and address historically situated social injustice. Dialogic spaces are necessary for *all* members to collaborate and co-create structures and knowledge of their shared communities. In other words, CCA “seeks to build dialogic spaces in subaltern communities to interrogate, theorize,

and formulate participatory communication in locally meaningful and contextually-situated ways, putting forth subaltern theories of health and wellbeing” (Dutta, 2018, p. 240). Because structural stigma and structural discrimination are foundational to marginalized populations’ experiences of injustice and disparities, meaningful and effective solutions can only emerge when marginalized populations’ voices are not only heard but also integrated into the structures and cultural orientations of the larger society.

Future Research Directions

We can only recognize our own cultural perspectives and limitations when we encounter differences. When we recognize the diverse and fluid approaches to conceptualizing culture in health communication, we can develop a deeper understanding of not only the Other but also ourselves. The field of intercultural health communication is transforming and expanding in the following ways.

First, we need to look beyond a group-based approach to conceptualize cultures. Researchers have cautioned that the different approaches to conceptualize culture and categorize groups can create blind spots in our ability to identify problems and develop solutions (Epstein, 2007). When interventions are designed for specific population-based labels, we may overlook populations that are not named. For example, by focusing on racial/ethnic Other, we can inadvertently fuel racism while silencing the suffering of the poor white Americans (Kawachi et al., 2005). Similarly, by highlighting specific characteristics, traits, or behaviors as risk factors, we may inadvertently pathologize these variables and overlook the underlying sociocultural issues that interact with and even fuel the disparities. For example, by viewing gender as a risk factor without recognizing our normative beliefs and cultural bias about gender differences in speech, we will continue to fuel women’s experiences of health disparities in pain management, diagnosis, and treatment.

Second, we need to recognize that culture is not just about differences in patterned behaviors. Rather, health behaviors and normative beliefs are situated in value systems imposing moral structures on its cultural participants. The actions of Catholic physicians whose religious intensity overshadows their patients’ treatment preferences or the Catholic hospitals that prohibit physicians from discussing or prescribing emergency contraception even if patients ask for it cannot be truly understood unless we can recognize (a) the importance of religious beliefs in shaping their moral compass for healthcare services and (b) the prominent role of religious freedom in shaping the U.S. healthcare and legal systems. Rather than attributing low health literacy to marginalized populations’ distrust of government and health authorities, we need to appreciate the role of historical and generational trauma of injustice in shaping their health behaviors. What appears as risky or uneducated (e.g., smoking and drug use) can be valuable resources to perform identities and relationships for the marginalized as they build resilience and survive in a hostile lived environment (Factor et al., 2011). We must not only understand but also appreciate how such health behaviors and normative beliefs are meaningful and valuable to the cultural Other. As we engage in dialogues with the Other, the goal is not to force conformity or assimilation. Dialogic spaces represent a commitment to collaborate and co-evolve with the Other—a willingness to change and to develop a fair and just system based on reasonable consensus of all parties involved.

Finally, intercultural health communication should not be limited to identifying, understanding, and addressing differences and disparities of the cultural Other. Rather, as we learn more about the Other *and* ourselves, we should aim to build infrastructures and social policies that are capable of ensuring sustainable justice. We need to be vigilant against exploitations and manipulations of our cultural practices that no longer serve the underlying cultural values we embrace. Recognizing how the cultural values of some may impose unfair burdens on others, we have moral obligations to seek solutions and reconciliations so that *all* people in our communities are free and equal. Equity and justice are public health issues. Without addressing structural injustice in our systems and institutions,

we will continue to view the cultural Other as deviants and ills of our society—when the truth is that the suffering and disparities of vulnerable populations are the symptoms of an ill society that has failed to maintain a just and fair system for all.

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